

EXAMINING THE IMPACT OF STATE MANDATES ON EMPLOYER PROVIDED HEALTH INSURANCE

HEARING

BEFORE THE
SUBCOMMITTEE ON EMPLOYER-EMPLOYEE
RELATIONS

OF THE

COMMITTEE ON EDUCATION
AND THE WORKFORCE
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED NINTH CONGRESS

SECOND SESSION

May 4, 2006

Serial No. 109-40

Printed for the use of the Committee on Education and the Workforce



Available via the World Wide Web: <http://www.access.gpo.gov/congress/house>
or
Committee address: <http://edworkforce.house.gov>

U.S. GOVERNMENT PRINTING OFFICE

27-984 PDF

WASHINGTON : 2006

For sale by the Superintendent of Documents, U.S. Government Printing Office
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**EXAMINING THE IMPACT OF
STATE MANDATES ON EMPLOYER
PROVIDED HEALTH INSURANCE**

Thursday, May 4, 2006

U.S. House of Representatives

Subcommittee on Employer-Employee Relations

Committee on Education and the Workforce

Washington, DC

The subcommittee met, pursuant to call, at 10:34 a.m., in room 2175, Rayburn House Office Building, Hon. Sam Johnson [chairman of the subcommittee] presiding.

Present: Representatives Johnson, Kline, McKeon, Platts, Tiberi, Wilson, Musgrave, Foxx, Kildee, Payne, McCarthy, Tierney, McCollum and Grijalva.

Staff Present: Robert Borden, General Counsel; Byron Campbell, Legislative Assistant; Steve Forde, Communications Director; Aron Griffin, Professional Staff Member; Jessica Gross, Legislative Assistant; Richard Hoar, Professional Staff Member; Kimberly Ketchel, Deputy Press Secretary; Jim Paretto, Workforce Policy counsel; Steve Perrotta, Professional Staff Member; Molly McLaughlin Salmi, Deputy Director of Workforce Policy; Deborah L. Emerson Samantar, Committee Clerk/Intern Coordinator; Jody Calemine, Minority Labor Counsel; Michele Evermore, Minority Legislative Associate/Labor; Tylease Fitzgerald, Minority Legislative Assistant/Labor; Tom Kiley, Minority Communications Director; Rachel Racusen, Minority Press Assistant; and Michele Varnhagen, Minority Senior Labor and Benefits Counsel.

Chairman JOHNSON. Good morning, everyone. A quorum being present, the Subcommittee on Employer-Employee Relations of the Committee on Education and the Workforce will come to order. We are holding this hearing today to hear testimony on examining the impact of State mandates on employer-provided health insurance. Under committee rule 12(b), opening statements are limited to the chairman, the ranking minority member of the subcommittee. Therefore, if other members have statements, they will be included in the hearing record.

With that, I ask unanimous consent for the hearing record to remain open 14 days to allow member statements and other extraneous material referenced during the hearing to be submitted in the official hearing record. Hearing no objection, so ordered.

Good morning, again. Let me extend a warm welcome to all of you, to the ranking member, Mr. Andrews, who isn't here, and my other colleagues who are here.

Most folks know I have a devout respect for democracy. Some of the cornerstones of democracy include freedom and free enterprise. Another hallmark of democracy is empowering States and cities and counties to be the laboratories of ideas, and as local areas experiment, the best ideas always seem to rise to the top.

Today I want to hear what local areas are doing to find health insurance solutions. Are they increasing the insured? Are they protecting patients? Are the costs rising or declining? We can use these test cases, if you will, to see what works and what doesn't. In Congress, we have a civic obligation to make sure that the proposals developing in the States don't override Federal law. That is especially true when it comes to health insurance because, one, peoples' lives are on the line; two, the laws that govern many health insurance plans are protected by Federal law called ERISA.

As you know, the vast majority of Americans with health insurance have their coverage through an employer. Let's be clear, employer-provided health insurance is a benefit to the employee. It is not mandatory. Governments that value freedom and free enterprise don't tell businesses how to operate. If States are tinkering with ERISA, we must make sure that the results are fair and have no unintended consequences, or, worse, giant problems in the future.

Close to Capitol Hill, we all watched the State of Maryland chart a new course. In Maryland, some believe that employers must be forced not only to provide health coverage to their employees but to provide a specific set or level of benefits.

For example, a much discussed law that recently passed in Maryland seeks to penalize companies—well, at this point, only a single company—that do not provide what politicians deem adequate health insurance for employees. In short, the folks in the State Capitol of Maryland are legislating what one company must do for its employees. In my mind, mandating certain health benefits on one company from a State Capitol, that is not freedom and that is not free enterprise. I am very concerned about what that would mean in the future for people, for States and for companies.

There is such a thing as good government. Overreaching government, it is not. Listen, as a former State legislator in Texas, I am happy to see these State legislatures working on solutions for the uninsured. However, I am deeply alarmed that some of these proposals override the good intentions of ERISA, the Federal law that governs employer benefits.

I am also concerned that these proposals largely ignore the problem of skyrocketing insurance costs and instead simply add additional burdens on employers and their employees who may end up with the short end of the stick.

As such, today we will hear from large and small business owners on how legislation in their States would affect their employees' livelihood and their businesses. In addition, we will hear from someone who can look at the issue from 30,000 feet and talk about potential results of enacting such mandates.

I welcome our witnesses and look forward to their testimony today. I now yield to the distinguished ranking member, Mr. Payne, today for whatever opening statement you wish to make, sir.

[The prepared statement of Chairman Johnson follows:]

Prepared Statement of Hon. Sam Johnson, Chairman, Subcommittee on Employer-Employee Relations

Good morning. Let me extend a warm welcome to all of you, to the ranking member, Mr. Andrews, and to my other colleagues.

Most folks here know I have a devout respect for democracy.

Some of the cornerstones of democracy include freedom and free enterprise.

Another hallmark of democracy is empowering states—and cities—and counties—to be the laboratories of ideas.

And as local areas experiment, the best ideas always seem to rise to the top.

Today I want to hear what local areas are doing to find health insurance solutions.

Are they increasing the insured? are they protecting patients? are the costs rising or declining?

We can use these test cases, if you will, to see what works—and what doesn't.

In congress, we have a civic obligation to make sure that the proposals developing in the states don't override any federal laws.

That's especially true when it comes to health insurance because:

One: peoples lives are on the line and,

Two: the laws that govern many health insurance plans are protected by a federal law, called E.R.I.S.A.

As you know, the vast majority of americans with health insurance have their coverage through an employer.

Let's be clear: employer-provided health insurance is a benefit to the employee; it's not mandatory. Governments who value freedom and free enterprise do not tell businesses how to operate.

If states are tinkering with E.R.I.S.A.—we must make sure that the results are fair and have no unintended consequences—or worse—giant problems in the future.

Close to capitol hill, we all watched the state of maryland chart a new course.

In Maryland, some believe that employers must be forced, not only to provide health coverage to their employees, but to provide a specific set or level of benefits.

For example, the much-discussed law that recently passed in maryland seeks to penalize companies, well, at this point only a single company, that do not provide what politicians deem "adequate" health insurance for employees.

In short—the folks in the state capital of maryland are legislating what one company must do for its employees.

In my mind—mandating certain health benefits on one company from a state capital is not freedom and free enterprise * * * and I'm very concerned about what that would mean in the future—for people * * * for states * * * and for companies.

Could you imagine if maryland told mcdonalds that they could only feed their employees big macs?

There is such a thing as good government.

Over-reaching government it is not.

Listen, as a former state legislator in Texas, I am happy to see state legislatures working on solutions for the uninsured.

However, I am deeply alarmed that some of these proposals over-ride the good intentions E.R.I.S.A.-the federal law that governs employer benefits.

I am also concerned that these proposals largely ignore the problem of sky-rocketing insurance costs and instead simply add additional burdens on employers—and their employees who may end up with the short end of the stick.

As such, today we will hear from large- and small-business owners on how legislation in the states would affect their employees' livelihood and their businesses.

In addition, we'll hear from someone who can look at the issue from a 30,000 foot level and talk about potential results of enacting such mandates.

I welcome our witnesses and look forward to their testimony today.

Mr. PAYNE. Thank you, very much, Mr. Chairman, and let me thank you for calling this very important hearing examining the impact of State mandates on employer-provided health insurance.

I think your background in the State legislature before coming here to Congress certainly suits you well on this committee. Let me just say, I appreciate the opportunity to talk about what States are doing to address the health care crisis facing our country covering the uninsured.

The urgent crisis demands our continued attention and debate; 46 million Americans are uninsured, and millions more are struggling to pay the skyrocketing cost of health care, and many are underinsured. So we really have a crisis, a dilemma in health care. I think really it is a crisis that has to be shared by all of us. We have to come up with a solution to the problem because it is a gigantic problem, and our Nation's health is going to be very important to our future development. This is a life or death problem, as we know.

The Institute of Medicine estimates that 18,000 Americans die unnecessarily each year because they lack health insurance. That is here in the United States of America, not a Third World country. People who need health care or medication are risking their lives because they just can't afford needed care.

As we talk about this, I hope that we can keep in mind the families that are forced to decide between paying for cancer treatments or their weekly groceries. With the skyrocketing cost of petrol and home heating fuel coming up this winter, serious dilemmas and crises are going to impact even millions more Americans.

I hope that we can think of the families who are trying to figure out how to keep a loved one alive and healthy when they are hit with an illness they simply can't afford to live for.

While health care costs are always a major problem for low-income workers, even people who have health insurance are having trouble keeping up with the bills, as we all here know. A survey done by USA Today to Kaiser Family Foundation and the Harvard School of Public Health found that 62 percent of people struggling to pay their bills actually have health insurance.

The Labor Center at Berkeley recently reported that Americans who have job-based family coverage paid 50 percent more for their health care in 2004 than they did in 2000, an increase of \$3,264 in out-of-pocket costs.

I would like to see this Congress do something to really address the rising cost of health care, to find creative ways to cover those people who can't afford it. But until that happens, we must not stand in the way of States that are working hard to come up with ways to provide their citizens with quality, affordable health care.

I have good, honest employers in my district who are working hard to provide health care to their employees. Rather than being rewarded for prioritizing the health of their workers, these employers are at an unfair disadvantage and are unable to compete with the larger employer, especially highly profitable ones that refuse to provide health care for their employees.

I understand that some of our witnesses today are opposed to requiring even those very large employers to provide workers with health coverage. I also know that, in my State, Wal-Mart tops the list of employers with employees on New Jersey Family Care, our State's Medicaid program, with 589 employees in the program. Currently, in New Jersey, there is legislation pending that is simi-

lar to the Maryland legislation which requires companies with over 10,000 employees to spend 8 percent of their payroll on health care or pay the State the difference. There is also a bill that would require companies with at least 1,000 employees to pay at least \$4.17 per hour on health care.

So, as I conclude, this is a timely and important issue to discuss. I know that companies are trying to do better. I know Wal-Mart has started some scholarship programs and is discussing these issues. We can't have a piecemeal approach, and I think that we really have to take this issue head on.

I yield back the balance of my time, Mr. Chairman.

Chairman JOHNSON. The gentleman's time has expired.

Mr. PAYNE. I figured I would yield back before you said it.

Chairman JOHNSON. You all watch those lights. The green light comes on, you have got 5 minutes. When the little yellow light comes on, you have 1 minute. And we would appreciate it if you would try to close it down when the red light comes on, unlike Mr. Payne, who went a half a second over.

Mr. PAYNE. I am color blind.

Chairman JOHNSON. Thank you, Mr. Payne.

We have got a distinguished panel of witnesses before us today, and I thank you all for coming, and I would like to introduce them one at a time. Mr. Greg Garthwaite is a research fellow in economics at the Employment Policies Institute where he manages research projects with labor economists at major universities across the country. Mr. Garthwaite's research focuses on issues such as minimum wage, health care mandates and the economic benefits of employment. Mr. Garthwaite holds a bachelors and a masters degrees from the University of Michigan.

Thank you for being here.

Ms. Mila Kofman is an associate research professor at the Georgetown University Health Policy Institute where she conducts studies on the uninsured and underinsured problems. Ms. Kofman was a Federal regulator at the U.S. Department of Labor from 1997 to 2001 and, prior to joining the Department of Labor, was counsel for health policy and regulation at the Institute For Health Policy Solutions. Ms. Kofman holds a law degree from Georgetown University and a bachelors degree from the University of Maryland, College Park.

Thank you for being here.

Mr. Larry Drombetta—is that pronounced correctly—is president and CEO of H.R. Stores, Inc., an independent retail shoe store group based in Maryland. H.R. Stores operates mall-based shoe stores located in Virginia, Maryland and North Carolina. Throughout his career, he has worked as an executive officer for several retail businesses. Mr. Drombetta holds a degree from the Youngstown State University.

Thank you for being here, sir.

Mr. Paul Kelly is senior vice president of Federal and State government affairs for the Retail Industry Leaders Association where he leads the association's overall government affairs and advocacy efforts. A government affairs veteran with more than 20 years in Washington, Mr. Kelly has also worked with the National Association of Chain Drug Stores, American Dietetic Association and the

American Chiropractic Association. Mr. Kelly holds a masters degree from Johns Hopkins University and bachelors degree from Lynchburg College.

Thank you for being here as well.

Before the witnesses begin their testimony, I would like to remind members we will be asking questions after the entire panel has testified. In addition, the committee rule imposes a 5-minute limit on all questions.

I have already explained the lights. So I would like to recognize the first witness, from my left to my right, for your testimony, sir.

**STATEMENT OF CRAIG GARTHWAITE, CHIEF ECONOMIST,
EMPLOYMENT POLICIES INSTITUTE**

Mr. GARTHWAITE. Thank you, Mr. Chairman, ranking member, members of the committee, for inviting me to testify today.

My name is Greg Garthwaite, and I am a research fellow in economics at the Employment Policies Institute. Founded in 1991, EPI is a nonprofit research organization dedicated to studying public policy issues surrounding employment growth. In particular, EPI focuses on issues that affect entry-level employment.

The vast majority of employees receive health insurance through their employer. Recent escalations in the cost of health insurance, however, has put added pressure on the continuation of these benefits. Faced with double-digit increases in premium costs, many employers are changing their health plans by either requiring employees to pay a larger share of the cost, increasing copays and deductibles, or restricting coverage in general.

Economists at Dartmouth University found these higher rates for employer-provided insurance have already led to significant job loss throughout the economy. As a result of these factors, a recent Gallup Poll ranked health care as the public's top concern. Over two-thirds of Americans said they personally worry a great deal about the affordability and availability of health care.

Due to these facts, it is no surprise that States have devoted so much energy this year to health care legislation. If States were examining policies that attempted to address the fundamentals behind the dramatic increases, their efforts would go toward expanding coverage. Unfortunately, States are largely avoiding this potentially productive discussion, instead, with the most blunt policy tool available, simply requiring someone to pay for it. Invariably these efforts are focused on forcing all employers to provide health benefits to their employees. Nominally, they require for increased coverage. Research shows, however, that the burden of these mandates will actually fall on employees through decreased job opportunities and wages.

Economic studies on mandated benefits reveal that, where possible, employers will pass these new costs onto their employees through lower wages. For the least skilled employees in the economy, lower wages are often not an option. Government data shows approximately 43 percent of all uninsured employees are working at or near the minimum wage. Bound by the minimum, employers are forced to react to the newly imposed health cost through layoffs. The end result is the least skilled employees in the economy end up footing the bill for these newly mandated benefits, often

with their jobs. As a result, many of these employees are forced to confront the bitter irony of a bill designed to provide employer-based coverage, leaving them with neither an employer or coverage.

The recent history of employer-mandated health care can be traced back to California's Proposition 72. This initiative would have employers with more than 20 employees provide individual health coverage, and those with more than 200 employees provide family insurance. Economists estimated that this legislation would have cost California employers upwards of \$12.9 billion and up to 150,000 jobs would have been destroyed.

Furthermore, those who lost their jobs would have been disproportionately younger, poor, less educated and minority. While Proposition 72 narrowly lost at the ballot box in 2004, the defeat did nothing to stem the tide of these costly mandates. In 2005, legislators in Washington debated the Health Care Responsibility Act, a similarly destructive mandate.

This year, 26 States considered legislation requiring employers to provide health benefits to their employees. The legislation varied significantly across the States. Some were limited to employers of a certain size while others sought to require a minimum level of benefit. High cost and fewer jobs may be justifiable if these mandates significantly reduce the problem of the uninsured. But research shows that employer mandates, due to their dependence on the workplace as the source of insurance, do little to address the problem of the uninsured. Often they leave the vast majority of uninsured without new coverage. In California, for example, the \$12.9 billion dollars in new spending would have only decreased the uninsured population by 31 percent, a shocking cost of nearly \$6,600 per newly insured individual.

Due to poor targeting, only 30 to 35 cents of every dollar spent on the legislation would have gone toward the uninsured. Similar results should be expected from any mandate that attempts to address the problem of the uninsured solely through the labor market. Often the very characteristics that have left these employees without insurance in the first place deny them the benefit of workplace dependent mandates.

True progress toward addressing the pressing problem of rising health cost and the uninsured will not come from simply shifting the cost and the responsibility onto the backs of employers. Rising health care costs have made it prohibitively expensive for many small businesses to either offer or continue to offer coverage. These same hire rates already contributed to significant job loss throughout the economy.

It is critical that States and Congress attempt to enact meaningful reforms to our health care market that will actually decrease the number of uninsured instead of simply trying to pass the buck. Thank you. I am happy to answer any questions.

[The prepared statement of Mr. Garthwaite follows:]

**Prepared Statement of Craig Garthwaite, Research Fellow in Economics,
Employment Policies Institute**

Thank you Mr. Chairman, Ranking Member and members of the subcommittee for inviting me to testify today. My name is Craig Garthwaite, Research Fellow in Economics at the Employment Policies Institute. Founded in 1991, the Employment Policies Institute is a non-profit research organization dedicated to studying public

policy issues surrounding employment growth. In particular, EPI focuses on issues that affect entry-level employment.

It is supported by contributions from private citizens and businesses and foundations. We also engage a panel of distinguished academic advisors, including Dr. James Heckman, winner of the Nobel Prize in economics, Dr. June O'Neil the former director of the Congressional Budget Office, and Dr. Kevin Murphy, a recipient of the 2005 MacArthur "Genius" Grant.

A recent Gallup poll ranked health-care as the public's top concern. Over two-thirds of Americans said they personally worry "a great deal" about affordability and availability of health-care. While policy issues are often cyclical, it is likely that health-care will remain a top concern for the foreseeable future. As our population ages there will be increasing demands on our health-care system. At the same time, companies in all industries are striving to restrain costs to better compete in the global economy. Many are finding it increasingly difficult to provide the kind of comprehensive health coverage the public has come to expect.

It is no surprise then that state legislatures are engaged in robust deliberations on health-care issues. Their efforts have largely been driven by the goal of expanding the number of people with health insurance. These efforts try to cement coverage that is already in place and reduce the ranks of the uninsured.

With these policy currents, naturally, states have devoted a great deal of energy this year to health-care legislation. Unfortunately, most of their efforts have been misdirected. Rather than delve into the underlying pressures that make health insurance increasingly unaffordable, state lawmakers have largely directed their energies at determining who should pay for it. Invariably, these efforts have focused on forcing employers to provide health benefits to their employees.

Employer-Provided Health-Care

In many respects, employer-provided health benefits are an historical anomaly. They arose during World War II, when wage and price controls made it difficult for businesses to compete for labor or retain valued workers. Offering health insurance as a benefit got around these controls, but created a lasting expectation that employment and health benefits were inextricably linked.

Today, around 60% of employees receive health insurance through their employer. Recent escalation in the cost of health insurance, however, has put added pressure on employers providing these benefits. Faced with double-digit increases in premium costs, many employers are changing their benefits: requiring employees to pay a larger share of the cost, increasing co-pays and deductibles, or restricting coverage in general.

Policies that fail to address the fundamentals behind the increases in the cost of health insurance will not make meaningful progress in expanding access to health insurance. This is an area where state legislative action can have a dramatic and positive impact. State policies that mandate the coverage of certain procedures have an enormous impact on the cost of health insurance. While any one mandate may seem inexpensive, the cumulative effect of 30 or 50 specific mandates can make insurance unaffordable. Research shows that across the states, the impact of these mandates can increase the cost of insurance by 20-50%.

The other consequence of these state mandates is that today's health insurance marketplace is a patchwork quilt of coverage requirements. Policies have to be designed to meet the requirements of each individual state, lessening the ability to achieve savings through economies of scale. Worse, state mandates are continually being adapted. Each year, states consider hundreds of pieces of legislation that seek to change the minimum benefit package that can be offered in the state. This creates enormous uncertainty within the insurance market.

Passing the Buck

Reforming coverage mandates or increasing the availability of "basic" health plans that are exempt from certain mandates would go far in increasing the affordability of health insurance. Unfortunately, states are largely avoiding this discussion. Instead, they are addressing the increase in the lack of health coverage with the most blunt policy tool: simply requiring someone to pay for it. Nominally, these bills require employers to foot the bill for increased coverage. Economic research shows, however, that the burden of these mandates will actually fall on employees through decreased job opportunities and wages.

While only one state has successfully implemented an employer-mandated health-care system, economists have used other mandate programs to estimate the economic impact of these policies. In total, the research reveals that-where possible-employers will pass the cost of mandated benefits onto employees through lower wages.

For the lowest-skilled employees in the economy, however, this is not an option. Government data shows that about 43 percent of all uninsured employees are working at or near the minimum wage. Bound by this minimum wage, employers are forced to react to the increased costs of the mandate through decreased hours and positions. The end result is that the least-skilled employees of the economy end up footing the bill for these newly mandated benefits.

Many of these employees are forced to confront the bitter irony that legislation designed to provide employer-based health-care leaves them with neither an employer nor healthcare.

Estimated Effects of Mandated Health Insurance

The recent history of employer mandated health-care can be traced back to California's defeated Proposition 72. This initiative would have required employers with more than 20 employees to provide individual health coverage to all employees working more than 100 hours a month. Employers with more than 200 employees would have to provide family insurance. The legislation would have cost California employers upwards of \$12.9 billion and destroyed up to 150,000 jobs.

While Proposition 72 was narrowly defeated at the ballot box in 2004, the defeat clearly did nothing to stem the tide of these costly mandates. In 2005, legislators in Washington debated the Health-care Responsibility Act which would have cost employers in that state upwards of \$1.6 billion and destroyed up to 25,500 jobs.

This year, 26 states considered legislation to require employers to provide health benefits to their employees. The legislation varied significantly across the states; many were limited to employers of a certain size, while others sought to additionally require a minimum level of benefit.

These costs may be justifiable if these mandates significantly reduced the problem of the uninsured. But, research shows that employer mandates—due to their dependence on the workplace as the source of insurance—do little to address the problem of the uninsured.

In California, for example, the \$12.9 billion in new spending would have only decreased California's uninsured population by 31%—a shocking cost of nearly \$6,600 per newly insured individual. Due to poor targeting, only 30 to 35 cents of every dollar spent under the legislation would have gone towards covering the uninsured.

Similar results should be expected from any mandate that attempts to address the problem of the uninsured, particularly the working uninsured, through the labor market. Often, the very characteristics that have left these employees without insurance in the first place deny them the benefits of these mandates.

Employer mandates often exempt small businesses and require employees to work a certain number of hours. Recent research from the University of California-Santa Cruz found that employees working in small firms were the most likely to lose insurance from year to year. In addition, the rates of working uninsured clearly increase in smaller firms. These companies may very well want to provide insurance to their employees, but find it too costly. Employer mandates will do little to address that problem.

Employer mandate legislation is based on a false premise of the labor market and a misunderstanding of the nature of today's uninsured population. It is not only ineffective at solving the problem, but it results in unintended consequences that are counter-productive.

By attempting to simply require employer-provided care, rather than address the underlying problems plaguing the nation's healthcare market, state legislators are doing little to address the problem of the uninsured. Even without the mandate, attempting to rely on employers as the primary provider of health coverage is already leading to significant job losses for Americans. Economists at UCLA and Harvard University found that the rising healthcare rates have potentially forced millions of Americans out of the labor force. Even without the presence of a mandate, employers have reacted to rising costs by laying off employees; mandating coverage would only exacerbate this problem.

Conclusion

True progress towards addressing the pressing problem of rising health-care costs and the uninsured will not come from simply shifting the cost and responsibility onto the backs of employers. Rising health-care costs have made it prohibitively expensive for many small businesses to either offer or continue to offer coverage. These same higher rates have already contributed to significant job loss throughout the economy. It is critical that states, and Congress, attempt to enact meaningful reforms to our health-care market that will actually decrease the number of uninsured instead of trying to simply pass the buck to employers.

Chairman JOHNSON. Thank you, sir. I appreciate your testimony. How quick we forget World War II price controls. I bet there is not a single one of you that remembers it. Are there? Anybody in the audience remember World War II price and wage controls. Outstanding. I guess you and I are the only ones.

Mr. PAYNE. I am trying not to admit it.

Chairman JOHNSON. There is a guy that remembers it, I know that.

Ms. Kofman, you are recognized for 5 minutes.

STATEMENT OF MILA KOFMAN, ASSOCIATE RESEARCH PROFESSOR, GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE

Ms. KOFMAN. Thank you. Thank you very much. My name is Mila Kofman and I am an associate research professor at Georgetown University. Thank you for having me here today. It is both an honor and a privilege to have a chance to chat with you for 5 minutes.

As you know, I have studied the insurance markets for over a decade, various health care reforms. I am currently co-chair—co-editor, excuse me, of the Journal of Insurance Regulation, and I am also a member of the Consumer Board of Trustees of the National Association of Insurance Commissioners, and before that, I was a Federal regulator working on ERISA-related issues at the Department of Labor.

I want to thank you for your leadership in holding this hearing during Cover the Uninsured week. As the number of uninsured people continues to rise, the problem gets greater and greater, and as you have heard, 18,000 Americans die each year preventable deaths because they don't have any health coverage whatsoever. This problem may cost our economy as much as \$130 billion dollars each year. It is timely to examine the interplay between ERISA and State health care reform initiatives. As States continue to find ways to address the health care crisis in the United States, ERISA continues to present a number of challenges to State-based reform, and today I will discuss just a few of those challenges.

Importantly, despite ERISA challenges, Governors and State-Elected officials are undeterred and continue to develop new strategies and successful programs to finance medical care for their residents. Federal interventions you look at now and in the future should support all of these State-based initiatives and efforts.

First, I would like to talk about why coverage is so expensive, then I want to talk about briefly some of these more recent State initiatives, as well as some of the older State-Based programs that seek to address the uninsured problem and then I want to make you aware of one ERISA related issue that prevents States from doing what they are supposed to in the criminal area, if there is time.

So, first, health coverage is expensive because medical care is expensive. And you all know this, this is nothing new. We know the cost drivers behind health coverage is higher prices for prescription drugs, higher prices for provider costs. We also know that we use more health care. We are an aging population, and more of us have

chronic conditions. Millions of Americans suffer from chronic conditions, and so we use more health care.

So as we think about solutions to the uninsured problem and the ever-increasing costs, we need to address those factors, the cost drivers, as well as come up with a more fair way to finance the medical care, more equitable way to finance care.

Many States have sought to address the Nation's health care crisis. State-based initiatives like fair-share health care seek a more fair way to finance medical care, and I believe will help employers in the long run. Cost shifting for uncompensated care costs of privately insured people are over \$40 billion each year out of your pockets to pay for uncompensated care. It is estimated that each family pays more than \$900 per year just to make up for uncompensated care.

So State initiatives that seek to achieve cost savings like the one in Massachusetts, like the one in Maryland will help employers because there will be less cost shifting. Maryland's lawmakers as you know passed a fair-share law program in response to financial pressure on public programs. One large employer, their employees use public programs extensively, and so Maryland found a way to pay for that coverage.

Similar things are happening in Massachusetts. State lawmakers are just trying to find a more fair way to finance medical care. Many States having enacted programs in the past decades that have worked to help people finance medical care and access company coverage. Things like high-risk pools and purchasing coalitions and reinsurance programs, those are all helping. None of them are free, and, in fact, they are very difficult to finance in the ERISA environment because self-funded employer plans don't pay into those programs, don't help finance those programs.

So as you consider new initiatives at the Federal level, keep in mind that any ERISA expansion will financially hurt those existing State-based programs. And I see that the light is on, so I will stop and take any questions. Thank you.

[The prepared statement of Ms. Kofman follows:]

**Prepared Statement of Mila Kofman, J.D., Associate Research Professor,
Georgetown University**

Good morning. My name is Mila Kofman and I am an associate research professor at Georgetown University's Health Policy Institute (Institute). Thank you for inviting me to testify today. It is both an honor and a privilege to be here.

As a way of background, researchers at the Institute conduct a range of studies on the uninsured problem. My specific focus is private health insurance. For the past decade I have studied regulation of health insurance products and companies, state and federal reform initiatives, and market failures like insolvency and fraud. Currently I am the co-editor of the Journal of Insurance Regulation and serve on the Consumer Board of Trustees of the National Association of Insurance Commissioners.

Before joining the faculty at Georgetown University, I was a federal regulator at the U.S. Department of Labor, where I worked on issues affecting ERISA health plans. Prior to that, I was Counsel for Health Policy and Regulation at the Institute for Health Policy Solutions, a non-profit, non-partisan firm, assisting small businesses in establishing health insurance purchasing coalitions and studying state small group reforms. My knowledge, therefore, is both practical and academic.

I want to thank you for your leadership in holding a hearing on state health reform initiatives and employer-sponsored medical benefits during "Cover the Uninsured Week." As the number of uninsured continues to rise, now at over 45 million people without any health coverage, you and other members of Congress, as well

as state policymakers are trying to address this problem. As you know, 18,000 Americans die preventable deaths each year because they are uninsured. This problem is estimated to cost our economy \$60 to \$130 billion annually.¹

It is very timely to examine the interplay between ERISA and state health care reform initiatives. As states continue to find ways to address the health care crisis in the United States, ERISA continues to present a number of challenges to state-based reform. Today, I will discuss some of those challenges.

As you deliberate about state health reform efforts by looking at “fair share health care” and “pay or play” proposals, it is important to remember that there are practical considerations and legal parameters, e.g., ERISA. One such consideration is the cost of medical care. Health coverage is expensive because medical care is expensive. The double-digit premium increases of the past five years, can be explained in part by certain cost drivers including increased prescription drug costs and higher provider costs (in part due to mergers).² Utilization of services is also increasing—we are using more health care services as our population ages and the number of people with chronic conditions continues to grow. It is important to address the cost drivers of medical care.

ERISA’s limitations on what states can require of employers, lawsuits using ERISA to question state authority and challenge state reform initiatives, and other ERISA-related issues make it difficult for states to address the health care crisis. This makes it difficult to adopt successful reforms, to cover millions of Americans who do not have health insurance, to address the ever growing cost of health coverage for people who are insured, and to assure that in fact health insurance is adequate, accessible, and secure for people who are sick today and those of us who will become sick in the future. Despite ERISA challenges to state initiatives, however, governors and state legislators are undeterred and continue to develop new strategies and successful programs to finance medical care for their residents.

Newest State Initiatives Background

In recent years, many states have sought to address the nation’s health care crisis. State-based initiatives like “fair share health care” seek a more equitable way to finance medical care and I believe will help employers. Cost-shifting (for uncompensated care) costs over \$40 billion per year and hurts employers that provide comprehensive and generous benefits. The cost-savings from eliminating uncompensated care that state initiatives like “fair share” seek to accomplish will help those businesses.

ERISA has been used to challenge state reforms. For example, the Maryland Legislature passed a law, called “The Fair Share Health Care Fund Act” that requires companies with more than 10,000 employees in Maryland to pay for medical care and coverage for their employees in the amount equal to or more than 8% of salaries (6% for non-profits). The law requires a company that falls below 8% to pay an assessment to help fund Maryland’s health care programs for moderate and low-wage income earners and poor people and families.³ Maryland’s lawmakers passed this law in response to financial pressure on public programs, after learning that Maryland’s public programs covered many employees of at least one large national company, drawing down the programs’ resources; similar bills have been introduced in 18 other states. Scheduled to go into effect in January 2007, Maryland’s law was immediately challenged using ERISA.⁴

In April, Massachusetts lawmakers enacted broad health care reforms called the “Health Care Access and Affordability” (a.k.a. Massachusetts Health Care Reform Plan), which include a requirement that employers with more than 10 employees provide health coverage or pay an annual fee per employee to help finance medical care that their employees use (currently care provided for free to patients but financed through public funding and other sources) in the state.⁵

Although both laws were carefully crafted to avoid ERISA preemption and many experts (including me) believe that these laws would not be preempted, it is difficult to predict (even for ERISA experts) how a federal court may interpret the scope of ERISA.⁶ It remains to be seen whether Maryland, Massachusetts, and other states seeking to implement meaningful reforms to address the nation’s health care problems will be precluded from achieving their goal of universal, affordable, and meaningful coverage for all residents.

Background: ERISA

In 1974 the Employee Retirement Income Security Act (ERISA) was passed to regulate job-based health and pension benefits. Under ERISA, state laws that “relate to” an “employee benefit plan” are generally preempted. Not all state laws have been found to “relate to” an ERISA plan, however. And ERISA explicitly exempts regulation of insurance from its broad preemption, thus allowing states to regulate

health insurance products and companies that sell coverage to ERISA plans. Employers that self-insure (also called self-funding) are not subject to state insurance laws, however. Self-insurance means that an employer is responsible for paying medical claims of workers and their dependents. When an employer buys health insurance, it pays a premium to an insurance company; this is called “fully-insured” and the insurance company not the employer is obligated to pay medical bills.

Insurance Reforms

ERISA presents challenges to meaningful state health reforms. As a way of example, take state benefit mandates. These are requirements for health insurance policies to cover certain benefits, like specific medical conditions and treatments. States have a wide range of such standards. For example, in 46 states health insurers are required to either cover (or offer to cover) benefits for diabetes supplies and education. Twenty-seven states require insurers to cover cervical cancer screening. Fifty states require coverage for mammograms and 32 require coverage for well-baby care (childhood immunizations and visits to pediatricians). Mandated benefits also include requirements that insurers reimburse certain types of medical providers, such as nurse practitioners. And they include state laws requiring coverage for special populations, e.g., adult handicapped children who age-off their parent’s policy and newborns (required to be covered from birth by their parent’s insurer).⁷

Benefit mandates are used to spread the cost of a medical condition or treatment among a broad population, making it less expensive for the group of people who need such coverage. Policymakers also use benefit mandates to encourage people to seek certain care (immunizations and preventive services) that otherwise may not be obtained if people have to pay for it out-of-pocket.⁸

In the absence of mandates, adding optional benefits to a policy can distort the price if only people who need that benefit select coverage. For example, in Washington State premiums for policies that covered maternity and mental health benefits were anywhere from 30 to 100 percent more expensive than policies that excluded those two benefits. The choice in benefit design led consumers to select those specific benefits based on their expectation of using them, with adverse selection fueling a steep increase in premiums for those products.⁹ Also, absent a requirement, some services and benefits may not be available even as an add-on (or “rider”). For example, in states that do not require maternity to be covered, an individual policy with a maternity rider is rarely available; and even when available, the price for a maternity rider is higher than paying for the average pregnancy out-of-pocket.

With respect to mandated benefits, state policymakers make tradeoffs: balancing the cost (added to the premium) with the need to help their constituents finance costly illnesses. Here, the impact of ERISA is felt. Self-funded ERISA health plans are not subject to benefit requirements and thus can avoid helping to finance the cost of such coverage. This, however, frustrates the public policy goal of broadly spreading the cost of certain medical conditions and achieving public health goals (such as immunizing the population against certain diseases, stabilizing mental health conditions, encouraging treatment for substance abuse, or financing supplies to control diabetes). It is important to note that many self-funded large employer plans are comprehensive, covering for example diabetes supplies. Absent federal mandates, not all self-funded plans provide such coverage. When employers choose to self-fund, because the cost of mandates is spread across a smaller population (among those in state-regulated products), the price is higher than it otherwise would be had the cost been spread over the entire population (self-funded and fully-insured plans).

How mandated benefits add to the cost of health insurance has been an issue of longstanding controversy and depends on the extent to which mandates spread the cost of a particular health care service over a large number of policyholders. Literature on the cost of mandates generally does not consider the true cost of the benefit because many benefits would have been covered absent the mandate.¹⁰ Even so, a recent industry study, for example, found that mandates add minimally to the cost of premium (an estimated 5 percent).¹¹ Given the recent double-digit premium increases for employers (for some in the range of 20%-30% annually), the anticipated cost savings from a mandate-free environment would be minimal. Importantly, both employers exempt from state mandates (self-insured) and fully insured have seen their premiums increase. There is a reason why GM, for example, adds \$1500 to the price of each car to pay for health coverage for workers and retirees. It is because the cost of medical care is expensive and thus reflected in the price of coverage; it is not because of mandates. So eliminating mandates will not address the rising costs of coverage.

Also, the studies on the cost of mandates generally do not consider the cost to the patient. In other words, if a health plan is excused from covering a treatment, then it does not mean that your illness disappears. It just means that you pay for it out-of-pocket, if you can afford it. And if not, then assuming you still receive the care, the cost of your treatment is added to the cost of uncompensated care (generally paid with public funds and cost-shifting to privately insured patients).¹² The question here is who pays for your illness: your health plan because it is required by a mandate, you pay out-of-pocket if you can afford it, or other people with comprehensive coverage pay for it (through cost-shifting). Additionally, studies on the cost of mandates generally do not consider system-wide costs, that is affordability issues and the increased costs of delayed or foregone medical care when patients cannot afford needed medical services.¹³

State Regulated Health Insurance Products: ERISA 's impact

ERISA influences prices for regulated health insurance products. Self-insuring all-ows employers to avoid having their medical claims pooled with other employers; especially for mid-size (500 employees or less) and small businesses that employ a relatively healthy workforce, this may be an advantage.¹⁴ Smaller firms that employ workers with higher medical needs are less likely to self-insure and are more likely to buy state-regulated products. Since guaranteed-issue laws were enacted, requiring insurers to sell products to any small business, it has in fact become easier to buy insurance. In the past insurers were free to sell insurance only to businesses with healthy workers. In addition, state small group rate reforms require insurers to pool risk and in some states insurers are prohibited (or restricted) from charging higher rates to businesses with sicker workers. Through risk pooling requirements, firms with sicker workers pay less than they otherwise would, which helps them to offer and maintain coverage. If employers with self-funded plans (small and mid-size) in fact have more favorable risk than other employers, the cost for state regulated products may be lowered if all businesses participated and everyone's claims experience was pooled.¹⁵

State Market Reforms and Programs: Background and ERISA Challenges

State insurance regulation has sought to promote several policy objectives, such as assuring the financial solvency of insurance companies, promoting risk spreading, protecting consumers against fraud, and ensuring that consumers are paid the benefits that they are promised. Also as products and markets evolve, e.g., managed care in the 1990's, states have responded to some abusive industry practices through "patient protections" like guaranteed access to emergency services and specialists, and external review of denied claims for medical care.

State policy makers have also instituted certain rules for insurance companies, establishing who they must sell coverage to, how products must be priced, and the types of benefits that must be covered. Absent legislative interventions, in a private health insurance market, insurers adopt practices to avoid incurring high medical claims, including denying coverage to applicants who have health conditions or a history of health problems. An estimated 20% of people account for about 80% of health care spending.¹⁶ Avoiding even a small number of high-cost individuals can substantially reduce an insurer's losses.

In addition to market reforms, state policymakers have tried a variety of ways to help their residents and businesses to access and afford health coverage. ERISA presents a number of challenges to states in how to finance certain health coverage programs. For instance, states require insurers to pay premium taxes and assessments, which helps to pay for certain state health programs for residents including high-risk pools. Risk pools are state programs for people with high medical needs who insurance companies won't cover. Thirty-three states have such pools. In 2004, they covered approximately 180,000 people. States fund high-risk pools in a variety of ways, but many rely on revenue from premium taxes and assessments on health insurance companies. For self-insured plans, an exemption from premium taxes is a small cost savings, but it cuts the amount of available revenue from health insurance companies by approximately 50%—the estimated portion of the insured population that is in self-funded plans.¹⁷

Another approach to expand access to health insurance has been through public/private partnerships called "HIPCs" (health insurance purchasing cooperatives)—these are also known as purchasing alliances and purchasing pools for small businesses. These programs use the state's purchasing power to negotiate rates and coverage with private insurance companies.¹⁸ Participating employers have a choice of products and typically a choice of insurers. Arizona, California, New Mexico, and New York City have such purchasing pools for small businesses.¹⁹ One of the newest operational programs was established in 2005 in Montana. The state has used

its purchasing power to negotiate rates that are better than available in the private market and is using tobacco taxes to help pay for the cost of coverage in the pool for moderate income wage earners.

Other states have tried to make coverage more affordable through “reinsurance,” subsidizing the cost of big losses (claims). This would limit insurers’ losses and thus seeks to keep premiums lower. Reinsurance programs have been tried in 21 states. Healthy New York, a state-wide program, for example, covers over 100,000 people and uses the state’s tobacco settlement funds to subsidize a portion of high-cost claims under the program.²⁰

While these state coverage expansion efforts vary, none are free. They all rely on some funding, and ERISA self-insured plans generally do not contribute to financing such programs. However, self-funded plans benefit when people with medical needs have insurance—there is less uncompensated care and therefore less cost-shifting. In other words, the cost of uncompensated care is borne by all people with insurance as the costs are shifted to all privately insured people—self-insured and fully insured plans.

In addition to funding, these state programs rely on insurers assuming significant risk. As policymakers provide new incentives for employers to withdraw from state-regulated policies (as some bills pending before Congress would do), insurers would have greater incentive to dump their poor risks.²¹ States may allow insurers to do so but pressure on state coverage expansion programs will be great. Expansion of ERISA is likely to escalate this pressure and impact adversely state coverage programs that rely on insurers taking on significant risk and on insurer assessments to spread cost broadly across the insured population.

ERISA Abuses

Operators of unauthorized entities (a.k.a. phony insurance companies) have used ERISA as a way to avoid or to delay state regulator actions. By way of background, phony insurance entities collect premiums but don’t pay medical bills, instead using the money for personal gain. During the most recent cycle of health insurance scams, more than 200,000 policyholders were left with over \$252 million in unpaid medical bills. The federal government and the states identified 144 scams between 2001 and 2003; the federal government shut down 3 and the states shut down 41.²² Operators of health insurance scams claim that they are regulated by the federal government under ERISA and therefore exempt from state regulation. Some create complex legal documents that, at least on paper, raise questions about their legal status under ERISA.

Although Congress clarified ERISA in 1983, some ambiguities remain and operators of phony health plans continue to use ERISA preemption as a shield to avoid state enforcement actions, challenging state authority by removing cases to federal court. Operators of phony plans use this tactic to delay final court action, which gives them an opportunity to spend or hide assets. This use of ERISA makes it difficult for states to protect their residents against criminal behavior.²³ Expanding ERISA, for example through AHPs or similar legislation, is likely to increase ERISA-related scams.²⁴

Conclusion

As the number of people in the United States without health insurance continues to rise, governors and state legislators continue to look for ways to address the problem, financing medical care through private and public insurance despite ERISA challenges. States are looking for equitable and effective ways to finance medical care for their residents. For this reason, Congress should be cautious when looking at proposals that seek to expand ERISA or to deregulate the market. Not only will some proposals not accomplish their desired goal, but they may actually add to the uninsured problem, make it even more difficult for state-based reforms to succeed and drive-up costs for people who have insurance. I encourage you to look for measures that will encourage and support state initiatives.

It is also important to remember that many self-funded large employer plans provide generous benefits to workers and dependents, covering expensive medical conditions and covering people with significant medical needs. America’s businesses need real help to address factors driving cost increases for medical care so they can keep their workers healthy and stay competitive in a global economy.

Thank you for your consideration of this important issue, and I look forward to assisting you as you look for ways to address the ever growing problem of millions of Americans without health insurance and rising costs of coverage for all Americans.

ENDNOTES

¹For highlights see, Press Release, January 14, 2004, "IOM Report Calls for Universal Health Coverage by 2010; Offers Principles to Judge, Compare Proposed Solutions" available at www4.nationalacademies.org/news.nsf/isbn.

²For example, in 2004, health care spending included: 30.4% for hospital care, 21.3% for physician services, 10.0% for prescription drugs. Distribution of National Health Expenditures, by Type of Service, 1994 and 2004. page 5, Trends and Indicators in the Changing Health Care Marketplace, KFF 2006 available at www.kff.org. Spending on prescription drugs increased two to five times more than spending on hospital care and physician services between 1995 and 2000. *Id.* at 6.

³See 2005 Regular Session, SB 790, Veto Override version, Jan. 12, 2006.

⁴See Plaintiff's Complaint, Retail Industry Leaders Association v. James D. Fielder, U.S. District Court for the District of Maryland (February 7, 2006).

⁵Massachusetts Reforms (House No. 4850) amends several state statutes including the insurance code.

⁶Maryland's Attorney General analyzed the bill and concluded that ERISA would not preempt it. See Letter from Joseph Curran, Attorney General, Maryland, to Michael Busch, Speaker of the House, Maryland General Assembly, January 9, 2006 (copy available from author).

⁷See Kofman, Mila and Karen Pollitz, "Health Insurance Regulation by the States and the Federal Government: A Review of Current Approaches and Proposals for Change," Health Policy Institute, Georgetown University (April 2006), available at www.allhealth.org.

⁸Which benefits are required to be covered is in part a function of how successful a particular group advocating for the mandate is in a state. Enacting benefit mandates is not done in a vacuum but is a part of a legislative process.

⁹See Kirk, Adele, "Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts," *Journal of Health Policy, Politics and Law* Vol. 25, No. 1, 2000.

¹⁰Chollet, Deborah "Finance Committee Hearing: Health Care Coverage for Small Businesses: Challenges and Opportunities. Questions Submitted for the Record" April 13, 2006 (copy available from author). ¹¹See Bender, Karen and Beth Fritchen, "Health Insurance Marketplace Modernization and Affordability Act of 2006," Mercer Report, March 2006, page 4 (copy available from author).

¹²In 2004, uncompensated care totaled \$40.7 billion. Jack Hadley and John Holahan, The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending? Issue Update 2004, Kaiser Family Foundation available at www.kff.org. One study estimates that cost-shifting adds over \$900 annually to the cost of family coverage. "Paying a Premium: The Added Cost of Paying for Care for the Uninsured" Families USA (June 2005) available at www.familiesusa.org/assets/pdfs/Paying-a-Premium-rev-July-1-3731-e.pdf.

¹³According to a RAND study, doubling co-payments for long-term prescription drug use caused patients to decrease the recommended use, which resulted in more and longer incidents in the hospital, including increased emergency room visits. Goldman, D. et al, "Pharmacy Benefits and the Use of Drugs by the Chronically Ill," *JAMA*, May 19, 2004, Vol. 291, No. 19, page 2344. One recent study found that patients delay going to the doctor, for example, because of affordability issues. Michelle Doty et al "Seeing Red: Americans Driven Into Debt by Medical Bills," Commonwealth Fund (August 2005) available at www.cmwf.org/usr-doc/837-Doty-seeing-red-medical-debt.pdf.

¹⁴Small businesses that self-insure may not be able to properly reserve for claims. The financial risk they take on is high.

¹⁵See Attachment A in Kofman, Mila and Karen Pollitz, "Health Insurance Regulation by the States and the Federal Government: A Review of Current Approaches and Proposals for Change," Health Policy Institute, Georgetown University (April 2006), available at www.allhealth.org. Additionally, self-insurance allows employers to save money by avoiding the cost of paying for reserves and minimum capital. Such requirements apply to insurers and are designed to ensure solvency. There are no solvency requirements for health plans in ERISA. While saving some cost, the trade-off here is that people in ERISA self-insured plans have fewer protections than those in fully-insured plans, and as such may be stuck with medical bills if their employer goes bankrupt. When an insurer becomes insolvent, outstanding medical claims are paid for by guaranty funds. There is no similar safety-net for people in self-insured arrangements. A problem for state policy makers is that ERISA self-funded plans do not contribute to state programs like guaranty funds, which are financed through assessments on health insurance companies. A broader financing base would make these safety-nets less costly; and of course, protect all workers against their health plan's insolvency.

¹⁶See Berk, Marc and Alan Monheit, "The Concentration of Health Care Expenditures, Revisited," *Health Affairs*, (March/April 2001): 145-149.

¹⁷Financing risk pools is also a question of fairness. Arguably because former workers of ERISA self-funded plans may enroll in high-risk pools, it is fair to ask self-funded employers to help finance that coverage. For a discussion of funding mechanisms and more information about state high-risk pool programs, see "Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis" 18th Edition, 2004-2005, Communicating for Agriculture and the Self-Employed, Inc.

¹⁸Maine also has a program similar to a purchasing pool, called Dirigo. Among its many features, it helps pay for the cost of private health insurance for moderate income wage earners insured through the program. The coverage is through a private insurer. Funding for the program partly comes through Medicaid.

¹⁹Kofman, Mila, Issue Brief: Group Purchasing Arrangements: Issues for States, State Coverage Initiatives, April 2003 available at <http://www.statecoverage.net/pdf/issuebrief403.pdf>.

²⁰ Chollet, Deborah, The Role of Reinsurance in State Efforts to Expand Coverage, State Coverage Initiatives, October 2004; see also, Chollet, Deborah and Carolyn Watts, Pooling and Reinsurance in Washington State Insurance Markets, 24 *Journal of Insurance Regulation* 81 (Winter 2005); Swartz, Katherine, "Reinsurance: How States Can Make Health Coverage More Affordable For Employers and Workers," Commonwealth Fund, July 2005.

²¹ For example, prior to guaranteed-issue requirements in the small group market, states allowed commercial insurers to choose to whom to sell coverage. In many states, Blue Cross/Blue Shield plans were looked to as insurers of "last resort" and generally offered coverage on a guaranteed issue basis. With a changing marketplace in the 1980s, as more large employers began to take themselves out of the insurance market (and self-funding their medical benefits), the market became more fragmented. Commercial carriers became more selective in who they would cover. Financial pressure on many Blues plans as insurers of last resort became significant. Taxpayer subsidies and whole scale market reforms became necessary requiring commercial insurers to bear more risk for sick groups. See Kofman, Mila and Karl Polzer, "What Would Association Health Plan Mean for California: Full Report?" Prepared for the California HealthCare Foundation, January 2004 available at <http://www.chcf.org/documents/insurance/AHPFullReport.pdf> (hereinafter California AHP Report).

²² U.S. General Accounting Office, Private Health Insurance: Employers and Individuals are Vulnerable to Unauthorized or Bogus Entities Selling Coverage, GAO-04-3 12 (Feb. 2004).

²³ Also some entities have developed complex "ERISA" schemes that they claim allows an exemption from state insurance laws protecting small businesses or to avoid state initiatives to increase the availability of affordable health insurance coverage. Unlike the outright scams these schemes straddle the line between regulatory violations and criminal conduct.

²⁴ In the case of American Benefit Plans, although the Texas Insurance Department had a letter from the U.S. Department of Labor stating that the arrangement was subject to state regulation, one of its promoters, nonetheless, removed the state case to a federal court. See Kofman, Mila "Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud," Georgetown University Health Policy Institute, July 2005, available at <http://hpi.georgetown.edu/ahp.html>.

Mr. KLINE [presiding]. Thank you very much. I am sure we will have an opportunity for increased dialog when we get to the question-and-answer session.

You have the floor, sir.

**STATEMENT OF LARRY DROMBETTA, PRESIDENT AND CEO,
H.R. STORES, INC.**

Mr. DROMBETTA. Thank you, Mr. Chairman, members of the committee. My name is Larry Drombetta, and I am the president and CEO of a small Maryland based company, H.R. Stores, Incorporated. I am pleased to be here today on behalf of the national retail federation. I commend you for holding these timely meetings focusing attention on health care mandates as they impact employees, employers and particularly on small retail businesses like my own.

The NRF is a large retail trade association, membership that comprises all retail format and channels of distribution. The NRF also represents more than a hundred State, local and national and international retail associations.

Mr. Chairman, as the employer of more than 23 million employees, about 1 in every 5 Americans, the retail industry is one of the biggest supporters of employer-based health insurance. We also are mainstays of the economy with 2005 sales of \$4.4 trillion. Ours is not an easy employee population to cover with health insurance. Our employees are fairly young; they have high turnover rates. We employ half of all the teenagers in the workforce, and one-third of all workers under the age of 24 years old. More than a third of our retail workforce is part-time, and two-thirds of that part-time workforce are women. Often retail industry employees are second-wage earners and mainstays of family economies.

I am the president and CEO of a very small company. We operate shoe stores in Maryland, Virginia, North Carolina and soon in

Pennsylvania. We have a staff of 35; 33 are full time, and 18 participate in the company health insurance program. My health care costs have steadily increased through the years and are increasingly unbearable. Coverage costs have increased by 155 percent in the period 2000 through 2006. My company has not grown 155 percent, and we cannot continue to sustain these coverage cost increases.

The cost increases are directly related to the impact of not just my business and company but the people who work for me and I work with. Let me explain how that relates. The younger members of my staff drop insurance out of a belief that they really don't need it. Some of us can recall how invincible we felt when we were young. This leaves in turn my group aging, having an increasing average age that in turn drives up the rate. This process repeats itself each year as my group becomes older and older.

My health insurance program is in what insurance industry people call a health insurance death spiral. I appreciate the Chairman's leadership in sponsoring legislation for association health plans. I am hopeful the Senate will soon develop a bipartisan counterpart bill and catch up with the House.

We as retailers offer good benefits but do not support mandated provisions of benefits, particularly the entire—the current cost environment and given the unique workforce mix we contain, State health mandates do nothing to address the cost of health care. In fact, they make matters worse. Legislation mandating that employers spend arbitrary percentages on benefits tends to—excuse me, a little nervous.

I believe that health care mandates amount to an ill-advised tax. It will result in a tax on workers, a tax on consumers and a tax on the economy in general. The National Retail Federation has established a Tax on Jobs Coalition to fight State health care mandates.

With the Chairman's permission, I would like to insert the coalition matrix of spending State health care mandates at the conclusion of my testimony.

[The information referred to follows:]

PENDING STATE HEALTH CARE MANDATE MATRIX

States targeted by AFL-CIO mandate	Bill number	Number of employees/mandate percentage	Status	Sponsor(s)	Date of introduction
Alabama	Session started 1/10/06	.....			.....
Alaska	HB 449	2,000/8%		Representative Croft; Representative Guttenberg; Representative Kertulla; Representative Crawford	2/13/06
Arizona	Session started 1/9/06	.....			.....

PENDING STATE HEALTH CARE MANDATE MATRIX—Continued

States targeted by AFL-CIO mandate	Bill number	Number of employees/mandate percentage	Status	Sponsor(s)	Date of introduction
California	SB 1414	10,000/8%	Hearing May 8 in Senate Appropriations Committee	Senator Midgen	2/22/06
	SB 593	20,000/don't use %		Senator Alarcon	2/18/05
Colorado	HB 1316	3,500/11%	Hearing Postponed Indefinitely	Representative Solano; Senator Tochtrop	2/6/06
Connecticut ..	SB 462	5,000	Labor and Public Employees Committee Hearing 3/9 at 2PM in Room 2A	Not Listed	3/1/06
Delaware	Session started 1/10/2006	.....			.....
Florida	HB 813	10,000/9%	Referred to Health Care Regulation Committee	Representative Bucher	1/23/06
	SB 1618	10,000/9%		Senator Campbell	1/25/06
Georgia	HB 1339	10,000/8%	Session adjourned	Representative Orock	2/15/06
	SB 579	10,000/10%	Session adjourned	Senator Miles	2/21/06
Illinois	Session started 1/11/2006	.....			.....
Indiana	Session started 1/09/2006	.....			.....
Iowa	HB 2430	10,000/8%	Referred to Human Resources	Representative Taylor T.	2/16/06
	SB 2246	8,000/9%	Referred to Commerce	Senator Bolkcom	2/21/06
Kansas	HB 2579	10,000/8%	Session adjourned	Representative Flaharty	1/9/06
	SB 557	10,000/8%	Session adjourned		2/14/06
Kentucky	HB 98	10,000/8%	Session adjourned	Representative Henley; Representative Gray; Representative Hoffman; Representative Jenkins; Representative Marzian	1/3/06
	HB 493	25,000/10%	Session adjourned	Representative Henley; Representative Gray	2/1/06
Louisiana	SB 69	Less than 8,000/8%	Referred to Senate Health and Welfare Committee	Senator Nevers	3/13/06

PENDING STATE HEALTH CARE MANDATE MATRIX—Continued

States targeted by AFL-CIO mandate	Bill number	Number of employees/mandate percentage	Status	Sponsor(s)	Date of introduction
	HB 552	5,000/6%	Referred to House Labor & Industrial Relations	Representative Herbert	3/16/06
Maryland	HB 1510	Less than 10,000/4.5%	Rejected by the Health and Govt Operations Committee	Delegate James Hubbard	2/15/06
Massachusetts.	MA SB 695 (intro in 2005)	99/don't use %	Referred to Committee on Health Care Financing	Senator McGee; Senator Tolman	1/26/05
Michigan	SB 734	10000/8%	Referred to Committee on Commerce & Labor	Senator Basham; Senator Clark-Coleman; Senator Jacobs; Senator Thomas; Senator Scott; Senator Brater; Senator Clarke	9/6/05
Minnesota	HF 74	10,000/6%		Representative Latz	6/13/05
	(2005 Special Session)	.....		Representative Peterson	.....
	HB 2786	10,000/10%		Representative Rukavina	2/16/06
	HF 3025	10,000/10%	Referred to Health Policy & Finance Committee	Representative Lesch	3/1/06
	HF 2573	10,000/10%	Health Policy & Finance Committee Hearing 3/10 at 8:15 AM, Room 10	Representative Mullery	1/19/06
	SB 2672	10,000/8%	Committee Meeting in Health & Human Services Budget Division 3/23/06 in Room 123 Capitol	Senator Lourey	3/2/06
	SB 2673	10,000/8%		Senator Lourey	3/2/06
	SB 2674	10,000/10%		Senator Lourey	3/2/06
	HF 3143	10,000/8%	Referred to Jobs & Economic Opportunity Policy & Finance Committees	Representative Lesch	3/8/06
	SB 2839	10,000/10%	Referred to Jobs, Energy, & Community Development Committee	Senator Tomassoni	3/8/06
Mississippi ...	SB 2684	10,000/8%	Legislation is dead	Senator Dawkins; Senator Williamson	.....
Missouri	SB 944	10,000/10%		Senator Bray; Senator Green; Senator Days	1/24/06

PENDING STATE HEALTH CARE MANDATE MATRIX—Continued

States targeted by AFL-CIO mandate	Bill number	Number of employees/mandate percentage	Status	Sponsor(s)	Date of introduction
New Hampshire.	HB 1704	1,500/10.5%	Legislation is dead	Representative Moody; Representative M.J. Quandt; Representative Waltz	1/10/06
New Jersey	SB 477	1,000/\$4.17 an hour		Senator Sweeney; Senator Coniglio	1/10/06
	SB 1320	10,000/8%	Referred to Senate Labor Committee	Senator Vitale; Senator Buono	2/6/06
	AB 2513	10,000/8%	Referred to Assembly Financial Institutions and Insurance Committee	Assemblyman Cohen	2/9/06
	AB 2891	1,000/\$4.17 an hour		Assemblyman Burzichelli	3/21/06
New Mexico ..	Session started 1/17/2006	.....			.....
New York	SB 6472	500 employees/\$3 per hr. for health care	Amended and re-committed to the Committee on Labor	Senator Klein	1/20/06
	A 10583	100 employees/\$3 per hr.	Referred to Health Cmte.	Assemblyman Gottfried	4/4/06
	SB 7090	100 /\$ 3 per hr	Committee on Health	Senator Spano	3/21/06
	A 9534	10,000/8%	Committee on Codes	Assemblyman O'Donnell	1/17/06
	A 9776	500 employees/\$3 per hr. for health care		Assemblyman Peralta	2/1/06
Ohio	HB 471	30,000/8%	Referred to House Finance & Appropriations Committee	Representative Garrison; Representative Healy	1/17/06
	SB 256	10,000/8%	Referred to Senate Commerce & Labor Committee	Senator Brady	1/18/06
	SB 258	1,000/8%	Referred to Senate Commerce & Labor Committee	Senator Brady; Senator Prentiss; Senator Roberts; Senator Hagan	1/19/06
Oklahoma	HB 2678	3,000/9%	Referred to House Insurance Committee	Representative Gilbert	1/18/06
Pennsylvania	HB 2495	10,000/9%	Referred to Committee on Insurance	Representative J. Taylor	4/5/06
Rhode Island	HB 6984	1,000/8%	Referred to House Finance	Representative Naughton; Representative Gallison; Representative Pacheco; Representative Almeida; Representative Slater	1/31/06

PENDING STATE HEALTH CARE MANDATE MATRIX—Continued

States targeted by AFL-CIO mandate	Bill number	Number of employees/mandate percentage	Status	Sponsor(s)	Date of introduction
	HB 6917	1,000/8%	Referred to House Finance	Representative Rice; Representative Handy; Representative Sullivan; Representative Faria; Representative Almeida	1/25/06
	SB 2201	1,000/8%	Referred to Senate Health and Human Services	Senator Pichardo; Senator Perrt; Senator Ciccone; Senator Issa; Senator Lanzi	1/26/06
Tennessee	SB 3392	10,000/8%	Referred to Senate Interim Committee	Senator Herron	2/16/06
	HB 3962	10,000/8%	Referred to House Interim Committee	Representative McMillan	2/23/06
	HB 3354	10,000/10%	Referred to House Interim Committee	Representative Turner	2/23/06
	SB 3729	10,000/10%	Referred to Senate Interim Committee	Senator Cohen	2/23/06
	HB 3686	1,000/8%	Referred to House Interim Committee	Representative Johnson R	2/24/06
	SB 3755	1,000/8%	Referred to Senate Interim Committee	Senator Burchett	2/24/06
Washington ..	HB 2517	5,000/9%	Legislation is dead	Representative Cody; Representative Conway; Representative Chase; Representative Morrell; Representative Appleton; Representative Green; Representative Wood; Representative Hasegawa; Representative Hudgins; Representative Ormsby; Representative Miloscia; Representative Dickerson; Representative Kenney; Representative Moeller; Representative McDermott; Representative Sells; Representative Hunt; Representative Williams; Representative Simpson; Representative Roberts; Representative Schual-Berke; Representative Lantz; Representative McIntire; Representative Kagi	1/10/06

PENDING STATE HEALTH CARE MANDATE MATRIX—Continued

States targeted by AFL-CIO mandate	Bill number	Number of employees/mandate percentage	Status	Sponsor(s)	Date of introduction
	S 6356	5,000/9%	Legislation is dead	Senator Kohl-Welles; Senator Keiser; Senator McAuliffe; Senator Franklin; Senator Thibaudeau; Senator Fairley; Senator Prentice; Senator Kline	1/11/06
West Virginia	SB 147	10,000/8%	Legislation is dead	Senator Hunter; Senator Kessler; Senator Dempsey; Senator Foster; Senator Lanham; Senator McCabe; Senator Jenkins	1/13/06
	HB 4024	10,000/8%	Legislation is dead	Delegate Brown; Delegate Caputo; Delegate Hartman; Delegate Hrutkay	1/16/06
Wisconsin	AB 860	10,000/don't use %	Legislation is dead	Representative Berceau; Representative Nelson; Representative Lehman; Representative Black; Representative Pope-Roberts; Representative Sinicki; Representative Zepnick; Representative Shilling; Representative Molepske	12/8/05
	SB 440	10,000/don't use %	Legislation is dead	Senator Hansen; Senator Robson; Senator Taylor	11/16/05

Mr. KLINE. Without objection, that will be inserted and all your written testimony will be inserted.

Mr. DROMBETTA. The special interest groups that are at the State level make no secret of the ambition to move to expand mandates to cover employers of all sizes. Let me be specific with two examples. In the aftermath of the Maryland veto override, legislation, House Bill 1510, was introduced by the original law sponsors that would apply the same Maryland payroll tax to all businesses in the State with fewer than 10,000 employees. These employees would be required to spend at least 4.5 percent of their payroll on health expense.

To the committee, I would tell you my raw dollars spent in support of health care exceed that. And if my costs had gone up from 2000 through 2006, which you heard me mention, I don't know how mandating a percentage changes that.

In New York, legislation is currently being considered that would mandate all employers in the State with more than 100 employees spending at least \$3 per hour on employee hours worked to pay for health cost. No distinction is made between part-time and seasonal employees. Obviously, the legislation would do nothing to address the fact in the State of New York the health care costs are the highest in the Nation.

I see my time has expired, and I haven't done a good job of delivering my entire text but you certainly have it, and I would welcome any questions the committee may have.

[The prepared statement of Mr. Drombetta follows:]

Prepared Statement of Larry Drombetta, President and CEO, HR Stores, Inc., on Behalf of the National Retail Federation

Mr. Chairman and honored members of the committee, my name Larry Drombetta and I am the President and CEO of HR Stores, Inc. I am pleased to appear today on behalf of the National Retail Federation (NRF). On behalf of my fellow NRF retailers, I commend you for holding this hearing to focus attention on the effect of health care mandates on employees and employers, particularly on smaller retail businesses like my own.

The NRF is the world's largest retail trade association, with membership that comprises all retail formats and channels of distribution including department, specialty, discount, catalog, Internet, independent stores, chain restaurants, drug and grocery stores as well as the industry's key trading partners of retail goods and services. The NRF represents an industry with more than 1.4 million U.S. retail establishments and 2005 sales of \$4.4 trillion. As the industry umbrella group, NRF also represents more than 100 state, national and international retail associations. www.nrf.com.

As the employer of more than 23 million employees (about one of every five Americans), the retail industry is one of the biggest supporters of the employer-based health insurance system. We are also mainstays of the economy. Our 1.6 million retail and restaurant establishments had sales of \$4.4 trillion in 2005, or 8.6% of our nation's Gross Domestic Product. According to the Bureau of Labor Statistics, our industry will add some 1.65 million new jobs over the next decade: an increase of 11%. We added 500,000 new jobs in 2005 alone.

Ours is not an easy workforce population to cover with health insurance. We have a fairly young workforce (though with a significant senior cohort) with a high turnover rate. We employ half of all teenagers in the workforce and a third of all workers under 24 years old. More than a third (35%) of this workforce is part-time. Two-thirds of our part-time employees are women. Often retail industry employees are second wage earners, mainstays of family economies. Some qualified retail workers opt-out of the coverage we offer because they already have alternative coverage through a family member or another job.

HR Stores, Inc.

Let me tell you a little about my own company. I am the President and CEO of a small company that operates 12 shoe stores in Maryland, Virginia, North Carolina and Pennsylvania. We have a staff of 35 of which 33 are full time and 18 participate in the company health insurance program.

My health care costs have steadily increased through the years and are increasingly unbearable. Coverage costs have increased by 155% from 2000-2006, a level my business cannot sustain with related growth. My company has not grown 155% in this same period and cannot continue to sustain these cost increases.

These cost increases directly impact my staff. This results in younger members of the staff dropping out in the belief that they are not likely to need the coverage at this price. This in turn results in the group having an increase in the average age, driving up the rates yet again. This process repeats itself year after year with the group becoming older and more costly to cover each year. My health insurance program is in what insurance industry people call a "health insurance death spiral." Under current law, there is nothing that I can do. The end result will be no more insurance for my employees.

A Federal Solution Needed

I believe that what is needed is a federal solution that allows a small business the same access to large group insurance rates that is now available to larger companies and unions. The mechanics needed to do so must be provided at a federal level and soon to avoid more small businesses like mine reaching the end of company provided/supported health insurance coverage.

We appreciate the work this committee has done to this end and especially appreciate the leadership of Chairman Johnson in sponsoring legislation for Association Health Plans (AHPs). I am hopeful that the Senate will vote soon on the bipartisan counterpart bill introduced by Sens. Enzi and Nelson. Perhaps then the Senate will at last catch up to the House in supporting health insurance relief to small businesses like my own.

I realize that there are many complexities involved in the cost of health coverage and that my request only impacts a small part of the solutions that we need nationally. The National Retail Federation stands ready to work with you and your colleagues from both parties to find these solutions.

I do hope that, on the way to seeking these solutions, we don't overlook the more immediate needs of companies like mine—small businesses caught in the health in-

insurance death spiral. I also urge you and your colleagues to avoid adding additional costs to my health insurance burden. I refer here to the health insurance mandates and mandates to provide coverage that are the focus of today's hearing.

Health Insurance Mandates Exacerbate Cost Pressures

Retailers provide their workers with good benefits that accommodate the unique dynamics of the retail workforce. As I noted previously, our workforce is dominated by young people, non-heads of household, retirees and part-time and seasonal employees, many of whom have coverage through sources other than their retail employer. We offer coverage to help attract workers and to maintain a productive workforce. Nevertheless, we are greatly concerned by the mandated expansion of these benefits, particularly in the current cost environment and given our unique workforce challenges.

State Health Care Mandates: Anti-Job, Anti-Business and Anti-Consumer

State health care mandates do nothing to address the real health care challenge: rising health care costs and reduced accessibility. In fact, they make matters worse. Legislation mandating that employers spend arbitrary percentages of their payroll on health care does not solve cost pressures but instead will jeopardize current employment levels, stunt future job growth and raise consumer prices.

We believe state health care mandates amount to an ill-advised tax on jobs. This is also a tax on workers, a tax on consumers and a tax on the economy. We believe that we are already taxed quite enough, thank you. Through my trade association, the National Retail Federation, my fellow retailers and I have established the Tax on Jobs Coalition to fight these state health care mandates.

Anti-Retail Industry

Many of these proposed state mandates have unfairly singled out the retail industry. Imposing an arbitrary payroll tax on an industry with already slim profit margins (averaging between two and three percent) will force retailers to make a choice between laying off workers and raising prices. Too often there is no choice but to look to both options. States that pass mandated health care legislation should not be surprised to see job losses, higher prices, fewer new stores, limited store hours and services as well as diminished tax revenues.

The special interest groups pushing these bills at the state level make no secret of their ambition to move beyond the retail industry to expand their mandates to employers of all sizes. Once they establish the precedent of gauging the sufficiency of employer contributions by payroll size, they will seek to lower the employee thresholds and raise the payroll tax—thus making all businesses susceptible to these mandates.

Let me provide two examples. In the aftermath of the Maryland veto override, legislation was introduced (H.B. 1510) by the original law's sponsors that would apply the same Maryland payroll tax on all businesses in the state with fewer than 10,000 employees. These employers would be required to spend at least 4.5% of their payroll on health expenses.

In New York, legislation is currently being considered that would mandate that all employers in the state with more than 100 employees spend at least \$3.00 an hour per employee hour worked to pay for employee health expenses. No distinction is made for part-time or seasonal employees. Obviously, this legislation would do nothing to address the fact that New York State still has the highest health care costs in the nation.

This "tax on jobs" legislation is not about health care at all but rather a legislative assault under the pretense of benefiting working families—throwing more money into a health care black hole. We hope that through the NRF Tax on Jobs Coalition we can work with you to help turn the tide against mandated health benefits and to help encourage policies that promote more affordable health insurance coverage. We urge Congress also to look to less expansive and less burdensome means to improving health insurance coverage. We stand ready to assist your efforts.

Thank you, Mr. Chairman. I will look forward to any questions you may have.

Mr. KLINE. Thank you very much.
Mr. Kelly.

**STATEMENT OF PAUL KELLY, SENIOR VICE PRESIDENT,
RETAIL INDUSTRY LEADERS ASSOCIATION**

Mr. KELLY. Thank you. I appreciate the opportunity to testify today.

Thank you, Mr. Kline, Chairman Johnson, and other distinguished members of the panel.

By way of introduction, the Retail Leaders Industry Association represents the largest and fastest-growing companies in the retail industry. Its members operate more than 100,000 places of business, have facilities in all 50 States and provide millions of jobs to American workers.

RILA is governed by a board of directors that includes the top leadership in some of the country's most innovative and successful companies, including Best Buy, Target, Ikea, Wal-Mart, Lowes, Dollar General, Petco and other retail leaders.

Let me get right to the bottom line. We are adamantly opposed to the unlawful State healthcare mandates that are the subject of today's hearing. RILA members want to and in fact do provide competitive health care benefits to their employees. But they do not intend to be dictated to by State governments about how those benefits should be structured or how much they should spend for those benefits. That is why our board of directors unanimously charged RILA to challenge these misguided statutes in court. These laws violate the Federal ERISA statute and are little more than hollow political gimmicks that do nothing to address the real health care challenges facing our Nation.

We strongly oppose healthcare spending mandates enacted in Maryland and Suffolk County, New York, and similar bills they have spawned across the country. These so-called fair-share bills remove a key element of flexibility by forcing businesses to spend a specific prescribed amount on health care benefits or, failing that, to pay a penalty to the state.

The exact percentage and the size of the companies captured by the mandate vary from jurisdiction, but the basic formula is the same: It is our position that these health mandates restrict employers' ability to be flexible, to respond to market conditions, and to react to the needs of their employees. Therefore, they significantly complicate and chill employers' efforts to provide health care benefits.

Just as important, we oppose these laws because they ignore the most pressing problems in health care today, namely ever-growing health care costs and the needs of the uninsured. Simply forcing employers to pay a specific amount for health care does nothing to reduce health care costs. To the contrary, it merely forces them to pay more for coverage that is already expensive.

Furthermore, the law does virtually nothing to address the needs of the uninsured and provides no assurance that a single person will gain coverage. In fact, Maryland's law affects only a tiny fraction of those working in the State partly due to the fact that the Maryland legislature excluded the government, the State Government from the bill. That is right, the law does nothing to provide health care for almost 20,000 uninsured employees who work for State and local governments in Maryland.

RILA recognized early that the Maryland law was a dangerous precedent not just for our members for all businesses who would likely—and that the bill would likely serve as a model for similar or even worse legislation in other States. And that is why RILA traveled to Annapolis last spring to testify against the Maryland law when it was being considered in the State legislature.

Each time we asked Maryland lawmakers to reject this spending mandate, we urge them to instead work with RILA and all stakeholders on figuring out ways to combat health care costs. Again, costs are the real problem in health care, but laws like these do nothing to address costs.

So once the Maryland bill became law, our industry had really only one avenue left to challenge this spending mandate and that was the Federal courts. In February, RILA filed two lawsuits seeking to overturn the new spending mandates in Maryland and Suffolk County. Our cases maintain that both laws violate the Federal ERISA statute and arbitrarily single out certainly employers for unfair discriminatory mandates.

We are pleased that four important allies have submitted friend of the court briefs in support of our leadership efforts to overturn the Maryland law. These groups include the U.S. and Maryland Chambers of Commerce, the National Federation of Independent Businesses, and the Society of Human Resource Management. RILA is confident that its lawsuits will be successful and that the recently enacted statutes will be overturned.

In the meantime, we hope other jurisdictions will await the results of our two court cases before considering similar legislation.

In closing, Mr. Chairman, RILA believes that ERISA is a key linchpin that undergirds our Nation's system of voluntary employer-sponsored health care. When Congress enacted ERISA more than three decades ago, it created a system that encourages employers to offer employee health benefits by permitting them to administer health plans uniformly and efficiently. This is especially important to employers like those who RILA represents who operate in multiple States. Without such uniformity, these employers would be faced with a hodgepodge of complex, conflicting State regulations that would make providing health benefits administratively cumbersome, more expensive and much less attractive to provide.

If we allow ERISA to be eroded by fair-share spending mandates or other State or local incursions, then we are headed down a dangerous track that could jeopardize employer-sponsored health care in this country. ERISA is critical, and it must be defended. Thank you, Mr. Chairman.

[The prepared statement of Mr. Kelly follows:]

Prepared Statement of Paul T. Kelly, Senior Vice President, Federal & State Government Affairs, Retail Industry Leaders Association

Introduction

Good morning. I am Paul T. Kelly, Senior Vice President, Federal & State Government Affairs for the Retail Industry Leaders Association (RILA). Allow me to begin by expressing my appreciation to Chairman Johnson, Ranking Member Andrews and the other Members of the Subcommittee for the opportunity to appear today, to offer RILA's position on state and local health care mandates.

By way of introduction, RILA represents the largest and fastest-growing companies in the retail industry. Its members include more than 400 companies world-

wide, including retailers, product manufacturers, and service suppliers, which together account for more than \$1.4 trillion in annual sales. RILA members operate more than 100,000 stores, manufacturing facilities, and distribution centers, have facilities in all 50 states, and provide millions of jobs both here and abroad. In fact, today, one in five Americans is employed by the retail sector making retail one of the most important employers and economic drivers in our economy. Finally, RILA is governed by a Board of Directors that includes the top leadership of some of the country's most innovative and successful companies, including Best Buy, PETCO Animal Supplies, Target, Wal-Mart Stores, IKEA, Procter & Gamble, Lowe's Home Improvement, Dollar General and other retail leaders.

For members of RILA, offering competitive salaries and comprehensive benefits is not just good for employees; it is also good for business. Attracting and retaining a qualified and satisfied team of employees is one of the most significant challenges that our members face everyday. Throughout the country, competition for employees is robust; especially in times of low unemployment such as we are experiencing in today's economy. As a result, RILA members on average pay their hourly employees nearly twice the federal minimum wage, and offer competitive benefit plans that often include health care benefits, employee discounts, profit sharing and retirement savings plans, stock option plans, disability insurance, training and educational opportunities, and other benefits. RILA members want employees who are healthy, productive and satisfied with their jobs—and the competitive nature of their industry demands that they provide attractive employee benefits. In short, RILA members have strong economic and altruistic incentives for providing competitive employee benefits and they oppose state and local government mandates that would limit their ability to design benefit plans that meet the needs of their workforce.

Leadership in Fighting Spending Mandates

RILA has a long history of involvement in federal, state and local public policy issues that impact our members, their customers and employees. RILA has worked closely with state retail associations, state and local business groups, and other organizations to take action whenever state and local policies threaten to adversely impact our members, such as the health plan spending mandates we are discussing today.

RILA has been at the forefront of efforts to resist health plan spending mandates imposed by states. Our members believe that lawmakers should focus on the root causes of our nation's health care challenges—particularly ever-increasing health care costs—rather than simplistically forcing employers to pay more for health care benefits that they are already struggling to afford.

In 2004, RILA organized its members and joined a larger business coalition to help defeat a California ballot initiative (Proposition 72) that would have forced most employers to provide expensive employee health care coverage. In the spring of 2005, RILA traveled to Annapolis, Maryland, to testify against legislation to impose a health plan spending mandate on large employers in the state. And, in the autumn of 2005, RILA urged legislators to reject the Suffolk County, New York, legislation that imposes a health care mandate on large, non-unionized retailers that sell groceries. RILA was the only national organization to testify before the legislature in opposition to Maryland's health care mandate, and is proud of its ongoing leadership on both the legislative and legal fronts in the battle against these mandates.

Since that time, both bills have been enacted into law, and while that is not the outcome we would have favored, RILA is heartened that other business organizations have increased their involvement in opposing these ill-advised proposals. Today, RILA continues to take a leading role in working with state retail associations, small business groups, and other organizations to oppose similar bills that have been introduced in more than 30 states and localities.

And, as the committee is aware, RILA has also challenged these unwise spending mandates in court on the grounds that they unlawfully regulate health benefit plans that Congress intended to be regulated under the federal Employee Retirement Income Security Act (ERISA). A discussion of these legal challenges follows later in this statement.

RILA's View on Health Care

Everyone agrees that good health care and good health benefits are important. Health care issues are a key concern for retailers, both large and small. As such, RILA supports meaningful efforts to improve our system of health care for everyone. For the last several years, RILA has urged lawmakers to focus on policies that will help reduce health care costs. Premiums for employer-sponsored health insurance have experienced significant increases for the last several years. Health care insur-

ance premiums increased 9.2 percent last year, and are projected to increase another 10 percent this year, and health care spending now represents 16 percent of the nation's gross domestic product—an all time record. Clearly, something needs to be done about costs. The retail industry is highly competitive with razor-thin profit margins, and ever-increasing health care costs put great pressure on our members' businesses. Penalizing low-margin businesses by forcing them to pay more for health benefits makes no sense, and does nothing to address the real problem in health care. Any additional costs forced upon retailers by local, state or federal governments will jeopardize their ability to continue to offer benefits that may be more important to workers.

As leaders in providing value to American consumers, RILA members see tremendous opportunity for Congress to take action on policies that will improve the health care system by stimulating more competition within that system. RILA members are not health care experts and we do not presume to have all the answers to our nation's complex and entrenched health care challenges. However, just as RILA members have transformed the retail market through competition and innovation—all to the benefit of consumers—we are confident that enhanced competition will bring important improvements to the health care system as well. We support policies that will:

- Empower individuals by giving them more control over their health care choices and spending—what is sometimes broadly called consumer-directed care;
- Provide individuals and employers with more and better information about prices and the quality of the care they are purchasing, including information about health providers and insurance plans;
- Help make health benefits portable, so workers can take benefits—or the money they would use to pay for benefits—with them when they switch jobs;
- Encourage wellness programs, preventative care and disease management services; and
- Stimulate innovative technologies to help reduce medical errors and shrink administrative costs.

We readily admit that none of these ideas are new or groundbreaking, and other policies surely will need to be explored. However, we believe these ideas will help move us toward a more competitive health care system where costs will be lowered—and that lower costs will help bring affordable health care options within reach of more Americans.

And, importantly, we also strongly support current policies that encourage employers to voluntarily provide health care coverage—of which ERISA is a key and indispensable component.

The Importance of ERISA

When Congress enacted ERISA more than three decades ago, it created a system that encourages employers to offer employee health benefits by permitting them to administer health plans uniformly and efficiently. This is especially important to employers that operate in multiple states, such as RILA's members. Without such uniformity, these employers would be faced with a patchwork of complex and conflicting state regulations that would make providing health care benefits much less attractive.

The single, national regulatory framework afforded by ERISA gives companies the flexibility they need to meet and respond to the unique requirements of their workforce. This is especially important to retailers who employ a much younger workforce than most industries. In fact, one-third of all retail workers are under 24 years of age, as compared with only 14 percent for all industries. Young people often decline to participate in employee-sponsored health care for a variety of reasons. Retailers also have a high percentage of workers who choose to work part time. Given the unique demographics of their workforce, retailers need flexibility in devising health plans that meet their distinctive characteristics, and ERISA gives them that flexibility.

Today, however, ERISA's uniformity and efficiency are under attack by lawmakers who seek to undermine it with a patchwork system in which state and local governments could regulate health plans—each imposing a unique set of regulations and costs on the benefit plans offered by employers. As RILA member James Myers, CEO of PETCO Animal Supplies, Inc., recently observed, “The health care system cannot be fixed with a patchwork of state and local mandates that require individual industries to play by different rules. It's a national issue that requires a national approach.”

State and local legislation seeking to mandate arbitrary health plan spending levels for businesses is misguided and unwise because it does nothing to address the most significant health care challenge that needs to be addressed, namely health

care costs. And this legislation is fundamentally unlawful, because it violates ERISA and, in some instances, the constitutional principle that our laws should not arbitrarily discriminate. Legislation that singles out any one company or industry in this way is unlawful, unwise, and should not be supported by policymakers.

State and Local Health Spending Mandates are Unwise, Ineffective and Unlawful

RILA and its members are strongly opposed to unwise statutory health plan spending mandates imposed by government at any level. We have been reminding policymakers that health plan spending mandates in themselves do nothing to improve the quality of health care or address health care costs. Paradoxical as it may seem, more health care spending does not equate with increased health care quality. Spending alone is not the solution.

In addition, we oppose these mandates because we believe they have the potential to harm both employers and the overall employment climate. If state and local health plan spending mandates are permitted, businesses may be forced to abandon plans for growth, reduce jobs or consider reducing employee compensation and other benefit areas.

We are continuing the efforts to combat health plan spending mandates at the state and local levels that target both large and small companies that belong to RILA. Based on experience, we believe that whenever legislation singles out just one commercial industry or one segment of an industry, all businesses should be concerned. Any bill that mandates health care spending makes no sense for retail businesses, regardless of size. Both large and small businesses oppose arbitrary requirements for health care benefits.

RILA is now coordinating opposition to these mandates through public policy, public relations, and networking efforts at the local, state, and federal levels. That is why we are here today. We also maintain an active liaison with other retail associations and business groups that share our concerns. Even groups whose members are not yet impacted by these laws stand with us in opposition because they recognize the threat that these laws represent. In fact, RILA's legal challenge to the Maryland health care mandate has been supported through "friend of the court" briefs by the National Federation of Independent Business, the Society of Human Resource Management and the Maryland and U.S. Chambers of Commerce. Clearly, these discriminatory mandates—even though narrowly focused on large businesses—are of grave concern to the broader business community.

Spending mandates such as these are bad policy and bad law, and should not be enacted elsewhere. In fact, given the well-grounded lawsuits that RILA filed in those two jurisdictions in February, which I will discuss in a moment, we would hope other jurisdictions would await the results in these two cases before considering similar legislation.

Laws Driven by Special Interest Concerns

At present there is an aggressive coordinated campaign underway across the country by organized labor to introduce health plan spending mandates. We understand that labor unions have their own agenda designed to advance their own interests, but in this case that agenda has harmful consequences for our members, customers and employees.

Organized labor groups are asking lawmakers in 33 states to enact model legislation forcing large employers to spend a percentage of their payroll on employee health care benefits or else pay a fine, in effect, to a state health care fund. The exact percentages, and the size of the companies captured by the mandate, vary from state-to-state, but the basic formula is the same: employers with a specific number of workers would be mandated to pay a specific amount or percentage on worker health benefits. To the extent an employer's spending falls short of these mandated amounts, the difference would have to be paid to a state fund set up by the legislation for the supposed purpose of defraying state expenditures on health care.

So far, the State of Maryland, New York City, and Suffolk County, New York have enacted discriminatory health care mandates that prescribe arbitrary spending requirements. As we have noted, earlier this year, the Maryland State Legislature enacted the so-called "Fair Share Health Care Fund Act," requiring employers with more than 10,000 employees to make expenditures on health benefits equal to 8 percent of total compensation paid to their employees. In Suffolk County, New York, the law specifically targeted non-unionized food retailers, requiring that they make health care payments at a rate of no less than \$3 per hour worked. Since that time, Suffolk County has amended its law, to modify the \$3 per hour mandate, in direct response to the litigation initiated by RILA. While RILA is still reviewing this

amended legislation, we believe that the amended law remains an unwise and unlawful health benefit mandate.

Versions proposed in other states include smaller businesses and mandate even higher levels of health spending. That is why all of our members and the business community at large are so concerned about these proposals. Clearly, it is only a matter of time before the proponents of this approach target even more businesses for these spending mandates. For example, in Oklahoma, a version of this bill requires businesses with 3000 workers to pay 9 percent of payroll on health care. In New Hampshire, the threshold is 1500 employees with a 10.5 percent spending requirement. In Rhode Island, the thresholds are 1,000 employees and 8 percent of payroll. In New Jersey, a spending mandate would apply to businesses with 1,000 employees and in New York, businesses with 100 workers would be hit. In all, 30 states have initiated these types of bills and the legislation remains a viable threat in many states. (RILA's detailed legislative matrix on the status of all these bills is attached.)

And while these bills have lately become of concern to the broader business community, there is little doubt that they initially were designed to discriminate against a specific segment of the retail community. Suffolk County Council public hearings reflected this. The head of the New York State Food Industry Alliance opposed the original version of the bill, saying it was "far-reaching," "inflationary," and would cause "major economic damage." He also expressed concern that it "gets into our collective bargaining agreements with our unions and supersedes them." The legal counsel for a large mini-market chain cautioned that "there are several areas where the bill could be challenged legally. * * * First of all, the definition of employee is broad * * * and there is an argument that ERISA may preempt this law. * * * There is also a potential that the bill could be preempted by the NLRA."

In response, Suffolk County legislators told concerned witnesses that this legislation was aimed only at out of town competitors. And that's why in the final bill they exempted unionized companies; the legislators had been told that the \$3-an-hour spending mandate was more than large unionized employers in Suffolk County were paying.

Since the law was initially enacted, Suffolk County has changed its law specifically in response to the legal action initiated by RILA. While RILA is still analyzing the revised Suffolk County law, we believe that this new law still violates ERISA.

RILA Lawsuits

More than 30 years ago, Congress wisely created a single law to govern employee health benefit plans—ERISA—to prevent a patchwork of different state and local laws. The Supreme Court of the United States has held repeatedly that state and local laws regulating employee health benefit plans are superseded by this federal law. Moreover, the U.S. Constitution and some state constitutions specifically prohibit laws that arbitrarily discriminate against any one entity or group of entities, as these laws do.

Recognizing the troubling precedent that the Maryland and Suffolk County, New York laws represented, in January 2006, RILA's Board of Directors unanimously authorized the association to pursue legal challenges to the laws. RILA filed two lawsuits in February 2006, one seeking to overturn the new benefits mandate law in Maryland, and the other addressing the similar statute in Suffolk County, New York. We maintain that both laws arbitrarily single out certain employers for improper and discriminatory health plan spending mandates. We are challenging these laws on a variety of federal and state bases.

The Maryland law requires significant expenditures by one large employer in the state, at present. Supposedly, this was done to improve health coverage in the state, but it will do no such thing. Maryland's law actually would affect only a very tiny fraction of the state's workers. Interestingly enough, more of the uninsured in Maryland work for state and local governments, and in sectors other than retailing.

As originally adopted, Suffolk County's law requiring health care payments at a rate of no less than \$3 per hour worked. This law also was discriminatory in a way that did nothing to address the problem it was supposed to solve.

Again, let me reiterate that while we recognize that the law has since been amended, we still believe that the mandate it imposes is unlawful.

ERISA

When the U.S. Congress created a single law to govern employee health benefit plans in 1974, as an incentive for employers to offer these plans, it correctly recognized that it was in employers' interests to have a uniform and consistent law regulating employee benefit plans. The protections that ERISA gives for employee benefit plans have proven to be good public policy; and over the last three decades, the

U.S. Supreme Court has repeatedly ruled that ERISA is preemptive. It says that states and localities cannot force mandates on employee health benefit plans. RILA believes that legislation in Maryland, like the Suffolk County law (in its original form, and as amended), violates this important and well-established principle.

U.S. Constitution

We also contend that discriminatory health care mandates are inconsistent with other important requirements of federal and state law. They violate the Equal Protection Clause of the Constitution, which prohibits irrational, discriminatory distinctions in the law. The Constitution prohibits anyone from arbitrarily targeting certain employers, and unreasonably singling some out for health care requirements not expected of others. Yet that is exactly what is done by discriminatory health care mandates.

RILA is confident in its position and optimistic that its lawsuits will be successful and that the recently enacted statutes in Maryland and Suffolk County, New York, will be overturned.

Conclusion

Mr. Chairman, we all know that our nation faces serious health care challenges today. But a real solution does not involve quick-fix, simplistic approaches that ignore the fundamental causes of the health care crisis in this country. I want to make clear that RILA supports initiatives designed to increase access to health care and to promote competition in the health care marketplace through comprehensive policies that will help control skyrocketing health care costs. Discriminatory health care mandates do nothing to reduce health care costs, but actually increase costs for employers who are already struggling to provide workers with affordable health coverage.

RILA urges Congress to work with retailers and other stakeholders concerned about this important issue to achieve meaningful reforms to the health care system, instead of imposing unwise and ineffective health care mandates on businesses.

Thank you very much.

Chairman JOHNSON [presiding]. Thank, you sir. I appreciate your testimony. I thank you all for testifying today.

Mr. Garthwaite, your testimony made sense to me. I sat through a couple of hours of testimony on the new Medicare prescription drug plan yesterday, part D. You all are aware, I am sure. And there was compelling evidence that choice and competition work so it makes perfect sense that a one-size-fit-all approach wouldn't succeed in bringing down costs for employers or employees.

One thing I would like to focus on is how the blunt instrument of a mandate affects options for employees. There are all kinds of insurance products out there, and it seems like people should be able to choose the option they want. For example, a younger person who doesn't smoke might not want the same kind of insurance a 55-year old smoker might want. Can you explain to me how a mandate might limit their options?

Mr. GARTHWAITE. Certainly. If you take, for example, California, which was the linchpin that started most of the State-mandated reforms in the recent years, they required a minimum level of benefit that was extremely rich. It required full HMO coverage, full prescription drug coverage, very gold standard coverage, which is good, as you said, for older Americans, someone who may smoke, may need that kind of day-to-day care.

For someone who is younger, it may make more sense for them to look for some sort of catastrophic plan where they are insured for some sort of horrible event but takes care of their regular routine maintenance out of pocket. Maybe they can come out with some sort of health care savings accounts. Any sort of mandate

that requires a minimum level of benefit would exclude the ability for companies to enact these kind of choices for their employees.

Chairman JOHNSON. So really what you are saying is that if the employer was forced to offer insurance, there is nothing that says a younger guy has to participate, unless the State requires it, and if they do, then he may not be getting the lowest cost insurance for himself. Is that true?

Mr. GARTHWAITE. In California, there was a mandate both on the employer to provide coverage and on the employee to accept it. So the employee was responsible for paying for 20 percent of the cost of this very expensive coverage and didn't have the option to seek out other insurance options.

Chairman JOHNSON. I think that I will pass to my friend Mr. Payne for questions.

You are recognized for 5 minutes, if you desire.

Mr. PAYNE. Thank you very much. Let me thank all of you for your testimony. I think the first speaker Mr. Garthwaite mentioned in your opinion it seems unfair that the cost of health care should be shifted to the backs of the employee. Since a person works for a company, how do you characterize that as shifting the burden back? Do you feel that in your—therefore, I would conclude that in your opinion that health care is simply the responsibility of the individual, period. Is that what you conclude by that statement you made?

Mr. GARTHWAITE. What I was referring to is what the research shows is, when you mandate an employer provides health coverage, they react in the way, I am sure Mr. Drombetta can speak better, they will look for ways to save money on that. They lower the wages of the employee. So it ends up that the employee ends up paying for the insurance even if they are not nominally footing the bill.

Furthermore, in cases where they can't actually lower the wages, they look to treat it like an increase in the minimum wage, for example, where they will lay off employees in order to maintain their profitability.

Mr. PAYNE. Mr. Drombetta, you were mentioning the names of the organizations, State chamber, et cetera, small business, whatever, that oppose this. How do they characterize, and maybe, Mr. Kelly, you have strong feelings too, maybe you can also chime in, how do you characterize the businesses that provide health care? I mean, you are all sitting around the table—a good example, UPS does provide health care for part-time employees. They compete against FedEx and even the new guys in from Germany, DL-something, subsidized by their government and creating problems in that industry.

You all sit around the table with the chamber guys, and the chamber comes out and says, we should not put the responsibility on the company that doesn't want to do it, and the guy next to him is doing it. How do you—how does that work?

Mr. DROMBETTA. I can't speak for UPS or FedEx.

Mr. PAYNE. Maybe Mr. Kelly.

Mr. DROMBETTA. But I would like an opportunity to respond because as part of it I want to bring to light, I believe the number I hear, if my recollection is correct, is that 65 percent of the unin-

sured nationally are in small businesses. They don't work for FedEx or UPS. They are small business owners, managers; they participate in small organizations. And I don't know that my organization is necessarily a good measure nationally of what is going on, but this I can tell the committee with confidence, the bottom-line earnings in my company cannot keep up with the increase in health care costs. I have a small company, much the same as many small businesses, and the rates are different for me than UPS.

Mr. PAYNE. I agree with you. As a matter of fact, the majority of people work for small businesses, 80 to 85 percent of Americans, believe it or not, work for small businesses, so it is a real dilemma for small businesses. Maybe Mr. Kelly might want to chime in on, how do you reconcile those who do it? Because therefore it is a disincentive for the companies who do provide it, and, second, when in our State, as we mentioned, 50 percent of the people that work for a particular company, I mentioned, have no coverage, and they, therefore, when they are hospitalized, they end up with charity care, which the taxpayers, someone who is paying health insurance themselves, really have to pay for that employee because the hospital is going to bill someone, and the State is usually the provider of last resort.

Mr. KELLY. Well, just to be clear, as we said in our written statement and I said in my oral statement, all of our members provide health care benefits. None of them provide exactly the same type of health care benefits, and that is why we are emphasizing the importance of ERISA, because ERISA provides them the opportunities to be flexible, to avoid State mandates, local mandates which tie their hands in how they provide care to employees.

I mentioned the U.S. Chamber of Commerce, the Maryland Chamber of Commerce, and the National Federation of Independent Businesses really to make the point that, while RILA represents large employers, this is a concern across the business community. Mr. Drombetta is evidence of that fact. These health care mandates that are being introduced across the country will eventually, people realize in the business community, get down to impacting businesses of all size. That was really played out in the State of Maryland. Shortly after we sued in Federal courts to overturn the Maryland law, a bill was introduced in Annapolis that would impact all employers with a similar mandate.

So our point is, it is a very bad precedent, and it concerns the entire business community.

Mr. PAYNE. My time has expired. But years ago, there was H.R. 1200 that President Clinton was attempting to get national health insurance. That would have been some way where everybody could participate, totally opposed by everybody in business, General Motors. That would have been some way the Federal Government could participate.

I don't understand, what are we going to finally do to help offset the cost? They don't want the Federal Government to be involved in national health insurance; it was killed; don't feel it is fair that a company should have the responsibility to provide it.

This problem is not going to go away unless there is some reconciliation of what way we are going to go as it relates to health insurance. Believe me, as I end before my time totally expires,

there are more and more serious problems in the world with climate change. You are going to have malaria in moderate zone countries. It used to only be in tropical. Because of the change of the weather, you are going to have countries that never had a malaria problem, have it. Wait until that, with the avian flu and all these other kinds of diseases, comes forward. We have got a serious problem in front of us.

I will stop, Mr. Chairman. Thank you. You have been kind.

Chairman JOHNSON. The gentleman's time has expired, twice. Thank you.

You know, part of the reason that companies provide insurance coverage in the first place is competition, and that happened some years ago when the companies were trying to get employees to come work for them so they provided insurance, and others didn't, so the guy has his choice. Nowadays, if you try to Federalize health care, I think it is a mistake because costs will go up, and that is why the most recent Medicare change that you see that we passed here I think is working. It has got an element of free enterprise involved in it. People pick and choose. I think it makes a difference.

Mr. Kline, you are recognized for 5 minutes.

Mr. KLINE. Thank you, Mr. Chairman. I would like to thank the witnesses. This is indeed a very, very important subject as we are looking at the cost of health insurance and how employers are struggling to provide that health insurance for their employees.

Mr. Drombetta, you mentioned the association of health plans. Many of us on this committee and this House have been trying for a very long time to get those enacted so that small employers would have some of the same advantages that larger employers have provided by ERISA. Now we are seeing that perhaps some of those advantages are being eroded and hence the subject of today's hearing.

Staff provided for us a piece of paper that looks like RILA had put forward, and it is interesting to look at what is going on in the States. I see that, in this year alone, it looks like Rhode Island has three different bills proposed mandating health care; Tennessee has about six. And I look at my own State of Minnesota, and there are eight different proposals in the legislature this year. It looks like to me we are building a very large, confusing and unmanageable situation. We have in Minnesota, we are the home of several very large companies, many of them that you have mentioned, big companies like General Mills and 3M and Best Buy and so forth. I can't imagine how they deal with providing health care if there are now—if the protections of ERISA go away, and they now have to comply with these many mandates. A perplexing problem.

It looked like we are very much aware of what was going on in Maryland because it is right next door here, but it looks like now that sort of thing is spreading. Mr. Kelly, you talked about this earlier. And you provided this.

What are you seeing in terms of success rates? This shows bills introduced. What is happening in other States as far as actually changing the law, getting it signed, Governors signing?

Mr. KELLY. Well, we are seeing, as you indicate, these have been introduced across the country. It is close to 30, if it is not 30 States where it has been introduced. Many States have really not acted

on them, but I will say there are other States where these remain legislative proposals subject to hearing and debate, large States like California, New York, New Jersey, smaller States like Rhode Island. It continues to be something that percolates and is something that has the entire business community, has their interest, and they are very concerned about, and we are doing everything we can to work with other trade groups, other business groups to again not just oppose this but to oppose it and help lawmakers figure out ways to reduce costs and to address the real problems in health care that could help make health insurance and health care affordable and within reach for more folks.

Mr. KLINE. I thank you. I think it is an issue that has been in front of us, and we have been grappling with it in many ways. I am a big proponent of the health savings accounts enacted into law with the Medicare modernization bill. I have talked to a number of employers, large and small and employees, who are finding this is working to their benefit. We have already mentioned the association health plans.

The point here is, we are looking for ways for more people to be insured and for companies to be able to provide that insurance in affordable ways, so I appreciate all of your testimony here today.

In the interest of keeping this moving along, I am going to do the unthinkable and yield back my time before the red light comes up.

Ms. KOFMAN. I am sorry, can I just add something to the discussion about States and what they are trying to do?

The impetus behind many of these State proposals is the problem that many employers that provide coverage to their employees don't provide adequate coverage, and the coverage doesn't cover all of their employees, so what happens is these workers rely on State programs, on government programs, and it becomes unsustainable to keep on funding these government safety net programs without income streams.

And so this is one way to help finance the programs that serve all of the States' residents, by asking employers to pay into those programs that their employees use. It is also a question of fairness. For example, you have companies that provide very generous, very comprehensive benefits to all their workers, and their workers never use State-funded programs. And of course, it is an issue on their bottom line because they pay for that comprehensive coverage, the company that is. It is very unfair for other employers to send their workers to government programs and not pay for that. They are making bigger profits, and it is really unfair, and I think it is not competitive. That is not the kind of competition we want to encourage. Thank you.

Chairman JOHNSON. Competition is what drives America. If somebody wants to make a little extra money by doing a better business plan, they ought to be allowed to do it, in my view.

Mr. Kildee, who remembers World War II price controls.

Mr. KILDEE. OPA.

Mr. Drombetta, if the four states in which your company does business were to replicate the Massachusetts plan recently passed by a Democratic legislature, signed by a Republican Governor, would that not give you and your competitors the same level which to compete?

Mr. DROMBETTA. I am not an expert on the Massachusetts plan. But from what I have heard of it, it wouldn't address a couple issues that need to be thought about at the committee. One is small businesses like mine won't buy health coverage in an vacuum. There are three providers that meet the standards set by the State, primarily, and those are my three choices. In the last 7 years, we have explored costs with each of those three providers on exactly the same coverage, and that is where the increases come from.

If I could find a way—well, let me restate that, I can bid my freight to move product into my stores, but I can't find as much competition to buy health care.

I am not the expert in the field, but something seems strange to me that I can go through and—let me explain a little bit better.

I belong to the National Shoe Retailers Association. I can tell you why I belong to that association, because they competitively talk to freight companies across the country and come out with the best rate they can get, which I, in turn as a member, elect to use. Each year I take health savings and freight, compare that to costs and benefits from that association.

I can't do that with health care. I don't know the intricacies of it. I don't understand the Massachusetts law. I would welcome an opportunity to add more people to the list of options I have.

Mr. KILDEE. But of all the retailers, particularly the shoe retailers, were required to provide insurance that would at least put you on the same level with your competitors.

Mr. DROMBETTA. I can tell you I did go out and take my employee base, 33 people, about 18 in health care, and considered moving them to their companies. I forget the term for them; but you take your employees to—I think it is a contractual relationship where my employees would really become—

Mr. KILDEE. Contract employees?

Mr. DROMBETTA. Contract employees. The health care cost of such an arrangement would have dropped by almost 40 percent. That is huge when you think about the cost of my health care going from X to 155percent higher. To be able to say that that cost can be driven down by 40percent is a lot of money, and to the people who work in my stores who run them, who turn the keys, this is a big impact.

I cannot do that. It is not permitted by law in the State I happen to live in, my company exists in, and I am sure there are good reasons for those laws, that they have a place, that they are needed. I am not debating their necessity, but the reality is that the committee, it puts restrictions on a small business choice.

Mr. KILDEE. Mr. Garthwaite, if employers shouldn't cover health costs for workers, the government also shouldn't bear the cost, and the minimum wage shouldn't be raised so the people can pay for their own premiums, where is it people will find the money to pay for it, their health insurance?

Mr. GARTHWAITE. With all due respect, I don't think I ever said employers shouldn't provide health care. I certainly didn't say the government shouldn't provide any money for health care. I think what I am talking about, employers shouldn't be required to provide health care to all their employees, because in the event that

happens, the economic realities that must be confronted, you can't ignore the economic reality that employers will look to save costs wherever possible, and they'll do that in many ways at the expense of the employee.

Mr. KILDEE. And the employer is not providing the health care cost, and they don't qualify for government health care costs or Medicaid, for example, or Medicare if they are older, then where would they find the money if you also take a strong position on not raising the minimum wage? Where will they provide for their own health care?

Mr. GARTHWAITE. I think the important thing we should be looking at, how we will decrease the cost of health care to make it affordable. Clearly as health care keeps getting more and more expensive, it will be almost impossible for anyone to buy health care in the private market, but we need to look for ways to lower the cost so that employers can.

There are a number of ways that have been discussed. Health savings accounts can be seen to lower the cost of health coverage. There have been proposals for tax credits. All of these will be ways that you can make coverage more affordable to people.

Mr. KILDEE. Thank you very much.

Ms. KOFMAN. May I add something to that?

Mr. KILDEE. Please do.

Ms. KOFMAN. When we think about people's needs, medical needs, we need to think about the question of who pays. Just because the employer doesn't pay doesn't mean the medical need go away. If the person is lucky enough to be able to pay for it out of pocket, that is fantastic, but many people can't. And so what happens is that person ends up waiting to too long to get the care that they need, end up paying more; and actually, all of us pay more for it because the cost of that care gets shifted to the rest of us.

So the question here we should all be thinking about is who pays, and how do we pay for it efficiently so it doesn't cost us more in the long run?

I know that some folks have raised the issue of HSAs and some of these other new products that are out there. The cost savings from those are on the employer side of it. Premiums are lower, but someone still has to pay for the medical care, for the cost of going to the doctor, and the cost of that is shifted to the patient. So when you need care, you pay for it out of pocket.

It used to be that your health plan or your employer paid for it. Now you pay for it with some of these proposals. So I would submit to you that some of these proposals will actually not help address any of the cost drivers and actually will shift costs to patients and will make it harder for us to address this ever-growing problem.

Chairman JOHNSON. Well, you made one misstatement, in my view. Employers did not used to pay for it. I mean, it is a competitive thing. Employers may or may not choose to provide health care coverage, and it is a competitive thing.

In the case of the gentleman sitting next to you, his company may not provide it because they don't have the profit margin to do it. So I think he is right. If you start mandating it, employee wages are going to decrease, it is a given, because they have to make a profit to make the business run.

Mr. PAYNE. Mr, Chairman, do you mind if I may have a second? Actually during World War II and actually following World War II, it was almost a rule that employers did provide health care. I mean, the whole new thrust of employers dropping health care is a new phenomenon in the last 20, 25 years; but it was almost—if you took those companies that were around at that time after World War II, it was more the rule than the exception that health care was provided. That is a fact.

Chairman JOHNSON. That is true. And the reason it was is because there were price and wage controls, which made them offer health care as an incentive to get more workers, more money.

Mr. PAYNE. However, following the war it remained, and even defined pension contributions were there. So we have seen something happen within the last 20 or 30 or 40 years that have taken away those benefits that American workers were privileged to have following the world war. And now we move into various 401(k)s, Roth IRAs and all that, which I am not saying it is necessarily bad, but I am just saying there has really been a big sea change in that. Thank you.

Chairman JOHNSON. Sure. Sixty years ago. I hope things are changing.

Mr. Wilson, you are recognized.

Mr. WILSON. Thank you, Mr. Chairman, and thank all of you for being here today. I particularly appreciate, Mr. Drombetta, your concern about small businesses. Those are the people I represent in the district that I represent. Around 99percent of the businesses that I represent are small businesses with about 85percent of the employment. So I really appreciate.

And, indeed, I want to join with my colleague from Minnesota to point out that with the Association of Health Plans, hopefully that will make a difference. And then with the health savings accounts, I really believe that has great potential and finally is being recognized, and it was pointed they may be limited. I disagree. I think they provide options. I think they provide for preventative health care, and so I am very, very hopeful.

In addition, looking at different States, I am happy to see that my home State, South Carolina, has zero planned mandates. I served 17 years in the State senate, and I remember well by providing for mandates, it really limited the competition. So South Carolina is wide open for business, wide open for jobs.

I am happy to see Mr. Kelly here with the Retail Industry Leaders Association, 100,000 stores. I want you to know I am doing my part because—innovative and successful, as I look at your testimony. Best Buy, I just bought a camera. Wal-Mart, I got a good deal on socks; on Monday some shoes. On Monday, you had a great deal at Lowe's on geraniums. I want you to know that the best deal on cough drops in the world is the Dollar General Store right here. And finally, in my home community, the biggest news in our home community—you would think it would be a brand new school or whatever. No, it is the new Target superstore in Lexington, South Carolina. That has caused quite a stir. So we appreciate the retail industry.

And that is why I am concerned about the Maryland law and would like to know how this law affects your members. Would it

force large employers to pay more for health care? Does this improve the quality of health care? And does it remove an incentive for employers to negotiate the best coverage for the money?

Mr. KELLY. I think our viewpoint on the Maryland law and those that—the legislation it has spawned across the country is that it doesn't do anything to reduce health care costs. It simply says a specific—an employer of a particular size provide health care benefits at a particular spending level. That doesn't do anything to impact reduction in costs of care. It doesn't even do anything to help provide coverage to people who don't have coverage. It simply says, you have to pay more for coverage than you are already providing.

That, to us, seems to really miss the point and, you know, gives State legislators a convenient way to say they are doing something on health care without actually addressing the issues of costs and coverage. With that being said, we continue to reach out to lawmakers across the country to try to figure out ways to help reduce costs.

Mr. WILSON. And what would happen to your members' health care costs if they did not operate ERISA plans?

Mr. KELLY. Well, if ERISA eroded in any way, we believe that would increase health care costs, making a much less attractive option to provide health care. Again, ERISA was designed originally to provide multistate employers an opportunity to offer benefits in a uniform way, to avoid sort of the patchwork or hodgepodge of State and local mandates on health care.

You know, our members are in competition with each other for good employees. They want to provide healthy and good benefits. They do provide good benefits packages. It is becoming increasingly difficult, given that health care costs continue to skyrocket every year. Again, I think the latest figures show that health care spending represents 16percent of our gross domestic product in this country. That is an all-time record. Let us address that so health care is more within reach for everybody.

Mr. WILSON. And in your testimony you indicated that your industry employees say a high percentage are young and part-time workers. And this really applies to all four of you. What can be done to educate younger employees about the need for health insurance?

Mr. KELLY. Mr. Drombetta did a great job talking about sort of the unique characteristics of the retail workforce. It does tend to be younger. About a third of all retail workers are 24 years of age or younger. You know, these are folks who, if offered health insurance, frequently don't want it. They may feel they would rather use the money they would otherwise use on insurance premiums for savings on a down payment for a car, or home, or for any other use.

It is important to educate folks about health care insurance. Our members do that. Our members provide broad packages of benefits; but there's not always a high rate of take-up on the benefits, and frankly, I am not sure we really know what the answer is to that. But more education certainly would help, and more options would certainly help as well.

Mr. WILSON. Anyone else want to comment?

Mr. DROMBETTA. My experience is limited, but I would tell you the younger members of my staff are at a point in their lives where

they have different priorities. They hope to come out of an apartment into a condo or out of a condo into a house or to have their first child, and it is hard—certainly hard for me to think back to those—that time of my life, to those years. But that is the choices they make, and in the small business environment, you are deciding what do you need to do. Our typical store has two people in it. Two people. One of them may be 24 or 26 and feel they don't need the coverage.

Mr. WILSON. Do you have a comment, too? Pardon me.

Ms. KOFMAN. I actually agree. There is a segment of the young population who believe they can fall out of an airplane and not get hurt without a parachute. So you can give coverage away, but they may not sign up. It is a very difficult segment of the population to reach and educate about insurance and financial security and why you need health insurance that would give you financial security.

If I could just go back to some points earlier that were made about Maryland's law. I think it is important to remember that Maryland legislators passed the law not in a vacuum, but they have a certain regulatory environment. They have done a number of different things in Maryland that all work together to help address the rising costs of medical care and the rising premiums.

For instance, Maryland has a high-risk pool which is now growing to be one of the biggest in the Nation, and it covers the people in Maryland with the highest medical needs so they don't go to the hospitals, and we all experience cost shifting as a result.

Maryland also has a hospital rate-setting commission so the hospital rates are all set. There is no negotiation. It is a more level playing field, for example, for insurance companies. They all know what they are going to pay the hospital for services and for employers in Maryland. Maryland has a variety of programs of a different nature that all work together to help provide medical care and coverage, a way to finance that medical care. So this new Maryland law is designed to work together with existing programs and help existing programs, especially the public programs, continue to exist.

Mr. WILSON. Thank you very much, Mr. Chairman.

Chairman JOHNSON. Yes. Thank you, ma'am. I appreciate some of the comments you made.

Mr. Tierney, you are recognized.

Mr. TIERNEY. Thank you, Mr. Chairman. Mr. Chairman, I am sure—maybe she appreciates some of the comments you have made, but I am not sure. We will have to check with that.

First of all, you know, Mr. Drombetta, I want to tell you that I sympathize with you because I was a small businessman—smaller than you; but I was the president of the Chamber of Commerce, and these were issues that we dealt with. Right off the top, I will tell you the United States Chamber of Commerce, from my experience, doesn't represent the chambers of commerce district to district in this country. It is not their interests they are looking out for, and I hope local retailers and other businesses appreciate and understand that.

The fact of the matter is, the cost is an issue. If you were in Massachusetts, Mr. Drombetta, you would have an option. Now you pay

\$295 per employee to cover your employees, and I think you might find some value in that or some assistance in that.

But the fact of the matter is while cost is an issue, coverage is an issue, too. Some States feel one way to do that is to either have the employees—employers cover their employees, if they choose, or to opt to be a partner with individuals and with the States to find a way to pay for whatever the cost is and move forward on that. And that is some of the rationale I understand from my State legislators they were thinking about that.

I would be curious to know from a show of the panelists who among you thinks health care is a right? And who among you thinks it is only a privilege? And some don't have an opinion either way. Interesting on that.

If cost is an issue—I have heard that repeatedly down the line here—I think the evidence is pretty clear that at least 20percent of every dollar we spend on health care is going to administration and profits for insurance companies and things of that nature. Do any of you object to the fact—Medicare is about a 3percent, or less than 3percent, administrative fact on that. Do any of you object to expanding Medicare to cover health care so that the employer won't be unburdened with this and individuals in society will cover it in some sort of an equitable fashion?

Mr. DROMBETTA. I certainly can't speak for the rest of the group, but to address that, of course not. I have 33 employees. I know them by name.

Mr. TIERNEY. Good.

Mr. DROMBETTA. Are we entitled to or do we have some given right to health care? As an employer who wants those 33 people to continue to work for me, I would be foolish from a competitive point of view to not want to have a reasonable, reasonably competitive product. That is not my issue.

Mr. TIERNEY. Let me interrupt you. I am not saying it is a right for you to pay for it. I am asking is it a right for them to have it; not necessarily that you have to pay for it as an employer, but do people generally have a right to have health insurance as opposed to it is only a privilege, and some will have it and some won't?

Mr. DROMBETTA. I don't know why I would want anyone on my staff not to have health benefits.

Mr. TIERNEY. Exactly. So my follow-up question on that is if cost is the overriding factor that I hear each of you talk about, and 20percent of every dollar at least is going to either insurance profits or administrative costs, whereas Medicare pays less than 3percent, is there objection amongst the individual panelists to have Medicare expanded to cover health care so you and your employees will have it?

Mr. DROMBETTA. I could only address that problem from the practical point. I don't know what is out there. I don't know. Besides association health plans, what else is there?

Mr. TIERNEY. Association health plans either give you their conflicting evidence on that or not a stitch of evidence. They will do nothing but increase the number of uninsured on that basis.

Mr. DROMBETTA. This I know. I bid my health care costs every year. If I were in a different pool, if legally I could take my 18 people to a pool of 70,000, exactly the same coverage costs less.

Mr. TIERNEY. You can do that within your State, right?

Mr. DROMBETTA. No, I cannot, sir.

Mr. TIERNEY. Not within your State?

Mr. DROMBETTA. No, sir.

Mr. TIERNEY. Well your State has an issue with that. In Massachusetts and most States and most other chambers of commerce—

Mr. DROMBETTA. Doesn't that draw back to the fact that we have a national crisis; that we don't need Massachusetts to solve problems for Massachusetts, we need the Federal Government to solve a Federal problem?

Mr. TIERNEY. Well, I agree with you, sir. You check my colleagues on the other side, they will probably have a stroke if they think that is the way we will approach providing health care for all. Ma'am, do you have any comments you would like to make?

Mr. DROMBETTA. Would you please tell me what the costs are, and I can compare it to what I am doing and give you a response.

Mr. KELLY. On the issue whether we should expand Medicare or not, our association hasn't developed a position on that. We would have to talk about it among our membership. The fact, as you point out. 20percent of the health care dollar goes to administrative costs, that seems pretty high. I think my members generally would support proposals that bring more competition to the health care system. I don't know what they would specifically be, but it ought to be explored to find new ways to help, you know, drive that kind of cost out of the system. If there are ways to do it, it ought to be explored.

Mr. TIERNEY. One of the problems you see with competition, you can have all sorts of competition if you want inferior plans and better plans, etc. One of the reasons it is difficult, shoes ain't health insurance, and health insurance aren't shoes. You can change shoes in a lot of different ways, and nobody's life will be at stake; but health insurance is a whole different item on the market than that.

Do you want to make a comment?

Ms. KOFMAN. Yes.

Chairman JOHNSON. The time for the gentleman has expired.

Mr. TIERNEY. Yes. And I appreciate the Chairman allowing my witness to respond, or at least ask for unanimous consent for the courtesy of that.

Chairman JOHNSON. Fine.

Ms. KOFMAN. Thank you.

When you think about competition in the insurance market, you know, most insurance companies are for profit, and their goal to their shareholders is to make profits, and the way to do that is to avoid risk, to avoid competing over sick people. You are not going to have insurance companies, no matter what the rules are, ever competing for sick people. So you just have to remember that when you think about competition in the insurance market.

In terms of expanding Medicare, it is a terrific option. It certainly would be cost-effective, and I believe it would make U.S. Companies more competitive globally. We are the only country in the world that is industrialized that is this wealthy that doesn't pay for medical care for our citizens, and that makes it more dif-

difficult for our U.S.-based companies to compete against Great Britain companies, against French companies, where they do have the government taking on most of the costs for providing medical care, for keeping workers healthy so companies could compete.

Chairman JOHNSON. Could I ask you if you would go to France to get your medical care?

Ms. KOFMAN. I am actually lucky enough to be married to someone who works for the Federal Government, so I have the best health care in the world.

Chairman JOHNSON. I didn't ask you that question.

Ms. KOFMAN. I might.

Chairman JOHNSON. Would you go to England for it? I have been in England when I was in the Air Force, and I am here to tell you their socialized medicine stinks. I also would like to—

Mr. TIERNEY. Mr. Chairman, if you would yield, I think you ought to go back because it is a whole different world over there, if that was the last time you were there.

Chairman JOHNSON. The fact that you stated a while ago that many companies provide health care for their employees, but the young ones don't take advantage of it. Exxon, I happen to know about, it is in our area, and they offered to match whatever the employee puts in for health care. And there is a large number that do not accept that health care because they think, as you said, they are bulletproof. You know, and it is that age bracket of 21 to 35. Once they get over that age bracket, they feel like maybe they need insurance.

And I don't know if insurance is a right or not. I think it may be an option, not a right. There is—you know, America has the best health care in the world. That is why people come over here for operations of various sorts and medical attention from other countries. Why do we have good health care? It is because we don't mandate it.

Mr. TIERNEY. Mr. Chairman, we love it when you riff like that, but it is hard not to respond. We may have great health care, but we have a terrible insurance system, and that is part of the problem. When I talk about people having a right, it is not a right to insurance, it is a right to health care, and there is a significant difference in that. And I thank you for the chance to make that point.

Chairman JOHNSON. You are welcome.

Mr. Tiberi.

Mr. TIBERI. Dr. Kofman.

Ms. KOFMAN. I think you just promoted me.

Mr. TIBERI. A professor?

Ms. KOFMAN. A lawyer.

Mr. TIBERI. Sorry. I was going to ask you a question, but the dialog we just had I find enlightening since I have more family in Europe and Canada, which I think you would agree the Canadians and the Europeans, for the most part, have a single-payer system that gives you the right to health care. But the thing that we don't hear about that my relatives tell me about—in fact, I have a cousin, or my mom's cousin, who just had a serious surgery operation in New York, and he is Canadian, by the way, and I have family in Italy who have had rationed care for years. And while we can talk about the right and how wonderful the single-payer system is,

there are also problems with the single-payer system that I hope you would acknowledge.

Ms. KOFMAN. Um, yes. I agree. No system out there is perfect, but the fact that we let 18,000 people, Americans, die each year, preventable deaths, because they don't have coverage is, I think, un-American and unacceptable.

Mr. TIBERI. Well, there are two sides to the story certainly. Mr. Drombetta—and my point is that there are, just so we are clear—we have in a single-payer system in Canada and a single-payer system in Europe. Thousands of people die, too, under rationed care. There is no question about it. And I have heard personal horror stories, family members who have had rationed care and have begged to come to the United States as well. So there is certainly another side to this debate.

Mr. Drombetta, you are a small business owner. I see you are educated in the great State of Ohio and appreciate—

Mr. DROMBETTA. I did take note of the fact that I have the lesser of the degrees at the table.

Mr. TIBERI. You operate, obviously, a small business, and I worked for a small retailer both in high school and college. And what, in your mind, would happen—I have heard from small employers in my district, friends of mine, who do everything in their power to try to offer as much benefits as they can to their employees because—particularly small employees, small employers. It is like a family business, and the people who work for them are family. And you are an employer with under 50 people, from what I remember reading your testimony. What would happen to the typical employer—don't even talk about retailer—typical employer that is mandated to apply a certain type of insurance to all their employees?

Mr. DROMBETTA. I can only really respond to what my reaction would be. I run a small business. I would look at that mandate and its costs and take it inside the organization and make the determination, and it is pretty black and white.

Mr. TIBERI. Do you believe, though, there are small organizations or small businesses that might not be able to survive the mandate?

Mr. DROMBETTA. Let me drive the point home. If a family plan inside—and with an HMO costs \$17,000 a year. That is a lot of money. That is an awful lot of money. And if we want the small business owner to pay it completely, his operation either will have the ability to do that, or it won't.

You can't deficit-spend a small business. It is called bankruptcy. You don't have that option. If you look at what your costs are, you look at what your margins are, and you say, I can or I can't. I don't think it is any small fact—there is a mistake or a court of economics that 65percent of the uninsured are involved in small businesses.

I have personal friends who run shoe stores with family dominating that don't have health care. Why is that? They don't want their son to have it or their wife? That is not the case.

Mr. TIBERI. It is the cost.

Mr. DROMBETTA. It is a cost issue. And I am willing to listen to anything, but I have difficulty understanding how mandated coverage is going to drive down costs, because when the gavel hits and

this is over, and we all leave, I still have those costs to deal with, along with millions of small businesses.

What would bring my rates down next year and the year after? And who's going to face my employee in 5 years when my insurance costs have gone up another 100 percent? It isn't going to be anybody on this committee.

Mr. TIBERI. Mr. Chairman, can I just ask one brief question?

Chairman JOHNSON. One brief one.

Mr. TIBERI. Mr. Kelly, do you know who the largest employer in the State of Maryland is that has the largest number of uninsured individuals? Do you know?

Mr. KELLY. I am sorry. Can you ask again?

Mr. TIBERI. Do you know who the largest employer in the State of Maryland is that has the largest number of uninsured individuals? I know it is not Mr. Drombetta. I had read somewhere that it was the State of Maryland itself. Do you know?

Mr. KELLY. That is right. I thought you were asking private. I don't know if they are the largest, but State and local employees in Maryland, there are 20,000 State and local employees in the State of Maryland who don't have health insurance.

Mr. TIBERI. Are they exempt by the Maryland bill?

Mr. KELLY. The Maryland bill does, in fact, have a specific exclusion for government employees.

Mr. TIBERI. Thank you.

Thank you, Mr. Chairman.

Mr. PAYNE. Mr. Chairman, if you could just yield on your question on the costs going down. If people had health coverage, there is a philosophy that it is preventative care, and that if people—oh, I am sorry. If people would—and no one mentioned it up to now. If people had precare to prevent these catastrophic, radical—for example, if you detect, say, breast cancer before you have to go in for a radical operation which costs tens of thousands of dollars—of course, what it does to the person is even worse—that is where this coverage can indirect—

Everyone is saying that by having people covered, it is not going to bring down the costs. I believe that if there was preventative health, it would. And I am sorry, Ms. McCarthy, I stole your—and I am not asking for an answer, but just an opinion. In my district where people make the minimum wage, they have no health coverage, they are very impoverished in the city of Newark. They go to the hospital; they are put in some intensive care for 5 or 6, 7 days. It is thousands of dollars a day because they haven't had any preventative care; and the cost is through the roof, which is eventually paid for by the State because it is uncompensated care. But I think that the overall health of people would get better, and it would over—I believe—therefore would have a driving-down effect on the prices. Thank you.

Chairman JOHNSON. Mr. Kelly, would HSAs provide preventative care in this instance that less expense—

Mr. KELLY. Well, as I understand health savings accounts, individuals are able to spend their money as they see fit on health care. So it certainly could cover preventative services and may, in fact—people may see that in their self-interest to have checkups, medical care, preventative care.

Chairman JOHNSON. Thank you.

Ms. MCCARTHY. I am enjoying the debate because I am the only one on the panel that has a nursing profession behind them. So I am kind of looking at this debate a little differently. When HMOs started, the whole idea of HMO was preventative care. Part of that conversation has come into play here.

With that, Mr. Chairman, I am hoping that I might be able to offer this article from the Chicago Tribune that talks about part of the debate that we are hearing today. Mind the Gap: England Found to Be Healthier Than America even though America spends twice the amount of money.

Which brings me to my point. Health care today is basically geared to illness instead of prevention, and that is one of the big problems that we are facing in this nation. And until we start actually recognizing that fact, you talk about a lot of your employees are older, and yet we know as you get older, obviously your health care costs are going to go up, whether it's diabetes, whether it's heart condition.

At the age of 50, all of a sudden I came down here, you know, one of the doctors examined me, OK you are on this medication, this medication, all preventative because of my age and probably because of the stress of the job, but all preventative.

So what I am saying is we are not the healthiest people in the world; and as far as Canada goes, they keep their costs down and their care because they only have, I believe, two MRs—two MRI in the country. So that kind of cuts back on the kind of care they are going to get.

But with that being said, I keep looking at the health care system that we, as Federal employees, have. I pick out which health care I want. I pick out what I am going to be paying, and that certainly is up to me. For the small businesses, I happen to agree that small businesses should be able to band together so that they have more of a pool to be able to pick from.

One of the things that I did not agree with the bill that came through this committee, we stripped out completely any preventative care, taking out mammographies.

My other statement would be the States are probably as frustrated as we are here in Congress because the people in the States are not getting the health care that they need, and it is ending up costing our health care system more money because you are going in the hospital at a later time, you are sicker, and a lot of times you are being released from the hospital when you really technically are not ready to be released, especially if you have no one home to take care of you.

So it is a problem all the way around. So the debate will go around in a circle. None of us have the full answers, but we need to address it. And it is going to take a unified—businesses working together with politicians on both sides of the aisle on how we are going to actually do this.

We, as Democrats, looked at—we want to give health care to everybody. I do, because I happen to think it saves money and especially to the children. We deny health care to children. I mean, that is unthinkable in my part mainly because it ends up costing us more money in the long run.

Diabetes. We fought in this government on giving basic allowances to some people that could control their diabetes. If we don't, we end up paying—we, the Federal Government, ends up paying millions and millions and millions of dollars more because someone should go—hopefully more Members of Congress would go to a dialysis center and look at those people that are on dialysis centers and all because they weren't treated at an early stage. So there are ways to cut, and administration costs are too high.

I offered legislation years ago to expand Medicare to a younger age; not for everybody, but to a younger age, to open up that pool. I think those are important things we need to look at.

We will never find one answer. I never thought that I would ever say I would look at a one-pay system; but when I have doctors coming to me saying, I take it because of the paperwork that they have to fill out; or in the nursing homes and the paperwork they have to fill out; or the home care nurses, the paperwork they have to fill out. We have to look at the health care system, certainly provide—and one other thing as far as, you know, we talk about—on pensions right now, 401(k)s, one of the things the businesses told us, if we are going to go to the 401(k), and I hope we don't, not for everybody, it should be mandatory. Anyone that goes into that employer, mandatory that employee has to join. Well, it should be the same for health care, even for a child, a young person, an 18-year-old, because they all think they are—you know, they are not going to get sick, or they are not going to get hurt. Even if it is basic care, they should have to join some sort of—I certainly had to.

As a young nurse I had to be in the health care system. I had no choice. It came out of my paycheck every single week. I think we should look at that again, too.

I thank you for your testimony. I don't actually have a question because it goes back and forth, and we all don't have the true answers, but it is a debate that needs to come to a head and a discussion that needs to be done. Thank you, Mr. Chairman.

Chairman JOHNSON. Thank you. The gentlelady's time has expired.

Ms. McCollum, you are recognized.

Ms. MCCOLLUM of Minnesota. Thank you, Mr. Chair.

Unfortunately the gentleman from Minnesota has left; but he referred to some bills that are pending in our statehouse.

In Minnesota we could only put five authors on a bill, so we clone bills, and that is why there are as many bills as there are. And they all are dealing with something that is very near and dear to the taxpayers' and providers' hearts in Minnesota, and that is the fact that we are trying to understand why Wal-Mart feels that the taxpayers in Minnesota and the providers who pay a provider tax in Minnesota, health care's available in Minnesota, go sign up for the State-Sponsored health care plan, which is called the Minnesota Care. So doctors are paying for it, hospitals are paying for it. We were just trying to get a handle on the costs.

Those are the bills that the gentleman from Minnesota was referring to. And on the handout that is passed out by the Retail Industry Leaders Association that says, States targeted by the AFL-CIO, yes, I am proud that labor is trying to help us collect this information on behalf of working families because we are the ones who ul-

timately pay for the emergency room visits and pay for people who don't have health insurance when they come into the emergency room sicker or were paying for it with States that do put plans together to—Mr.—nobody has said your name again, and I want to—Larry, if I say it wrong—

Mr. DROMBETTA. Drombetta.

Ms. MCCOLLUM of Minnesota. I worked retail for 27 years, and I would love to work for you in a heartbeat. We would.

Mr. DROMBETTA. We would welcome you in joining us.

Ms. MCCOLLUM of Minnesota. Because we do need—you are addressing—you are speaking for America's families here in small business, and I thank you for coming.

But the problem that we are facing here in Congress, it is either associated health plans or nothing, and we need to have a full, enriched debate on this issue.

Mr. DROMBETTA. Can I address that? I don't want to impose on your time, but I think it was 1993, if my recollection is correct, about 25 million uninsured existed in the country. We need to stop looking.

Ms. MCCOLLUM of Minnesota. Right.

Mr. DROMBETTA. And we would have 46 million uninsured, most of them out of small businesses, my kind of business. I hate to say this, but your constituents aren't adding any risk really in what you are looking at. They want to know what brings down cost. That is really what—

Ms. MCCOLLUM of Minnesota. Excuse me, Mr. Drombetta. I have to reclaim my time here. I am going to speak as a woman. You look at me, it is obvious I am one.

The associated health plans offer no protection for women. Contraceptive protection, mammography, breast cancer, maternity coverage, all those things, when we just try to say by gender, can associated health plans not discriminate against women—and that is how a lot of these mandates came into play was just basic health care coverage for women—we were told no. And so associated health plans that discriminate against women for their coverage, in the United States of America, I just don't see as acceptable.

I would like to ask Mr. Garthwaite—am I saying your name right, sir? A couple of things you have said intrigued me, as being the mother of 20-somethings.

First off, my children want to drive. They have to have car insurance, they have to have health insurance, and they have no choice. They pay it. Health care insurance, if we tell people they have to have it, they have to have it. And so do you see that there is something wrong with saying that young adults have to have health insurance versus car insurance? And then how do you figure into the whole pension debate? Because part of what we were talking about was, you know, Social Security doesn't work, we should abolish it, and that young adults were going to automatically save for themselves.

So as a young, bright man, can you speak for your entire generation and why car insurance is OK, health insurance is bad to be mandated, and everybody will save and set aside for their pensions in this young age group?

Mr. GARTHWAITE. We can start with the car insurance versus health insurance first. I think the important thing to realize, you set a minimum level of car insurance people have to have, and people then choose to buy more than that, buy collision coverage, buy other things.

I don't see that the needs in terms of health insurance for a 55-year-old person are the same as for a 20-year-old young man or a woman. So I think mandating the same level of health insurance, which a lot of these bills are trying to do regardless of age group, is not a very good way to tackle the problem.

I mean, Social Security is a little outside the pivot we are talking about, but the way I understand a lot of what was proposed, there was a certain amount that had to be invested in terms of your contribution to the Social Security plan, and it wouldn't be a voluntary system.

Chairman JOHNSON. Time of the gentlelady has expired. Thank you for your questions. I guess we are drawing to a close.

Mr. Kelly, I would just like to ask you, if the State mandated 8percent of your pay or of the company to be awarded the health care, as a mandate, would there be any negotiation room; they would go up instead of down, wouldn't they? Insurance companies wouldn't—if they knew there was an 8percent requirement or whatever?

Mr. KELLY. It would seem to tie the hands of companies who were forced with the mandate to accept the mandate, yeah, and might take away some negotiating leverage that they might otherwise have. I agree with that.

Chairman JOHNSON. OK. Thank you.

I want to enter in the record Ms. McCarthy asked if we would allow an article from the Chicago Tribune to be entered in the record. Is there any objection?

Hearing none, so ordered.

[The information referred to follows:]

[From the Chicago Tribune, May 3, 2006]

Mind the Gap: England Found to Be Healthier Than America

By CARLA K. JOHNSON and MIKE STOBBE, Associated Press

White, middle-age Americans—even those who are rich—are far less healthy than their peers in England, according to new research that has experts scratching their heads.

Americans had higher rates of diabetes, heart disease, strokes, lung disease and cancer—findings that held true no matter what income or education level.

U.S. health-care spending is double what England spends on each of its citizens. “Everybody should be discussing it: Why isn't the richest country in the world the healthiest country in the world?” asks study co-author Dr. Michael Marmot, an epidemiologist at University College London.

The study, based on government statistics in both countries, adds context to the fact that the United States spends more on health care than any other industrialized nation yet trails in rankings of life expectancy.

The U.S. spends about \$5,200 per person on health care. England spends about half that in adjusted dollars.

Even experts familiar with the weaknesses in the U.S. health system seemed surprised by the study's conclusions.

“I knew we were less healthy, but I didn't know the magnitude of the disparities,” said Gerard Anderson, an expert in chronic disease and international health at Johns Hopkins University who had no role in the research.

Just why the United States fared so miserably wasn't clear. Answers ranging from too little exercise to too little money and too much stress were offered.

Even the U.S. obesity epidemic couldn't solve the mystery. The researchers crunched numbers to create a hypothetical statistical world in which the English had American lifestyle risk factors, including being as fat as Americans. In that model, Americans still were sicker.

Smoking rates are about the same on both sides of the pond. The English have a higher rate of heavy drinking.

Only non-Hispanic whites were included in the study, to eliminate the influence of racial disparities.

The researchers looked only at people age 55 through 64, and the average age of the samples was the same.

The upper crust in both countries was healthier than middle-class and low-income people in the same country.

But richer Americans' health status resembled the health of the low-income English.

"It's something of a mystery," said Richard Suzman of the U.S. National Institutes of Health, which helped fund the study.

Health experts have known the U.S. population is less healthy than that of other industrialized nations, according to several important measurements, including life expectancy. The U.S. ranks behind about two dozen other countries, according to the World Health Organization.

The study, supported by grants from government agencies in both countries, is published in Wednesday's Journal of the American Medical Association.

This is the first to focus on prevalence of chronic conditions, said Anderson, the Johns Hopkins professor.

Differences in exercise might partly explain the gap, he suggested. One of the study's authors, Jim Smith, said the English exercise somewhat more than Americans. But physical activity differences won't fully explain the study's results, he added.

Marmot offered a different explanation for the gap: Americans' financial insecurity. Improvements in household income have eluded all but the top fifth of Americans since the mid-1970s. Meanwhile, the English saw their incomes improve, he said.

Robert Blendon, a professor of health policy at the Harvard School of Public Health who was not involved in the study, said the stress of striving for the American dream may account for Americans' lousy health.

Americans don't have a reliable government safety net like the English enjoy, Blendon said.

However, Britain's universal health-care system shouldn't get credit for better health, Marmot and Blendon agreed.

Both said it might explain better health for low-income citizens, but it can't account for better health of Britain's more affluent residents.

"It's not just how we treat people when they get ill, but why they get ill in the first place," Marmot said.

SELF-REPORTED ILLNESSES
[In non-Hispanic whites age 55-64, percentage]

Health disorder	United States	England
Hypertension	42.4%	33.8%
Heart disease	15.1%	9.6%
Diabetes	12.5%	6.1%
Cancer	9.5%	5.5%
Lung disease	8.1%	6.3%
Heart attack	5.4%	4.0%
Stroke	3.8%	2.3%

Note: Based on unweighted samples of the 2002 Health and Retirement Survey in the U.S. and the 2002 English Longitudinal Survey of Aging in England.
Source: Journal of the American Medical Association.

Ms. MCCOLLUM of Minnesota. Mr. Chair, Mr. Chair, I have two items, if this is a proper time, to submit for the record as well.

Chairman JOHNSON. Sure.

Ms. MCCOLLUM of Minnesota. I have an article from Minnesota Public Radio, the number of uninsured children in Minnesota. Minnesota, in order to balance its budget decided to remove children

from health insurance, and these are children under the age of 1 and 2.

And I have from the Atlantic Monthly an article, The New War Over Wal-Mart, dealing with the way Wal-Mart is not insuring its employees and is putting it on the public for taxpayers to cover their employees.

Chairman JOHNSON. Without objection, so ordered.
[The information referred to follows:]

[From Minnesota Public Radio, April 19, 2006]

Number of Uninsured Kids Grows in Minnesota

By LORNA BENSON

The number of Minnesota children without health insurance has grown by at least 8,000 in the past few years. The figures, collected by the Minnesota Department of Health, are included in a new report by the Children's Defense Fund Minnesota.

The Children's Defense Fund says the trend is troubling because access to health care coverage is a key indicator of child well-being. The group says without insurance, kids are more likely to develop long-term health problems.

St. Paul, Minn.—Sixty-eight thousand Minnesota children were without health insurance in 2004. That compares to 60,000 uninsured kids in 2001, the last time the Department of Health collected the data.

Jim Koppel, the executive director of the Children's Defense Fund Minnesota, says the spike in uninsured kids is most noticeable in the youngest age group. "There has been an increase of 11,000 children under the age of 5. The very youngest children in Minnesota have seen the most dramatic rise of all children," Koppel said.

Koppel attributes some of the growth in this group to changes in state eligibility rules.

Before 2003, he says newborns were automatically enrolled in Medical Assistance until age 2, if their mothers qualified for the program when they were pregnant. Medical Assistance is Minnesota's version of the federal Medicaid program.

Koppel says lawmakers decided to cut off automatic enrollment at age 1, as a way to help balance the state budget in 2003. As a result, 3,800 kids were kicked off the program.

Koppel says many of those kids still qualified for the state's other subsidized health insurance program, MinnesotaCare, but he says many didn't realize it—in part because lawmakers cut the budget to promote MinnesotaCare. The number of enrollment forms to be filled out has tripled, and families now have to re-enroll every six months, rather than every year.

"That's how you get rid of kids in coverage. That's how you cut participation. Just make it complicated," Koppel said.

Of the 68,000 uninsured kids in Minnesota, it's believed that more than three-fourths are eligible for public health insurance programs.

Department of Human Services Commissioner Kevin Goodno says many of the eligibility changes were prompted by a desire to make the program more accountable.

"What we want to do is make sure we're covering the kids that are uninsured, and not covering kids that already have good insurance in the private sector, by taking away some of those elements that were preventing the erosion from the private sector," Goodno said.

Goodno is referring to parents who decline their employer-sponsored health insurance to buy cheaper state-subsidized insurance. The state has a rule that if a family has access to employer-based insurance where the employer pays at least 50 percent of the premium, the family cannot use MinnesotaCare.

On the complexity issue, Goodno agrees that enrollment paperwork can be daunting. He says the state is working on a project right now that would streamline the eligibility process by helping parents get connected with the right programs. But he says there's only so much the state can do.

"Parents do have to take responsibility for * * * coming into the counties or coming into our agency, and asking how they can cover their kids for health insurance. So there is some personal responsibility involved in all this as well," he said.

Goodno says while he does think it's a serious problem that so many children are uninsured in the state, he points out that Minnesota is doing well compared to other states. He says the state has one of the lowest overall uninsured rates in the country. He says it's also one of the healthiest states.

But that doesn't satisfy the Children's Defense Fund's Jim Koppel. He says other states are showing more progress when it comes to kids.

"Forty states in this same time period we're talking about, 40 states, decreased the number of uninsured children in their state," he said.

Koppel says three other states—Massachusetts, Illinois and Maine—have recently passed legislation that makes sure that all of their children have health insurance. Legislative proposals to do the same thing in Minnesota have not gone anywhere.

[From the Atlantic Monthly, June 2006]

The New War Over Wal-Mart

The mounting attacks on the world's largest company could change American business—and transform the health-care system

Wal-Mart has made its slogan ("Always Low Prices. Always.") into a blood oath. The company has grown to prominence through legendary cost-saving acumen and a relentless adherence to low prices, which it maintains by rigid cost control. Today, Wal-Mart employs more people—1.7 million—than any other private employer, and by this measure is not just the largest company in the world but the largest company in the history of the world.

With size comes power. Several years ago, economists coined the term "Wal-Mart effect" to describe the consequences, large and small, that flow from the company's unending war on prices. The Wal-Mart effect drives down consumer prices so powerfully that it helps check U.S. inflation. But it has hastened the outsourcing of U.S. manufacturing jobs to cheaper countries, and, some argue, it also drives down wages and benefits.

Big business in America is both admired and instinctively suspected, and the biggest business of all is a natural magnet for criticism. The overwhelming focus lately has been its health-care policy, which covers fewer than half its workers and leaves the government to care for tens of thousands of its employees and their children through programs, like Medicaid, that were created to help poor people. Some states have begun to retaliate. Maryland passed a bill in January forcing any company with more than 10,000 workers to spend at least 8 percent of its payroll on employee health care—a law aimed squarely at Wal-Mart, the only company that qualifies. Similar "fair share" bills are pending or planned in thirty states. Especially in the nation's capital, there's a growing sense that after years of frustration the Lilliputians are finally tying down their man.

One of the major forces opposing Wal-Mart is organized labor. The United Food and Commercial Workers International Union has long wanted to organize Wal-Mart's stores. Last year, it succeeded at a Canadian Wal-Mart, which the company immediately shut down. "If Wal-Mart doesn't change its ways, we'll turn it into Big Tobacco," Chris Kofinis, communications director for the UFCW-funded Wake Up Wal-Mart, told me recently.

The company's other main antagonist, Wal-Mart Watch, is also backed by labor, though at first glance its motivations are opaque. Wal-Mart Watch is heavily financed by the Service Employees International Union, whose president, Andy Stern, says he has no intention of organizing Wal-Mart. Not long after the Maryland law passed, I asked Stern, who helped push it, what he was up to. He smiled. A social service worker turned union organizer, Stern at fifty-five already has a full head of white hair. But he hardly resembles the stereotypical, cigar-chomping union boss. Fit and energetic, he speaks with the assuredness and big-picture worldview of a motivational speaker, an effect amplified by his bright purple shirt (purple is SEIU's official color). The sleek purple chairs and frosted glass in the union's Washington offices lend an air of Scandinavian minimalism and further the sense of calculated nonconformity. "Why go after Wal-Mart?" Stern replied. "Because Wal-Mart is the GM of our era. Whatever business practices they adopt have huge influence across other American businesses."

Stern has something much grander in mind even than unionizing Wal-Mart. "Ford wasn't created to be a health-care provider; it was created to produce cars," Stern says. "My goal is to get Wal-Mart's leadership out there in traffic and holler, 'We can no longer compete in the global economy when health care is factored into the cost of our products.' If Wal-Mart's CEO, Lee Scott, were to come out and say, 'We need a national health-care system that works for everyone,' then it's a whole new ball game."

Stern says that he first contemplated trying to get Wal-Mart to change its practices in 2003, after the company announced plans to open forty Supercenters in California. Local grocery chains reacted by proposing to cut wages and health benefits in a preemptive bid to remain competitive, some even locking out their employees.

The result was a massive strike. "When you saw that, you realized what an incredible effect this one company has on a market," Stern said. It was a classic example of the Wal-Mart effect-and it didn't stop there. When the supermarkets did in fact cut their health-care plans, the janitorial companies whose workers SEIU represents complained that they, too, could no longer remain competitive. "They came to us and said, 'We're not as big as the supermarket chains, and if they can't afford to pay for health care, how can we be expected to?'" Stern said.

After the 2004 election, SEIU joined with environmentalists, women's groups, and community activists to form Wal-Mart Watch, hiring seasoned Democratic operatives and jumping into the public debate. The new group focused much of its efforts on the company's healthcare programs, with considerable success. Wal-Mart, despite investing heavily in public relations and making slight improvements in its plans, was unable to stop the Maryland law or quiet the growing chorus of critics.

The company appears to have no clear idea of how to stop the fallout. Some Wall Street analysts believe the "headline risk" associated with the negative publicity is one reason for Wal-Mart's sagging stock price. The company topped Fortunes most-admired list in 2003 and 2004-but slipped to twelfth place this year.

Stern seemed to take a Bart Simpson-like delight at the spectacle of a flummoxed symbol of authority whose current chaos he'd helped devise. Spending around \$5 million annually, Wal-Mart Watch has pushed anti-Wal-Mart laws in dozens of states, leaked damaging internal documents, and helped make the company known as much for its exploitation of government health plans as for its business acumen. Over the last year, and very much against its will, Wal-Mart has been moved to the center of the national debate over health care, and Stern has drawn one step closer to what he's really after.

In Stern's thinking, if the world's largest company could be coaxed or bullied into publicly favoring a national health-care policy, here's how things might play out: a rush of other companies already beset by health-care costs and accustomed to mimicking Wal-Mart would fall in line, putting business on the same side as labor. Governors burdened with soaring Medicaid costs might also join in. The pressure on the federal government would be overwhelming. Stern, in other words, is seeking to turn the Wal-Mart effect to his own ends, harnessing it to transform health-care policy just as it routinely transforms business policy. It's an audacious plan.

In late February, Wal-Mart CEO Lee Scott gave a speech to the National Governors Association in Washington, D.C. The group's chairman this year, Arkansas Governor Mike Huckabee, chose health care as the focus of the annual meeting. (Huckabee is an able governor and possible Republican presidential nominee, but he's most famous for losing a hundred pounds and writing a diet book, *Quit Digging Your Grave With a Knife and Fork*, and he extols the virtues of healthy living just about any time he can.) His one sense Huckabee's invitation to Scott was natural: Wal-Mart is based in Bentonville, Arkansas. But it promised a certain drama, too, because fewer than half of Wal-Mart's American workers are covered through the company's health plan.

Scott's audience was also significant. Governors are caught in the middle of Wal-Mart's health-care crisis. The company is believed to be the largest employer in at least two dozen states, so its well-being is important to them. But in many of those states, Wal-Mart workers correspondingly top the list of Medicaid recipients. The program itself has exploded, adding 8 million Americans between 2000 and 2004 and putting enormous strain on state budgets, which fund about 40 percent of Medicaid. What's especially troubling is that so many new recipients aren't jobless-their employers simply don't offer health care, or not cheaply enough to keep them off public assistance. Many of these people work for Wal-Mart.

Scott got right to the point. "America is facing some pretty tough challenges these days," he stated. "We know our benefits are not perfect." His goal before the governors was to slow the onrushing storm directed at Wal-Mart's healthcare coverage. For maximum effect the press had been notified ahead of time that he had come bearing a peace offering of sorts-his speech would announce improvements in the company's benefits.

These turned out to be relatively minor concessions: reducing the waiting period for part-time employees to qualify for benefits, broadening availability of Wal-Mart's cheapest plan, and allowing children of part-timers to become eligible with their parents. Though constructive, such increments won't solve the larger problem, as Scott seemed to understand. Wal-Mart's CEO is fifty-seven and slightly doughy, with the bland, unassuming aspect of a middle manager. But when he finished his pitch, he became soberly defiant: "We cannot do it alone. No business can. No business should have to. The fact is the soaring cost of health care in America cannot be sustained over the long term by any business that offers health benefits to its employees." This is exactly Andy Stern's position.

Scott made clear that he had not come to surrender, to unions or state governments. "I believe we're seeing a little too much politics," he said. Bills like Maryland's "may score short-term political points, but they won't solve America's health-care challenges." He angrily denounced them as "horrible public policy." Clearly, Stern and his fellow critics have Wal-Mart seeing purple.

For all Wal-Mart's size, its business model leaves it more vulnerable than most companies to the rising cost of health care. Its key to consistently outcompeting everyone else on price is low margins and high volume. Wal-Mart doesn't make a lot of money on any individual sale; it makes huge multiples of small profits on a torrent of sales.

In 2005, Wal-Mart earned profits of \$11.2 billion on sales of \$312.4 billion—a hefty sum, to be sure, but a startlingly thin margin of less than four cents per sales dollar—about \$6,000 in profit per employee. (Exxon Mobile, by comparison, earned around \$300,000.) That's fine if you can keep holding down costs, as Wal-Mart goes to incredible lengths to do. (Among the exquisite revelations in Charles Fishman's recent book, *The Wal-Mart Effect*, is the company's policy of reimbursing meal tips only up to 10 percent—there goes its image with one big sector of the American workforce!) But one cost that is well outside its formidable power to control is health care. At Wal-Mart that outlay has risen 19 percent over each of the last three years.

Just how big a problem this poses was brought to light last October, when someone leaked an internal memo written by the company's executive vice president for benefits, Susan Chambers, to Wal-Mart Watch. The Chambers memo reported that the company's cost of benefits was outpacing its profits. "Growth in benefits is unsustainable," it warned, going on to recommend fourteen measures of containment: nine "limited-risk initiatives" and five "bold steps." These ranged from such benign ideas as giving employees discounts on healthy foods to highly controversial ones like thinning the number of unhealthy (and thus more expensive) workers by adding physical tasks, like collecting carts, to jobs that currently don't require them.

The uproar that ensued focused on the practice of discriminating against unhealthy workers—a potential violation of federal law. But the truly startling thing is the memo's estimate of how little even the most extreme "steps" could accomplish. Enact every proposal, and Wal-Mart will still merely maintain its current ratio of benefit costs to profits for five more years. That's it.

The significance of the Chambers memo isn't that a major company is plotting to scale back health-care coverage; it's that employer health-care costs are growing so sharply that the apotheosis of American capitalism is frantically digging in its heels merely to slow their rate of growth. The alarming implication for a company whose greatness rests upon squeezing a few pennies out of every dollar in sales is a microcosm of the health-care issues beating against American business. As employers are hit with spiraling benefits bills, economic rationality leads them to want to dump their most costly employees. This pushes those most in need of care into the ranks of the uninsured or onto the dole.

Wal-Mart has little cushion to absorb increased costs, which is why laws like Maryland's, which force it to spend more on health care, are such a threat. Stern's gamble is that Wal-Mart won't be able to maintain its profit margin in the face of sustained political and economic pressure, and that sooner or later this reality will force the company in the direction he wants it to go.

There's something shrewd, and at the same time deeply cynical, about the critics' moves against Wal-Mart. Stern shows no qualms about supporting "fair share" laws like Maryland's, even if they slow the arrival of a national plan, operating as they do through the current employer-based system he says is broken—and do so by singling out one company and punishing it for shortcomings that exist across the entire retail sector. "Fair share is not the ultimate answer to this problem," Stern concedes. "But it's the difference between tactical and strategic. There will be state-based efforts like Maryland's to shore up the present health-care system or there's going to be a national effort to convert from it."

What the war against Wal-Mart tends to gloss over is that it's not at all clear that the company behaves any worse than its competitors. When it comes to payroll and benefits, Wal-Mart's median hourly wage pretty much tracks the national median wage for general merchandise retail jobs. And its health-care benefits are a good deal more accessible, if still not entirely affordable, than those of many of its competitors. Target, for instance—unlike Wal-Mart, to which it is often compared—does not offer benefits to part-timers. A recent report on the company by Jason Furman, a visiting scholar at New York University and a former Clinton health-care official, dubbed Wal-Mart a "progressive success story," noting that "more Wal-Mart employees are eligible for health insurance than in the retail sector as a whole and even slightly more than the nationwide total."

Looked at from another angle, the most damning statistic deployed against Wal-Mart—that its workers and their families form the largest company group on the Medicaid rolls in so many states—is a function of Wal-Mart’s size more than mean-spirited company policy. In percentage terms, rather than raw numbers, the company’s workers and their children are less likely to draw Medicaid coverage than their counterparts elsewhere in the retail sector. Among retailers, Wal-Mart is actually one of the better providers of health care—which shows how terrible the problem has become.

There is every technical reason why Wal-Mart should support universal health care and shift the burden onto the only entity in the country bigger than itself: the federal government. Lee Scott’s speech to the governors very nearly went this far. What lies at the bottom of Wal-Mart’s angry resistance to what is in its own self-interest are matters of corporate culture that extend to most big businesses. First, corporations typically don’t think in broad public policy terms—particularly not Wal-Mart, which until recently was a regional company so reverent of its small-town heritage that most of its executives started as hourly workers. Second, business in general, and Wal-Mart in particular, reflexively distrusts anything that resembles “Democratic” policy or is favored by labor unions, like universal care. This is not an unreasonable reaction when the chief advocate is a union president busily promoting laws aimed at boosting your company’s health-care spending. Third, businesses are inherently suspicious of government—in this case fearful that bargaining over a national system could leave them worse off than they are now, by saddling them with new spending mandates. This concern is reinforced by their Republican allies, who are ideologically opposed to government-run health care.

Wal-Mart’s health-care problem, and the nation’s, is partly the result of historical accident. During World War II, a labor shortage forced U.S. employers to compete for workers. Wage controls at the time prevented them from offering higher salaries. So health and pension benefits, which were unregulated, became a means of competing for employees. This turned out to be popular with workers and businesses alike, because employer-provided health benefits, while unquestionably valuable, are not part of a worker’s taxable income; and they gave employers a justification for paying more moderate wages.

For a long time, health benefits were not a major expense. But as health-care costs have spiraled upward, they’ve become a significant part of the payroll—more and more, the most significant part. Stern’s real reason for pursuing national health care is that he’s every bit as hurt by soaring costs as business is: “As a union we are steadily trading wages for health care.”

During the last presidential campaign, a couple of hard-hit automakers indicated privately that they liked John Kerry’s health-care plan, recognizing how significantly it would reduce their burden. Under Kerry’s plan, the government would have helped pay catastrophic medical expenses—greatly relieving businesses of the fastest growing benefit cost, the one driving Wal-Mart and others to try to dump unhealthy workers. “But none of [the automakers] would say that publicly,” says Furman, who worked on the Kerry campaign. “None of them wanted to get involved in the political debate.”

That won’t be true forever. The sheer economics of the health-care crisis for business is forcing Wal-Mart and other large companies to balance reflexive opposition to government with enlightened self-interest. “What makes Stern’s idea so intriguing is that this is no typical union shakedown: it is in Wal-Mart’s own financial interest, as well as Stern’s. As much as Lee Scott must dislike his critics, it’s hard to dispute much of what they’re arguing—indeed, Scott sounded the same themes in his speech to the governors.

And what Scott is saying lately is changing the debate. “The controversy over Wal-Mart is framing the failure of the health-care system in a very public way,” says Chris Jennings, a former senior adviser to Bill Clinton and a health-care-policy consultant. “And not just failing workers but businesses, too.”

Barring a major terrorist attack, health care could be the biggest domestic issue in 2008, and a vehicle for any number of presidential hopefuls. It would be a natural for a Republican governor and economic moderate like Mike Huckabee, a dark horse who must distinguish himself. In Massachusetts, Republican Governor Mitt Romney just agreed to a bill creating the first mandatory statewide health plan. The most politically astute Democrat has already taken a provocative step: Hillary Clinton recently brought in as her legislative director Laurie Rubiner, who helped write the late Republican Senator John Chafee’s plan for universal coverage.

A national health-care plan need not be a “single-payer” system in which government covers all costs—most likely it won’t. Stern suggests something modeled after the health benefits plan for federal employees. Most of the Democrats who sought the nomination in 2004 offered plans based on expanding existing programs like

Medicaid. Rubiner has proposed a system modeled after auto insurance: everyone would be required by law to have health insurance, but government would subsidize the poor. (The Massachusetts plan works like this.) None of these approaches would be the dreaded “socialized” medicine—they would be organized by government but operate through private doctors and health plans. Employers would still contribute something toward health care, but their contribution would go through the government, and in exchange they would at last receive a measure of cost predictability.

Still, Washington’s hypercautious culture seems unlikely to produce a solution anytime soon. The United States currently spends 16 percent of its gross domestic product on health care—far more than any other country. Who better to initiate the mother of all cost-saving efficiencies than Wal-Mart?

Mr. PAYNE. Mr. Chair, are you going to conclude and end the program right now? I just want to say, just let me thank you once again for having this hearing. Let me thank the panel. I think it is—when we can have sound discussions without a whole lot of acrimony, it makes a lot of sense to try to come up with solutions. I would hope that our colleagues would have this quorum.

And let me just commend you for having a civil kind of a conversation where we could have give and take. If we have more of that, perhaps we could not be the do-nothing Congress, which we happen to be this year, and get something done.

Chairman JOHNSON. Wait a minute. It is a—

Mr. PAYNE. So I think that we really want to work on health care to see whether we can provide it for our people in this country. Maybe look at the Europeans, and we are a little wealthier than they are, so maybe we can throw a little more cash to make what they are doing better.

I do believe it is something we will have to come up with a solution to, or we are going to be in serious problems in the future. And it can’t be all born by your little shoe people; I won’t be able to afford the shoes. But we need to take a look at some sound solutions.

And your question about, you know, these health savings accounts, all of those things are great. Even tax credits are great. The only problem when you don’t have any savings, you can’t do the savings account. And if we had minimum wage people, they are not going to be able to provide health savings account for themselves because they have got nothing to save. They don’t even have enough to live on. So these—we have to think of the totality, but once again, Mr. Chairman, let me commend you for having a very good hearing.

Chairman JOHNSON. Thank you. I think that if you look at the HSAs in a lot of cases, the employers would provide some savings buildup for the individual. It seems like Congress ought not to get lazy and just put the burden on employers. I think there are other ways to reduce costs, and HSAs and AAPs and whatever the Senate wants to call them reduces the tax burden on individuals who do not get their insurance from their employer, making cost and quality information available. I think the list goes on and on. We can be more creative and more effective than a mandate on employers, I believe, as you do.

I want to thank the witnesses for their valuable time and testimony, and both the witnesses and members for their participation. If there is no further business, committee stands adjourned.

[Whereupon, at 12:18 p.m., the subcommittee was adjourned.]

[Additional submission from Chairman Johnson follows:]

[Fact sheet provided by Wal-Mart, Inc.]

Wal-Mart's Health Care Benefits Are Competitive in the Retail Sector

When compared to other retailers with similar business models—such as Target and The Home Depot—Wal-Mart's health benefits are competitive in the retail sector. In many areas we, along with Target and The Home Depot, are setting the standard.

Eligibility: Wal-Mart offers health coverage to both full- and part-time associates—only 23% of all employers offer coverage to their part-time employees.

On average in 2005, 73% of all associates were eligible for Wal-Mart plans and 43% of all associates chose to enroll. In January 2006, the number of associates covered by Wal-Mart health care insurance increased to 46%.

According to a 2005 survey by the Kaiser Family Foundation, the proportion of Wal-Mart associates eligible for company health care benefits (73%) is comparable to other large employers (79%) and significantly higher than the retail industry average (61%).

Coverage: We estimate that more than three-fourths of Wal-Mart associates have some health insurance, through either a company plan, a spouse's plan, or Medicare.

According to a survey conducted by The Segmentation Company, 5% of Wal-Mart associates are on Medicaid. This is lower than the retail sector average of 6% and only slightly higher than the national average of 4%. 27% of the children of Wal-Mart associates are on Medicaid or S-CHIP programs, a proportion lower than the retail sector average of 36%.

Affordability: Wal-Mart's deductible for individual coverage starts at \$350, which is comparable to our competitors.

We have plans available for as little as \$11 per month for associates and 30 cents more per day for children. These innovative plans include some first-dollar coverage for doctor visits and drugs.

Preventive dental coverage with no deductible is available to individuals for as little as \$6.52 per month, to associates and their children or spouses for \$13.58 per month, and to families for \$20.64 per month.

Company Contribution: Historically, Wal-Mart's contribution to both individual and family health care coverage has been approximately two-thirds of the total cost.

The total benefits package for a Wal-Mart associate includes, in addition to health care, programs such as company contributions to 401(K)/profit-sharing plans, associate discount cards, paid time off and life insurance. In FY 2006, Wal-Mart is projected to spend roughly \$4.7 billion on associate benefits.

The Current State of Health Care in America

Providing access to quality, affordable health care is a challenge facing businesses large and small across the country. Health care costs are soaring, some of the most vulnerable Americans are not receiving care, and the current health care system is inefficient and wasteful. Simply put, our health care system is unhealthy, and its deficiencies are profoundly impacting millions of Americans and businesses.

All Americans are affected:

- There are about 46 million uninsured Americans.
- Disproportionately represented among the uninsured are young adults ages 19 to 34 who make up a quarter of the total U.S. population, but represent 40% of the nation's uninsured population.
- Of the 53 million Americans relying on Medicaid or other public assistance programs, 32% are adults who work full or part time.

Working families are affected:

- In 2005, the average annual premium for family coverage was \$10,880. Health premiums in 2005 increased 9.2% on average over the year before. Since 2000, premiums have risen 73%.

- Retail prescription drug prices increased an average of 8.3% per year from 1994 to 2004 (from \$28.67 to \$63.59), more than triple the average annual inflation rate.

- All this despite wages rising only 2.7% in 2005.

Businesses, large and small, are affected:

- Health care costs represent a significant portion of payroll costs for all American businesses, and in particular, for low-margin, labor-intensive businesses like retail. In 2005, 60% of employers offered medical coverage to their employees, down from 69% five years ago.

- The cost of providing health benefits has been increasing faster than the growth in sales and earnings of a typical business. Furthermore, higher spending is often not translated into greater value to employees.

Wal-Mart is affected * * *

- In FY 2006, Wal-Mart is projected to spend roughly \$4.7 billion on associate benefits including, for example, contributions to health and dental plans, 401(K)/profit-sharing plans and associate discount cards. For perspective, Wal-Mart's net income for FY 2005 was \$10.3 billion.

- Benefits spending at Wal-Mart has grown 15% per year over the last three years, increasing from 1.5% to 1.9% of sales between FY 2002 and FY 2005.

- Health care spending alone has grown 19% per year during the same period * * * and Wal-Mart is responding with solutions:

- We are providing access to private insurance: Wal-Mart provides health insurance to full- and part-time associates after a waiting period considered standard in the retail industry. For many associates, a job at Wal-Mart means new access to health coverage. Surveys of hourly associates showed that 30% had no health coverage before coming to work for Wal-Mart. After joining Wal-Mart, the percentage of associates who are uninsured drops. By our estimates, we have helped over 160,000 associates get off the rolls of the uninsured.

- We are taking people off public assistance programs: According to a survey by The Segmentation Company, 7% of associates join Wal-Mart on Medicaid. Only 3% of associates remain on Medicaid after working for Wal-Mart for two years.

Wal-Mart is exploring ideas and working hard to find solutions to America's health care challenges. We believe that America's health care challenges are larger than any individual corporation—even one of the largest. We want and need partners—leaders in government and industry, our loyal associates and customers, and thoughtful associations and academics—to work with us toward these solutions. Together, we are working on some exciting new initiatives, and we're confident these will lead to many more.

Current Wal-Mart Health Care Overview

Every business in America is dealing with the rising cost of health care and shares a concern about the number of Americans who are uninsured or relying on government-sponsored health programs. Millions of working Americans put their trust in us, and we take that trust very seriously. That's why we continue to work hard to find affordable, accessible health benefit solutions for our associates and our customers.

The health care demands placed on Wal-Mart are unique. Understanding the size and diversity of our workforce puts into perspective the range of choices and plans that we offer our associates.

- As the largest private employer in America, Wal-Mart employs approximately 1.3 million people.

- The majority of Wal-Mart's hourly associates are full-time. (Fulltime at Wal-Mart is 34+ hours per week.) That's well above the 20% to 40% typically found in the retail industry.

- Many associates—such as students looking for work experience, seniors supplementing their retirement income and individuals working a second job—join Wal-Mart with existing health care benefits.

Wal-Mart's offerings are tailored to the needs of our diverse workforce, and associates are provided a great deal of choice.

- In some markets, associates can choose from as many as 18 medical coverage options. This gives them the opportunity to tailor their benefits to their individual needs and the needs of their families.

- Wal-Mart offers Health Savings Accounts (HSAs) to our associates, which provide yet another option for families to gain access to health insurance and save for future health care needs. Wal-Mart matches associates' contributions to their HSAs dollar-for-dollar up to certain amounts, and associates own the accounts. (The match ranges from \$250 to \$1,000, depending on coverage level selected.)

- Based on input from associates, in 2006 Wal-Mart introduced a new Value Plan—specifically designed to provide more affordable access to health care coverage with some first dollar coverage for doctor visits and prescriptions—all before associates have to meet their deductibles.

Our plans have some very attractive features.

- Unlike the employees of many of our retail competitors, both full- and part-time Wal-Mart associates can become eligible for health coverage.

- After one year, there's no lifetime maximum on health care expenses—protecting employees and their families from catastrophic loss. Wal-Mart is one of few retailers to offer this benefit.

- After an annual deductible is met, Wal-Mart's medical plan typically covers 80% of charges for all services included in the plan. After an associate reaches an annual out-of-pocket maximum, the plan pays 100% of all eligible charges.

New offerings are making health care even more affordable for our associates.

- In some markets, premiums for the new Value Plans are as low as \$11 per month and 30 cents more per day for children, no matter how many children an associate insures. Nationwide, every eligible associate—both full- and part-time—has access to individual coverage for no more than \$23 per month and 50 cents more per day for children. Family coverage starts at \$65 per month.

- Prescription drugs for some common conditions are available for as little as a \$3 co-pay.

- Wal-Mart continues to set up “high-performance networks,” which establish a competitive environment among health care providers and continue to lower the costs of health care services and monthly premiums for associates.

Our initiatives are working.

- During our recent open enrollment, about 70,000 associates who had previously waived coverage signed up for Wal-Mart plans.

- Of these associates, 78% of those surveyed said they were previously uninsured.

- Over one-third of those associates, previously uninsured and recently electing coverage, selected the Wal-Mart Value Plan.

- Considering factors that include associates who left Wal-Mart, those that elected to drop coverage as well as those who recently became eligible, this growth in enrollment leaves Wal-Mart in January 2006 with over 615,000 associates, (or over 1 million Americans, including spouses and dependants) on Wal-Mart health plans.

Wal-Mart is also working on behalf of our customers.

- Currently, Wal-Mart is conducting a pilot project that puts health clinics in our stores. With an emphasis on affordability and convenience, these clinics will give the communities we serve access to quality care while providing an alternative to expensive emergency room visits.

- Wal-Mart is committed to sharing our expertise in supply chain management and technology to reduce costs and increase efficiency within the health care system.

These are bold, innovative, outside-the-box solutions that reflect our care for our associates and a desire to be a leader in our industry. They’re just a start and much more is to come. We welcome partners in this effort to further these goals. Additional details on all Wal-Mart health plans can be found at www.walmartfacts.com.

[Statement from the United Food and Commercial Workers International Union follows:]

**Prepared Statement of the United Food and Commercial Workers
International Union, (UFCW)**

Thank you for the opportunity to submit written testimony to the Subcommittee on the important issue of state law innovations in covering the uninsured. As the Subcommittee is aware, the nation is facing a crisis in the number of Americans who lack health insurance coverage and, as a result, do not have access to critical health care services. There are approximately 45 million uninsured Americans in this country today and 8.5 million of these are children. As health care numbers and costs rise and publicly funded federal health care programs are cut, states have been left with no choice but to develop approaches to address with this issue.

The Subcommittee has learned through Congressional testimony about innovative ways states are acting to deal with this crisis. For example, Massachusetts and Maryland both passed laws earlier this year to help their own uninsured citizens. These two states took very different approaches—with Massachusetts, among other things, requiring state residents to obtain health insurance, and Maryland enacting a fair share law. Fair share laws assess a state tax on employers that is offset, in whole or in part, by the amount of money the employer spends on employee health expenditures. States must be free to try these different and innovative approaches that best fit the needs of their residents. Congress should not impede their progress.

Some opponents have wrongly argued that Maryland-type fair share laws are preempted by the federal Employee Retirement Income Security Act (ERISA). ERISA preempts states laws that relate to employee benefit plans, including health benefit plans. Opponents, including some who have testified before this Subcommittee, point out that ERISA preempts state laws that mandate health benefits, except for state laws that mandate benefits in insurance policies. As the Subcommittee has heard, large employers usually do not buy insurance policies for their employee benefits and employers that do not buy insurance policies are not subject to state law mandates for their health plans. Some large employers view state mandates as good guidance for appropriate benefit offerings.

The Subcommittee has heard about the advantages and disadvantages of state law mandated benefits, including mandates for coverage of diabetes supplies, cancer

screening, well-baby care, and childhood immunizations. However, fair share laws (those that impose a tax on employers with a credit against the tax based on money spent on employee health expenditures) are not preempted because such laws do not mandate particular benefits as do the other mandated benefit laws. Instead, fair share laws offer employers three choices—to pay the full amount of the tax to the state and paying no health care expenses in order to obtain the credit, to pay no tax by obtaining the full credit against the tax and paying the specified amount (or more) on employee health expenses, or an employer may also choose to pay some amount toward employee health expenses and some tax. States need the revenue to help support the public financing of medical treatment for those workers availing themselves of the state-based safety-net. This is because employees not receiving payment of health expenses through their employer must use the public system and therefore costs are shifted onto the safety-net.

States have traditionally regulated areas related to medical care received by state residents and raising state revenue, and have done so both before and after Congress passed ERISA in 1974. Certainly in passing ERISA, Congress did not intend to undermine these traditional areas of state regulation. ERISA was not intended to, and does not, restrict the states' ability to raise revenue through taxes or assessments or the states' ability to provide offsets, deductions, or credits against state taxes or assessments. This is what the fair share laws do and therefore, they are not mandating benefits and are not preempted by ERISA.

The states are merely taking action to protect their citizens and their state treasuries since Congress has not dealt with the growing problem of Americans without health coverage on a national scale. Clearly Congress could—and in our view, should—enact a sweeping overhaul of our health care system. Until Congress acts, states should be free to innovate and experiment, thereby providing models of success that can be emulated in other states and, in time, at the national level. Existing federal law under ERISA does not preclude this and fair share laws such as the Maryland law must be considered in other states.

Congress must recognize the important contributions of both the private and public sector in working to make quality, affordable health care available to all of our citizens. Whether there are collectively-bargained efforts that improve and expand health care coverage for working families, innovative public policy proposals that ensure public-private partnerships or private sector initiatives that improve health care quality, these small steps should be acknowledged as positive. While comprehensive health care reform at the national level is clearly preferable, it is also obvious that it is not on the agenda of the 109th Congress or the current administration. In the meantime, more than two dozen states have introduced “fair share” legislation in 2006. These are states from all over the nation; Georgia, West Virginia, New Hampshire, Washington, Kentucky, Tennessee, Minnesota and others. In addition, the state of Vermont recently enacted sweeping health care legislation. We applaud the actions of these states and urge the Congress to act as well. The need for thorough health care reform is an approaching national crisis, and a national solution provides the most consistent and far reaching answer. In the absence of national leadership, however, we applaud the legally appropriate and thoughtful approach of state governments.

Thank you again for the opportunity shares our views on this vitally important issue with the Subcommittee.

