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Heath Care and the Budget: The Healthy Americans Act and Other Options for Reform

before the
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Chairman Conrad, Ranking Member Gregg, other Members of the Committee, thank you for inviting me to testify today on health system reform. My name is Len M. Nichols and I direct the Health Policy Program at the New America Foundation, a non-profit, non-partisan public policy research institute based in Washington, DC. We also have an active branch office in Sacramento, California. Our program is committed to pursuing policy ideas and conversations that will lead to all Americans having affordable access to a high quality and sustainable health care system. We are involved in this work here in our nation's capital and in various state capitals across the country. I am happy to share ideas for your consideration today and hereafter with you or with committee or personal staff.

I applaud you all for being willing to lead our nation in a serious bi-partisan conversation about reform that is long overdue. With your help, I believe it is possible, this time, for us to fashion an American solution that will both work and engender broad and lasting support.

Your letter of invitation asked me to address three specific questions, which I do in turn below.

How should we evaluate health care reform proposals?

I would encourage you to adopt two criteria: (1) Does the proposal match the scale of our problems? (2) Is the proposal capable of earning bi-partisan support?

Scale

CBO Director Peter Orszag's testimony before you last week[1] ably laid out the macroeconomic and budget stresses, as well as some of what we know about poor health outcomes, that are caused by our health system's inefficiencies. Most of you are not new to these issues, and I know you are well aware of the immensity of the scale of our problems.

I would offer one additional fact to convey a family dimension to the economic imperative for health reform (see slide #2). In 1987, a family insurance policy cost 7.7% of median family income. Today, health insurance claims almost 20% of the median family's income. In my view, this is the single most important reason such a wide range of people across our nation are calling for you and other leaders to help us reform health care. Health care cost growth has exceeded average productivity growth for so long and by so much, that the simple truth is an increasing fraction of our workforce cannot afford health insurance as we know it. This trajectory is unsustainable, whatever the aggregate facts about shares of GDP and budget projections and all the rest. So the scale of our problems is definitely large.

[1] Statement of Peter R. Orszag, Director, Congressional Budget Office, *Health Care and the Budget: Issues and Challenges for Reform*, before the Senate Committee of the Budget (June 21, 2007).

To match this scale, a "major league" proposal worthy of your serious consideration must have three elements: it must cover everyone, it must reduce cost growth in the long run, and it must offer a credible financing package that can sustain the program over time. Any proposal without all three elements, in my view, should be labeled "minor league" and be relegated to the distant rear of proposals vying for your attention.

If a reform proposal would not extend health insurance to all Americans (and legal immigrants), then it is not serious, for it deliberately continues to ignore the cost-shifts and selection problems that plague insurance markets today. These problems perpetuate high costs for some at the expense of others, and keep insurance unaffordable for many. Health insurance is not an end in and of itself, but overwhelming research evidence supports the view that insurance *is* a necessary (but not sufficient) condition for access to timely and efficacious high quality care in our country.[2]

If a reform proposal does not have a credible plan for reducing cost growth and improving clinical value per dollar spent, then very few of us are going to be able to afford health insurance in the coming decades.

If a reform proposal does not have a credible financing package, then it is not being honest with the American people about the costs and benefits of investing in a reformed health system. You all know we've tried dishonesty before. It didn't work and never will. Let's just agree now, at least in this committee, to be honest with each other about how we intend to pay for what we want. My favorite new financing sources include redirecting existing tax subsidy dollars and capturing savings from increased efficiencies, which over time, ought to be close to enough to finance a reformed health system that can serve all Americans well.

Bi-partisanship

The second evaluation question I recommend you ask of reform proposals is this: is the proposal capable of earning bi-partisan support? There is no inherent reason health reform has to be a partisan issue. The cry of a sick child or of an uninsured adult in untreated pain is not a partisan sound. Health reform becomes partisan when it gets used by those who prefer rigid ideology over objective analysis of the essential roles for government or employers. We can keep analysis front and center, if we agree to try.

Bi-partisan reform is the only kind that will be politically sustainable over time. This simple truth is why you must reach across the aisle and fashion compromise. Bi-partisan reform will require that each side realize the key elements of their own values and priorities within the structure of the solution. For Republicans, this means individual

[2] Institute of Medicine, *Coverage Matters: Insurance and Health Care* (Washington, D.C.: National Academies Press, 2001); Jack Hadley "Insurance Coverage, Medical Care Use, and Short-term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition," *Journal of the American Medical Association* 297(March 2007): 1074-1084.

choice and market forces must be central, and for Democrats it means that the solution must work for *all* of us, including those with low incomes or high health risks.

Bi-partisan reform does not mean unanimity is required, for that would grant veto power to the most extreme views in each caucus. Nor does it mean that support has to be balanced at the outset: only 13 Republicans voted in favor of Medicare in 1965, but I daresay very few would vote to abolish the program today. Today, most Republicans I know want to reform Medicare, not end it, as do most Democrats (as do most policy wonks, in case you are wondering). But bi-partisanship does require that thoughtful leaders on each side of the aisle be involved in shaping the proposal to ensure that the core values of their respective caucuses are actually present in the contours of the solution, whatever the press releases might say.

I believe sharing these perspectives is what brought Senator Wyden (D-OR) and Senator Bennett (R-UT) to agree to co-sponsor S. 334, the Healthy Americans Act. This is the only "major league" proposal in the 110th Congress at this moment, in my view.

What are some possible options for health care reform?

There are only three analytically credible ways to cover all Americans: (1) tax-financed single payer/Medicare for all; (2) employer plus individual mandates to purchase private health insurance; (3) individual mandates alone. Programs that do not require participation will never approach universality, analysts with long histories advising those on either side of the aisle agree.[3]

"Medicare for all" or **single payer** is technically feasible, and could save considerable administrative costs in a "one time" adjustment to standard claims forms and the end of insurer underwriting and risk selection. However, a single payer system would require a generalized level of trust toward elites and governmental decision-making that I for one do not observe throughout the country, despite the well-intentioned efforts of many advocates, and notwithstanding the political popularity of the Medicare program *for the elderly*. The truth is, as Peter Orszag showed us again last week, private and public health care costs have grown at practically the same average rate since 1970. Therefore, our current "single payer" buyer has been no more effective at containing costs over time than the private sector. This may be because Congress will not delegate the authority it would take to run the program as efficiently as advocates imagine it could be, but that is the point.[4] If Congress can not delegate enough authority to run Medicare efficiently, then why would the American people trust the government to run an efficient single payer system for us all?

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[3] Robert Reischauer, Catherine G. McLaughlin, Mark V. Pauly, Len Nichols and Chip Kahn, *Top Ten Myths About the Uninsured*, (February 11, 2004), http://eriu.sph.umich.edu/pdf/bookevent_transcript.pdf, accessed June 25, 2007.

[4] King, Kathleen M. et al. 2002. "Improving Medicare's Governance and Management; Final Report of the Study Panel on Medicare's Governance and Management." *National Academy of Social Insurance*:39-42

In addition, most of the administrative efficiencies of a single payer system could be obtained through a program of mandatory private coverage, which eliminates the profit from avoiding high risk patients. It would seem telling that only one Democratic candidate for president in 2008, Rep. Dennis Kucinich (D-OH), has proposed a single payer system as a campaign plank, despite its appeal among Democratic primary activists. None of the candidates considered most likely to win the nomination and the presidency comes close to embracing single payer as a systemic solution to our complex health care problems.

The employer plus individual mandate solution could also work technically, and many variants of "pay-or-play" proposals (in which the employer pays a fee or payroll tax in lieu of offering insurance to its workers) have surfaced lately.[5] The common goal of employer mandate proposals is to ensure employers do not spend less than x% of payroll on health benefits for their workers, where "x" is chosen for different strategic and tactical purposes. For example, in Governor Schwarzenegger's proposal, the 4% of payroll "in lieu of fee" for non-offering firms with more than 20 workers, was really designed to establish credibility with Democrats in the California legislature, and raise one billion of the 12 billion dollars needed to finance his health reform plan (more about that later). By contrast, the Democratic leadership in that legislature (Senate President Pro Tempore Perata and Assembly Speaker Nunez) have both proposed a 7.5% levy on virtually all firms regardless of size. This seems to be more about shoring up current benefits and putting the full burden of financing coverage expansion on the business community rather than expanding coverage per se. Details will always differ. The overarching fundamental policy question should be, is it wise to increase reliance on employer financing of our health care system in the 21st century economy?

This question is largely motivated by concern about international competitiveness. A typical argument made by CEOs of American companies engaged in international trade is that other countries spend far less on health care than we do, and are less reliant on employer financing than we are. Thus, US firms already face a comparative disadvantage vs. employers in the developed world, due to their higher health care cost burden.[6] Is it smart to add more costs to this disadvantage?

Many economists dismiss this particular worry, citing conventional theory to argue that higher premium payments are "paid for" with reductions in wages. Any new burden on employers will be financed by workers, not firms. There is empirical evidence to support this "full wage-incidence" theory in the long run, on average.[7] However, there is an

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[5] John Edwards, http://johnedwards.com/issues/health-care/health-care-fact-sheet/, accessed June 25, 2007; Barack Obama, http://www.barackobama.com/pdf/HealthPlanFull.pdf, accessed June 25, 2007; An Act Providing Access to Affordable, Quality, Accountable Health Care, 2006 Mass. Acts Chapter 58.; Governor Arnold Schwarzenegger, http://www.stayhealthycalifornia.com/, accessed June 25, 2007; Governor Edward G. Rendell, http://www.gohcr.state.pa.us/prescription-for-pennsylvania/Rx-for-Pennsylvania-News-Release.pdf, accessed June 25, 2007.

[6] Harold McGraw III, "Business Roundtable Chairman Outlines Strategies for Strengthening America's Competitiveness" (speech to the Detroit Economic Club, May 2, 2007).

[7] Jonathan Gruber, "Health Insurance and the Labor Market," in *Handbook of Health Economics*, ed. A. J. Culyer and J. P. Newhouse (San Diego, CA: Elsevier, Inc., 2000), 1A: 645-706.

important difference of opinion about how long the "short run" is, i.e., how long does it take for "full wage-incidence" to take effect? If the "short run" of less than full wage-incidence lasts long enough, then the CEOs have a point: adding to the employer burden, however well-intentioned, could harm both economic and health system performance.

CBO Director Orszag's testimony of last week acknowledges this issue, on p. 14:

> "Over time, any changes in these [employer premium] contributions, which are substantial, should be reflected in workers' wages or other benefits, *but the speed of that adjustment could vary."* [italics added for emphasis].

My colleague Topher Spiro and I will argue against the simple-minded long run view of full wage-incidence as a guide to policy conclusions in a forthcoming paper.[8] I summarize some of our arguments below.

First, growth in employer premium payments exceeds revenue growth regardless of the actions of employers to reduce premiums and the strength of macroeconomic demand (see slide 3). This puts pressure on employers to reduce wage growth below inflation plus productivity, reduce profits, or reduce investment which will decrease profit in the long run. None of these choices are good for management, even the first, which makes it harder to attract and hold qualified workers. And note, if full incidence takes more than one year, each year adds to the burden, since premium growth continually outstrips revenue and nominal wage increases.

To provide a sense of the magnitude of this problem, see slide 4. This shows employer premium costs as a percent of payroll, over time for all firms, and recently for firms that offer health insurance and for the workers that actually enroll in employer-sponsored health insurance. These are averages that vary by industry. The bottom line is that currently offering firms are already paying between 10% and 20% of payroll for health insurance.

Slide 5 compares the average employer burden as a percent of payroll across a number of trading partners and international competitors. France (which just elected a more pro-business President) and Germany (for whom reduction of business burden was also a recent election issue) are the only two with burdens within 40% of US firms. These and other countries are glad our health care system is so inefficient and that our firms help bear such a share of the costs.

Again, this differential burden would not be an issue – and employer mandates would be "costless" to jobs and the economy – if employers could just shift premium cost increases to workers smoothly and immediately. We infer that they cannot do this from their own behavior. If employers could shift premium increases to workers' wages, firms would

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[8] Len M. Nichols and Topher Spiro, "Employer-Based Health Care: A Competitive Disadvantage in a Global Economy," New America Foundation Health Policy Program Issue Brief, forthcoming, 2007.

not be dropping health insurance offerings altogether, increasing the share that employees pay and reducing the generosity of benefits offered. We note instead that employers have been using all three strategies as assiduously as labor market competition constraints allow. Employer survey data from AHRQ and the Kaiser Family Foundation confirm that employer offer rates, share of premiums paid, and the generosity of benefits have all declined since 2000.[9]

The implications of these trends are clear. A recent analysis of Current Population Survey data confirms that between 2001 and 2005, the percent of the non-elderly population who were covered by employer-sponsored plans declined by 3.8 percentage points. Half of this decline was due to firms dropping coverage, a little over a quarter of the decline was due to lower employee take-up (due to rising premiums) and the rest of the decline was due to reduced eligibility for coverage.[10]

In the face of these trends, and in recognition that young workers today will likely change jobs far more often than the current crop of older workers did,[11] I sincerely doubt the smartest health reform is to place more burdens on business and thereby reduce our already precarious competitiveness in the world economy. In the "best" case of full incidence, a pay-or-play employer mandate is a form of taxation of lower wage workers to finance universal coverage for lower wage workers. This is not likely to leave them much better off, on balance. In the worst case, many low wage workers would lose their jobs to the "pay" requirements, and mid-level workers would also lose jobs as firms would have even more incentive to move middle-class jobs overseas.

An individual mandate strategy has the virtue of avoiding all the downsides of employer mandates and being easily reconciled with the personal responsibility vision of more conservative reformers. Being required to acquire health insurance is just the logical extension of being responsible for one's own health, which not only includes attention to diet and exercise but also seeking care when appropriate and paying a fair share of one's own health costs. Indeed, it was the strong desire to punish "free riders" -- those who could afford health insurance but remained uninsured and shifted the cost of

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[9] Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_results.jsp?component=2&subcomponent=1&year=-1&tableSeries=1&tableSubSeries=&searchText=&searchMethod=1&Action=Search, accessed June 25, 2007; Kaiser Family Foundation, Employer Health Benefits 2006 Annual Survey, http://www.kff.org/insurance/7527/index.cfm, accessed June 25, 2007; The decline in generosity of benefits is clear from both the percent of workers with deductibles above $500 (Kaiser) and the rise in median out-of-pocket payments as a percent of income. Agency for Healthcare Research and Quality, Rockville, MD. AHRQ Working Paper. Jessica S. Banthin and Didem M. Bernard, "Changes in Median Burdens for Health Care, 1996 to 2003," Agency for Healthcare Research and Quality, Rockville, MD. AHRQ Working Paper, June 2007.

[10] Kaiser Commission on Medicaid and the Uninsured, *Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001 to 2005* (December 2006), http://www.kff.org/uninsured/upload/7599.pdf, accessed June 25, 2007.

[11] Meg Kissinger, "The Millennials," *Milwaukee Journal Sentinel*, June 5, 2005, p. 1; David M. Walker, Comptroller General of the United States, "A Look at Our Future: When Baby Boomers Retire," The Frank M. Engle Lecture, The American College, Bryn Mawr, Pennsylvania, September 28, 2005, p. online.

their emergency acute care to the insured and to taxpayers generally -- that motivated Mitt Romney, former governor of Massachusetts and now a leading Republican presidential candidate, to eventually develop a full universal coverage proposal with an individual mandate at its core. Of course, he had considerable help from Democratic legislators along the way, in the first serious bi-partisan reform effort of the 21st century.

Individual purchase mandates also help achieve more traditionally liberal goals of making insurance markets work better, as purchase mandates significantly reduce the likelihood and insurer's fear of adverse selection. While some of the uninsured are very high risk and consequently uninsurable in current markets, many if not most of the uninsured are healthy. Therefore, requirements to cover everyone, especially those who think they do not "need" insurance, will actually *lower* the average risk of the overall risk pool.[12] The reduction in adverse selection risk will enable fairer restrictions on premiums – e.g., modified community rating – to be enforced without reducing coverage among the healthy. Plus, modified community rating and lower average risk means that the underwriting and selective marketing activities that so many insurers engage in now would be rendered largely redundant, and thus would disappear in a reformed marketplace. This should translate into considerable savings off insurer administrative loads that inflate premiums today.

The downside and opposition to individual mandates stem not from disagreement with all these likely positive effects, but rather from an innate skepticism that adequate subsidies for the low income population and a reformed insurance marketplace are likely to be maintained in a reform centered on individual mandates. Reassurance on this point is essential for this strategy to be widely accepted, and by implication, for single payer and employer mandates to be avoided. John Edwards' campaign proposal,[13] the New America plan,[14] the Wyden-Bennett legislation,[15] the Federation of American Hospitals plan,[16] and ERIC, the ERISA Industry Committee's plan,[17] all promise to couple individual mandates and personal responsibility with the shared responsibility of financing adequate subsidies, a reformed marketplace, and stewardship over the efficiency of the health delivery system (more on that below).

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[12]. Mark V. Pauly and Len M. Nichols, "The Nongroup Insurance Market: Short on Facts, Long on Opinions and Policy Disputes" *Health Affairs* (October 2002): web exclusive.
[13] John Edwards, "Reforming Health Care to Make it Affordable, Accountable, and Universal," http://johnedwards.com/news/headlines/20070614-health-care-costs-quality.pdf, accessed June 25, 2007.
[14] Len Nichols, "Mandatory, Affordable Health Insurance" in *Ten Big Ideas for a New America*, http://www.newamerica.net/files/NAF_10big_IdeasComplete.pdf, accessed June 25, 2007.
[15] Senator Ron Wyden, *Healthy Americans Act*, 110th Cong., 1st sess., 2007, S.. 334, http://www.thomas.gov/cgi-bin/query/z?c110:S.334, accessed June 25, 2007; Senator Ron Wyden, *Healthy Americans Act Section by Section*, http://wyden.senate.gov/Healthy_Americans_Act/HAA_Section_by_Section.pdf, accessed June 25, 2007.
[16] Federation of American Hospitals, *Health Coverage Passport: A Proposal to Cover All Americans*, http://www.fah.org/passport/HCP%20PPT%20Designed%202-16-07.pdf, accessed June 25, 2007.
[17] The ERISA Industry Committee, *A New Benefits Plan for Life Security*, May 2007, http://www.eric.org/forms/uploadFiles/b86a00000009.filename.ERIC_New_Benefit_Platform_FL06060.pdf, accessed June 25, 2007.

However, in the one case of an individual mandate approach being put into practice to date, in Massachusetts, political disagreements over what qualifies as "affordable" (in terms of cost sharing requirements) or "adequate" (in terms of subsidies) led to a relaxation of the mandate for about 20% of the uninsured. This, plus the widespread perception that Governor Schwazenegger's proposed individual mandate plan, while laudable for many reasons, is not generous enough for people just above the highest income eligible for subsidies (about $50,000 for a family of four), has led many (including Senator Obama) to be reluctant to embrace an individual mandate as a requirement in a health reform proposal. In my view, these kinds of excessively parsimonious details can be fixed fairly easily (though at the cost of more subsidy dollars in the short run). However, the burden of politically acceptable proof is clearly on reformers to insure that health insurance and health care will be affordable and that markets will be *both* more efficient and more fair. This appears to be necessary for a national "individual mandate only" proposal to be embraced by a majority of Democrats.

Finally, turning to the final question the Committee asked:

How do we provide quality health insurance to more individuals and families, decrease the number of uninsured, improve health outcomes, and contain costs?

This is the proverbial key question. I offer a two-part overarching answer: (1) buy smarter; and (2) think hard about whom we are buying for, and why we are buying it.

Buy Smarter

While coverage and financing issues are important enough to claim most of what I've written so far, the fundamental flaw in our health system is this: we buy health care blindly, stupidly, and without learning fast enough from past mistakes. If we fail to significantly improve the efficiency with which our health system produces health, a majority of working Americans will likely be uninsured by 2020. I expect my co-panelist Arnie Milstein to devote much of his testimony to this topic and for this to figure prominently in the question and answer session, so I will focus on just the highlights of my vision here.

The first key to buying smarter is, we have to know what we are buying. We should be buying health improvement and maintenance or the management of a chronic condition, but instead we buy procedures and products which are rarely linked and traced to specific outcomes over time. Astonishingly, we have no system of tracking the outcomes of our interventions through the millions of encounters that occur every day. This lack of systematic review and accountability – we basically trust physicians to remember what they were taught and to learn from their own practice experiences and whatever they happen to read or learn from colleagues along the way – is why huge variations in medical practice are perpetuated, why we cannot get most to do what others know works, and also why we cannot stop those providers who are doing many things that add no value. We have no system of proving superior methods to local providers' satisfaction in ways they will accept in real time.

Electronic health records are a key first plank in an infrastructure of excellence, for not only will the patient have a record that will be fully portable across providers, but the research which combined record sets will make possible will enable us to turbocharge our production of useful health- and efficiency-enhancing information. While EHRs will eventually help providers provide better care, the reality is that the upfront investment will likely not pay for itself quickly, and therefore some public investment is probably necessary to spread them nationwide in less than 5 years, like we should. The payoff from such an investment could be huge.[18]

The second plank in buying smarter by building an infrastructure of excellence is to revamp our skewed and counterproductive incentives, on both the demand and the supply sides. Basically, we get what we pay for, and what we pay for are services that providers want to perform, whether they add clinical value or not. The secret is not, however, to re-jigger 10,000 prices in 3,000 counties so that we get them "right" once and for all (or until medical knowledge or technology or input prices change again). The secret is to pay for what we want – health – and then monitor our progress toward that end with EHRs while bundling ever-larger sets of services into one payment, which frees clinicians and providers to find the most efficient way to deliver health, given our particular circumstances. Bundled payments are steps away from fee-for-service payment, a clearly flawed system with a bias toward excess care, and towards (though not reaching) capitation, which alienated a lot of clinicians whose practices could not handle the financial risk and also worried patients about incentives to deny care. Again, the EHR is a key to balancing this tension or squaring this circle. EHRs and the benchmarks they will generate will enable patients and their agents (e.g., insurers, health coaches, medical home directors, etc.,) to monitor quality and thus prevent stinting on care. In addition, the absence of a marginal incentive for low value care will prevent providers from pushing to do unnecessary procedures.

The other supply side incentive that it is imperative to fix, not because it will save lots of money but because it is essential to free physicians to focus appropriately on all the other reforms that are necessary, is our malpractice system. An inordinate amount of energy on both sides of malpractice – spurious suits on the one hand, defensive medicine and a culture of hiding honest mistakes instead of sharing and learning from them on the other – makes this an area ripe for reform. I am no malpractice expert, but simple economics suggests that some combination of a no-fault insurance system – which will compensate harmed patients while creating a culture of learning from mistakes – along with strict quality improvement enforcement – or practice termination – are probably elements of a solution.

On the demand side, there is clearly a role for increased cost-sharing, at least among the middle and upper classes, and maybe even for the lower income population as well, as long as cost-sharing requirements are commensurate with income. The principle is to

[18] Richard Hillestad, James Bigelow, Anthony Bower, Federico Girosi, Robin Meili, Richard Scoville and Roger Taylor, "Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, And Costs," Health Affairs 24 (September/October 2005): 1103-17.

apply the logic of generic drugs – given free or low priced generics, make consumers pay large marginal prices for brand name drugs, unless the brand name works a lot better for the particular patient – to all of medicine. This will require more comparative quality information, which is the third plank in this infrastructure of excellence.

The third plank in buying smarter by building an infrastructure of excellence is to substantially expand the scope of comparative effectiveness research. Unproductive medical practice variation persists partly because we actually know surprisingly little about which diagnostic and treatment regimens have the greatest likelihood of success for specific groups of patients. Consider the FDA drug approval process as an example. Current law and practice requires a pharmaceutical company to show that a new drug is safe and effective, i.e., it does not have high incidence of debilitating side-effects and is more effective than a placebo. With all due respect (and you will read below some of the respect I have for our religious traditions), there is considerable evidence that prayer beats a placebo. If we raised the bar and said in order to be approved for sale a company will have to show the comparative effectiveness of a new drug vs. existing treatments and for specific sub-populations, that would both change the incentives to develop drugs that truly add clinical value and provide far more useful information to clinicians and patients as they make choices. In exchange for the longer time this research would take, we would need to grant longer periods of exclusivity for the successful drug, thus preserving and even enhancing the incentive to invest in compounds that will add significantly to the quality of our lives.

This principle, better comparative effectiveness information prior to widespread use, could be applied across the board to medical devices and to diagnostic and treatment modalities in a systematic research effort that is the long run key to the large dividends in improved efficiency which we need to earn from our delivery system. Information and incentives for providers as well as patients can enable us to buy smarter, but we cannot develop effective incentives until we develop and disseminate more useful information. A recent paper by Gail Wilensky in *Health Affairs* [19]lays out some options in this regard, including making the agency that leads this effort a public-private partnership, that are worthy of consideration, indeed a number of Members of Congress already are, including Senator Clinton, as well as Congressman Allen (D-ME) and Congresswoman Emerson (R-MO).

Finally, in some ways the most important point about health reform:

For Whom Are We Buying Smarter, and Why?

There are 10,000 technical questions about health reform. We have covered lots of them today and you will consider them all again a thousand times before we come to agreement, I think we all know that. But there is one fundamental question, I think it is a moral question, that we should ask before we begin to answer any of the technical questions: Who should be allowed to sit at our health care table of plenty?

[19] Gail R. Wilensky, "Developing A Center For Comparative Effectiveness Information," *Health Affairs* (November 2006): w572-85.

This is a question about community, what kind of community do we think we live in, what kind of community do we want to live in, what kind of community do you want to nurture and build, maybe rebuild? The older I get the more I am convinced that the best descriptions of community are the oldest descriptions we have. Yes, I'm talking about the Hebrew prophets.

Before you settle your views on health reform, I would encourage you to re-read Leviticus, the 3rd book of the Torah and Old Testament, chapter 23 verse 22, where you will find the concept of "gleaning" rights. Gleaning rights stem from the admonition to landowners to leave some of their harvest in the field "for the poor and the alien." In Deuteronomy (the fifth book) and Isaiah (a later prophet) the description of those who must be assisted is the more familiar, "widow, orphan, and stranger."

Now the widow and orphan are easy to understand. In many ancient societies, only adult males could own land, and thus widows and orphans had no claim to food, and so could quite literally starve to death without some form of gleaning rights. Life expectancy was very short, so one can readily see the inter-family self-interest in each community agreeing to provide for widows and orphans of their own clan, tribe, village, or nation.

But the "stranger?" Here is an important and unique concept, for one didn't have to be Jewish, didn't even have to be local, to have an equal claim to essential food when merely passing through any Israelite community. The stranger, being a wayfarer, was potentially as vulnerable as the local widows and orphans. The common theme of the widow, the orphan, and the stranger, who must be fed, was their vulnerability in the absence of community largesse.

Jesus, 1400 years after Moses, among other things put a human face on and helped make clear the universal nature of the stranger, by teaching and eating with those considered "unclean" in his time, e.g., lepers, prostitutes, tax collectors, etc. Mohammed, 600 years after Jesus, studied theology with Jews in Yathrib (now Medina) and with Christian monks in the Sinai, and his revelation from God we call the Qur'an uses at various times the poor, the needy, the orphan, the beggar, the captive, as well as the alien or wayfarer, to describe the necessary objects of Muslim charity in the name of serving God's will.[20]

So what was the basis of the stranger's claim on scarce food resources? Every human being was believed to have been created in the image of God, and every human being had a right to participate in the life of the community. True participation requires a more vibrant form of life than abject poverty. At the time our monotheistic scriptures were written, food was the only commodity one human being could give another that would guarantee life. We weren't so good at health care then. The prophets were highly focused on preserving the life of the community -- and individuals within it -- against innumerable physical and spiritual threats. As Isaiah is interpreted to have meant, what

[20] More detail on the sources underlying these interpretations can be found in Len M. Nichols, "The Moral Case for Covering Children (And Everyone Else)," *Health Affairs* (March/April 2007): 405-07.

good is mere physical survival if we forget our covenant to live according to God's Just laws?

And Justice clearly compelled the "haves" to make sure the vulnerable did not starve, for such a preventable death was simply unacceptable then. As it is in our time, for the one thing we Americans DO guarantee to all who want is food to eat – through food stamps, food banks, soup kitchens, etc. I submit our unshakeable commitment to avoiding noticeable starvation comes from our unspoken but unbroken allegiance to this biblical requirement of Justice laid down in many traditions so long ago.

You may think this is an odd digression for testimony to a Budget Committee, but I submit that you are the most important committee to have this conversation in the context of health reform. Consider this: health care has become like food in ancient times, a unique gift capable of restoring and sustaining lives stricken with certain illnesses, which could of course be any of us any time. For the Institute of Medicine (IOM), after 3 years of committee meetings and six volumes of published reports of literature syntheses and interpretations, has concluded that 18,000 Americans, children and adults, *die* each year due to lack of health insurance, since the lack of health insurance prevents them from getting the timely and efficacious care the insured routinely get.[21] These preventable deaths – and the human suffering and lost productivity of preventable illness -- are a dark stain on our nation. The fact that most uninsured lack health insurance because of cost is tantamount to us denying food to the poor widow, orphan, and stranger when Moses, Jesus, and Mohammed taught. I do not believe they would approve.

At the same time, no community was ever told to give all its food to one person, nor to share the amount of food equally among all people. Stewardship of the collective resources of the community, for the purposes of nurturing and strengthening the life of the community as a whole, was presumed to be a responsibility of leadership. Indeed, when you consider another of the Institute of Medicine's findings, that the total social cost of the uninsured -- including the economic loss from premature deaths, unnecessarily prolonged illnesses, etc. -- is roughly equal to the net new public costs of covering the uninsured,[22] you realize that health reform is at least as much about stewardship, buying smarter, as it is about charity.

I would also point out that in Leviticus, the landowner is not told to cook the food and invite the alien home to dinner, but is rather told to leave some harvest in the field for the poor to gather for themselves. Our oldest obligations to each other have always been reciprocal. Each community has the right to define the rules of participation, but it must keep the door open to willing passersby. Thus, requiring people to obtain properly subsidized coverage and to take personal responsibility for their own health is perfectly consistent with this interpretation of the timeless moral case. As is expecting the

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[21] Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America* (Washington, D.C.: National Academies Press, 2003).

[22] Ibid.

community at large, with proper leadership, to exercise stewardship over its collective resources, including the health care delivery system. Thus shared responsibility extends to making the system more efficient, so we can buy health care smarter, for us all.