DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR 2009

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

SUBCOMMITTEE ON THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES

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NOTE: Under Committee Rules, Mr. Obey, as Chairman of the Full Committee, and Mr. Lewis, as Ranking Minority Member of the Full Committee, are authorized to sit as Members of all Subcommittees.

CHERYL SMITH, SUE QUANTIUS, NICOLE KUNKO,
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Subcommittee Staff

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DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR 2009

WEDNESDAY, FEBRUARY 13, 2008.

OVERVIEW HEARING: IMPLICATIONS OF ECONOMIC TRENDS FOR WORKERS, FAMILIES, AND THE NATION

WITNESSES

HAROLD MEYERSON, EXECUTIVE EDITOR-AT-LARGE, AMERICAN PROSPECT

JARED BERNSTEIN, PH.D., DIRECTOR, LIVING STANDARDS PROGRAM, ECONOMIC POLICY INSTITUTE

ROBERT GREENSTEIN, EXECUTIVE DIRECTOR, CENTER ON BUDGET AND POLICY PRIORITIES

ALAN D. VIARD, PH.D., RESIDENT SCHOLAR, AMERICAN ENTERPRISE INSTITUTE

Mr. OBEY. Why don't we begin?

Let me thank you all for coming this morning. I appreciate your willingness to testify, and I appreciate the fact that our minority members are here. I don't know where our majority members are but, we are going to have to hold down the fort.

Let me explain what we are trying to do with the first couple of hearings we are having for the Subcommittee this year. Not everybody in life starts out as a winner, and not everybody in life ends up as a winner. This Subcommittee has jurisdiction over programs that help determine what Government does to help those who start out behind the starting line and what Government does to help those who, sometime along life's way, need a helping hand.

Before Franklin Roosevelt, the Federal Government largely let people struggle on their own. When the Great Depression showed that cost was unacceptable, FDR and the Congress adopted many mechanisms in the New Deal that tried to make life less rocky and tried to make opportunity more widely available to more people in our society.

When Dwight Eisenhower led a Republican resurgence, he chose largely not to try to repeal those achievements and, in fact, he created the Department of Health, Education and Welfare, which along with the Department of Labor and those agencies now as you know evolved, those agencies administer many of the programs that impact today's working families in so many ways.

Before we begin to take testimony on the President's budget and its impact on those programs, I thought it would be useful to sim-

ply have several hearings to try to help us achieve a clear understanding of the context in which these programs are impacting today's American families.

So today's hearing will focus on the economic and social conditions that are impacting the average American family, families that are in turn being impacted by the action that this Committee will take today and tomorrow. Before we hear testimony about the cost of taking certain actions in the healthcare area, we will be focusing on the cost of not taking those actions.

Today, the Subcommittee will hear from a panel of distinguished witnesses who will present testimony to help us understand the broad economic and social trends impacting the Country and their implications. I have asked our witnesses to address national, economic and budget trends including wage stagnation, growing income inequality, and increasing globalization, competition and immigration.

What we hear today I hope will help us to better understand how these trends impact the standard of living, the economic security and the well-being of American workers, families and those in need, particularly those at the bottom of the income spectrum, and I hope that the testimony will provide a larger economic framework and the context within which we will be considering the President's budget for these programs this year.

Tomorrow and in the coming weeks, we will also hear from a variety of experts in public health, biomedical research, education and workforce development to help us understand the price of progress and the price of inertia and indifference as well.

Today's hearing is the beginning of the process. Our first witness will be Mr. Harold Meyerson, the Executive Editor-at-Large of the American Prospect. Many of you are familiar with Mr. Meyerson's weekly column in the Washington Post.

Our second witness is Dr. Jared Bernstein, Director of the Living Standards Program at the Economic Policy Institute. His area of research includes income inequality and mobility, trends in employment and earnings, low-wage labor markets and poverty, and the analysis of Federal and State economic policies.

Our third witness is Bob Greenstein. Mr. Greenstein is the founder and Executive Director of the Center on Budget and Policy Priorities, one of the Country's leading experts on the Federal budget and a range of domestic policy issues including low-income assistance programs, tax policy and social security.

Dr. Alan Viard, he has one strike against him. He is from Ohio State, and they regularly maul the Badgers in football, but other than that he has excellent credentials. [Laughter.]

Mr. OBEY. He is a scholar at the American Enterprise Institute. He was a Senior Economist at the Federal Reserve Bank in Dallas and a Senior Economist on the Council on Economic Advisors.

Gentlemen, I am happy that you are all here, and I will ask for your comments as soon as I have asked Mr. Walsh, the Ranking Member, for any comments that he might have.

Mr. WALSH. Thank you, Mr. Chairman.

I would like to welcome our witnesses and thank all of you for coming today.

Mr. Chairman, nice job, a multi-talented guy. You can conduct hearings and run a Committee and interior decorate at the same time which is pretty neat, and I have no objection to the Green Bay green carpet on the floor, especially since my Giants finally, the first time in my lifetime, defeated the Packers at Lambeau in the post-season. So I am a happy camper.

Mr. OBEY. It won't happen again for a long time. [Laughter.]

Mr. WALSH. I won't even talk about the Patriots, that new team from New England.

I think our discussion today will really get to the heart of the philosophical differences between Republicans and Democrats, liberals, conservatives and those of us who fall somewhere in between when it comes to issues surrounding the economy.

I have always felt that we have a responsibility to provide everyone with equal opportunity. Success is up to them.

There is no question in my mind that everyone in this room wants to continue our Country's historic economic success well into the future. While we may be at a little bump in the road today, I am confident and optimistic that the American people will overcome this downturn as we always have.

My view is that one of the very worst things we, the Congress, can do is follow economic policies that result in raising taxes on the American citizen and businesses. We have enjoyed economic success in the past in large part because of our relatively low tax rates. To raise taxes will, in my view, stifle the prospect of economic prosperity in the future.

We need only to look back into our Country's recent history. For example, in the 1960s, President Kennedy dramatically reduced capital gains and other Federal taxes and sparked a dramatic period of economic prosperity and growth.

President Reagan shook the American economy out of its malaise, ending double-digit inflation, unemployment and interest rates by working with Congress to again cut income taxes across the board. The commensurate cut in spending, unfortunately, didn't happen.

We can look across the pond to Ireland with its historically sleepy agricultural economy and poverty, beginning with Albert Reynolds, then John Bruton and now Bertie Ahern, the Irish slashed corporate and personal income taxes and, in doing so, woke up the Celtic tiger. In 25 years, Ireland went from one of the poorest countries in Western Europe to now its wealthiest.

Exemplary public education was also essential. Today, the Irish immigrants to the United States are going back to Ireland for opportunity.

Kennedy, Reagan, Ireland, there seems to be a trend there. President Bush picked up on it in 2002, and it worked again.

With that said, I also believe there are things the Congress can do proactively that can help spur the economy in the future.

I think one of those things is to provide the resources to ensure that every child in America receives a high quality education from early childhood through college and beyond, whether that child lives in an affluent community or a poor community, whether rural, urban or suburban, whether the child has a disability or not. While this is and should be the responsibility of local communities,

we should make sure that any mandates we lay on those school districts be fully funded by us.

I do not think it is unreasonable for the Government, working with businesses and employees, to seek ways to reduce workplace injuries and thereby promote better health and greater efficiency. Making prudent investments in workplace safety provides an economic benefit to both employer and employee.

Regarding healthcare, the American public, I believe, is now demanding universal healthcare. The Democrats have endorsed and embraced that by utilizing a Government-run system.

I believe the Republican Party is ready to endorse universal healthcare soon also but based on a private sector model where people continue to have choices, where they maintain the doctor-patient relationship, and Government empowers them by providing tax incentives and deductions and makes the proper investment in research and then gets out of the way.

We need to do this to be globally competitive and to maintain our quality of life.

Mr. Chairman, I thank you for holding these hearings, and I look very much forward to hearing the testimony.

Mr. OBEY. Gentleman, why don't you proceed?

Your statements will be placed in the record. Why don't you each take roughly 10 minutes and say whatever you have on your minds?

Why don't we start with Mr. Meyerson?

Mr. MEYERSON. Thank you, Mr. Chairman, and I thank the Ranking Member as well.

I am honored to be here today, and I am honored to be here particularly before the Chairman of this Subcommittee and Committee whom I know to be a tenacious champion of the rights and interests of the ordinary Americans.

My name is Harold Meyerson. I am Executive Editor of the American Prospect which is an avowedly liberal political monthly founded 18 years ago by Robert Reich, Bob Kuttner and Paul Starr. I am also an op-ed columnist for the Washington Post. My testimony today, like my columns in the Post, clearly expresses my opinions only, and any overlap with the editorial positions of the Post is coincidental, accidental, very rare.

Also, I am the odd man out here today. I am not even close to being an economist, and I presume I have been asked here to offer testimony because much of my writing deals with broad historic trends in the social and economic life of the American people.

So I will endeavor to deal with that today, beginning by noting that over the past three decades, not the bottom, but the middle has fallen out of the American economy. The great social achievement of the United States in the 30 years following World War II, which was the creation of the first majority middle class of a society that offered more economic stability to more people than any society ever before in human history, has to a significant degree been undone.

What happened that changed the economic life of the American people and why are we seeing polls that show a clear plurality of Americans—this is in several polls over the past two years, not simply in response to the immediate downturn—showing that

Americans say they now believe that their children will have a harder economic life than they themselves have had?

Can this really be the voice of Americans, this most optimistic of peoples, believers for centuries in the certitude that their children, if they work hard, will have a better life than they themselves had?

How has a Nation of incorrigible optimists—one of the many things you have to love about this Country—become, in many ways, a Nation of pessimists?

What changes in public policy does our Government need to embrace in order to create again that valid sense of optimism?

I am going to argue that what has fundamentally shifted in America today is that jobs, jobs for high school graduates, jobs even for quite a number of college graduates, no longer provide the upward level of income that they once did nor do they offer the level of benefits nor the assurance of steady, long term employment.

In many ways, we are no longer a Nation of the kind of good jobs that was the case in the America I grew up in. The benefits, the pensions, the rising annual income that were a common, but by no means universal, experience of American workers a generation ago are now a thing increasingly in the past to all but the talented or fortunate tenth. That is why Americans now tell pollsters they fear that their children are going to have a harder time than they themselves did.

The key determinants in the decline of the American job, there are many. I would say to a certain degree: de-unionization, de-industrialization, globalization, even to a certain extent, automation. Each of these trends, moreover, reinforces the others and each is a cause and a consequence of the others.

In the two decades following World War II, close to a third of the American nonagricultural workforce was unionized. During those years and from 1947 to 1973, median household income rose at the exact same rate that productivity rose. During those years, health insurance and defined benefit pensions became the norm for most major and many minor American employers.

What has happened since then? Many things. The increased willingness of American employers to resist unionization, exploiting weaknesses in the National Labor Relations Act has certainly been a factor.

De-industrialization has certainly been a factor. Manufacturing jobs, particularly durable goods manufacturing, have long paid more than service sector jobs. But, as the members of this Committee need not have pointed out to them in detail, we have been losing manufacturing jobs steady for many years. This doesn't simply begin with the Bush Administration. This is a long term development.

The effects of globalization are many and varied and widely debated. Alan Blinder, the economist who served as Vice Chairman of the Federal Reserve, has focused, I think rightly, less on jobs lost and jobs created and more on the effect on incomes of American workers whose jobs are, in a broad sense, in competition with workers in other countries though their jobs may never in fact be offshored.

That clearly extends now not simply to blue collar workers in manufacturing but to even professionals whose work can be digitized. It can be done by people in other countries.

Blinder, as I recall, once said that we may have a decline in the number of attorneys whose jobs do not require face to face interaction, but there will still be a need for divorce attorneys in the United States and you have to get with your clients and figure that out. That is not a bright prospect for the American economy.

Broadly speaking, I just want to address this last broad thing and what it suggests for Government policy.

We all remember the time when the American economy was the marvel of the world because of our productive capacities. Our production along with the strategic competence of our leaders and the dedication of soldiers and sailors is what won World War II. It was the exports of manufacturing goods, of agriculture that revitalized the postwar Europe and Asia and one of the goals of the Marshall Plan, in fact, was to ensure that Europe had enough funds to buy those products.

I am afraid that our role in the world economy today has changed in ways that nobody really could have prophesied. We have become really the consumers of last resort and, for that matter, the consumers of first resort.

Stephen Roach, an eminent economist with Morgan Stanley, recently said that by his calculations, personal consumption in the American economy now amounts to 72 percent of our gross domestic product.

England, you will recall, in the 19th Century was known as a nation of shopkeepers. America in the 21st Century is a Nation of shoppers. This is a problem. Consider what it means that our largest employer in most of the post-war period, General Motors, has been supplanted by Wal-Mart.

GM, following the lead of Henry Ford, worked on the premise that if you work at GM you should be able to buy a new Chevy, a new GM car. Wal-Mart never had the premise that if you work at Wal-Mart you should be able to buy a car, though certainly you should be able to shop at Wal-Mart. That makes a difference for the dominant employer, shifting from production to retail.

In the 1980s, there was some debate over industrial policy, and a lot of economists said we shouldn't have an industrial policy. We shouldn't pick winners. We should stay out of this altogether.

Well, 20 years, we don't have an industrial policy. We have a diminished industrial base, and what has kept the economy afloat isn't the proceeds of production. It has been asset inflation, the rising value of homes against which Americans have had to borrow to purchase things they couldn't afford had they been dependent on their relatively static work-derived incomes.

This isn't a sustainable strategy. Increasingly, the macroeconomic policy of the United States has been shop until you drop. Okay, we have shopped, and now we have dropped.

What I would suggest broadly since my time is just about up, in reference to Government policy, is that I see a role for the public sector where the private sector is no longer willing or even able to go.

The private sector welfare state—that is employer-provided health insurance, retirement funds, retirement health insurance—is crumbling. For the past two decades, American employers have been cutting back. In a global economy, they feel this renders them uncompetitive. This suggests to me a need for Government to step up and provide those things which Americans have counted upon as ancillary to their work and no longer is.

Second, I think we need to foster a public works and industrial policy to create decent jobs here in the U.S. as long as most major transnational corporations no longer consider this necessarily part of their business plan. So I think that is an important element for Government to involve itself in.

The third is to upgrade the jobs of those fifty or sixty million Americans who don't work in offshorable work, who aren't really in the global economy, in healthcare and construction and transportation, in retail sales, education, tourism, security, maintenance, logistics, elder care and child care.

I see two ways of doing this. One is to upgrade some of these works, some of these jobs and credentialing them, making them more professional, doing what some European countries do which is professionalizing the people who take care of small children and seniors. I think that is a necessary strategy that will benefit the United States.

Secondly is for the Government to enact a piece of legislation that has been kicking around Capitol Hill for a number of years, the Employee Free Choice Act which would enable workers more freely to join unions without fear of employer harassment and which I think would have a significant effect in these non-offshorable jobs, though I don't necessarily think it would in offshorable jobs.

Capitalism creates prosperity, but it is governments that create the legal and social environment in which prosperity can be broadly shared. By assuming the responsibility for benefits programs that employers no longer offer, by investing in strategic industries, offering serious vocational education, creating green jobs and human service jobs and amending the labor law, I think the Government can begin the arduous and necessary work for building the American middle class and setting the Nation's economy on sounder footing.

These are fundamental tasks. The preamble to the Constitution refers to it as promoting the general welfare, and our Government has been AWOL in these duties for a long time.

Thank you, Mr. Chairman.

[The information follows:]

TESTIMONY TO THE LABOR SUBCOMMITTEE OF

THE HOUSE APPROPRIATIONS COMMITTEE

FEBRUARY 13, 2008

BY HAROLD MEYERSON

Chairman Obey, I am honored to be here today before the committee and its chairman, whom I know as a tenacious champion of the rights and interests of ordinary Americans. And I am honored and pleased to be in the company of my fellow panelists, economists who believe in the capacity of laws and institutions to shape a more vibrant and fair economic life for the American people.

My name is Harold Meyerson. I'm the executive editor of *The American Prospect*, a monthly magazine of news and opinion with an avowedly liberal perspective. The *Prospect* was founded 18 years ago by Robert Kuttner, Paul Starr and Robert Reich (who took a leave from the magazine to serve as Secretary of Labor under President Clinton), all three of whom are very active today in editing and writing for the magazine. The opinions I express today broadly reflect those of the *Prospect*, but nonetheless, they are idiosyncratically and distinctly my own.

I am also an op-ed columnist for *The Washington Post*, a position I've been privileged to hold since 2003. My testimony today, like my columns, expresses my opinions only, and any overlap with the editorial positions of the paper are coincidental and rare.

Mr. Chairman, I am not even close to being an economist, and I presume I have been invited to offer testimony today because much of my writing deals with broad historic trends in the social and economic life of the American people. I will endeavor to address myself to those trends today.

Mr. Chairman, over the past three decades, not the bottom, but the middle has fallen out of the American economy. The great social achievement of the United States in the 30 years after World War II – the creation of the world's first majority middle-class, of a society that offered more economic stability to more people than any in human history – has been undone.

The stagnation of incomes for most Americans, the injection of insecurity and instability into the lives of the American people, is at the root of many of the seemingly discrete problems that we are grappling with today. The subprime mortgage crisis is fundamentally a crisis of the rising cost of housing rwhile the income of many Americans has flat-lined. As home-building executive Michael

Hill pointed out in a *Washington Post* op-ed column just this Monday, "forty years ago, the median national price of a house was about twice the median household income. In some parts of the country, this ratio was closer to 1 to 1. Twenty years ago, the median home price was about three times income. In the past 10 years, it jumped to four times income." And in most thriving metropolitan areas, Hill adds, the ratio is far higher than that.

Conclusion: If median income in America had continued to increase as it did in the years from 1947 to 1973, when it doubled, we would not be facing the mortgage-market meltdown we are experiencing today. So, too, with credit cards, where default rates are also increasing sharply, reflecting the growing desperation of Americans struggling to pay their bills, and further destabilizing many of our already shaky financial institutions.

I do not mean by these assertions to hold those financial institutions blameless in the current crisis, far from it. They aggressively marketed credit cards and mortgages to consumers whom they knew would have trouble paying back their debt. I merely wish to point out that had the incomes of ordinary Americans continued to rise over the past 30 years as they had in the previous 30, the American people would not have taken on so much debt.

What has happened that has so changed the economic life of the American people? Why do a clear plurality of Americans, in several polls over the past two years, now say they believe that their children will have a harder economic life than they themselves have had? Can this really be Americans speaking – that most optimistic of peoples, believers for centuries in the certitude that their children will have a better life than they had? How has this nation of incorrigible optimists become a nation of pessimists? And what changes in public policy can our government undertake to remedy the problems that have caused so many Americans to believe that our best days may be behind us?

My fellow witnesses have convincingly laid out in their written testimony the data on the rise in relative income stagnation for a majority of Americans and on the sharp increase in economic inequality in America after the post-war decades in which prosperity was broadly shared. I will not belabor the points they have so ably made. What I will do today is endeavor to look at that inequality more closely, to look at the institutional and industrial factors that have thrown the long egalitarian trajectory of American economic life into reverse, and to suggest some public policy remedies.

THE MIDDLE VANISHES

In 1980, economist Alan Blinder, later to become Vice-Chairman of the Federal Reserve, wrote that the level of economic equality in America had become a constant. "Income inequality," he wrote, "was just about the same in 1977 ... as it was in 1947." Blinder was right, but even as he was writing, the situation was beginning to change.

In the 1980s, economic inequality in America soared. Many mainstream economists at the time laid the blame on technological change, which enabled better educated Americans to benefit from productivity gains while less educated Americans lagged behind. As Thomas Lemieux, an economist at the University of British Columbia, argues in a paper ("The Changing Nature of Wage Inequality") issued by the National Bureau of Economic Research last October, that thesis failed to explain why the same rise in inequality wasn't evident in other advanced economies undergoing analogous technological changes.

Lemieux divides our new era of inequality into two acts. In Act I, in the 1980s, there are widening gaps between the wealthiest Americans and Americans with median incomes, and between Americans with median incomes and the poor. That is, both the gaps between the 90th percentile of Americans and the 50th percentile, and between the 50th percentile and the 10th percentile were growing.

In the 1990s and 2000s, however, the gap between the 90th and 50th percentile continues to expand. However, the gap between the 50th percentile and the 10th percentile grows no wider for women, and actually declines a bit for men.

The same pattern is evident when we segment the American public by level of educational attainment. While the gap between high school dropouts and high school dropouts expands in the early 1980s, along with the gap between college post-graduates and high-school graduates, the situation changes in the 1990s and 2000s. For both men and women, the gap between high school graduates and dropouts ceases to expand, while the gap between college post-graduates and high school graduates explodes.

In short, America in the past two decades has not been becoming more unequal at all points in the economic spectrum. Rather, Americans at median levels of income and education – indeed, Americans at all levels of income and education save the highest decile – have been falling dramatically behind the nation's wealthiest and most highly credentialed citizens, and most dramatically behind the nation's wealthiest one percent, whose share of the nation's income hasn't been this high since the late 1920s – that is, since before the New Deal set in place the laws and institutions that led to the broadly shared prosperity of mid-20th century America. As economists Ian Dew-Becker and Robert Gordon have

demonstrated, over the past couple of decades, all the income from productivity gains have gone to the wealthiest 10 percent of Americans. All.

It's important to realize that in our new post-egalitarian America education is no longer the magic carpet to prosperity. Elite education is. As my friend Wally Knox, the former chairman of the Revenue and Taxation Committee of the California State Assembly has noted, higher education today stratifies us more than it equalizes us. The 50 or so elite colleges and universities have not expanded in size over the past half-century. There's been a huge expansion, though, in the number and size of colleges generally. College graduations almost quadrupled between 1960 and 2003. Again, though, the benefits of college accrue chiefly to the graduates of the better schools. In inflation-adjusted dollars, the paychecks of 60 percent of college graduates are lower today than they were in 1960. Worse yet, Knox concludes, "one sixth of male college graduates earn less today than the least paid high school graduates of the late 1960s."

Let's cut to the chase. What has fundamentally shifted in American economic life is that jobs in America – jobs for high school graduates, jobs for college graduates – no longer provide the level of income they once did. Nor the level of benefits, nor the assurance of steady, long-term employment. We are no longer a nation of good jobs. The benefits, pensions, and rising annual income that were the common, though by no means universal, experience of American workers a generation ago are now a thing of the past to all but the talented, or more precisely, fortunate tenth. That is why Americans now tell pollsters they fear their children will have a harder time than they did. Those fears are well grounded.

WHAT HAPPENED TO THE AMERICAN JOB?

The key determinants in the decline of the American job are deunionization, deindustrialization, and globalization. Each of these trends, moreover, reinforces the other two; each is a cause and consequence of the others.

In the two decades following World War II, close to one-third of the American non-agricultural work force was unionized. In consequence, median household income doubled between 1947 and 1973, rising at exactly the same rate as productivity. In consequence, health insurance and defined benefit pensions became the norm for major, and many minor, American employers.

In the late 1970s, however, American employers began to fiercely resist all further attempts at unionization, and were willing to incur the minor penalties for violating, say, the National Labor Relations Act's strictures against firing workers involved in organizing campaigns rather than allow their employees to unionize. A union-avoidance industry arose within the legal profession and management

consultancies. Today, the rate of private sector unionization, which is 1955 stood at 39 percent, hovers at just over 7 percent. In consequence, wages have decoupled from productivity gains. Defined benefit pensions have gone the way of the dodo. And, according to a study by the Kaiser Family Foundation, the percentage of companies with 200 or more employees that offered retiree health benefits declined from 66 percent in 1988 to 33 percent in 2005.

Deindustrialization has also played a role in the decline of the American job. Manufacturing jobs, particularly jobs in durable-goods manufacturing, have long paid more than service-sector jobs. But the combination of automation and the eagerness of corporations to offshore production to nations with cheaper labor costs has led to a significant decline in the share of workers employed in manufacturing. From the late 1970s through the early 1990s, America lost 2.4 million manufacturing jobs. Since 2001, we've lost an additional 2.7 million.

Economists debate how much of that loss is due to globalization and how much to automated production. But the chief effect of globalization may not be direct job loss, but rather a constant downward pressure on wages in sectors – service as well as manufacturing – where the work can be done more cheaply in another country. Economist Alan Blinder has calculated that the number of American jobs with incomes held in check by globalization to be close to 30 million. Nor are these jobs to be found exclusively in blue-collar America. Scientists, mathematicians and engineers are particularly vulnerable to having their jobs performed elsewhere, which is one reason why the wages of computer software writers haven't kept pace with those of other highly-credentialed professionals. In 2006, economists Jerry and Marie Thursby, of Emory and Georgia Tech, respectively, surveyed 200 U.S.-based multinationals and concluded that 38 percent of them planned to relocate at least some of their research and development facilities to other nations, chiefly India and China.

Put these all together – the deunionization, the deindustrialization, the globalization – and what you get is the ratcheting down of the American job. Dead-end service and retail jobs proliferate. Technical and professional jobs involving information that can be digitized have pay and benefits held in check by technical and professional employees in Asia. Jobs in manufacturing decline in quality as well as quantity. Highly profitable Caterpillar Tractor, for instance, now offers its new hires just $22 an hour in wages and benefits, half of what it pays its more senior employees. "There is a balance that must be struck," Caterpillar group president Douglas Oberhelman told *The New York Times*, "between being competitive and being middle class." The balance that has been struck by the American economy is entirely toward being competitive. Being middle class will just have to go.

AMERICA IN THE WORLD ECONOMY

Time was – and we all remember it – when the American economy was the marvel of the world. It was American production, along with the strategy of our leaders and the dedication of our soldiers and sailors, that won World War II. It was the exports of American manufacturing and agriculture that revitalized postwar Europe and Asia – indeed, one of the several goals of the Marshall Plan was to ensure Europe had enough funds to buy American products.

And what is the role of the United States in the world economy today? We are the consumers of last resort – and first resort as well. According to economist Stephen Roach of Morgan Stanley, the personal consumption has amounted to 72 percent of our Gross Domestic Product in recent years – up from 66 percent just a few years previous.

You may recall that England in the 19th century was called a nation of shopkeepers. America today is a nation of shoppers, and our role in the world economy is to buy what other countries make. Or, more accurately, what U.S.-based corporations have made for them in other countries so they can sell it to us here at home.

Consider, for a moment, the difference between a nation in which the largest employer is General Motors, as was the case in the United States for four decades after World War II, and a nation in which the largest employer is Wal-Mart, as has been the case for the past decade. GM followed in the footsteps of Henry Ford, who by 1913 had concluded he needed to pay his workers enough so that they could afford to buy a new Ford. Wal-Mart, by contrast, pays its workers so little that they are compelled to shop at Wal-Mart. And with its mastery over and control of logistics, Wal-Mart has been able to reduce wages at its suppliers and shippers across the land.

But even if Wal-Mart weren't a downward force on wages throughout much of the economy, consider the implications of a nation whose chief economic activity, whose designated place in the world division of labor, is personal consumption. More particularly, personal consumption at a time when incomes are stagnating. The only way such a nation can get along economically is to go into debt, which is precisely what Americans, collectively and individually, have done.

In the 1980s, economists tended to dismiss the idea that the United States should have an industrial policy. The government, it was argued, couldn't pick winners and should stay out of promoting industries altogether. Twenty years later, we don't have an industrial policy, we have a diminished industrial base, and what has kept the economy afloat during the current decade hasn't been the

proceeds of production. It has been asset inflation – the rising value of homes, against which Americans have borrowed to purchase the things they could not afford had they been dependent on their static work-derived incomes. This was not a sustainable strategy.

Increasingly, the macro-economic policy of the United States has been, Shop Till You Drop. So we've shopped. And now, we've dropped.

TOWARDS AN INDUSTRIAL POLICY AND AN INCOMES POLICY

In an era of globalization, when U.S.-based transnational corporations no longer think of themselves as American entities, the reconstruction of a vibrant American economy can no longer be left to the private sector. Creating a well-paid, secure, sizable U.S. work force is no longer necessarily a part of these corporations' business plans. Indeed, such a goal is more characteristically inimical to these corporations' business plans, since a flexible labor force increasingly paid by world labor standards is the goal to which a growing number of these companies aspire.

And so it falls to government to rebuild a thriving middle class. The project, as I see it, has several elements.

The first is to step in where America's employer-based private welfare state is crumbling. Beginning in World War II, American companies provided health insurance and retirement benefits to their workers. For the past two decades, however, American companies have either cut back or altogether scrapped their benefit packages, or, if new, refused to adopt any. Employers such as Wal-Mart have relied on Medicaid to provide health care to those of their workers too poor to afford either the company's plan or coverage of their own. Accordingly, it falls to the government to offer affordable health coverage when employers choose not to, and to assist workers in setting aside income for retirement in a Social Security-Plus plan.

The second is to foster industry and public-works projects that create decent jobs within the U.S. With the advent of sovereign wealth funds, we've reached the point where other nations' governments make strategic investments in the American economy while our own government makes no such commitment. It's time for our own government to foster a range of strategic industries. The vast majority of machine tools used in U.S. factories and shops, for instance, are made abroad now, and with them have vanished a generation of American workers familiar with high-end machine technology. The need to reduce greenhouse gases requires far greater public investment in alternative energy technologies, and in retrofitting our homes, offices, plants and infrastructure.

The third is to upgrade all non-offshorable work. Upwards of 50 million private-sector jobs – in health care, construction, transportation, retail sales, education, tourism, security, maintenance, logistics, elder- and childcare – cannot be offshored and aren't in competition with lower-wage versions of the same jobs in other countries.

There are two components to upgrading industrial, infrastructure and unexportable jobs. The first is for the government to credentialize and professionalize these jobs where possible. That means a far greater commitment to vocational education. It means professionalizing childcare and elder care service jobs, as is currently done in the Scandinavian nations. "We usually think of a revived WPA creating employment in construction and manufacturing work," Nobel laureate economist Robert Solow told me for a *Prospect* article I wrote in 2006, "but if it's not focused on the service sector, it won't be that useful."

The second is for the government to enact the Employee Free Choice Act, which would enable workers to join unions again without fear of employer harassment and being fired, which is a common occurrence under the lax terms of the current labor law. It is no accident that the one period of broadly shared prosperity in American history coincides with the one period of union strength in American history – World War II and the three subsequent decades.

We may not think of retail, tourism and security jobs as commanding decent wages – but there was a time before the NLRA was passed in 1935 when auto factory jobs didn't command decent wages, either. In general, union density is determinative. In cities where hotels are largely unionized, room maids make $20 an hour; in cities where half the hotels are unionized, they make $12 an hour; in non-union cities, $7 an hour. In heavily unionized Las Vegas, hotel workers can avail themselves of employer-funded training programs to advance to more highly-skilled jobs, and make enough to buy homes that would be beyond the reach of hotel workers in non-union towns.

Capitalism creates prosperity. Governments create the legal and social environments in which prosperity can be broadly shared. By assuming the responsibility for benefit programs employers no longer offer, investing in strategic industries, offering serious vocational education programs, creating "green jobs" and human-service jobs requiring credentialing and offering commensurate pay, and amending labor law so it unambiguously permits workers to join unions, our government can begin the arduous and utterly necessary work of rebuilding the American middle class and setting the nation's economy on a far sounder footing. These are fundamental tasks – promoting the general welfare, as the Preamble to our Constitution puts it – from which our government has been AWOL for far too long.

Mr. OBEY. Dr. Bernstein.

Mr. BERNSTEIN. Chairman Obey, Ranking Member Walsh and members of the Subcommittee, I thank you for this opportunity to testify today on the important topic of income trends in the United States.

Mr. Chairman, the biography on your Web site states "Every American who works hard should be able to fully share in the bounty of America."

This statement is much like that of our mission statement at the Economic Policy Institute. To us, this is not nearly common sense. It is a fundamental American value and a benchmark against which economic progress must be judged.

If the economy is expanding, if productivity is increasing smartly, if unemployment is low, then most families should be benefitting from the economy's overall growth. Yet, as the evidence I will show confirms, over the last few decades, broadly shared prosperity has been the exception, not the rule.

The mechanisms which historically could be counted on to ensure a fair distribution of the fruits of growth are broken, and those crafting economic policy must offer ideas to repair them. As this campaign season progresses, polling data suggest that the American electorate is anxious for policy-makers to address these concerns and to do so ambitiously with an agenda that meets the magnitude of the problems.

Now I again applaud this Committee for its foresight in getting in front of this wave.

Before briefly outlining some policy ideas in this spirit, I present a set of facts that motivate these policies.

Despite the impressive productivity growth that occurred in the 2000s, the real income of typical middle income families has stagnated. Census Bureau data show that between 2000 and 2006, median family income is actually down by $1,000 or 2 percent after adjusting for inflation. If, as many economists believe, the economy is or near recession, this may be the first business cycle on record wherein the median family fails to regain its prior peak.

Note also that the Nation's poverty rate was actually one percentage point higher in 2006 than in 2000. Yet, the American workforce has been highly productive over these years with productivity up 19 percent in 2007.

Now how can it be that productivity has grown quickly yet middle and low incomes have stagnated or fallen? The answer, of course, is growth has flowed largely to those at the very top of the income scale. By one measure, 22 percent of national income went to the top 1 percent in 2005, and this represents the highest level of income concentration since 1929.

The trend towards greater inequality has been ongoing for almost 30 years. Back in 1979, the post-tax income of the top 1 percent was 8 times higher than that of middle income families. By 2005, that ratio had grown to 21 times, a vast increase in the distance between income classes.

The pace of income inequality has accelerated alarmingly in recent years. The growth in the share of income going to the richest income households was faster in 2003 to 2005 than over any other two-year period covered by the CBO data that began in 1979.

Over these few years, $400 billion in pre-tax 2005 dollars was shifted from the bottom 90 percent of household to those in the top 5 percent. Had income shares not shifted as they did, the income of each of the 109 million households in the bottom 95 percent would have been, on average, $3,700 higher in 2005.

Now some analysts have downplayed these income findings by making the following types of counter-arguments:

Consumption inequality has grown more slowly than that of income inequality. That is true, but the rise in consumption over a period of stagnating income growth has meant the accumulation of highly problematic levels of debt for many American households.

As I show in my written testimony, real expenditures actually fell about 3 percent, 2000 to 2006, for households in the bottom 40 percent while rising 7 percent for households in the top fifth.

A second counter-argument is that real incomes of low and middle class households have grown over the last few decades. Of course, they have. The question is how fast relative to prior years and to other standard benchmarks like productivity growth.

Again, as I show in my written work, by these two criteria, income growth has been far less favorable since the mid-1970s. Simply beating zero is not evidence of adequately shared prosperity.

Finally, some argue that income mobility, the ability of families to move up the income scale over their life cycle, offsets the rise in inequality that I have emphasized. This is not so.

Only if the rate of mobility, only if people are more likely to get ahead over time can it offset the growing inequality that I have documented. The solid consensus among mobility analysts is that the rate of mobility has not accelerated and may have slowed.

Also, the extent of mobility in our economy is often exaggerated. According to a recent Treasury study, 79 percent of taxpayers who started in the bottom fifth of the income scale in 1996 remained in the bottom 40 percent by 2005.

What policies might legislators consider to reconnect the living standards of working families to economic growth? In the interest of time, I will focus on two areas: Bargaining power and public investment.

The ability of most workers to bargain for a greater share of the value they are adding to our economy is at the heart of the various gaps I have documented. Unions play a key role in precisely this area.

The decline of unions over the past decades is partly a mechanical function of the loss of jobs in unionized industries, but the more important explanation is the very unbalanced playing field on which unions try to gain a foothold. Polls show that slightly more than half of the nonunion workforce would like some type of union representation, a finding that is not particularly surprising given the wage and income data I have shown above.

The problem is that the legal and institutional forces that have historically balanced the power of anti-union employers and their proxies have deteriorated in recent decades. One legislative solution is the Employee Free Choice Act, the bill that helps to restore the right to organize in the workplace. EFCA gives members of a workplace the ability to certify a union once a majority signs au-

thorizations in favor of the union and puts much-needed teeth back into labor law.

Turning to our investment agenda, I do not need to convince the members of this panel, this Committee that it is critical to invest in the skills of our workforce of both today and tomorrow. Unfortunately, as Bob Greenstein stresses in his testimony, our budgetary priorities have been moving in the opposite direction.

Now one reason this disinvestment is misguided is that recent initiatives in worker training have shown considerable promise relative to earlier less effective approaches such as the so-called Work First policies that de-emphasize job training and career paths.

Effective strategies are grounded in extensive knowledge of the local labor market focusing on occupations and industries that offer the best opportunities for advancement. They help workers access education and training at community colleges, community-based training programs and union-sponsored programs that work with employers to design curricula based on skills that employers actually need.

Now, in the current economic context with a recession possibly underway or soon to be so, there has been considerable discussion of investment in public infrastructure as a component of a stimulus plan. Though the plan agreed upon by Congress and the White House did not include such investment, I strongly believe it is an important topic for Congress to consider and not simply in the context of recession.

Four facts motivate this contention: First, American households are highly leveraged and may be poised for a period of enhanced savings and diminished consumption. In this context, public investment should be viewed as an important source of labor demand.

Second, there are deep needs for productivity enhancing investments in public goods that will not be made by any private entities who cannot, by definition, capture the returns on such investments.

Three, climate change heightens the urgency to make these investments with an eye toward reduction of greenhouse gases and the conservation of energy resources.

And, fourth, our job market appears to be weakening considerably. One area of particularly significant job loss has, of course, been construction. Jobs in residential building and contracting are down 244,000 over the past year. When we include other jobs related to housing such as real estate, we find a decline in almost half a million jobs since the peak of April 2006.

In other words, there exists considerable slack in our labor market that will almost certainly deepen in coming quarters. In this regard, infrastructure investment serves a dual role of deepening our investments in public capital while creating good jobs for workers that might otherwise be unemployed or underemployed.

Economists at EPI have carefully documented our public infrastructure needs, and I present these recommendations in my written testimony. They include water and sewage repairs, the maintenance of school buildings, highways, bridges, roads, rails and other productivity enhancements in public goods that private sector investments will not make.

Moreover, it is important to recognize that (a) these are all necessary investments that should be made regardless of the state of

the business cycle and (b) recent history suggests it is a mistake to think that labor market slack will no longer be a problem when the recession officially ends. Now this last point deserves a bit of elaboration.

Much of the current recession and stimulus debate has stressed that recent recessions, such as the one in the early nineties or 2001, were both mild and short lived and perhaps the next recession will follow the same pattern, but such claims are based solely on real output growth and not on job market conditions.

The allegedly mild 2001 recession wherein real GDP barely contracted at all was followed by the longest jobless recovery on record. Though real GDP grew, payroll shed another 1.1 million jobs. The unemployment rate rose for another 19 months and for just under 2 years for African Americans.

In conclusion, I stress that this agenda is but one set of ideas designed to move our politics and ultimately our economy back towards one where every hardworking family is "able to fully share in the bounty of America."

I thank you and look forward to addressing your questions and comments.

[The information follows:]

Testimony to the Subcommittee on Labor, Health & Human Services, Education, and Related Agencies

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2/13/09

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Introduction

Chairman Obey, Ranking Member Walsh, and members of the subcommittee, I thank you for this opportunity to testify on the topic of income trends in the United States. I can think of few other topics as timely and important, especially given current economic conditions.

Chairman Obey, I noted that the first sentence of your biography on your website reads: "Every American who works hard should be able to fully share in the bounty of America and so should their families." Interestingly, this statement is much like that of our mission statement at the Economic Policy Institute.[1] To us, this is not merely simple common sense. It is a fundamental American value and a benchmark against which economic progress must be judged.

If the economy is expanding, if productivity is increasing smartly, if unemployment is low, then most families should be benefiting from the economy's overall growth. Yet, as the evidence I will show will confirm, over the last few decades, broadly shared prosperity has been the exception, not the rule. If we are to judge our progress against your benchmark, Mr. Chairman, we must admit that we have far to go.

The mechanisms which historically could be counted upon to ensure a fair distribution of the fruits of growth are broken, and those crafting economic policy must offer ideas to repair them. I do so in my conclusion, wherein I outline a set of policies intended to re-couple the American economy's growth and productivity with the living standards of the majority of families, not simply those of a narrow sliver at the top of the income scale.

But it is equally important not to exacerbate the problems we have with policies that further incapacitate working families' ability to get ahead. Too often in recent years, we

[1] EPI's mission statement is: "To inform people and empower them to seek solutions that will ensure broadly shared prosperity and opportunity."

have failed to strengthen workers' legal ability to organize, gutted investments in their skills and training, under-invested in our public infrastructure, or stood by as the employer-based systems of health coverage and pensions slowly unravel. Similarly, changes over the past few years to the Federal tax code have worsened the distributional outcomes, by disproportionately lowering the tax liabilities of the wealthiest families.

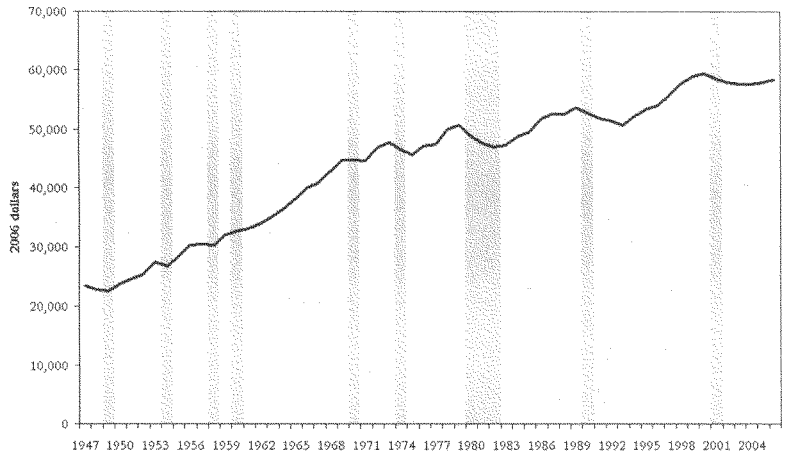
Such regressive tax policies hurt most families both directly and indirectly. Directly, they exacerbate the already excessive inequalities in market outcomes (i.e., the pretax distribution). Indirectly, they diminish revenues such that the Federal government is less able to perform needed functions, many of which, like safety net policies, disproportionately benefit the least well off. While the direct impact of the regressive tax cuts has been extensively measured and is well-appreciated, this indirect effect—the defunding of public services that boost economic security of the least advantaged—is also important and problematic.

As I stress in my concluding remarks, polling data suggest that the American electorate is anxious for policy makers to address these concerns, and to do so ambitiously, with an agenda that meets the magnitude of the problems. I again applaud this committee for its foresight in "getting in front" of this wave.

The Long-Term Picture

The Census Bureau provides a long and consistent series on the inflation-adjusted income of the median family, shown in Figure 1 and Table 1. A few patterns are worth noting.

FIGURE 1: Real median family income, 1947-06



Source: Census Bureau, shaded areas are recessions.

First, the typical family's income grew at a faster and steadier rate up to the mid-1970s than has been the case since that time. This is partly a function of slower economic and productivity growth, post-1973, but it also reflects one of today's primary economic challenges: increased income inequality.

That point is made in Table 2, which compares the annualized growth rates of real median income to those of productivity. There are, of course, good reasons why we wouldn't expect these two series to track each other identically. Family income is influenced by family labor supply, family size and type, and non-labor income sources. But barring large changes in those factors, holding inequality constant, we might expect the trends to more or less mirror each other (one large change in family labor supply—the increased labor force participation of women—should have boosted the rate of family income growth).

In fact, productivity and real median family income did grow at precisely the same annual rate, 1947-73: 2.8%, i.e., they both doubled. Since then, income has grown one-

third as fast. In other words, it is not simply a matter of slower productivity growth in the post-1973 period, though that was of course problematic. Median family income growth slowed far more, due in part to inequality playing a wedge-like role between overall economic growth and the living standards of middle-income families.

More recently, as shown in the last line of the table, productivity growth has accelerated, growing only slightly slower in the past 11 years as over the "golden era" of the 1940s-mid-70s.[2] But the growth of middle-class incomes accelerated only slightly. In fact, and this will be a point of emphasis later in this testimony, the 0.8% annual rate of income growth, 1995-2006, combines two very different periods. In the latter half of the 1990s, real median family income grew 2.2% per year. In the 2000s, it fell 0.3% per year.

TABLE 1: Annualized Growth Rates: Productivity and Real Median Family Income, 1947-2006

	Productivity	Real Median Income
1947-73	2.8%	2.8%
1973-2006	1.8%	0.6%
1995-2006	2.6%	0.8%

Source: Census Bureau and BLS nonfarm business sector productivity.

The second point made in Figure 1 is that real median income is a cyclical variable, stagnating or falling in recessions. But importantly, as shown in Figure 2, it has been taking longer in recent years for families to recover the real income lost in the downturn. Each bar in the figure represents the number of years it has taken the median family income to recover the economic ground lost in the recession. One reason this time period

[2] In the last few years, productivity growth has decelerated, and nonfarm business sector productivity rose at an annual rate of only 1.7% (2005q4-2007q4). Some economists believe this may simply by a temporary, cyclical slowdown, though it could also be structural.

has gotten longer is, as can be seen in Figure 1, incomes have kept falling after the recession and into the recovery.

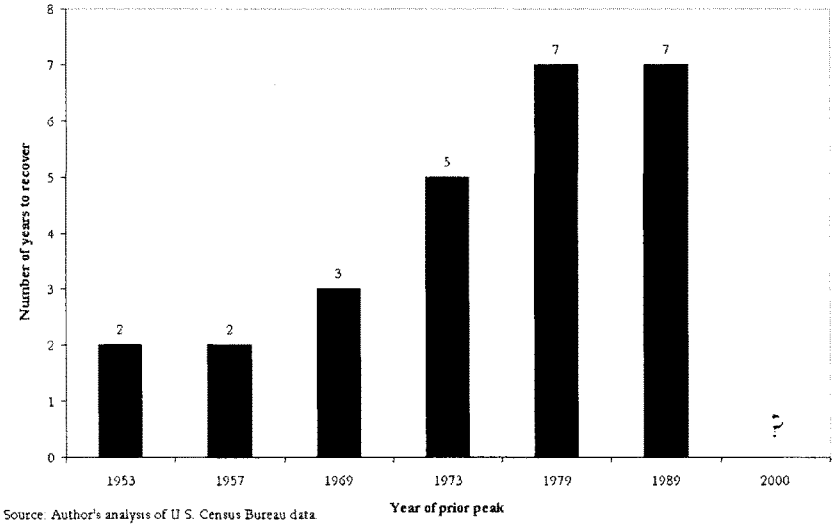
This is particularly the case in the current business cycle. As of 2006, the most recent available data, real median family income remains about 2%, or $1,000 (2006 dollars), below its 2000 peak. Using a reliable forecasting model,[3] my forecast for 2007 is for median family income to remain about $500 below its 2000 peak. If this is correct, and if 2007 is in fact the peak of the recovery that began in 2001, this will mark the first time on record that median family income failed to regain its prior peak.

Given the highly touted macro-economic performance of key variables over this business cycle, such as productivity and unemployment, this stands as quite an indictment. Of course, my forecast may be too pessimistic and income may surpass its previous peak, but it is unlikely to do so by much, and if we are truly in a recession, real median income will soon start to decline.

In sum, the long history of median family income growth is characterized by sharp break with productivity growth occurring around the mid-1970s. Productivity has since accelerated, but income growth, especially in the 2000s, remains stagnant. A major factor has been the increase in income inequality, to which I now turn.

[3] That is, this model consistently provides one-step-ahead forecasts of annual growth that are within a few tenths of the actual values. I regress the log change in nominal income on a flexible trend and the log change in aggregate hours worked from the BLS establishment survey.

FIGURE 2: Years it took for median family income to regain prior peak.



Source: Author's analysis of U S. Census Bureau data.

Income Inequality: Growth Fails to Reach Most Households

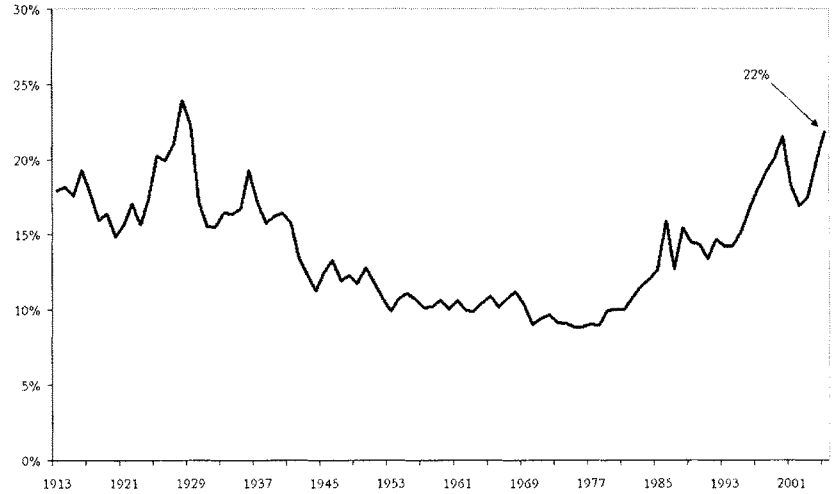
The earlier table comparing productivity growth to that of median income suggested that income inequality has grown over the past few decades. After all, the benefits of productivity growth had to flow somewhere. The evidence in this section confirms that development, showing that we have achieved particularly high levels of income concentration. Taken together, these facts—strong productivity growth, historically high levels of inequality, and stagnant median income—tell a consistent story: working families are working harder and smarter, contributing to a growing pie, yet their slices are diminished.

The work of economists Piketty and Saez provides us with a long time series of the share of income, including capital gains, accruing to the top 1% (Figure 3). After flattening out at around 10%, the series begins to rise in the 1980s, and picks up speed in the latter

1990s, driven partly by the increase in realized capital gains over those years.[4] There was a sharp dip when the dot.com bubble burst in late 2000, but this was a temporary setback. The underlying forces, discussed below, that have been driving the rise in inequality remained operative, and by 2005, the most recent observation for these data, the share was 22%, only slightly below the all-time highs achieved in the late 1920s.

The sources for these data arrive with a lag, which is why the series ends in 2005, but other relevant information on trends in wages, bonuses for high-end earners, and profitability suggest that income became even more concentrated in 2006 and 2007.[5]

FIGURE 3: Share of Income to Top 1%, 1913-2005



Source: Piketty and Saez, 2006

[4] The Piketty and Saez data shown in the figure reveal that between 1994 and 2000, the top percent's income share grew by 7.6 percentage points. In their series excluding capital gains, the increase was half as large.

[5] For example, CBO forecast the capital gains realizations increased by 16 and 8 percent, respectively, in 2006 and 2007 (see table 4.3: http://www.cbo.gov/ftpdocs/89xx/doc8917/01-23-2008_BudgetOutlook.pdf). Though these are slower growth rates than 2003-05, gains of this magnitude in this income source—capital gains flow largely to the top of the income scale—are usually associated with increased income concentration.

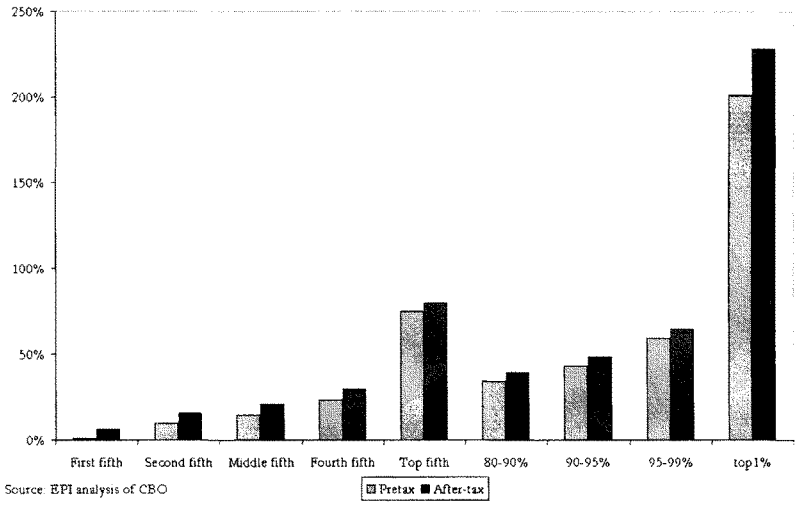
While the Piketty and Saez inequality data provide invaluable information on the very top of the income scale, their data on lower income families are less complete than another valuable resource: the household data series constructed by the Congressional Budget Office.

Figure 4 uses this series to show the long-term growth in real income for each fifth, 1979-2005, with the top fifth broken out into its various sub-classes. The "staircase" pattern is evidence of the increase in unequal income growth over this period. Note also that while the federal tax system raised the income growth of each group of families (after-tax income grew more than pretax), it steepened the tide of inequality. After-tax income growth was much higher for the top 1% than was pretax growth (the decline in effective tax rates—the share of income paid in federal taxes—was largest for households in the top 1%).

Real income growth over this period was minimal to moderate for most households. Income for the poorest households grew only 1.3%, pretax, but grew 6.3% post-tax, thanks largely to the increase in the refundable Earned Income Tax Credit over these years. Middle incomes grew 15% pretax, and 21% post-tax, or less than 1% per year over this 26 year period. Income for the top fifth grew much more quickly, 1979-2005: 75% pretax, and 80% post-tax. But the most dramatic growth occurred at the top of the income scale. Households in the top 1% saw their income triple over these years, up by 200% pretax and 228%, post-tax.

These trends led to stark differences in actual income levels by 2005. In that year, the average after-tax income for households in the bottom fifth was $15,300; for the middle fifth, $50,200; and for the top 1%, just over $1 million. These gaps have led to much greater economic distance between income classes over the years. Back in 1979, the post-tax income of the top 1% was 8 times higher than that of middle-income families and 23 times higher than the lowest fifth. In 2005, those ratios grew to 21 (top compared to middle) and 70 (top to bottom), a vast increase in the distance between income classes.
Figure 4

FIGURE 4: Household Income Growth by Income Group, 1979-2005, Pre- and After-tax



Source: EPI analysis of CBO

The 2000s: A Closer Look

How are these trends playing out most recently? As noted above, the median family income has been stagnant at best in the 2000s, and inequality, after reversing briefly, has again been rising sharply. Before we turn to a set of policy ideas to address the income challenges facing American households, let us more closely examine these most recent developments.

Table 2 below focuses on inflation-adjusted gains and losses in a broad set of living standards indicators. Earlier, I focused on recent losses by middle-class incomes, but this table shows that African-American and working-age households have done considerably worse. Poverty is up a percentage point, from 11.3% in 2000 to 12.3% in 2006, underscoring the failure of growth to reach the lowest income families.

Since most working-age families depend on their earnings, real wage trends are an important part of this story. The median wage grew less than 3% in real terms over these

years, and for men, it was essentially unchanged. Women made much stronger gains at the median, though their pace was still less than 1% per year, about one-third the pace of productivity growth.

Average compensation grew more quickly over these years, but that reflects two factors with great influence on economic outcomes in the 2000s: inequality and health costs. In an environment of rising inequality, average values, unlike medians, are pulled up by very high values at the top of scale. This has certainly occurred in the 2000s. As the median wage rose 2.6% over this period, the 95th percentile wage was up 9.4%.

Fringe benefit costs are omitted from these wage values, but included in the real average compensation measure in the table, which rose almost 6%. Average real wages from this same series were up only 2.2%, meaning that benefit costs were a major factor in driving this result. In theory, workers are indifferent between compensation spent on fringes and that on wages. In reality, the difference can be significant, as paychecks cover less of the basic needs and wants of working families. As I have written elsewhere, the stagnation of most workers' real wages, net of benefits, in the 2000s is a major factor behind the so-called middle-class squeeze (Bernstein and Allegretto, 2006). In addition, insurance and pension costs rose considerably faster than average inflation over these years, and while some of these higher payments arguably reflected better quality, some share certainly accrued to providers of health and pension plans, and not to workers.

TABLE 2: Real Income and Wages, 2000-2006/07

	Percent change
Median HH Income*	-2.0%
African-American	-8.0%
Working-Age	-4.2%
Poverty (PPt increase)*	1.0
Median Wage	2.6%
Men	0.4%
Women	5.0%
High-School Average Wage	1.4%
College Average Wage	2.5%
Average Compensation (ECI)	5.7%
Productivity	18.9%

Sources: BLS, Census, EPI
* Latest available data point is 2006.

Inequality also rose quickly over the last few years. The CBO household inequality series cited above reveals that the growth of both pre- and post-tax income inequality, as measured by the change in the shares of income going to different income classes, was greater, 2003-05, than over any other two year period covered by the CBO data (the series begins in 1979). As I elaborated shortly after these data were released (Bernstein, 2007b), over these few years, $400 billion in pretax 2005 dollars was shifted from the bottom 95% of households to those in the top 5%. That is, had income shares not shifted as they did, the income of each of the 109 million households in the bottom 95% would have been, on average, $3,660 higher in 2005.

Finally, some analysts criticize living standards analysis based on income, arguing that consumption is a better measure. The argument has some merit because a) a family's economic well-being is in large part a function of their access to the consumption goods and services they desire, and b) families can "smooth over" periods of income disruption with borrowing to maintain a desired level of consumption.

Of course, over the long term, a family's wage and income flows determine their consumption possibilities. The fact that the median family income has stagnated in the 2000s does imply limited lifetime consumption possibilities for middle-income families against a counterfactual where middle-incomes were rising. Families can of course finance consumption through debt, and, as occurred recently, when assets appreciate (e.g., home values), this becomes an important source of greater consumption. But, as we are also seeing in real time, without the underlying incomes (including asset-flows) to support the borrowing, it cannot continue unabated. In other words, living standards analysts cannot dismiss the importance of income in favor of consumption.

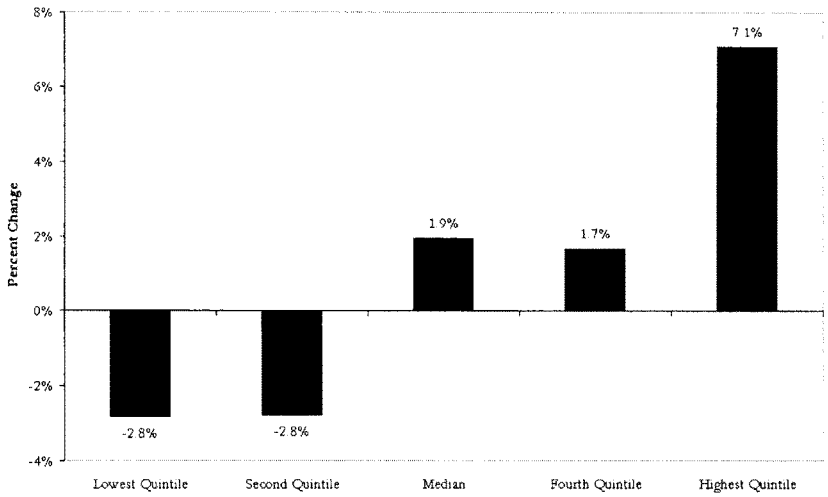
Moreover, consumption trends, even in the heavily leveraged 2000s, also reflect both real stagnation among middle and low-income households and greater inequality as well. The data in Figure 5 show real expenditures by income fifth from the BLS Consumer Expenditure Survey.[6] Expenditures are not synonymous with consumption but, especially over relatively short periods, they are very highly correlated.[7]

Expenditures among low-income households—those in the bottom 40%—actually fell about three percent in these years. Among the next 40% of households, expenditures rose by about 2%, suggesting that despite stagnating incomes, middle-income households slightly increased their expenditures, presumably by borrowing. But the largest gains were, once again, among the highest-income households, whose expenditures rose 7.1%, more than three-times the rate of middle-income households.

[6] Another approach would be to deflate these nominal expenditure values by the PCE deflator from the NIPA accounts. This does not, of course, change the inequality results, but since this price index grows more slowly than the RS deflator, the bars in the figure would show these changes, from lowest fifth to top fifth: 0.8%, 0.7%,. 4.1%, 3.8%, 9.3%.

[7] For example, properly measured, consumption would include the depreciation of assets, essentially the consumption of fixed capital. Expenditure data usually fails to take account of such depreciation.

FIGURE 5: Real Expenditures by Income Fifth, 2000-06



Source: BLS Consumer Expenditure Survey

Summarizing, whether we consider wages, income, or consumption, low and middle income families have reaped few of the highly touted gains of the economy thus far in the 2000s. Real incomes are down, especially for minorities, and wages, apart from rising benefit costs, have generally grown slowly, especially for men. As of 2006, poverty rates were actually a percentage point higher than in 2000. Consumption growth was stagnant among low-income households, and grew only moderately among middle-income households, while posting strong gains for wealthy households. Inequality grew particularly sharply through the mid-2000s, the latest years for which we have such data.

A new policy agenda is called for, one directed at reconnecting the living standards of most families with the economy's overall performance. In the final section of this testimony, I suggest what the architecture of this policy framework might look like.

The Policies That Can Help Reconnect Growth and Prosperity

These policies can be grouped into four categories, bargaining power, macro conditions, safety nets, and investments in human and physical capital.

Bargaining Power: The inability of most workers' to bargain for a greater share of the value they're adding to our economy is at the heart of the various gaps documented above. Historically, a broad set of policies and norms, discussed compellingly in Levy and Temin (2007), helped to lift workers' ability to bargain, and were thus associated with more broadly shared prosperity.

Many factors have eroded these institutions and norms. Global competition clearly has strong upsides, as the increased supply of goods and capital has lowered prices and interest rates. But this same increased supply has hurt the bargaining power of many workers in this country, particularly those with less than a college education. Indeed, recent trends in the offshoring of white collar work are reducing the bargaining power of more highly educated workers as well: Table 2 reveals the relatively minor wage gains among college-educated workers in the 2000s (up 2.5%; see also Blinder, 2007, and Bernstein et al, 2007).

Unions play a key role in precisely this area. Research reviewed in Mishel et al (2007, table 3.37) shows that the decline in union density explains one-fifth to one-half the increase in male wage differentials over the past 25 years, and union wage premiums remain highly significant, even after controlling for human capital and observable characteristics.

The decline in unions is partly a mechanical function of the loss of jobs in unionized industries, like manufacturing, but the more important explanation is the very unbalanced playing field on which unions try to gain a foothold. In fact, Freeman (2007) argues that slightly more than half of the non-union workforce would like some type of union representation, a finding that is not particularly surprising given the wage and income data shown above.

The problem here is that the legal and institutional forces that have historically tried to balance the power of anti-union employers and their proxies have significantly deteriorated in recent decades, as described by Shaiken (2007). One legislative solution is the Employee Free Choice Act (EFCA), a bill that helps to restore the right to organize in the workplace. A central component of EFCA is so-called majority sign-up or "card-check," which gives the members of a workplace the ability to certify a union once a majority sign authorizations in favor the union. The law also puts much needed teeth back into labor law by ratcheting up the penalties for those who violate the rights of workers trying to organize or negotiate a contract.

Macro-Economic Conditions: Full employment—a tight match between labor supply and labor demand—is another important criterion for reducing the gap between overall growth and living standards of working families. Historically, very low unemployment rates have also been a key contributor to workers' bargaining power, ensuring that employers needed to bid compensation up to get and keep the workers they needed in order to meet the demand for their goods and services.

We do not need to look back too far in time to corroborate such assertions. Most of the data I discussed above did much better for middle and low wage workers over the latter 1990s, when the unemployment rate headed towards levels associated with full employment, dipping below 4% in 2000. Overall poverty fell by 2.5 points, 1995-2000, with decline among minorities that were more than twice that magnitude.

And such trends are not at all unique to the 1990s cycle: longer term analysis confirms the result. For many of the years over the period 1949-73, the unemployment rate was actually below the so-called NAIRU: the lowest unemployment rate considered to be consistent with stable prices.[8] Recall from Table 1, however, that this was the period when real median family income grew in step with the overall economy. Conversely, over the post-73 period, the labor market was often slack, as unemployment was higher

[8] NAIRU is an acronym for non-accelerating rate of unemployment. These findings are described in Bernstein (2007a).

than the rate associated with full employment. As has been shown, middle-incomes grew much more slowly over these years and inequality increased.

Of course, the conventional response would be that inflation must have grown more quickly over the earlier period, when job markets were especially tight but, in fact, the opposite is true. Even controlling for the steep inflation of the latter 1970s, inflation actually grew more slowly when the job market was "tight than recommended," at least based on the NAIRU criterion. We relearned this lesson in the latter 1990s, also a period of decelerating price growth, even while the unemployment rate was headed for 30-year lows.

The policy levers here, at least in normal times, i.e., outside of recessions, rest mainly with the Federal Reserve, but Congress can also play an important role which I discuss below under the rubric of investment policy.

Safety Nets: Historically, working families in our country have depended on employers to provide health care and pensions, but it is not an exaggeration to observe that this system of employer-based coverage is slowly unraveling. A slow but undeniable shift is occurring, as the economic risks associated with illness and aging out of the workforce are shifting from employers to workers. This shift is not simply affecting the least skilled workers, but, as Gould (2007) shows in the area of employer-based health coverage, it is reaching workers at all wage and skill levels. In the area of pensions, the shift from defined benefits (a guaranteed pension) to defined contribution has been at the heart of the process of shifting risks from firms to workers.

The presidential campaigns have brought this issue to the fore, particularly regarding reform of our health care system. Such reform is especially urgent given the realization that the rate of increase in health spending in both the public and private sector is unsustainable. Similarly, the lack of savings preparedness among many persons approaching retirement (see Weller and Wolfe, 2005) and the shift from guaranteed pension underscores the need for pension reform as well.

It is beyond my scope here to review these plans. I refer interested parties to EPI's Agenda for Shared Propserity, an initiative by our institute to elaborate in some detail the best plans for meeting these challenges. I raise these issues in the context of this testimony for one simple reason: health and pension coverage mean the difference between a good job and a bad one. As ongoing technological change, globalization, and the lost bargaining power of many in the workforce have led to trends documented above, employers have been in the process of backing off their historical commitments to their workforce in many ways, including these types of coverage. And of course, the least advantaged workers rarely had such coverage to lose in the first place.

The inequality data along with information on profitability reveal that it is not for lack of resources that firms have been cutting back on health and pension coverage, although rising health costs can and should also be viewed as a competitiveness issue. Instead, it is yet another symptom of the unbalanced nature of growth in the current economy, as wealth flows upwards and risks flow down.

As these policy debates unfold, I urge the committee to view the issue of health care and pension reform as one that is intimately related to the findings regarding incomes, wages, and inequality in the first section of my testimony. By helping to provide workers with access to health care and pensions, we take a huge step towards improving job quality and blocking the ongoing risk shift.

Finally, our nation's Unemployment Insurance system is also in need of reform and modernization. In the short term, extended UI benefits are an important component of a stimulus package, providing a necessary safety net for the long-term unemployed as well as a much larger bang-for-the-buck than most other forms of stimulus, including tax rebates.

Over the longer term, our UI system needs to be updated to reflect changes in the structure of work and the demography of the workforce. The Unemployment Insurance Modernization Act, already passed by this chamber, would make such changes, including

providing benefits to both part-time workers and those who leave their jobs for compelling family reasons. The bill also accounts for shorter job tenures by considering a worker's most recent work history when determining eligibility for UI benefits.

Investments in Human and Physical Capital: The emphasis in this section thus far has been more towards creating good jobs than on improving the skills of workers. That "demand-side" emphasis is important, because 70% of the workforce is non-college educated, and we must have a strategy for improving the quality of all jobs, not just those for workers with high levels of education. Similarly, regardless of skill levels, all workers will benefit from more effective and efficient safety nets.

But it's also critical to invest in the skills of the workforce of both today and tomorrow. Unfortunately, our budgetary priorities have been moving in the opposite direction, as federal budgets over the past few decades have shortchanged training programs. Eisenbrey (2007), for example, shows that Federal investment in employment services and training is down about $1 billion in real terms since 1986 (from about $6 to $5 billion, 2006 dollars) even while the workforce has grown in size considerably over those years. The result is a decline in the budget for worker training and services from $63 to $35 per worker, in 2006 dollars.

According to the Coalition for Human Needs (2008) analysis of Congressional appropriations for a number of training programs, real declines have occurred in a number of job training programs between FY05 and FY08. Spending on both adult (-12%) and youth training (-14%) through the Workforce Investment Act are down, as are dislocated worker training (-9%) and adult basic education (-12%).

As Savner and Bernstein (2004) discuss, one reason this disinvestment is misguided is that recent initiatives in worker training have shown considerable promise relative to earlier, less effective approaches. Our analysis was partly motivated by the evident limitations of work-first policies, i.e., programs that placed workers in jobs with little attention to job quality or career opportunities. In reaction, there has been a growing

emphasis on programs designed to help job seekers prepare for good jobs and advance to careers. As we wrote:

"This new generation of programs shares several key elements. First, they're grounded in extensive knowledge of the local labor market, focusing on occupations and industries that offer the best opportunities for advancement. Second, they help workers access education and training at community colleges, community-based training programs, and union-sponsored programs that work with employers to design curricula based on the skills that employers actually need. And third, they provide access to remedial services -- often referred to as "bridge" programs -- so that people who have weak basic skills can prepare for postsecondary-level programs."

Savner and I also recognized that even the best training programs will not work when the jobs aren't there. There will always be disadvantage localities beyond the reach of even the strongest macroeconomic booms, and neither full employment in the rest of the economy nor the most integrated training program will help. In these cases, we advocate the creation of public-service jobs to keep people gainfully employed, drawing on the successful experience of transitional jobs programs that have sprung up around the country using public funds to create work for people struggling to get a foothold in the labor market.

In the current economic context, with a recession probably either underway or soon to be so, there has been considerable discussion of investment in public infrastructure as a component of a stimulus plan. Though the plan agreed upon by Congress and the White House did not include such investment, I strongly believe it is an important topic for Congress to consider, and not simply in the context of recession.

Four facts motivate this contention. First, American households are highly leveraged, and may well be poised for a period of enhanced savings and diminished consumption. In this context, public investment should be viewed as an important source of labor demand. Second, there are deep needs for productivity-enhancing investments in public

goods that will not be not made by any private entities, who by definition cannot capture the returns on public investments in roads, bridges, waste systems, water systems, schools, libraries, parks, etc. Three, climate change heightens the urgency to make these investments with an eye towards the reduction of greenhouse gases and the conservation of energy resources.

Fourth, our job market appears to be weakening considerably. Though these figures may undergo positive revision, payrolls contracted last month for the first time in over four years. The rate of job growth has slowed considerably, from 2% per year in early 2006 down to less than 1% over the past few months. The unemployment rate, though still low in historical terms, has been inching up in recent months.

One area of particularly significant job loss has been in construction. Jobs in residential building and contracting are down 244,000 over the past year, and when we include other jobs related to housing, such as real estate, we find a decline in almost half-a-million jobs since the peak of April 2006. In other words, there exists considerable labor market slack that will certainly deepen if the economy is in or near recession.

In this regard, infrastructure investment serves a dual role of deepening on investments in pubic capital while creating good jobs for workers that might otherwise by un- or underemployed.

Most recently, EPI economists have carefully documented infrastructure needs in the context of the stimulus debate (Mishel et al, 2007). The following are examples of the infrastructure needs identified by these researchers:

- There are 772 communities in 33 states with a total of 9,471 identified combined sewer overflow problems, releasing approximately 850 billion gallons of raw or partially treated sewage annually. In addition, the Environmental Protection Agency (EPA) estimates that between 23,000 and 75,000 sanitary sewer overflows occur each year in the United States, releasing between three to 10 billion gallons of sewage per year.

- According to a survey by the National Association of Clean Water Agencies, communities throughout the nation have more than $4 billion of wastewater treatment projects that are ready to go to construction, if funding is made available. Funds can be distributed immediately through the Safe Drinking Water and Clean Water State Revolving Funds and designated for repair and construction projects that can begin within 90 days.
- The National Center for Education Statistics (NCES) put the average age of the main instructional public school building at 40 years. Estimates by EPI find that the United States should be spending approximately an [additional] $17 billion per year on public school facility maintenance and repair to catch up with and maintain its K-12 public education infrastructure repairs.
- According to a 1999 survey, 76% of all schools reported that they had deferred maintenance of their buildings and needed additional funding to bring them up to standard. The total deferred maintenance exceeded $100 billion, an estimate in line with earlier findings by the Government Accounting Office (GAO). In just New York City alone, officials have identified $1.7 billion of deferred maintenance projects on 800 city school buildings.
- The U.S. Department of Transportation has identified more than 6,000 high-priority, structurally deficient bridges in the National Highway System that need to be replaced, at a total cost of about $30 billion. A relatively small acceleration of existing plans to address this need—appropriating $5 billion to replace the worst of these dangerous bridges—could employ 70,000 construction workers, stimulate demand for steel and other materials, and boost local economies across the nation.
- The House Committee on Transportation and Infrastructure has identified more than $70 billion in construction projects that could begin soon after being funded. An effective short-term stimulus plan could include $16 billion directed at projects for roads, rails, ports, and aviation; only projects that can begin within three months would be considered.

Finally, while I have discussed these infrastructure needs in the context of recession and stimulus, it is important to recognize that a) these are all necessary and productivity-enhancing investments that should be made regardless of the state of business cycle, and b) recent history suggest that it is a mistake to think that labor market slack will no longer be a problem when the recession officially ends.

This last point deserves a bit of elaboration. Much of the current recession/stimulus debate has stressed that recent recessions—the ones in 1990-91 and 2001—were both mild and short-lived, and perhaps the next recession will follow the same pattern. It is critical to recognize that these claims are based solely on real output growth, and not on job market conditions. The allegedly mild 2001 recession, wherein real GDP barely contracted, was followed by the longest "jobless recovery" on record. Though real GDP grew, payrolls shed another net 1.1 million jobs. The unemployment rate rose for another 19 months and for just under two years for African-Americans. The pattern was similar, though not quite as deep, after the early 1990s recession.

Part of the explanation for this disjuncture has to do with the way recessions are officially dated by the committee at the National Bureau of Economic Research, as they have apparently given less weight to the job market and greater weight to output growth. But policy makers are likely to give greater consideration to working families whose employment and income opportunities are significantly weakened as unemployment rises and job growth contracts. Thus, from a stimulus perspective, the investments I stress will likely be relevant after the recession is officially ended.

Conclusion

Clearly, this is an ambitious program, and legislators may well ask where they might be expected to find the resources to fund these investments, especially given current and especially future budget constraints. This tough question is beyond the scope of this testimony, but I will stress that our nation has found the resources for what many view, at least at this point in time, as a much less productive investment: the war in Iraq. Basic

economics reminds us that the opportunity cost of that conflict is not simply the hundreds of billions we have sacrificed thus far, much of which is borrowed from future generations. We must also consider the costs of forgoing the productive investments, the good jobs, and the opportunities for our citizens to achieve greater levels of learning and training. In each case, the quality of life of working families is diminished when public officials ignore or downplay these steep opportunity costs.

A similar argument could be made about the tax cuts that have largely benefited those at the high end of the income scale. As the data in this testimony reveal, pretax outcomes have become more highly unequal over the past few decades, and there is no obvious reason to exacerbate this with regressive tax changes. On the other hand, I have provided what many see as a compelling list of investments that our country and its citizens sorely need.

During the current election season, a central thematic among some of the candidates has been a call for a change in direction. Polling data repeatedly reinforce this notion that most citizens view our country to be on "the wrong track." Of course, an unpopular war looms large in this result, but those same polls have most recently stressed the role of the economy in these negative assessments. While economists still quibble as to whether a recession is underway, majorities of the public have believed this to be the case for at least six months. And given the evidence presented above, this should not surprise anyone.

In this light, reconnecting growth and living standards has to be at the heart of our political agenda in coming years. The agenda I have outlined today—full employment, universal health and pension coverage, freedom to organize, and investment in human and physical capital—is but one set of ideas designed to move our politics and ultimately, our economy back towards the values so clearly articulated in Chairman Obey's biography, an economy where every hard working family is "able to fully share in the bounty of America."

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Mr. OBEY. Thank you very much.

We are going to have to recess for a few minutes. I understand that we have a vote on the floor, and we may have a series of votes intermittently throughout the day. So it is just another contribution to the orderly consideration of issues in the Congress.

We will be back as soon as we can.

[Recess.]

Mr. OBEY. Well, I am told that we will have another one of these protest votes around 11:15. So why don't we proceed and maybe we can get both of your statements in before we have another one of these little sidetracking efforts?

Mr. Greenstein, why don't you go ahead?

Mr. GREENSTEIN. Well, thank you, Mr. Chairman.

As you know, income inequality has widened significantly in recent decades. I just want to take a minute and review a few key figures from one of the best data sources we have on this, the Congressional Budget Office data which cover the period from 1979 through 2005.

Now the CBO data show that during this period the average annual after tax income of the top 1 percent of Americans, after adjusting for inflation, more than tripled, rising 228 percent.

By contrast, the average after tax income of the middle fifth of the population rose a modest 21 percent, which looks particularly modest when you recognize that this is over a 26-year period, and the average income of the bottom 20 percent of the population, CBO found, was only 6 percent.

Or, if you put this in dollar terms, the CBO data show that the average after tax income of the top 1 percent rose by $745,000 a year from $326,000 a year in 1979 to nearly $1.1 million a year in 2005.

Mr. OBEY. One point what?

Mr. GREENSTEIN. $1.07 million in 2005. These figures are all adjusted for inflation and in 2005 dollars.

Meanwhile, in the middle, the increase was $8,700, and they ended up at $50,200 in 2005. For the bottom 20 percent, the increase over this 26-year period was all of $900, and their average annual after tax income in 2005 was $15,300.

Now this long term trend shows no signs of abating. If you look at the CBO data for the most recent year for which the data are available, 2004 to 2005, you find that real after tax income jumped an average of $180,000 per household for the top 1 percent in this year while rising $400 for the average middle income household and $200 for the average household in the bottom fifth.

Other research shows that nearly half of the income gain in the Nation in 2005 went to the top 1 percent and that the concentration of income at the top of the income scale appears to be greater now than at any time since 1929.

Now this growing inequality has created concern across the political spectrum. Among those who have voiced strong concern about it in recent years are former Fed Chair Alan Greenspan and current Fed Chair Ben Bernanke. They and others, such as former Treasury Secretary Larry Summers, have also talked about some of the connections between inequality and areas where increased

investments are needed to improve the competitiveness of the workforce and, therefore, the economy.

I would like to talk just for a minute about this connection between inequality, the workforce and competitiveness, and domestic discretionary programs.

So both Bernanke and Summers have emphasized the need for increased investment.

Summers noted that to boost productivity, we need increased investment in education infrastructure and R&D, and he noted nothing is more important to our prosperity than the quality of the labor force. "A growing body of evidence suggests that preschool education has an enormous rate of return, particularly for children from a disadvantaged background, and funding for these programs should be a high priority."

He also talked about transportation and other infrastructure areas where investment has been inadequate.

In Chairman Bernanke's speech last year, he too called for "policies that boost our national investment in education and training." Bernanke noted that a substantial body of research demonstrates that investments in education and training pay high rates of return and that early childhood programs can also pay high returns in terms of subsequent educational attainment and lower rates of social problems.

This is underscored by recent path-breaking research by a team of researchers from the University of Chicago, Northwestern and Harvard who estimated that eliminating poverty among children under five would substantially boost annual work hours and earnings among those children when they grew up.

As you know, although the children of today are the workers of tomorrow, the United States has a higher level of child poverty than that of most other western industrialized nations.

This takes me to some particular issues related to the Appropriations Committee where I think all of these issues come together. I will just mention three of these in the interest of time.

First is early education and childcare initiatives as I just noted. Research has shown that quality early education can result in marked improvements in school readiness and success in elementary school. Research has also shown that childcare subsidy programs have significant impact on parents' employment rates and earning.

But despite this evidence, Federal investment here has been falling. Head Start funding in 2008, for example, is 11 percent below the 2002 level, adjusting for inflation. Childcare funding 2008 is 17 percent below the 2002 level, adjusting for inflation.

A secondary, I will briefly mention, involves housing vouchers which enable poor families to move to where there are more job opportunities and better schools. A number of studies have documented positive effects, especially for children, when families use vouchers to relocate to lower poverty areas.

But, for example, the President's new budget falls $1.3 billion short of simply maintaining the current vouchers in use and has shortfalls in other low income housing areas as well.

The third and final area I will make is financial assistance to enable low income students to attend college. This is an area where

the Nation is not performing adequately, and the inadequate performance both limits future gains in productivity and growth and contributes to inequality.

A study by the Department of Education that looked at the period 2003 to 2004 found that among students from families below $20,000 87 percent of community college students had unmet needs that averaged $4,500 per student, 80 percent of students in that income bracket who were in four-year colleges had unmet needs averaging $6,000 a year. Many low income students facing such gaps drop out before completing college or are deterred from enrolling in the first place.

Last year's student aid legislation is not going to make that large a dent in this. If you look at it, that legislation increases Pell Grants in increments through 2012–2013, but the level the maximum Pell Grant would reach 2012–2013 is only $250 above the 2003–2004 level that the Department of Education study found left such big gaps.

That is only $250 over it after adjusting for general inflation, and it is actually below the 2003–2004 level if you adjust for increasing tuition and fee charges which have been rising faster than inflation.

To me, the growth in the financial aid gap for low income students at a time when inequality is widening due to a variety of forces in the private economy is an emblem of how Government policies are not responding adequately here either in terms of the economy's need for highly productive workers in future decades or in terms of the need to lean against the trend towards greater inequality.

In recent years, policy-makers have increased financial aid for students from affluent families, who would attend college anyway, through such means as the creation of 529 plans in the tax code but have allowed financial aid for low income students to erode significantly in relation to tuition and fee charges which is increasing barriers that the lower income students face in obtaining higher education at a time when we should be reducing those barriers.

Now I understand the concerns about the broader budgetary picture and future deficits, and our center has written frequently about the need for tough choices in the areas of healthcare revenues and social security, but domestic discretionary programs have not been the cause of the return of deficits and they are not the cause of the large projected deficits in the future.

They have been falling for 30 years as a share of GDP. For nondefense discretionary, it was 5.2 percent of GDP in 1980. It is 3.7 percent today. Under the CBO baseline, it falls to 2.8 percent by 2018.

The bottom line here, I think, is that we need to make some very tough choices in the coming years in various parts of the budget, but we really cannot afford not to make investments that would both keep the United States more competitive in the international economy in future decades and boost the opportunities, to use Mr. Walsh's term at the start of the hearing, boost the opportunities for lower income children and families to get ahead and to lean against this widening income inequality that I believe ultimately

poses some dangers both for the economy and for the Nation's political and social fabric.

Thank you.

[The information follows:]

TESTIMONY OF ROBERT GREENSTEIN
Executive Director
Center on Budget and Policy Priorities

Prepared for the
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
House Committee on Appropriations

February 13, 2008

I am Robert Greenstein, executive director of the Center on Budget and Policy Priorities. The Center is an independent, nonprofit policy institute that conducts research and analysis on a range of federal and state policy issues, with particular emphasis on fiscal policies and policies affecting low- and moderate-income families. We receive no government grants or contracts and are funded by foundations and individual donors.

My testimony today will focus on three areas: 1) trends in funding for domestic discretionary programs and how this part of the budget is affecting the short-term and long-term budget outlook; 2) the President's budget proposals with regard to this part of the budget; and 3) how broader national and global forces and the trend toward widening income inequality are likely to affect needs for non-defense discretionary funding in the years ahead.

I. Domestic Discretionary Funding Trends and their Impact on the Budget

In some quarters, there is misunderstanding of recent trends in funding for domestic discretionary programs. Some people believe that funding for these programs has exploded since 2001 and been a key factor driving the federal budget from surpluses at the start of the decade to the deficits we face today. The facts do not support this view.

There has been — and continues to be — a long-term decline in expenditures for non-defense discretionary programs both as a share of the economy and as a share of the budget. Expenditures for non-defense discretionary programs (including international affairs and homeland security) equaled 5.2 percent of the Gross Domestic Product in 1980; they amount to 3.7 percent of GDP today, and under the Congressional Budget Office baseline, will decline to 2.8 percent of GDP by 2018.

Similarly, these programs accounted for 24 percent of the budget in 1980, make up 18.2 percent of the budget today, and will constitute about 14.7 percent of the budget by 2018 under the budget baseline.

Changes Since 2001

Some people argue that whatever the longer-term trend, appropriations for discretionary programs unrelated to national security have mushroomed since the start of 2001 and have helped fuel the return of deficits. This perception reflects, in part, the fact that significant increases in domestic appropriations were enacted in 2001, when policymakers believed we would be running

large budget surpluses for the indefinite future and sought to address perceived needs to invest more in education, biomedical research, and other areas.

In the six-year period since deficits have returned, however — i.e., from fiscal year 2002 to fiscal year 2008 — funding for domestic discretionary programs outside homeland security has increased only modestly in real terms and actually has fallen in real *per-capita* terms and as a share of the economy.

- Total funding for domestic discretionary programs outside homeland security is 5.4 percent greater in fiscal year 2008 than in fiscal year 2001, after adjustment for inflation and population growth (i.e., in real per capita terms). This is an average annual rate of growth of seven-tenths of one percent.[1] [2]

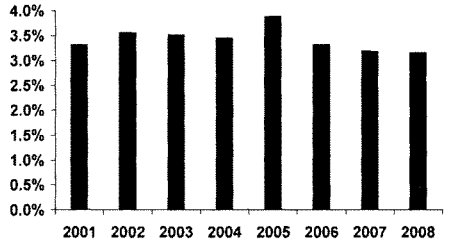
- When policymakers wrote the fiscal year 2002 appropriations bills in summer of 2001, the budget appeared to be awash in surpluses, and significant increases were provided for many discretionary programs. After deficits returned as a result of a combination of factors, that growth first slowed and then began to be reversed, with overall funding for domestic discretionary programs outside homeland security being cut over the past few years by most measures. If one compares the overall funding level for domestic discretionary programs outside homeland security in fiscal year 2002 to the levels for fiscal year 2008, one finds a *decline* of 2.6 percent in real per capita terms over the six-year period.[3]

- Figure 1 shows that, as a share of the economy, funding for domestic discretionary programs

Figure 1

Funding for Domestic Discretionary Programs Is Lower As a Share of the Economy Than in 2001

Domestic Discretionary Funding Outside Homeland Security as a Share of GDP



Source: CBPP calculations based on CBO data. Figures include emergency and supplemental funding.

[1] If one adjusts only for inflation and not for population growth as well, the increase from 2001 to 2008 equals 12.5 percent, for an annual average growth rate of 1.7 percent.

[2] Funding data are from the Office of Management and Budget, *Historical Tables*, February 2008, and include amounts designated as "emergency funding." These data are adjusted in two ways. First, the amount of obligations specified in appropriations bills for program funded by the highway and aviation trust funds are counted as discretionary funding. Second, the officially scored levels of budget authority in a few areas are adjusted to avoid serious distortions as a result of timing anomalies. For example, changes that Congress has made over time in how it provides advance appropriations for various education and training programs will distort comparisons of funding levels for different fiscal years, unless an appropriate adjustment is made to ensure that one is comparing "apples to apples" rather than "apples to oranges." To address this problem, we treat all such advance appropriations on a "program year" basis, so that valid comparisons can be made across fiscal years. For more information on these and other adjustments, see the appendix to Richard Kogan, *The Omnibus Appropriations Act*, Center on Budget and Policy Priorities, February 1, 2004.

[3] Adjusting only for inflation, there has been an increase of 3 percent over the six-year period.

outside homeland security has unquestionably declined, falling from 3.31 percent of GDP in 2001 and 3.56 percent of GDP in 2002 to 3.15 percent of GDP in 2008, which is one of the lowest levels in at least half a century.

The Shift from Surpluses to Deficits

Another way to assess these trends is to consider the causes of the shift from the surpluses that the Congressional Budget Office forecast at the start of 2001 to the deficits we have actually experienced. At the start of the decade, CBO forecast sizeable surpluses for each of the next ten years. Instead, the government has ended up running significant deficits. What caused the turnabout?

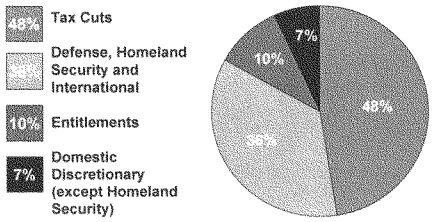
CBO data indicate that poorer-than-expected economic performance (including the effects of the recession that hit in 2001) and technical estimating errors accounted for about 31 percent of the budgetary deterioration that occurred in the 2002-2007 period (i.e., 31 percent of the difference between the surpluses forecast for those years at the start of 2001 and the deficits that actually resulted). The other 69 percent of the deterioration, however, was the consequence of spending increases and tax cuts that Congress passed and the President signed.

The CBO data allow us to determine the particular types of legislation responsible for the fiscal deterioration that was caused by legislative action. As Figure 2 indicates, nearly half of this deterioration resulted from tax cuts. A little more than one-third resulted from increases in what the Administration terms security-related spending (i.e., defense, homeland security, Iraq, Afghanistan, other anti-terrorism expenses, and international affairs). A smaller portion — one-tenth of the deterioration — resulted from entitlement expansions. Note that only seven percent of the deterioration resulted from increases in domestic discretionary spending above the 2001 levels adjusted for inflation.

Furthermore, the share of the fiscal deterioration attributable to domestic discretionary programs will shrink below 7 percent in the years ahead. The discretionary spending levels in 2007 include spending related to Hurricane Katrina, which will eventually diminish. In addition, the portion of the deterioration that is due to the prescription drug legislation enacted in 2003 will rise in the years ahead, causing the shares attributable to other factors to become somewhat smaller. In short, as these data indicate, domestic appropriations have been a bit player at best in the budgetary deterioration of this decade.

Figure 2

Cost, 2001-2007, of Legislation Enacted Since January 2001



Source: CBPP calculations based on Congressional Budget Office data.

The Nation's Long-Term Fiscal Problems

The more important budgetary questions relate to the difficult decades that lie ahead. Levels of deficit and debt are projected that are unprecedented in the nation's history.

Last year, the Center on Budget and Policy Priorities released projections of what the fiscal landscape will look like through 2050 if we remain on our current policy course — i.e., if the tax cuts of recent years are made permanent, no changes are made in Medicare or Social Security, relief from the Alternative Minimum Tax is continued, etc. The results are extremely disquieting. Deficits, which currently are below 3 percent of GDP, are projected to reach 20 percent of GDP by 2050, and the federal debt (now about 37 percent of GDP) is projected to spiral to more than 200 percent of GDP by 2050. (Our projections are based heavily on CBO estimates and are in line with the long-term projections previously issued by CBO, GAO, and others.)

We also examined the causes of this projected fiscal collapse. The findings are clear: the fiscal deterioration projected over the next half century is due entirely to three factors: increases in health care costs throughout the U.S. health care system that will drive up both private-sector health care costs and Medicare and Medicaid costs; the aging of the population, which will raise the costs of Social Security, as well as Medicare and Medicaid costs; and the costs of extending the tax cuts without offsetting their costs. *None* of the long-term deterioration of the budget that is projected through 2050 is attributable to discretionary programs — for the basic reason that spending on discretionary programs has been shrinking as a share of GDP for more than 30 years, and the CBO baseline projects it will continue to do so in the years ahead. If discretionary spending *falls* as a share of GDP, it cannot cause overall federal spending, deficits, and debt to *rise* as a share of GDP.

In addition, with domestic discretionary spending projected by CBO to equal only one-seventh of the federal budget by 2018, there simply are not large savings to be had here, unless policymakers wish to make increasingly draconian cuts in this part of the budget.

The bottom line is that domestic discretionary spending has had little to do with the return of deficits in recent years and has virtually nothing to do with the projected deterioration of the budget outlook in coming decades. In terms of addressing the nation's very serious long-term fiscal problems, domestic discretionary programs are essentially a sideshow. Major progress in addressing the grim long-term budget outlook will not be made until policymakers institute major, system-wide health care reforms that materially slow projected rates of growth in Medicare and Medicaid costs, raise more revenues, and close the Social Security shortfall.

II. The Proposals in the President's Budget

The President's new budget is not gentle to domestic discretionary programs. The President's budget essentially has four major elements:

- It would make the 2001 and 2003 tax cuts permanent at a cost the budget shows at $2.2 trillion over ten years. (The actual cost is higher, because the budget assumes that the Alternative Minimum Tax will mushroom, affect close to 40 million taxpayers by 2012, cancel out a substantial portion of the tax cuts for many taxpayers, and thereby lower — on paper — the cost of making the 2001 and 2003 tax cuts permanent.)

- The budget includes new funding for operations in Iraq and Afghanistan in 2008 and 2009, as well as substantial increases in 2009 for defense costs not related to the Global War on Terrorism. By 2009, defense funding unrelated to Iraq, Afghanistan, and the Global War on Terror would be 40 percent — or $150 billion — higher than in 2001, after adjusting for inflation. Smaller increases are included in the international area.

- The budget includes almost $230 billion in reductions over five years in projected entitlement costs, the majority of which would come from Medicare.

- The budget includes reductions in funding for domestic discretionary programs of as much as $160 billion over five years — that is, over the next five years, funding for these programs would be set a cumulative total of roughly $160 billion below the 2008 level, adjusted for inflation.[4]

There has been some confusion about the effect of the President's budget on domestic discretionary programs in 2009, as a result of a statement included in the President's budget that the budget would increase "non-security" discretionary funding by three-tenths of one percent. For several reasons, this figure is somewhat misleading. First, the group of programs that OMB said would increase by 0.3 percent includes some *defense* programs, such as the Department of Energy's nuclear weapons programs. Second, the figure was derived by *excluding* some veterans' and border security funding from the 2008 level, while *including* the continuation of such funding in the level reflecting the President's request for 2009. This makes the 2008 level look artificially low and causes the President's 2009 request to appear to be an increase. Finally, in making the 0.3 percent computation, OMB did not adjust the 2008 levels for inflation.

When these matters are corrected, the result is that the Administration's overall funding level for domestic discretionary programs (other than homeland security) in 2009 would be $20.5 billion — or 4.6 percent — *below* the 2008 level adjusted for inflation.[5]

The domestic discretionary cuts proposed in 2009 include the following:

- In the poverty area, funding for the Low Income Home Energy Assistance Program (LIHEAP) would be cut $570 million or 22 percent. (This is the reduction before adjusting for changes in energy prices.) This would require cutting more than 1 million low-income families and elderly people off the program entirely, shrinking the average amount of assistance provided to poor families by 22 percent, or some combination of the two. The funding level that the President proposes for LIHEAP in 2009 — $2.0 billion — is identical to the program's funding level in 2001, even though home energy prices are now 65 percent higher than in 2001.

- The budget would freeze funding for child care assistance for low-income families for the seventh consecutive year. After adjusting for inflation, child care funding in 2008 already is

[4] The $160 billion decline is for domestic discretionary programs as a whole, *including* homeland security programs (except for homeland security programs classified as part of the defense budget). If homeland security programs are excluded, the five-year decline exceeds $160 billion.

[5] Before adjustment for inflation, the drop is $10.6 billion, or 2.3 percent. It should be noted that the President's budget also proposes that the fiscal year 2009 appropriations bills include $6.4 billion in non-controversial mandatory savings. If those savings are accepted, then domestic discretionary programs outside homeland security would have to be cut $14.1 billion in 2009, after adjusting for inflation, rather than $20.5 billion.

almost 17 percent below the 2002 level. (Between 2002 and 2006, the last year for which these data are available, the number of low-income children under age five *grew* by more than 8 percent.[6]) According to the Administration's own data, 200,000 fewer children in low-income families would receive federal child care assistance in 2009 under the President's proposed levels for discretionary and mandatory child care funding streams than received such assistance in 2007.

- The budget reduces or freezes funding for a number of other low-income assistance programs, as well. For example, because of cuts in the Section 8 housing voucher program, the nation's largest low-income rental assistance program, at least 100,000 fewer low-income households would receive voucher assistance. The budget falls approximately $1.3 billion short of the amount need to renew the vouchers in use.

- The budget would cut funding for the Centers for Disease Control and Prevention by $433 million, even before adjusting for inflation. These reductions include sharp cuts in funding for detection and control of infectious diseases and preventive health services.

- The budget would reduce funding for the Environmental Protection Agency by $330 million, before adjusting for inflation. EPA funding in 2009 would fall more than $1 billion below the 2004 level (and $700 million below the 2001 level), before adjusting for inflation.

- While the budget would expand some education programs, it would cut others, and its total funding for K-12 education would, at best, simply keep pace with inflation. Although resources for K-12 education were increased in the years immediately following enactment of the No Child Left Behind law, funding has eroded since then. Overall funding for K-12 education in 2008 is 9 percent below its 2004 level, after adjusting for inflation.

- Finally, the budget would cut overall discretionary program grants to states and local governments in 2009 by $15.1 billion, or 9 percent, even before adjusting for inflation — and by $19.1 billion, or 11 percent, after inflation is taken into account. For example, grants to states and cities for homeland security, law enforcement, and firefighters and other first responders would be cut by $1.5 billion, or 45 percent, even before adjusting for inflation. Cuts such as these would force states to institute even larger program cuts or tax increases than otherwise will be needed to close the budget gaps now emerging in states across the country as a result of the economic downturn. Unlike the federal government, states must balance their budgets, even during economic downturns, when revenues slow or contract.

In short, the cuts proposed in domestic discretionary programs are substantial and would affect a number of important services. The cuts would affect many disadvantaged children, parents, and seniors of limited means and would squeeze state and local governments. One of the combined effects of these program reductions and the tax cuts the budget proposes would be to further widen inequality.

Discretionary Program Cuts, Tax Cuts, and Medicare Savings

Before concluding the part of my testimony that focuses on the President's budget, I would like to offer a few observations about the Administration's budget as a whole. For the pain that the $20.5

[6] "Low-income" here refers to children whose families have incomes below twice the poverty line.

billion in proposed domestic discretionary reductions in 2009 — and the roughly $160 billion in proposed reductions over five years — would cause, the savings would be modest, especially compared with the cost of the tax cuts. Making the tax cuts permanent would cost $2.2 trillion over the next ten years under OMB estimates (and $3.1 trillion if one uses CBO estimates of the cost of the tax cuts and takes into account the cost of the portion of continued AMT relief that would simply prevent the AMT from canceling out part of the President's tax cuts).

Based on cost estimates from CBO and estimates of the distribution of the tax cuts by the Urban Institute-Brookings Tax Policy Center, the top 1 percent of households (currently those with incomes above $450,000) will receive a total of *$1.1 trillion in tax cuts over the next ten years* if the tax cuts and AMT relief are extended. The Tax Policy Center estimates that the average tax cut for these households will be $67,000 a year by 2012; in today's dollars, this is more than the entire annual income of the typical American household. Similarly, people with incomes of over $1 million a year will receive more than $800 billion in tax cuts over the next ten years if the tax cuts are extended, and their average tax cut will be $162,000 a year by 2012, according to the Tax Policy Center.

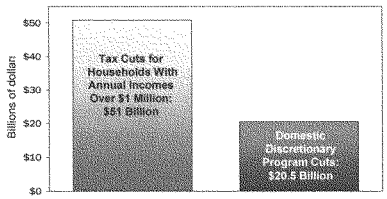
These figures lead to a few comparisons. In 2009, the cost of the tax cuts for people with incomes over $1 million (the top 0.3 percent of households) will be *$51 billion.* This is more than double the *$20.5 billion* the President's budget would save in 2009 through all of the cuts it proposes in domestic discretionary programs.

Another way of looking at this is to compare the cost of the tax cuts to what the federal government devotes to areas like education and veterans' health care. The annual cost of the tax cuts just for people with incomes over $1 million *exceeds* the total amount the federal government devotes each year to K-12 education and vocational education. Similarly, it exceeds the total amount the federal government spends on veterans' health care.

Figure 3

President's Budget Proposes Large Cuts in Domestic Programs, But Tax Cuts for Millionaires Are Larger

Tax Cuts and Spending Cuts, 2009



Source: CBPP calculations based on Office of Management and Budget, Joint Committee on Taxation, and Urban-Brookings Tax Policy Center data. If certain mandatory savings are adopted, domestic discretionary cut would drop to $14.1 billion; see footnote 4.

As these observations may indicate, I do not think that we can afford the full panoply of the President's tax proposals. I also believe we must begin to work on systemwide health-care reform to slow the rate of growth in health care costs in both the public and private sectors. It is in the tax code and the health care system, along with Social Security, that tough decisions will have to be made sooner or later.

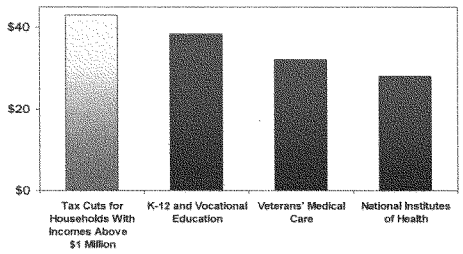
If policymakers cannot make progress in these areas, then the first part of the budget to get squeezed substantially as the long-term fiscal picture darkens is likely to be domestic discretionary programs. And to get big savings out of the domestic discretionary part of the budget, the reductions would have to be severe.

Such reductions would threaten the ability of the government to perform a number of its most basic functions. They also would prevent policymakers from addressing important unmet needs, some of which are discussed later in this testimony.

Figure 4

Cost of Tax Cuts for the Households with Incomes Over $1 Million Exceeds Spending on High-Priority Programs

2007 Program Expenditures and Tax Cuts



Source: CBPP calculations based on Tax Policy Center, CBO, & Treasury Department data.

III. Widening Inequality

There is little question that income inequality has widened significantly in recent decades. Congressional Budget Office data, which cover the period from 1979 to 2005, show the following.

- The average annual after-tax income of the top 1 percent of Americans more than tripled between 1979 and 2005 — rising from $326,000 a year to $1.07 million a year, an increase of $745,000 per household, or 228 percent. (This and all other income figures cited here have been adjusted for inflation by CBO and are presented in 2005 dollars.)

- In contrast, the average after-tax income of the middle fifth of the population rose a modest $8,700 — or 21 percent — over this 26-year period. It stood at $50,200 in 2005.

- And the average income of the bottom 20 percent rose just $900 — or 6 percent — over this 26-year period and stood at $15,300 in 2005.

- Looked at another way, the *share* of the national income going to the top 1 percent of households doubled, while the share going to the bottom four-fifths of households declined.

Another way to illustrate what has occurred is to note that in 1979, the average after-tax income of households in the top 1 percent was *23 times* the average after-tax income of households in the bottom fifth of the income scale. By 2005, the top 1 percent made *70 times* as much, the widest such gap on record. Similarly, in 2005, the average income of the top 1 percent in 2005 was 21 times that of the *middle* fifth, another record.

This long-term trend shows no signs of abating. The CBO data show that just between 2004 and 2005, real after-tax income jumped by an average of $180,000 for households in the top 1 percent of the income scale, while rising only $400 on average for middle-income households and $200 for

low-income households. This $180,000 average gain for households in the top 1 percent in 2005 translated into about $180 billion in additional after-tax income for the top 1 percent.

Another principal source of data on this matter — the research findings of economists Thomas Piketty and Emanuel Saez — show similar results. Piketty and Saez found that nearly half — 47 percent — of the income gains in the nation in 2005 went to people in the top 1 percent. Their research also indicates that the concentration of income at the top of the income scale is now greater than at any time since 1929.

IV. Domestic Discretionary Funding Need in the Future

Various developments in the nation and the world, including the stunning increases in inequality, are creating an imperative for increased resources for certain discretionary program areas. I would like to address developments and needs in four broad areas: 1) the need to make American workers and businesses more competitive, and to do so in a way that leans against the trend toward greater inequality, by improving the skills and prospects of less-fortunate Americans and by easing child poverty; 2) addressing needs that will arise from the aging of the population; 3) meeting certain global challenges; and 4) enabling the federal government to perform its basic functions adequately. This is not intended to be an exhaustive list of areas where increased investment should be considered.

1. Improving U.S. competitiveness and addressing growing income inequality and high levels of poverty in the United States

In an increasingly global economy, there is growing concern about jobs and economic activity shifting from the United States to other countries. There is also mounting concern over the increase in income inequality over the past quarter century and the fact that many Americans are not sharing in the gains of economic growth. Among those who have voiced strong concern about growing inequality in recent years are former Federal Reserve Chair Alan Greenspan, current Fed Chair Ben Bernanke, and President Bush in a speech on Wall Street in January 2007.

Both Chairman Bernanke (in a speech last year) and former Treasury Secretary Larry Summers (in testimony last year before the Joint Economic Committee) have emphasized the need for increased investments. To boost productivity, Summers has called for increased investment in education (including early education), infrastructure, and research and development. He pointed to what he termed a "remarkable" decline in federal support for basic research. He also observed that "nothing is more important to our prosperity then the quality of the American labor force" and explained that "A growing body of evidence suggests that pre-school education has an enormous rate of return, particularly for children from a disadvantaged background, and funding for these kinds of programs should be a high priority." Finally, he pointed to "key areas such as transportation and other infrastructure facilities where investment has been grossly inadequate."[7]

In Chairman Bernanke's speech, he, too, called for "policies that boost our national investment in education and training," noting that "A substantial body of research demonstrates that investments in education and training pay high rates of return both to individuals and to the society at large."

[7] Testimony of Lawrence H. Summers before the Joint Economic Committee, January 31, 2007.

Like Summers, he added that recent research "has documented the high returns that early childhood programs can pay in terms of subsequent educational attainment and in lower rates of social problems, such as teen age pregnancy and welfare dependency."[8]

Recent pathbreaking research by a team of researchers at the University of Chicago, Northwestern University, and Harvard also is of note. These researchers, who have produced the first high quality national study that follows children from infancy through adulthood (the study follows individuals to age 37), have found that poverty in early childhood is linked with large shortfalls in work hours and lower earnings later in life. The researchers estimate that eliminating poverty among children under five would boost annual work hours among these children when they grow up by an average of 12 percent per year, and boost their annual earnings by an average of 29 percent. These are among a growing number of findings that suggest the importance of government supports and policies that directly reduce child poverty, both in the current generation and in future generations.

Although the children of today are the workers of tomorrow, the United States tolerates a level of child poverty well above that of nearly all other western industrialized nations. For hard-headed economic reasons as well as for humanitarian reasons, this matter ought to be addressed. It is noteworthy that the United Kingdom set a goal of cutting child poverty in half between 1999 and and 2010 and ultimately of eliminating it, and has made impressive initial progress toward this goal.

Poverty and Inequality

After years of experience with various programs, we know that certain programs and types of interventions can deliver results. But we underfund them. Although many of the federal policy reforms needed to address poverty and rising inequality lie outside the discretionary part of the budget, there are some discretionary areas that will need more funding if we are serious about making significant progress here.

This includes early education and child care initiatives. As noted above, research has shown that quality early education can result in marked improvements in children's school readiness and success in elementary school. Moreover, the issues of child care and early education are closely linked. Low-income working parents either need quality preschool that lasts through the full work-day or need child care that "wraps around" educationally-oriented preschool programs. The child care piece is significant; research has shown that child care subsidy programs have significant impacts on parents' employment rates and earnings.[9]

Despite the strong evidence of the importance of early education and child care, however, federal investment in both has been falling since 2002. Head Start funding in 2008 is 11 percent below the 2002 level, and child care funding 17 percent below the 2002 level, after adjusting for inflation. Head Start and child care assistance programs serve only a minority of the low-income children

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[8] Chairman Ben S. Bernanke, "The Level and Distribution of Economic Well-Being," Remarks before the Greater Omaha Chamber of Commerce, February 6, 2007. See also Julia B. Isaacs, "Cost-Effective Investments in Children," The Brookings Institution, January 2007.

[9] Hannah Matthews, *Child Care Assistance Helps Families Work: A Review of the Effects of Subsidy Receipt on Employment*, Center for Law and Social Policy, 2006 http://www.clasp.org/publications/ccassistance_employment.pdf.

eligible for these programs. While some states have made significant investments in preschool, particularly for 4 year olds, wide gaps remain between the early education opportunities available to more affluent children and those available to low-income children.

Another such area is housing vouchers, which enable poor families to move to where there are more job opportunities and better schools. A number of studies have documented positive effects, especially for children, when families use vouchers to relocate to lower poverty areas. Recent research also highlights the role of housing vouchers in preventing homelessness among very poor families with children, finding a 74 percent reduction in homelessness among very poor families that receive voucher assistance. Only about one-quarter of the low-income families eligible for housing assistance receive such assistance from either the voucher program or another low-income housing program.

Increased funding also is needed for financial assistance to enable low-income students to attend college. The nation is failing to perform adequately in this area, a failure that limits future gains in productivity and economic growth and contributes to inequality.

A study by the Department of Education's National Center for Education Statistics compared the financial aid received by students enrolled in college in 2003-2004 with the amount needed to meet these students' financial needs, as determined under federal financial aid formulas. The study found that among students from families with incomes below $20,000, some 87 percent of community college students had unmet needs that averaged $4,500 per student per year, and 80 percent of students in public four-year colleges had unmet needs averaging $6,000 per year.[10] Many low-income students who face these financial gaps drop out before completing college. Others are deterred from enrolling in the first place.

Nor does last year's student aid legislation make that much of a dent. That legislation increases Pell Grants in increments through 2012-2013. But the level that the maximum Pell Grant will reach in 2012-2013 will be *only $250* over the highly inadequate 2003-2004 level, after adjusting for general inflation — and will likely be significantly *below* the 2003-2004 level, relative to average tuition and fee costs at public four-year colleges and universities, which have been rising faster than the overall inflation rate. (This calculation of the maximum Pell Grant in 2012-2013 assumes that Congress appropriates discretionary funds for the Pell Grant program each year that are sufficient to maintain the *current* maximum award, and that the mandatory Pell Grant funding provided by last year's student aid law is used to raise the grant above that level.) During the 2003-2004 school year, the maximum Pell Grant covered 87 percent of average tuition and fees at public four-year institutions. If college costs continue to rise at their recent pace, the maximum Pell Grant in 2012-2013 will cover only about 65 percent of average four-year college tuition costs and fees.

The growth in the financial aid gap for low-income students is an emblem of how government policies are failing to adequately address the economy's need for highly productive workers in coming decades and also are exacerbating the trend toward greater inequality. In recent years,

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[10] Figures are from the 2003-2004 National Postsecondary Student Aid Study. Figures here are for undergraduate students who are dependents of their parents (and are classified into income groups based on their parents' incomes), but the figures for low-income independent students are similar. See National Center for Education Statistics, "Student Financing of Undergraduate Education: 2003-2004," U.S. Department of Education, August 2006, http://nces.gov/pubs2006/2006186.pdf.

policymakers have increased financial aid for students from very affluent families who would attend college anyway by creating very generous new tax breaks, such as 529 plans. At the same time, policymakers have allowed financial aid for low-income students to erode significantly and thereby increased the barriers that such students face in obtaining higher education.

2. The Aging of the Population

The proportion of Americans who are elderly will rise in the decades ahead. Although there is no reason to believe that the *percentage* of elderly people who live in poverty will rise, the *number* of elderly people living on small incomes will increase substantially.

Increases in funding will be necessary for various programs that provide services to elderly people who are needy and frail, such as programs operated under the Older Americans Act. This is also true of funding to preserve the existing stock of federally assisted housing units that serve low-income elderly people; shortfalls in funding for the project-based section 8 program, as well as chronic underfunding for maintenance and capital repairs at public housing developments, pose a growing risk to housing for 1.2 million low-income elderly households. Funding increases also will be needed for staffing at the Social Security Administration and the Centers for Medicare and Medicaid Services as the number of Americans relying on these agencies swells.

3. Global Challenges

President Bush has spoken in several State of the Union addresses of the need for increased funding to fight diseases such as HIV/AIDS and malaria around the world, especially in very poor countries, and to help combat severe poverty and underdevelopment abroad through the Millennium Challenge Account. These measures are important from both a security and a humanitarian standpoint. Because of overly tight levels placed on the Appropriations Committees, however, Congress has yet to fully fund the President's request in this area.

The United States continues to rank near the bottom in the western world in terms of the share of its budget and its economy that it devotes to such matters. Increased resources are needed here and will continue to be needed for a considerable period of time.

4. Enabling the Federal Government to Perform Adequately

There are at least three areas where increased resources will be needed for the government to do an adequate job — IRS enforcement, government statistics that guide decisions economy-wide, and resources needed to ensure a stable, well-functioning federal workforce.

The tax gap is estimated at over $300 billion a year. Most Americans would agree that having those who are shirking their obligations pay the taxes they owe is preferable to raising taxes on law-abiding households. But the IRS lacks the resources to do the job that it needs to do. Given the huge budget holes we face in coming decades, this matter badly needs to be addressed.

There also is growing concern that a squeeze on appropriations levels will place some important government surveys and statistical reports in jeopardy. In both the private and the public sectors, decisions that are informed by solid data are generally sounder, and produce better results, than decisions that are not.

Last, but certainly not least, analysts are increasingly concerned about the hollowing out of the federal workforce that lies just around the corner. For years, the federal workforce has been squeezed down, even as Congress has placed more tasks on many federal agencies. Across the federal government, a large cohort of dedicated, highly skilled individuals who joined federal service in the 1960s, 1970s, or early 1980s is now approaching retirement. In not that many years, most of this cohort of senior, high-performing civil servants will be gone. Unfortunately, the workforce coming up behind these highly skilled individuals is, in many agencies, quite thin — in no small part because years of reductions in real resources for agency staffing made it difficult for many agencies to hire talented new blood in adequate numbers.

There is now growing risk that performance will decline significantly in many agencies across the federal government in the coming decade. This is a matter that needs urgent attention. To be sure, more is needed than simply infusions of resources. But in many agencies, more resources for staffing are a necessary, if not a sufficient, condition to averting the marked deterioration in performance that threatens in the years ahead.

Conclusion

This testimony is not meant to imply that all discretionary programs are essential or that no savings can be secured in any of them. That certainly is not the case. But the savings that can be achieved are likely, in my view, to fall well short of the additional resources that will be needed in critical areas such as those discussed above.

Domestic discretionary programs are not the cause of the nation's budget woes. It would be unfortunate if failure to act on the budgetary challenges that we face — especially in the areas of health care, taxes, and Social Security — were to lead policymakers to make unsound decisions regarding the discretionary side of the federal budget and to fail to provide resources essential to remaining competitive, confronting global challenges, addressing challenges posed by galloping income inequality, and providing adequate-quality public services for the American people.

Mr. OBEY. Thank you.

I was evidently misinformed by those who told us that this vote wouldn't come until 11:15. We have nine minutes, so I would suggest we go vote.

Mr. WALSH. We have a vote right now?

Mr. OBEY. Yes, another one.

Mr. SIMPSON. We went through this already.

Mr. OBEY. I know.

Mr. SIMPSON. I already voted. [Laughter.]

Mr. OBEY. Well, I am happy to stay if anybody else wants to stay. I don't think it is in any danger of passing. If members want to go vote, please go vote.

Dr. Viard, why don't you proceed and we will try to get yours in before the next disruption?

Mr. VIARD. Thank you, Mr. Chairman.

Chairman Obey, Ranking Member Walsh, members of the Subcommittee, it is an honor to appear before you today to discuss implications of economic trends for workers' families of the Nation. In my written testimony, I make three points which I will discuss briefly here now.

Despite the rise in inequality during the last few decades, a development that no one disputes, real incomes have continued to rise in the middle of the income distribution. Real incomes have even risen at the bottom of the income distribution although the gains have been very small at that place.

The existing Federal tax system is highly progressive. A large portion of the Federal tax burden is currently borne by a very small group of high income households. Also, economic mobility can make computations of income inequality, that are based on annual income, misleading. Households do move between low income and high income years to a significant extent.

On the first point, the rise of real incomes at the middle of the income distribution, I will actually be repeating much of what Bob Greenstein has just told you. I think that is an indication of the fact that there is some agreement on some of the facts as to what is happening here.

Some people have claimed that the middle class is actually failing to keep up with inflation, that the real incomes are actually falling, that the middle class is being destroyed and so on. I think it is important to realize that even though we are experiencing a rise in inequality in the United States, that those claims are simply not factual.

Some people look at particular measures like average hourly earnings and point out that measure has not always kept up with inflation, but that is an incomplete measure because, at best, it is only telling you something about the labor earnings, the cash labor earnings that households are receiving.

To actually see how households are doing, it is important to add in their other sources of income such as fringe benefits and Government benefits and then to subtract the taxes that they are paying to see what resources they actually have available for themselves and their families.

Like Bob Greenstein, I will actually be using the Congressional Budget Office numbers. I agree with him that those are a reliable,

high quality data source. They are available from 1979 through 2005, and I think they paint an interesting picture.

The middle quintile, the 20 percent who are in the middle of the distribution with 40 percent above them and 40 percent below them, did experience a real income gain of 21 percent over that 26-year period. It is a smaller gain than one would have liked.

I think that it is more than simply beating zero, to use Jared Bernstein's phrase, and of course it is true that the income gains that have occurred in the highest two quintiles and particularly the top 1 percent are much more rapid. Nevertheless, I think it is important to point out that even as inequality has risen the tide of economic growth has continued to lift the middle income boat.

The bottom two quintiles have not experienced the same degree of growth as the middle quintile. The second quintile, after tax income, grew 16 percent over that period, a bit less than the middle quintile. As Bob Greenstein mentioned to you, the bottom quintile grew by a very meager 6 percent over this 26-year period. Clearly, there is a source of concern with respect to that group of individuals.

The second point I wanted to briefly discuss is the role that the Federal tax system plays in reducing income inequality in the United States. It is obviously a value judgment as to how the tax burden should be divided among different income groups. Of course, that is a responsibility that you have along with the members of the Senate and the President in determining how the tax burden should be divided. There are difficult value judgments involved.

As those value judgments are made, I think it is important to have a clear understanding of the point that we are starting from, and the point that we are starting from is one in which the Federal tax system is highly progressive. Again, I turn to the CBO data for this point.

In 2005, the top 1 percent of the population paid 28 percent of the taxes. Now, if you were to look at individual income taxes alone, that number would be even more striking, 39 percent in the CBO data.

Of course, we know that individual income taxes do not make up the entire Federal tax system. Social insurance taxes, mainly the social security/Medicare payroll tax, are also an important part of the system, and that tax, of course, is regressive by itself. The top 1 percent, for example, pays only 4 percent of the social insurance taxes in the Country.

But when CBO adds together those taxes as well as the corporate income tax and excise taxes, nonetheless, the total tax system remains strikingly progressive. The top 1 percent pays 28 percent. The top quintile, the top 20 percent, pays 69 percent of the cost of Government. The bottom quintile, which actually has a negative income tax burden, bears 1 percent of the overall Federal tax burden.

So I think that we might have to recognize that we are starting from a Federal tax system that is highly progressive, and this does not merely reflect the income concentration that the other witnesses have described. The higher income groups are actually pay-

ing a higher share of the tax burden than their before tax incomes would indicate.

For example, the top 1 percent has 18 percent of the before tax income in the CBO data, but they do bear 28 percent of the Federal tax burden. So, at the top, a higher fraction of income is being paid to the Federal Government than at the lower income groups.

As a third point, I want to discuss the importance of economic mobility, and here I will turn to the Treasury mobility study that was released in November. This is actually the same study that Jared Bernstein referred to in part of his testimony. I think it shows that there is a significant degree of mobility in the United States and that for some households looking at their annual income can provide a misleading picture of their true economic circumstance.

There are a lot of numbers in that Treasury study. In my written statement, I have a chart that presents what I consider some of the more striking numbers.

The Treasury study looked at the bottom quintile, the bottom 20 percent of taxpayers based on 1996 income, and it looked at what happened to their real inflation adjusted income over the next nine years, so where did they end up in 2005 compared to where they started in 1996.

For this bottom quintile, 49 percent, nearly half, experienced a doubling or more of their real income during that 9-year period. In fact, the average income of this group more than doubled during that time period. So it is clear that there was a significant number of low income households based on their 1996 income who in fact experienced very large income gains.

There are others who experienced more modest gains. Eighty-two percent of this low income group experienced some real income gain during that nine years compared to 67 percent of the taxpayers in all income groups.

Of course, there is no denying that, for some households, being at a low income level is a longer term or more permanent condition. The Treasury study does show, for example, that of those taxpayers in the bottom quintile, that 18 percent did actually lose income and that roughly 6 or 7 percent actually lost more than half of their initial modest income during that 9-year period.

Clearly, there is a group there with long term difficulties that we have to be concerned about, but it is important to realize that looking at annual income can overstate the situation.

The converse, of course, is that those taxpayers who are at the top of the income distribution do not necessarily maintain their incomes over time. The Treasury looked at the top 1 percent in 1996. Sixty-five percent of that group lost real income to some extent over the next nine years. So a majority are losing income from that top point compared to a large majority gaining income at the bottom.

Sixty percent of that top 1 percent moved out of the top one percent during the nine years of the sample. Thirteen percent of them actually moved out of the top quintile or top 20 percent and moved somewhere into the bottom 80 over that nine-year interval.

So while there is certainly no doubt that there is a group of people with long term low incomes, there is also a group with tempo-

rarily low incomes, and it is important to distinguish between them.

In summary, Mr. Chairman, there has been a rise in economic inequality over the last few decades, an undeniable fact supported by all of the data that we have at our disposal. It is nonetheless true that middle incomes continued to rise during this period and low incomes even to a slight extent, although at an appallingly slow rate.

The current Federal tax system is highly progressive. A small group of high income taxpayers pay a significant share of the cost of Government, including those programs that aid the less fortunate.

While it is certainly true that there are some households that are at a long term low income position, there are others who move out of that position, and it is important to keep that distinction in mind.

Thank you, Mr. Chairman.

[The information follows:]

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Committee on Appropriations
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Alan D. Viard is a Resident Scholar at the American Enterprise Institute. The views expressed in this testimony are solely his own and do not reflect the views of the American Enterprise Institute or any other institution.

Chairman Obey, Ranking Member Walsh, Members of the Subcommittee; it is an honor to appear before you today to discuss, "Implications of Economic Trends for Workers, Families, and the Nation."

I would like to make three major points:

- Despite the rise in inequality during the last few decades, real incomes have risen significantly in the middle of the income distribution. Real incomes have also risen at the bottom of the income distribution, although at a very slow pace.
- The existing federal tax system is highly progressive, with a small group of high-income taxpayers bearing a large portion of the federal tax burden.
- Due to economic mobility, annual income can be a misleading measure of wellbeing. A significant portion of households with low incomes in any given year experience large income gains in later years.

Real Incomes Have Risen in the Middle of the Income Distribution

Some observers have claimed that the middle class has experienced falling living standards in recent decades, as their incomes have failed to keep up with inflation. The best evidence demonstrates, however, that real incomes have risen significantly in the middle of the distribution, although not as rapidly as at the top of the distribution. Real incomes have also risen in the bottom of the distribution, although those gains have been extremely small.

To assess this issue correctly, it is necessary to use a measure of the overall economic status of middle-income Americans. Incomplete measures can yield misleading results.

For example, the Bureau of Labor Statistics' measure of average hourly earnings of production and non-supervisory workers has often failed to keep pace with inflation. At best, however, that measure reflects households' before-tax cash wage income, which is only part of the picture. To obtain a comprehensive measure of the economic resources available to households, it is necessary to include their other sources of income – fringe benefits, property income, and government benefits – and to subtract their tax payments. Even the Census Bureau's measure of household money income is incomplete, because it omits fringe benefits, in-kind government benefits, and capital gains and does not subtract tax payments.

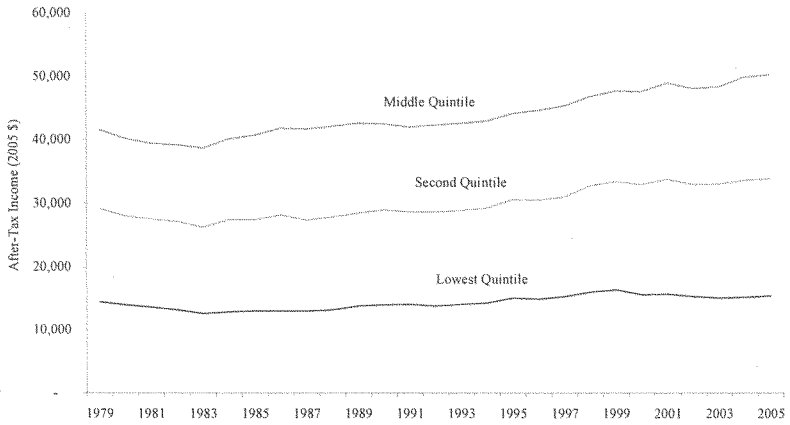
The Congressional Budget Office (CBO) has constructed a more comprehensive measure of income. CBO uses tax return data to obtain a broad measure of wages and property income, including realized capital gains and retirement benefits, and then draws on other data sources to include additional forms of income, such as employer-provided health insurance, government cash benefits, and some in-kind government benefits.

CBO classifies households into different income groups based on their before-tax income, divided by the square root of household size. For each income group, CBO reports average before-tax and after-tax incomes. To compare incomes across different

years, CBO reports real (inflation-adjusted) incomes, computed using the Consumer Price Index Research Series.

Figure 1 presents average real after-tax incomes for the bottom three quintiles of the income distribution for 1979 through 2005. Each quintile is 20 percent of the population. I will first focus on the middle quintile. (In 2005, a four-person household was classified in this quintile if its before-tax income was between $61,000 and $90,400; a one-person household was so classified if its before-tax income was between $30,500 and $45,200.) This quintile is in the middle of the income distribution; 40 percent of the population has higher income and 40 percent has lower income.

Figure 1: Real After-Tax Incomes Have Risen for Middle Quintile



Source: Congressional Budget Office, *Historical Effective Federal Tax Rates: 1979 to 2005*, December 2007. Income groups are classified by comprehensive before-tax household income divided by square root of household size. For each quintile, the chart shows after-tax comprehensive income, not weighted by household size, deflated by the Consumer Price Index Research Series.

From 1979 to 2005, the average real after-tax income of the middle quintile, as shown by the top line in Figure 1, rose 21 percent. This finding decisively refutes the claim that middle-income households have not kept up with inflation. The 2005 value of real after-tax income was the highest value in the 26-year period, 6 percent higher than in 2000 and 14 percent higher than in 1995.

It is true, of course, that incomes have not risen as rapidly for the middle quintile as for those further up in the income distribution. From 1979 to 2005, average real after-tax income rose 29 percent for the fourth quintile and 80 percent for the top quintile. The disparity in growth rates confirms the rise in inequality during this period. Nevertheless, the tide of economic growth still lifted the middle-income boat.

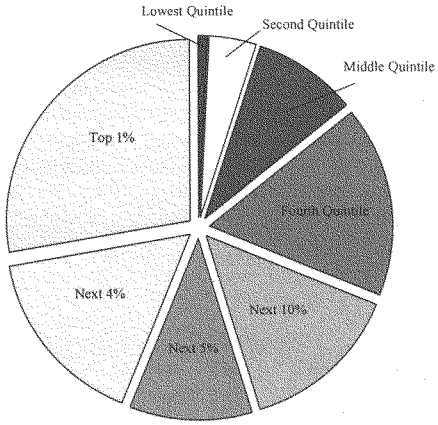
The CBO data show that real after-tax incomes also rose for the bottom two quintiles, although by smaller amounts. For 1979 to 2005, the second quintile's real after-tax income grew by 16 percent, not quite as fast the middle quintile's income gain. The lowest quintile registered a meager 6 percent gain. (In 2005, the lowest quintile included four-person households with before-tax income less than $35,800 and one-person households with before-tax income below $17,900). The slow income growth at the bottom is clearly a source of concern.

The Federal Tax System Is Highly Progressive

In the face of rising inequality, some have complained that the federal tax system is too generous towards those with high incomes. Of course, the appropriate division of the tax burden between different income groups requires difficult value judgments. In making these judgments, however, it is important to recognize that the federal tax system is already highly progressive, placing much of the federal tax burden on a small group of high-income taxpayers.

Figure 2 depicts the allocation of the federal tax burden across income groups in 2005, as computed by CBO. The income classification is the same as that described above. The data include nearly all federal taxes; individual income taxes, corporate income taxes (which are assumed to be borne by households with capital income), social insurance taxes such as the Social Security-Medicare payroll tax (which is assumed to be borne by workers), and excise taxes.

Figure 2: High-Income Groups Bear Most of Federal Tax Burden
(Shares of Federal Tax Liabilities, 2005)



Source: Congressional Budget Office, *Historical Effective Federal Tax Rates: 1979 to 2005*, December 2007. Data include federal individual and corporate income taxes, social insurance taxes, and excise taxes. Corporate income taxes are assumed to be borne by households with capital income and social insurance taxes are assumed to be borne by workers.

The data reveal a striking degree of progressivity. The lowest quintile bears about 1 percent of the federal tax burden and the second quintile bears 4 percent. The burden is higher for the next income groups, as the middle quintile bears 9 percent of the burden and the fourth quintile bears 17 percent.

That leaves the top quintile paying 69 percent of the cost of government; one fifth of the population pays more than two-thirds of the cost. The breakdown within that quintile is even more striking. Most notably, the top 1 percent of the population bears a staggering 28 percent of the tax burden. In other words, a mere 1 percent of the population shoulders more than one-quarter of the costs of the various services that the federal government provides – Social Security, Medicare, national defense, the FBI, and so on.

Furthermore, the shares of the tax burden borne by high-income groups exceed their shares of national income. In other words, these groups pay bigger portions of their incomes to the government than other Americans. For example, the top 1 percent has 18 percent of the country's before-tax income, but pays 28 percent of the taxes.

Individual income taxes alone are even more progressive; the top 1 percent pays 39 percent of those taxes in 2005 while the bottom 40 percent pays *negative* 4 percent of those taxes. Of course, the progressivity of individual income taxes is partly offset by the regressivity of social insurance taxes. As Figure 2 shows, however, the overall federal tax system remains highly progressive, even when the regressive social insurance taxes are included.

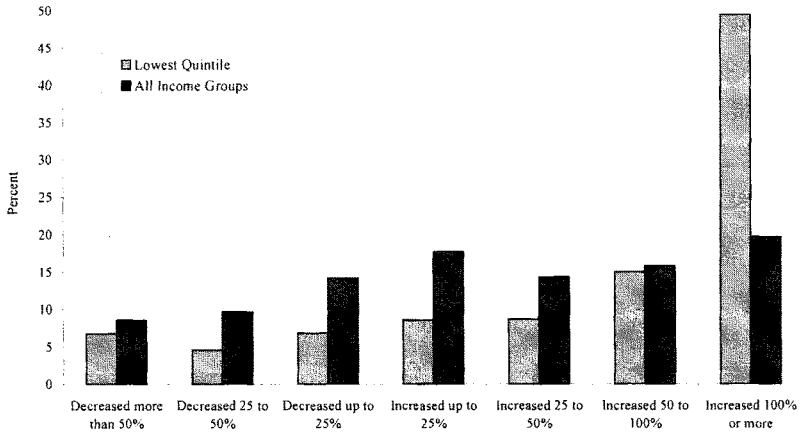
Economic Mobility Can Make Annual Income a Misleading Measure of Wellbeing

All of the above discussion relies on annual income measures. These measures can be misleading because household incomes can change over time. In particular, some of the households who are in the bottom of the income distribution in a particular year are likely to be there due to temporary factors and may experience higher incomes in later years. As a result, their living standards and economic wellbeing may not be as unfavorable as their current income would suggest.

A recent Treasury Department study documents economic mobility between 1996 and 2005. The study examined a large sample of taxpayers 25 years and older in 1996 who filed tax returns in both 1996 and 2005. Each taxpayer's income was measured as adjusted gross income plus tax-exempt interest and the non-taxable portion of Social Security benefits minus alimony paid by the taxpayer. As in the CBO study mentioned above, the Consumer Price Index Research Series was used to measure real (inflation-adjusted) incomes.

Figure 3 shows the distribution of real income changes from 1996 to 2005 for those taxpayers who were in the bottom quintile of the income distribution in 1996. For comparison, the figure also shows the corresponding distribution of real income changes for taxpayers in all income groups.

Figure 3: Large Gains for Many Taxpayers with Low 1996 Incomes
(Distribution of Percentage Changes in Real Income, 1996 to 2005)



Source: Department of the Treasury, *Income Mobility in the U.S. from 1996 to 2005*, November 13, 2007, Table 3. Income is adjusted gross income plus tax-exempt interest and non-taxable portion of Social Security benefits minus alimony payments. Results are for taxpayers 25 and older in 1996 who filed tax returns in both 1996 and 2005.

Most strikingly, the figure shows that 49 percent of the low-income taxpayers in 1996 had an income gain of 100 percent or more from 1996 to 2005. In other words, almost half of this group saw their real incomes double or better over a nine-year period. In contrast, only 20 percent of taxpayers in all income groups saw income gains of that magnitude.

More generally, 82 percent of the low-income group (compared to 67 percent of taxpayers in all income groups) experienced real income gains from 1996 to 2005. Also, the mean income for the low-income group more than tripled from 1996 to 2005. Due to their income gains, 45 percent of those in the bottom 1996 quintile moved out of the bottom quintile of the sample in 2005.

Conversely, taxpayers with high incomes in a given year do not always maintain their incomes. The Treasury study found that, among the top 1 percent in 1996, 65 percent experienced losses in real income over the next nine years, with 60 percent moving out of the top 1 percent of the sample and 13 percent moving out of the entire top quintile.

These data make clear that some taxpayers with low income in a given year will move to higher incomes in later years while some with high income in a given year will move to lower incomes. For those taxpayers, annual income may be a misleading measure of their economic wellbeing. As a result, inequality in economic wellbeing may be smaller than inequality in annual income.

Of course, some low-income taxpayers suffer from longer-term problems. The Treasury data show that 18 percent of the taxpayers in the bottom quintile in 1996 experienced a loss in real income over the next nine years. Indeed, 7 percent of the bottom quintile lost half or more of their initial meager income. Also, the Treasury study did not include households that do not file tax returns, some of whom may face long-term economic difficulties. The plight of households with long-term low incomes is clearly a source of concern.

Summary

Despite the rise in economic inequality over the last few decades, real income growth has continued at the middle of the income distribution. Real incomes have also risen at the bottom of the income distribution, though very slowly. Also, the current federal tax system is highly progressive, with a small group of high-income households paying a large share of the federal tax burden. Furthermore, economic mobility allows some households with initially low incomes to move to higher income levels, casting doubt on the accuracy of inequality measures based on annual income.

Mr. OBEY. Thank you. Thank you all.

Mr. Walsh.

Mr. WALSH. Thank you, Mr. Chairman.

It is amazing. All of you, I think, cited the same Treasury study and all came up with very different conclusions which doesn't surprise me, but a lot of it is philosophy and outlook.

I tend to be an optimist. I guess I wouldn't be in this business all these years if I weren't.

But to Mr. Viard's point, there is mobility. It is not that a certain family for generation after generation after generation is stuck in this lowest quintile. There is mobility.

As we talked about, we have a very competitive society. Some people don't compete as well as others. Government has to be there for them, but again we are providing people with equal opportunity and it is not all about Federal spending. It is about opportunity, opportunity within this system that we have.

Mr. Meyerson suggested that since people are now polling, that they can't do better, that the next generation can't do better than prior generations. Does that reflect reality or does that reflect a preponderant message in our media today? People do reflect what they see on TV and read in the newspapers to a certain extent.

In any event, I am not a Pollyanna. We have certainly had problems, but I just don't believe that this huge disparity that we keep hearing about between rich and poor is real.

The facts are, and I think they are facts that Mr. Viard mentioned, and I would like to maybe have all of you comment on these things. First of all, when you measure these things, how you measure them matters too.

If, for example, the median income universe, if you look at that and you look at that median income universe, approximately one-third of those are very young folks who are just out of college or those who are retired, living on fixed incomes. If somebody has a fixed income, by its very nature, their income is fixed. Everybody else is in a more dynamic situation where they have the opportunity to grow their income.

As we age, as our society ages, you are going to have more and more people on fixed incomes and therefore a wider disparity. I am not an economist, but it seems somewhat logical.

If you take those, that third out, and you talk about who is left in that middle income, that median income group, the income per family goes from $46,000 a year to about $61,000 a year. The median income for married couple households under this scenario is $72,000 per year. Two income married couples' average income is $81,000 a year. Those are not poor folks.

I mean are you all, are three of you convinced that society is becoming the monarchy versus the serfs or are we just talking around the margins or do we still have a dynamic society that allows people with equal opportunity to grow through these income strata?

Anybody care to take a whack at that?

Mr. BERNSTEIN. Well, you have asked a lot of good, provocative questions. There is only one thing you said that I flat-out disagree with which is that somehow the gap between the highest and the

lowest income families is a mirage or what you said was you just don't believe it.

I think the best data that we have on this and I suspect every member on this panel including Alan would agree, in terms of just a snapshot of income at a point in time very comprehensively done is the CBO. You heard from my and Mr. Greenstein's testimony just how large those gaps are now relative to what they used to be, and I believe those are real.

You do make the point that there is mobility, and you are absolutely right.

How much mobility is there? Are we a Nation of serfs and kings? Of course we are not.

The problem is that when you measure this, in my view, correctly—and we probably would have to have a whole seminar to debate what correctly is—you find that there is, I think, less mobility than Alan suggested in his report.

The Treasury report that we have been talking about itself disagrees on this point. Its Table 1 is quite different than its Table 2. I think Table 2 is done correctly, and that controls for a cohort effect.

As cohorts come into a sample and they age, their incomes go up by definition. You have to control for that. When you do, you find out that more than half, 55 percent, of those families who started out in the bottom fifth were in the bottom fifth at the end, 10 years later basically.

Is that a lot? Is that a little mobility? We could argue. Those are adjectives that I don't know bring that much light to the matter. But it suggests there is significant immobility. More than half of those families start there and stay there.

Secondly, and I will be brief, unless the rate of income mobility is increasing, families are facing a much more unequal income distribution over time. Families do get ahead over time, unquestionably, even when you control for age the way you are supposed to, but they are not getting ahead any more quickly.

Therefore, families who are moving from, say, the bottom fifth to the middle fifth have a lot further to go than they used to have. The income gaps between these income classes are much larger and getting across that distance, I think, is a much harder climb particularly when wages are stagnant.

Mr. GREENSTEIN. A couple of points: I don't think there can be disagreement that there are very substantial income gaps between the top, the middle and the bottom. One can disagree as to whether that is a problem, but there are really substantial gaps.

The second, I think we all agree. Alan noted this. We all agree that inequality has widened significantly since the CBO data began being collected in 1979.

Mr. WALSH. Is that a function of the unfairness of society or the changes in age and fixed income levels and that sort?

Is this an inherently unfair system that we have? Is that what you are saying.

Mr. GREENSTEIN. One can make judgments as to whether it is fair or unfair, but this is not primarily an issue of demographics. The population is not a lot older. Now it will become, but it is not a lot older now than it was in 1979.

There have been—there are many studies on this—very large gaps, widening of the gaps between the income and the earnings of very highly paid individuals and those of people in the middle of the income scale.

Just to give you a couple figures, in 1979, the average after tax income of households in the top 1 percent was 23 times the average after tax income of households in the bottom fifth. By 2005, it was a 70 times ratio. Well, that was the highest on record.

You can compare the top 1 percent to the middle fifth. Again, the ratio is much wider now than it was.

Now the key point Jared mentioned is we would all be less concerned about this if the increase in inequality in a given year were paralleled by an increase in mobility across income groups. The best evidence is that there has not been an increase in mobility. Some studies find a decrease; some don't.

This is: Is the glass half full or half empty? Some people move out; others don't.

Of the people that were in the bottom fifth, the Treasury study shows in a given year, 10 years later 71 percent of them were either still in the bottom fifth or the next to the bottom fifth.

Last little fact, last year, OECD issued a study of mobility in 12 advanced industrialized countries including the United States. The United States ranked among the three lowest in the degree of mobility.

You could draw two conclusions from this. One is one may think—probably some of us on the panel do and some don't—one may think that the degree of inequality itself is too large now, but whether you agree with that or not, presumably, we would all agree that we want to increase mobility. We want a larger share of those at the bottom to move up, and I do think that leads to certain kinds of conclusions in various areas such as some of the education and other investments I talked about.

Mr. OBEY. I think we are going to have to move on.

Mr. WALSH. Thank you, Mr. Chairman.

Ms. MCCOLLUM. Thank you, Mr. Chairman.

Gentlemen, although I was going up and down, I can show you the highlighted markings from last night, staying up, reading your testimony. So I am familiar with your testimony, and thank you for providing it ahead of time to the Committee.

I am just going to cut right to the chase here. There are two issues that I would like to talk to you about and how they are affecting our economy and our competitiveness.

The first is education, and it was touched on in some of the testimony about early childhood education. It was the Federal Reserve Bank in Minnesota that was really involved in releasing and following up on the study. So we have taken it to heart in Minnesota with discussions and hearings at a State level.

But having said that, Congress and States and local property taxpayers, because they have felt stressed for a long time, aren't keeping up with the needs of making sure that our schools are ready to be globally competitive. That doesn't mean necessarily having all the bells and the whistles, but it means having enough textbooks with current and accurate information, teachers that are trained in science and technology and know how to teach it in an

interesting and stimulating way, and ways in which our rural communities are fully integrated and hooked up to the Internet.

In reading the testimony, I know it is not a silver bullet, saying, geez, if we just bring everybody up to a certain level of education, everything is fixed here because there are other pressures and squeezes on it.

But as we watch China invest, as we watch the E.U. even change its higher education system, and as we know that our colleges are still where people come to get the very best in higher education from engineering and that, what should we as a Nation be doing from K–12 to higher ed to make sure that we are fully integrating our citizens?

On a very selfish note, unless you have a fairly well educated population, you won't have a vibrant democracy as well. So this also goes to the core of our very being as a Nation.

Then healthcare, the discussions that I hear a lot about healthcare are single payer, universal, all those great things, private sector, public sector. I think one of the key pieces that is missing is what does our healthcare system look like? What does it cover? What is a basic guarantee to an American for what their healthcare will be like?

In my opinion, if we don't have that discussion and we allow all the other discussions to take place, it is going to be all the stakeholders that either have profits or a direct connection as to how the healthcare is delivered that are going to be making the decisions to what the healthcare looks like.

I point out with Association Health Plans, we had votes in the last Congress which would have allowed employers to discriminate from even carrying basic healthcare coverage for women, obstetric and gynecology services.

So healthcare and education, what should our platform look like if we are going to be successful into the future?

Mr. BERNSTEIN. I just want to make a few comments about education. I will leave the healthcare comments to others. This also speaks to some of the issues you raised, Mr. Walsh.

To answer your question that you posed very directly to us, I don't think that you can explain away the kinds of trends we are talking about by citing demographics or aging.

I think there has been an increase in the lack of fairness in the way economic awards are distributed, and one of the places I see it is in education. I think there is an intimate connection between income inequality and access to higher education.

The idea is that as incomes become more unequal and the actual absolute values, as we have noted, of the lower income families grow more slowly in real terms, conversely while those at the high end are growing very quickly in real terms, the barriers to accessing our education system become that much steeper. There is solid research that shows even gifted children who come from lower income classes are having a more and more difficult time accessing our educational system.

So, in that regard, I think we need to look in terms of a solution much more closely at policies that create access to higher education for children regardless of their income levels.

There is an interesting rule that has been applied in various States called the 10 Percent Rule which says if you are performing in the top decile of your high school, you should have automatic entry into your State university. I also think, as others have mentioned, that entry itself isn't enough. These folks, these kids also need remedial help.

But it is an interesting policy because it doesn't say you scored high on the SATs or any standardized test. All it says is you have done well relative to your cohort. Your cohort may be the most disadvantaged cohort in the Country, but you have shown in a relative sense that you can perform.

Those kids ought to have automatic admission into public universities, and they are going to need some help in remediation both in terms of skills and, I think, income.

Mr. GREENSTEIN. If I could just briefly note, I would like to come back again to Mr. Walsh's phrase of equal opportunity. We don't have equal opportunity by income group in access to higher education or to adequate quality preschool education, and I think we need to address both of those.

I think in the higher education area, we have particular problems now in the Federal tax code where subsidies for higher education delivered through the tax code are skewed to middle and higher income students and lower income students don't quality for them because their families don't earn enough to owe income tax.

There is a bill, a bipartisan bill introduced by Congressman Emanuel and Congressman Camp to start to address that, to make some of the education tax credits partially refundable to help more lower income students go to college. I think we ought to take a serious look at that.

I also think we need to look at—I am not an expert in the area but—the kinds of policy improvements and investments we need to make so that we don't have a situation where children from high income families are getting high quality preschool education, which the evidence increasingly indicates is important, while children from lower income, working poor families and lower income working families either have difficulty getting a childcare slot at all or are getting more of a maintenance slot that doesn't have the preschool education components that are important with it.

Mr. VIARD. I will address the education question as well which I think is very important.

It is certainly the responsibility of Government to ensure that everyone receives an adequate elementary and secondary education. I think the preschool also is important. I agree with Bob Greenstein on that and that it is important to give people the basic skills they will need in life and in the workforce.

I also, of course, favor equal opportunity for higher education. There may be more that can be done there.

I do think it is important to realize the tax breaks that we have, of course, are one component of how we help people afford college. Those, of course, don't apply as much at the lower end of the scale, but obviously we also have public universities and a variety of programs on the spending side that are available at the lower income levels.

I think that it is important to provide equal opportunity for higher education, and yet at the same time we have to be realistic about what can and cannot be accomplished by that.

On the one hand, the information we have from the labor market suggests that college graduates and people with higher degrees are being rewarded to a greater extent than in the past, but it is unclear to what extent that is a reward to the education credential per se and to what extent it is a reward for particular skills, cognitive skills and others that are more likely to be possessed by those who have gone to college.

To the extent that it is the latter, simply enabling people to go to college, while a good thing in and of itself, may not yield as many results as we would all like to see in terms of reducing earnings inequality. There, too, I think it is important to ensure that the adequate education is provided at the elementary and secondary levels when many of those skills are developed.

Mr. MEYERSON. Actually, in response to that, let me just say that it is still the case that a clear majority of the American people in the American workforce do not have BAs or BSes after four years of college.

If you look at issues around income stagnation in the United States, I think you want to look as well at the issue of vocational education, skill development and more credentialing for people who don't go to college because the sharpest declines in income, if you look at the American workforce over the last 50 years, are among folks who have high school degrees but no more. It is the work lives of those people that have become less remunerative over the years. Unless you can posit an America in which everyone is going through college, we really need to address those folks in particular.

Mr. OBEY. Thank you.

Mr. Regula.

Mr. REGULA. Thank you, Mr. Chairman.

Along the lines of what you have just said, should we have policies that will encourage the development of two-year institutions that are focused on skills for the marketplace and would that address some of the concerns you have expressed here today?

Mr. MEYERSON. It sure would, and I am always happy to agree with a member of your party because these instances are not always that common, but I think you are absolutely right. I think we have fallen down on specific educational programs for people who are going to be going into those trades and those crafts.

If you look at the project that the Bureau of Labor Statistics comes out with every year as to what are the jobs of the future, what are we going to be creating, it is kind of an alarming high-low list. You can be a cashier at Wal-Mart. You can be a sales clerk or you can be an attorney, but it is the middle stratum that we, I think in many ways, need to concern ourselves more with.

And so, I think, Congressman, you are absolutely right.

Mr. REGULA. Along the same lines, as they develop income statistics, do most of these case studies factor in the value received by people in the lower income in housing grants, food stamps, a whole series of things? Wouldn't that have to be considered part of the totality of an income in making comparisons?

Mr. GREENSTEIN. This is one of the reasons many of us like the Congressional Budget Office data series because they do that, yes.

Mr. REGULA. I know they do that.

I would like to ask you, Mr. Greenstein, and this is a budget question sort of unrelated to this. What do you think of the potential for a two-year budget whereby the second year would be spent in oversight?

It seems to me in my experience here that we don't do enough oversight and, if we could adopt a two-year budget, it would enable administrators to plan more efficiently in the operation of a park or a program of whatever and, in turn, give us an opportunity to do more oversight. I would like your observation on that as a budget expert.

Mr. GREENSTEIN. Well, I think different budget experts have different views on this. I am not a proponent of the two-year budgeting, and I think my view is probably shaped some by my experience in developing budgets for a Federal agency back in the late 1970s.

But what concerns me is if you are in an Executive Branch agency and you are developing a budget, you are delivering your budget to the department, your department heads maybe in July. It goes to OMB in September.

If you think of a two-year budget, the lag between when the basic planning gets done and the year for which the funding would be provided, the gap is so long that my concern is we would end up providing some money for things that are no longer needed, we wouldn't meet other things that emerged, and I fear that the number of supplemental appropriations bills the Congress would have to do would grow so much that I am not sure you would get that much of a benefit in terms of the timing. But my main concern is the timeliness question.

Mr. OBEY. Would the gentleman yield?

Mr. REGULA. Yes, I yield.

Mr. OBEY. I simply think one of the things that gives me considerable disquiet is the fact that I think that because of the difference in rules between the House and the Senate, the Senate would absolutely have a field day if we went to two-year budgets because we would be relying on supplementals all the time and they could throw anything but the kitchen sink into a must-pass supplemental.

Thanks for yielding.

Mr. REGULA. You have discovered that, have you? [Laughter.]

Mr. REGULA. How much time do I have left?

Mr. OBEY. One minute.

Mr. REGULA. Is there any analysis available—well, I guess CBO does this—in which they score all the extra benefits in arriving at the income disparities? I think you are saying that the CBO budget does do that Yes, okay.

I thank you, Mr. Chairman.

Mr. OBEY. Thank you.

Ms. Lee.

Ms. LEE. Thank you, Mr. Chairman. I want to thank our panelists and thank you for this hearing.

Let me say a couple things. First of all, I believe like many believe that budgets really are moral documents and should reflect our values and sense of ethics as a Nation. I am really pleased that we have Hubert Humphrey's quote reminding us of that.

But as I look at this budget, we are out of whack with what I think Hubert Humphrey was trying to convey. I think this budget shows that, first of all, we are wasting our limited resources on a war that did not need to be fought.

So I want to ask, I guess, Mr. Greenstein, if you have made an assessment or an impact as it relates to the war. Has it been a drag on the economy?

We see now unprecedented amounts of money going into our military budget. Yes, we all want and believe and know we must have a strong national defense. But when you look at some of these Cold War era weapon systems, the waste, fraud and abuse that is being funded at taxpayers' expense, and then when you look at this terrible budget that cuts the children, the safety net, our senior citizens programs, you have to wonder what is going on there.

Then the second question I have has to do with the impact of this budget on people of color in our Country and communities of color because when you look at income inequality and when you look at the programs that have been proposed in terms of the cuts, it is shameful what I see is happening.

You have the national unemployment rate according to the Bureau of Labor Statistics, in January, it was about 4.9 percent, but yet in the African American community it is 9.2 percent, twice that. In the Latino community, it is 6.3 percent.

So how do we move forward as we look at income inequality in its total on everyone in our Country and then specifically on communities that are being hit the hardest?

Mr. GREENSTEIN. I don't know that one could say that there is an adverse economic impact at this point in terms of the defense spending, but there has definitely been an impact on the budget if one uses CBO data and looks at the swing from surpluses to deficits.

In other words, you take in 2001, as you will recall, CBO projected surpluses as far as the eye could see, and we have had deficits rather than surpluses. If you look at the years through 2007 and you compare the forecast at the beginning of the decade of a surplus with the deficit that actually occurred, you find that a little under a third of the deterioration fiscally was due to economic and technical factors largely beyond policy-makers' concerns but more than two-thirds of it was due to legislation that was enacted.

Then if you say, okay, what was the cost, where did the money go for that legislation that was responsible for about 70 percent of the budgetary deterioration? About 48 percent of that cost is tax cuts. About 36 percent is security-related spending. Now that would include Iraq and Afghanistan and Pentagon increases and homeland security and the global war on terror.

What particularly strikes me and I should note that I am not an expert on the defense budget, and others who know this better than I, I hope will look into this at depth.

But what strikes me is that under the President's budget, the funding level for defense in 2009 exclusive of Iraq, Afghanistan and

the global war on terror, exclusive of all those things, the non-war on terror part of the defense budget, would be $150 billion or 40 percent in real terms higher than it was in 2001.

The question that I think needs to be asked is: Are we doing enough to scrutinize those parts of the defense budget that are unrelated, regardless of one's view on Iraq and so forth?

Putting that to the side, for the base part of the defense budget that is not related to that, are we giving it the same level of scrutiny that we are giving the domestic side of appropriations? I am not sure we have in recent years, and I think we need to.

Mr. VIARD. I would like to make a few comments on that. I think it is important.

Bob Greenstein mentioned earlier the fact that non-defense discretionary spending had been falling and over a long time period. It depends on the time period you look at, but it is right that if you look at 1980, we were spending 5.2 percent of GDP on non-defense discretionary and that is down to 3.7 percent as of last year.

But I think it is interesting to note that defense spending has fallen as a share of GDP over exactly that same time period despite the fact that we are at war in Iraq and Afghanistan today when there was no similar war in 1980.

We were spending 4.9 percent of GDP on defense at that point, and we are now down to 4 percent of GDP even with the spending in Iraq and Afghanistan. This is last year's number, so it includes all of the money that was spent in Iraq and Afghanistan, whether it was in the supplemental appropriation or in the regular appropriation.

I think, more generally, neither type of discretionary spending is the key to the long term budget trends that we face. Bob and I are in complete agreement on that.

But I do think it is important to realize, of course, every dollar spent on defense, every dollar spent on anything else is always an opportunity cost. That dollar is not available for other purposes that it could be used for, and every dollar needs to be scrutinized. But we actually have seen a downward trend in defense spending.

Mr. BERNSTEIN. Can I make a quick comment on that?

Mr. OBEY. Just very briefly.

Mr. BERNSTEIN. Very brief, it picks up on something Alan just said. Basic economics reminds us that the opportunity cost of the conflict is not simply the hundreds of billions that we have sacrificed so far.

We also have to consider the cost of foregoing the productive investments we might have made otherwise with those dollars. In my testimony, I outline a fairly detailed set of infrastructure investments, human capital investments that I believe would have strong offsetting effects to income inequality.

So it is not simply the economic cost of war. It is the opportunity cost of not engaging in what I think are more productive investments.

Mr. OBEY. Mr. Rehberg.

Mr. REHBERG. Thank you, Mr. Chairman.

Mr. Greenstein, I would like to go back. I apologize for coming in and out, and I heard part of your testimony. I have looked through your testimony.

I am trying to make a determination. Have you stated a percentage of gross domestic product that you think that discretionary spending ought to achieve?

Mr. GREENSTEIN. No, I hadn't in the testimony.

Do I have a specific? I have not really done that. I could come up probably with some various areas that I would be happy to reduce funding on, but the changes regardless of which party was in control of actually getting them through would be near zero.

So the level one need would depend in part on what one could do in some of those areas, but in particular what I don't think I would like to see is a further continuing decline in the percentage of GDP that goes to domestic discretionary programs. I think they are now a little over 3 percent of GDP.

Mr. REHBERG. Philosophically, would you believe that as GDP increases it ought to be a percentage of that increase like an inflationary increase similar to what we do with most of the budgets or is that going too far?

Mr. GREENSTEIN. If I thought we were adequately meeting current needs in domestic discretionary, then I would recommend that they stay even with inflation and population growth which would be smaller than staying, lower than staying constant as a share of GDP.

Mr. REHBERG. Objectively, how would you, under this theory then, ever in your mind determine that we are spending enough money?

I would assume under your philosophy we are never spending enough.

Mr. GREENSTEIN. I wouldn't say never. I think there are particular areas—I have talked about some of them here today—that I think we are under-funding. I think one has to make some hard choices.

At a minimum, I would keep domestic discretionary constant as a share of GDP until we do a better job of meeting some of these key needs. Ideally, I would probably go up a little bit.

But I do want to agree with Alan here and then bring it back into this context. If at some point we are able to make tough choices that involve, first and foremost, system-wide healthcare reform, this isn't just Medicare and Medicaid, system-wide reform that slows the rate of growth in healthcare costs, we make decisions that close the long term social security shortfall and—you and I would probably not agree on this—I think we are going to have to raise more revenues. I don't think you can do it all on the spending side.

If we make the tough choices elsewhere, there would be room in the budget to do somewhat more. Is it one percentage more? I am not talking about a lot more as a share of GDP on the discretionary side. But the big decisions are the ones that have to be made on healthcare revenues and, to a lesser degree, Social Security.

Mr. REHBERG. The problem with the hearing today—and I know that you had probably been given very specific not necessarily talking points but ideas to present to the Committee—is your brief discussion of mandatory or entitlement spending and how that is in fact going to be the big elephant in the room.

I guess, philosophically then, would you agree that we should tie discretionary and non-discretionary Health and Human Services funding together as a percent of GDP, which according to my calculations is somewhere around 20 percent as opposed to the 3.7 percent number I have been hearing thrown around?

Mr. GREENSTEIN. To get to 20 percent, you would have to be including mandatory spending.

Mr. REHBERG. That is what I am, yes, which you can't ignore. You can ignore for this hearing because probably your charge was to discuss that, but we can't ignore that any more than I would certainly.

Mr. OBEY. Would the gentleman yield on that?

Mr. REHBERG. Yes, sir.

Mr. OBEY. Nobody has any instructions to ignore or include anything. We simply took note of the fact that we have no jurisdiction over mandatorys, and so while we may have opinions about it the operational question is what we do on the discretionary portion of the budget.

Mr. REHBERG. And I didn't mean to suggest that the Chairman was doing that. It was the topic of the hearing is discretionary spending but if we are going to bring in defense spending and inefficiencies, which I happen to agree probably with the Chairman and the speakers that I think that defense and homeland security ought to be on the table as well for the waste, fraud and abuse. So we tend to agree on that.

But if we are going to have a meaningful discussion about GDP and discretionary spending and percentages, while esoterically it is kind of fun to talk from an economic standpoint, but it is not very practical because it takes the human aspect of the Appropriations Committee out when we make a determination.

I don't like it any better when members of my party say, well, we need to set defense spending at 4 percent of GDP and that is what our spending is going to be. I don't find that to be any more relevant to human needs and how we are going to spend our Federal dollars.

Let me ask for a point of discussion of the four gentlemen if I still have the time.

Mr. OBEY. Thirty seconds.

Mr. REHBERG. Then I will wait for another round

Mr. OBEY. Go ahead and ask. You have 30 seconds.

Mr. REHBERG. No. It will take too long. I don't mind if you go ahead. I don't mind waiting.

Mr. OBEY. Mr. Kennedy.

Mr. KENNEDY. Thank you, Mr. Chairman.

Could you all comment on the real impact of what you see the sub-prime lending crisis having on the economy and in the ongoing years and the underestimation of that in terms of Wall Street even today?

Even after the impact that we already know it has had, how much do you think it still has been underestimated and to what extent regulatory-wise in Government the processes in terms of transfer of wealth?

We talk a lot about taxes and regulation and what it does to stimulate growth. Can you put in the context of the last several

years about how people's primary wealth is in their home and yet for the middle class their home values are now, because of this crisis of the fall of real estate, really stagnant and because of this regulatory relaxation that allowed people to speculate so freely and widely that we now have the very wealthy be able to have such a windfall, and yet the middle class are struggling to keep their heads above water, if you could?

Mr. MEYERSON. Let me address that in a couple of ways, Congressman.

I think a lot of what is behind the sub-prime housing crisis gets us back to one of the larger topics, not that that isn't a huge topic but one of the larger topics of the day which is the relative falling behind and relative stagnation of median American incomes.

Jared, help me out here. You said that since around 1980 the middle quintile's income had increased, what was it, 26 percent? Was that the figure?

Mr. BERNSTEIN. Yes.

Mr. MEYERSON. Well, let's compare that to the relative increase in housing costs or medical care or college since 1980 which is way higher than 26 percent.

There was actually an op-ed column Monday in the Washington Post, and I will merely say one should not believe everything one reads on the op-ed page of the Washington Post, speaking as a Washington Post op-ed writer, by Michael Hill who is not a columnist but a house builder executive. He is a home builder.

It pointed out that 40 years ago the median price of a house in the United States was about twice the median household annual income. Twenty years ago, it was about three times higher. In the past 10 years, it is about 4 times higher. In most metropolitan areas, the gap is a lot wider than that.

And so, in a broad sense, Americans have been keeping up by going into greater debt and, obviously, we have seen in the case of many Americans by taking out mortgages which really weren't all that great an idea to begin with.

So I think when we talk, as we have earlier today, about median incomes of Americans and whether they are rising in compared to what. They are not rising compared to some of the fundamental costs that Americans need to spend on housing, medicine, higher ed, et cetera.

Then on the regulatory front, I think it is really clear across the board that Wall Street as a metaphor and as a reality has created all kinds of financial which, as we found out over the last six months, they themselves don't understand the full implications of at times, that have created pockets of risk that have gone largely undetected.

From my point of view, and I am sure our economists witnesses can get into this in greater detail, but from my point of view, we clearly need a financial system that is more transparent to borrowers, to lenders, to some of the banks that created them in order to reestablish a confidence in our financial system, which confidence, by the way, is not shared by many members of the financial system because that has been the whole point of pumping liquidity into our banks. Our banks, nobody knows what's on any-

body else's balance sheets these days, and they have some questions as to what is on their own balance sheets.

Mr. KENNEDY. Right, right.

Mr. MEYERSON. That is a pretty dangerous situation.

Mr. KENNEDY. Can I ask?

Mr. OBEY. If you can take 20 seconds because the gentleman's time is expired.

Mr. KENNEDY. If I could, the mechanisms that you were talking about, Dr. Bernstein, about helping to grow the middle class. We have the tax system that is all designed to help those with wealth save, but it is not designed to help those who need to save, save, because they don't have any wealth to save. So can you comment on the mechanisms to help do that?

The British have the baby bond program where when you are born, the Government allows you to have a $500 setaside and then it is matched on a sliding scale much like the reverse earned income tax credit. Then it is rolled into, basically, a 401(k). When you are 18, you can turn that over for a college education or for a savings account for healthcare and the like.

Do you think those kinds of programs that are designed and an automatic checkoff so that you don't have voluntary checkoff? Could you comment on that?

Mr. OBEY. Could I ask you to be very, very brief because the gentleman's time is expired?

Mr. BERNSTEIN. Okay, I will try to be very, very brief.

The automatic checkoff is an excellent idea. That would be a simple change that would help increase precisely those kinds of savings.

The idea of some sort of a demi-grant or a bond for middle class or low income people or in the case of a demi-grant for everyone, it has been discussed and perhaps could be helpful too.

But I think the biggest challenge facing middle income families trying to save is the fact that the market basket of goods that they want to and aspire to consume, what we might sort of think of as the American dream package of the middle class, the idea that you could buy a reliable, decent home in a safe neighborhood and have an income from the labor market that enables you to pay for that package while saving for college tuition and paying for healthcare.

That is where the problem is and that is where I think middle income families have been dis-saving and borrowing and becoming excessively leveraged and now are facing the costs they are in and going through a period of probably great de-leveraging. Probably we will see less savings as folks try to pay down their debt.

Mr. OBEY. Thank you.

Next is Dr. Weldon, but let me simply say I am somewhat concerned about his medical abilities because there are two people on this Subcommittee who seem to have a bug, a retirement bug with Dr. Weldon and Mr. Peterson and Mr. Regula, three. My God, four in a row. What did we do?

Mr. PETERSON. We are moving up. [Laughter.]

Mr. PETERSON. We don't want to be stuck with him.

Mr. OBEY. I would think that the good doctor could find a way to stop this epidemic. I don't know what is going on here.

Mr. WELDON. Yes, I think one of the things that could quell the epidemic is if, well, I don't want to go there.

Mr. PETERSON. We are not going to buy.

Mr. WELDON. Let me just thank the Chairman for this hearing. I wish I had been able to stay for all of it. I think this is a very interesting topic, and certainly you have a very interesting panel here.

I would have stayed and listened to everybody, but it seems that ever since I announced my retirement I am busier than I ever was. Hopefully, that will begin to slow down.

The question I had I was going to direct it to Dr. Viard. You go and stay at a hotel. Over the last 10 years, it is common for people to say were it not for all the illegal aliens working at this hotel the room rate would be higher, and you hear people say that at restaurants. Certainly on a construction site, construction costs would be higher.

One of the most dramatic examples of this phenomenon of illegal immigration depressing wages in the lowest strata of our workforce I saw in a news report of a Swift's meat packing plant. I think it was somewhere in the Carolinas. Immigration came in and discovered about 80 percent of the employees there were not legal and shut the plant down.

The interesting part of the story is they reopened two weeks later, fully staffed up, suggesting that these claims that illegal aliens are doing what Americans don't want to do is not really true. But, lo and behold, they have to offer higher wages for the workers that were there.

Interestingly, I think a very high percentage of them were African Americans, suggesting that this illegal immigration issue is most acutely affecting, at least in some areas, the African American community in terms of their jobs and their wages.

Now I know this is a complicated issue because I guess people in the second and third and fourth quintile are able to stay in hotels at a lower cost and do an expansion on their property at a lower cost, but I don't think this has been commented on, the impact that illegal immigration has.

I knew Mr. Meyerson was commenting, and I caught a little of your concerns about this gap and how much of this ever widening gap in wages is illegal immigration playing a role in this. If we do more as a government to try to stem this, is that going to have a positive effect on the people that I think we are most concerned about in this hearing, the people who are struggling to make ends meet and afford benefits and things like that?

Mr. VIARD. Well, this is certainly an important issue. I am not an expert on immigration, but I can try to summarize what I understand from the literature that has looked at the economic effects of illegal immigration.

I think that you are right, Mr. Congressman, to pinpoint the impact at the lower wage levels because the evidence that economists have gathered demonstrates, I think, that illegal immigration has not had a depressing effect on wages throughout the income distribution but that there probably is some depressing effect at the bottom of the income distribution.

Economists expect that if there is an increase in the supply of labor, whether it is from illegal immigration, legal immigration, more people in the United States deciding to work, anything, that it will tend to depress the wages of those who are the closest substitutes for those workers but that there are economic gains for other people in the economy who could take advantage of those services more cheaply.

Some illegal immigrants probably are performing work that would not be done by Americans, and so in some cases there may not be a depressing impact on anyone's wages. But, in other cases, I think there is no doubt that wages in certain occupations and some of the ones you mentioned, Mr. Congressman, are depressed to some extent by the presence of illegal immigrants.

Obviously, that having been said, it remains an open question exactly what policy should or should not be adopted to address the situation of illegal immigration.

Mr. MEYERSON. If I could just add to that for one moment, you are absolutely right that there are particularly small sectors and maybe not so small sectors of the American economy where this kind of replacement has gone on, but in some of them what determines wage level actually is rate of unionization.

If you look at what determines, since you used the example of hotels, wage levels in hotels, there are, and I can assure you this is maybe the one area of economics where I may actually have more data than the three distinguished economists on my left. Hotel contracts essentially vary from city to city. What the person who makes the bed in your room makes depends really on the percentage of hotels that are unionized.

There are hotel locals in the United States, hotel workforces in the United States that are very, very heavily immigrant and, in some cases, I bet you fairly highly undocumented immigrants, people who are not here with documentation, where there may be a relatively decent level of wage anyway simply because of the rate of unionization in that particular city.

Mr. OBEY. The gentleman's time is expired.

Mr. WELDON. Thank you, Mr. Chairman. I thank the witnesses.

Mr. OBEY. Mr. Simpson.

Mr. SIMPSON. Thanks, Mr. Chairman. Before you start timing me, I want you to know that today it speaks of the two-year budget, Mr. Chairman.

Mr. Chairman, Mr. Domenici says today we are going to go to a two-year budget cycle. I want you to know. He says that this year could be different since more members are complaining about the increasing difficulty in pushing annual spending bills through both chambers.

Mr. OBEY. I would be more interested in Mr. Domenici's opinion in the appropriations process if, with his long experience on the Budget Committee, he had been able to get a budget resolution through in two of the last three years.

Mr. SIMPSON. I agree with you on that.

Anyway, I appreciate the comments here today in this hearing, and I agree with the comments that have been made about education and the focus that has been placed on education and the barrier that has to mobility and so forth.

I don't think we have done an adequate job in education in this Country over the last 20 years. We need to do a much better job, and we fail to invest in that at our own peril, quite frankly. That is for all people. There are different ways of doing that, whether it is two-year schools, whether it is community colleges, whether it is vocational education and other types of things that need to be done.

One thing I have always been interested in is we always seem to measure an education system by how many people go to college. I don't know that everybody has to go to college, but we do have to be trained for our next job.

The average, what is it? The average high school graduate today is going to be retrained for a completely new job seven times in his lifetime. If we don't have the training available for that, they are not going to have the ability to move within this mobility scale that we are talking about. They won't have the mobility to be able to move from one quintile to another, to enrich themselves.

What other factors are there that contribute to the loss of being able to move? Certainly, education is an important one, but are there other factors?

Mr. BERNSTEIN. Yes, there are a set of factors that, and each one of them explains a small part of the change. Economic research has not found a silver bullet that explains 51 percent.

But the other factors have to do with the loss of higher paying jobs for non-college-educated workers particularly in the manufacturing sector. That has contributed probably 15 to 20 percent of the increase in wage inequality.

Mr. SIMPSON. Have those been replaced with high tech jobs?

Mr. BERNSTEIN. To the extent that those have been replaced with high tech jobs, those haven't gone to the non-college-educated workers who have been displaced from manufacturing. In that sense, technology itself is implicated in higher levels of inequality. I am not saying it is a bad thing. In fact, if anything, it speaks to your point that we need to train workers for the types of jobs we are creating.

But it is important to recognize something that was mentioned earlier, that the quality of jobs that we are creating is high at the top and pretty low at the middle and the bottom. If you actually look at the types of jobs that we are projected to create over the next decade or so, you will see home health aides. You will see security.

These are of the 10 occupations adding the most jobs over the next 10 years. About six or seven are demonstrably low skill jobs. They are home health aides. They are security guards. They are cashiers, folks in retail. It is the quality of those jobs that is hurting.

When a worker is displaced from a high value-added, unionized manufacturing job and ends up in the lower end of the service sector, they take a big hit and that is part of the inequality problem.

Mr. SIMPSON. Then if you talk about inequality in incomes, you assume that income is related to productivity somehow. You assume that there is some relationship.

Mr. BERNSTEIN. Not as much as we should.

Mr. SIMPSON. Is there a productivity disparity that is growing within the Country?

Mr. BERNSTEIN. A huge disparity, it is a real focus of my written testimony. I have a table in there that shows for about 25 years the median income—you could look at the wage of the typical worker as well—was rising in step with productivity. They both grew at around close to 3 percent per year. They doubled between the mid-1940s and the mid-1970s.

Since then, productivity has accelerated. By the way, over the last 10 years, it has accelerated again. Yet, the typical earnings and the median family income have been flat.

Since 2000, productivity is up 19 percent. That is a real success story about the American economy. But the median wage is flat, and the median family income is flat, and the income of working age families is down about 4 percent. So there is a big productivity gap, and it is one of the reasons why inequality is so problematic right now.

Mr. SIMPSON. You know this goes back to one of the other things that Harold mentioned. You said in your testimony that Americans now believe their children will have a tougher time than they had. I hear that all the time, and I think that is probably true.

But I think there is another factor that contributes to that. One is that 30 or 40 years ago when my parents were in the workforce and so forth, jobs existed such that you graduated from high school and you went to work at a factory and you could pretty much be assured you were going to retire from that factory if you wanted to.

Those jobs aren't there anymore, and we are animals that like security. We like to know the sun is going to come up tomorrow like it did today. Those types of jobs aren't there anymore.

I think there is a great deal of insecurity in the world where people are going to have to be retrained for completely new jobs. Seven times in their lifetime is what I hear, and that creates uncertainty that is going to put enormous strains on all of our institutions. Governmental, religious, social institutions are going to be strained by this, I think.

Mr. MEYERSON. And, it is also a regional concern. When there is a dominant manufacturing industry in a particular place such as the State of Michigan, it doesn't follow that the new jobs for which people need to be retrained are going to be popping up in the State of Michigan.

So, in addition to the economic instability, there is really a kind of the economy moves out on you. It moves out on you sometimes geographically as well as in your budget, and that is a big problem as well.

Mr. SIMPSON. That is what trade does, quite frankly. We may get more jobs from trade, but they are not going to be jobs that we lost to trade. They are going to be in other areas.

Mr. BERNSTEIN. Well, that is why many of us argue that it would be very useful to take the benefits from our expanded trading regime from globalization and plow them into improving the quality of precisely the types of jobs we are creating. These jobs lack pension coverage. They lack health coverage. They often lack the kind of career training you are suggesting.

I have suggested in my arguments for offsetting these inequality trends, investing in precisely those areas of these jobs.

Mr. KENNEDY [presiding]. Mr. Peterson.

Mr. PETERSON. Thank you very much.

I am going to try to be brief here, but I wanted to lay out my thought processes.

I have been in government 39 years: 8 at the local, 19 at the State and my 12th year here. When I first got in government, it was an urban-driven government at the State level, but the urban areas were declining. The wealth was starting to move out. The successful wanted to live in the suburbs.

As I have been in government, we have had another shift. The merging of banks, the merging of corporations, the merging of utilities have moved the wealth to the suburbs and taken it out of the rural.

So opportunity in the rural continues to decline. Farming is on the decline. Rural was sort of a fertile bed for reasonably priced manufacturing, lots of manufacturing plants out there.

So I see us developing two different economies in America, and the rural economy doesn't really have any swing. They don't have much to say. At the same time, we have the globalization of the economy, and that is over. That has happened.

Now, in the beginning, we were trading pretty well. We had more winners than losers. Now I think we have more losers than winners, and you sort of all stated that.

But, currently, what is driving the jobs out of this Country is the inability of American manufacturing, processing, whatever they are doing. In a global economy, energy costs are number one. We have the highest energy costs in the world.

This Congress isn't going to deal with that. We have ignored it. It never was a problem until the last eight years, but I can guarantee you this Congress is not going to deal with available, affordable energy for America, so that cost driver.

We are putting $181 billion into the economy that energy took out. That is why Americans don't have money to spend. To heat your home, to drive your car takes a bigger part of your income, so you don't have any money to spend. I was a retailer all my life, so I understand people spending money.

So we are going to give $181 billion to Americans so they can spend it, and that will help, but it won't solve any problems because if we don't deal with the cost factor.

This Country has always been the big dog. For the first time in the history of this Country, we are not the only big dog anymore. We are just one of the dogs, and we are going to have a lot of countries nipping at our heels. I mean there are developing nations everywhere, not just China, India, South America, Malaysia. Developing countries are going to compete with us.

If we don't have a competitive model for people to process, manufacture and do things, we won't have jobs for working people. That is my view. We have to learn to compete in the world marketplace we are in.

I would like you to respond to that. Do you agree with that or disagree with that?

Mr. BERNSTEIN. I agree with a lot of what you said.

I guess you probably know better than I. I am maybe less skeptical than you in that this body won't address the energy challenges we face, but you are sitting there and I am sitting here. That is discouraging to hear because it is obviously a critical point.

I think that the issue of America's competitiveness, bringing it down to the level that we are talking about today because you are raising many big global issues, should be discussed in the current context in the following way: We are facing a downturn, and I agree with you that a stimulus package that is appropriately crafted can and should help. The package that we discussed, by pumping a percent or so of GDP in the economy will help, but it won't solve the fundamental problems.

Now one of the problems that we have, that I articulate in great detail, in some detail in my written testimony, basing it off the work of economists who have looked into this quite carefully, is that in order for our Nation to compete there are investments that the private sector won't make, public sector investments in infrastructure that really do make a big difference in the Nation's productivity.

This has to do with our infrastructure in transportation, roads, bridges, water, sewage systems, ideas that his Committee has talked about and are fundamental.

Mr. PETERSON. Because we don't fund those.

Mr. BERNSTEIN. No, no, but I know that the Chairman has raised interest in these issues.

I am speaking broadly. For the Congress to investigate the productivity-enhancing effects of a new program that invests in productive infrastructure of the type that I have discussed, I think would help a great deal in offsetting the letter D grade that the American Society of Civil Engineers has given this infrastructure.

We have the capacity to compete globally, but that capacity is diminished if our own public infrastructure is in deficit, and so I would argue that that is part of the answer as well as the human capital investments that we have spoken of here. I think we all agree that the quality of our workforce is a critical component to solving the problems you raise.

Mr. PETERSON. Your question of the energy issue——

Mr. OBEY. [presiding.] Your time was expired.

Mr. PETERSON. Whew, that was quick.

Mr. KENNEDY. I would like to give you a little bit more, but we really have to stick to the clock.

Mr. PETERSON. Oh, I didn't realize. I will be real quick.

On the energy issue, less than two decades ago, we were self-sufficient. We are now 66 percent dependent on foreign oil, and that is increasing 2 percent a year every year I have been there. There is nothing on the horizon being considered by this body or the Senate that is going to change that.

Renewables are wonderful. I am for them all, but their growth is minuscule. Until we have real energy to bring prices down, until the renewables play a bigger role, we are turning our back on them.

The one last issue I wanted to share with you is the other thing that I have seen.

Mr. OBEY. I am going to have to ask you to take 20 seconds because we have to get to vote, and I haven't had any questions yet.

Mr. PETERSON. Oh, I am sorry.

Technical training, it was mentioned by Mr. Regula. We exceed in academic training that trains the people who run the companies. They are running companies that are doing business all over the world. But to train workers in this America, I think we fail abysmally, and my State is even worse than the Country, Pennsylvania. We don't even have a community college system available to most Pennsylvanians.

Mr. BERNSTEIN. Agreed.

Mr. OBEY. I am sorry we have to bring this to a close. I am told we are probably going to have, what—four or five votes—four votes, which means if we do that we would keep you waiting here until 1:30. I don't want to do that. So I am going to forego my questions and simply thank all four of you for appearing.

We can debate what the extent of the gap is but, Mr. Bernstein, you said that we had seen about $400 billion transferred up the income scale from the bottom 90 percent to the top 10 percent over what period of time?

Mr. BERNSTEIN. It is only over 2003 to 2005.

Mr. OBEY. I would like to have that race car if I could.

It just seems to me that also, Mr. Viard, that when I look at your chart on Figure 1, it certainly does show that the lowest, the second lowest and middle quintile have edged up somewhat in terms of income gain. But if you complete the picture with the top brackets, that line goes off the graph. The top 1 percent at 228 percent as opposed to less than 1 percent a year for the middle.

The only reason I emphasize that is to make the point that we will be making decisions on appropriations that will, in very modest degrees, impact the families who are experiencing this very, very, very slow growth in their own incomes. It would be kind of nice if we focused our efforts on those elements of the bill before us that actually focus on folks who need the help the most.

Thanks very much for coming. I appreciate it.

THURSDAY, FEBRUARY 14, 2008.

OPPORTUNITIES LOST AND COSTS TO SOCIETY: THE SOCIAL AND ECONOMIC BURDEN OF DISEASE, INJURIES, AND DISABILITY

WITNESSES

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Mr. OBEY. Well, good morning, or good afternoon, or whatever it is. Let me apologize ahead of time. We have a mini-filibuster going on on the Floor, one that is so tasteless that they even called a roll call in the middle of a memorial service for Congressman Lantos. Outside of that, the House has covered itself with grace today.

But let me simply explain why we are here. Yesterday we had a hearing in which we discussed the economic context in which the choices that this Subcommittee makes on the various programs under our jurisdiction will be made, and we talked about who is getting what in the economy and we talked primarily, I guess, about the gap between the most well-off and others in our society. Today we are going to be focusing on health care.

It has been my experience through the years that whenever we discuss Federal budgets, whenever we discuss appropriations, that people are very good at describing the cost of doing something, but they are not very good at describing the cost of doing nothing. Virtually every program with which we deal in this Subcommittee has a purpose. The purpose is to attack some problem.

For instance, if we spend $43,000,000 on Lou Gehrig's Disease research around the Country, even though we do not specifically appropriate disease by disease, but if the effect of what happens is we spend about $43,000,000 on Lou Gehrig's Disease, that is a visible number to everybody. But we do not get a chance to compare it to the cost to this society of that disease itself, of the hospitalization cost, the lost income cost, all the other costs, not to mention the human cost.

So today I would simply like to have our witnesses describe essentially what the costs are of problems that we are trying to at-

tack through the health care budget, at least the portion of the health care budget that is appropriated and comes through this Subcommittee. So we have three witnesses who will present testimony on trends and health status of the U.S. population, the economic costs created by those trends, the health benefits and economic value of Federal investments in research and public health measures to help counter those trends.

Our first witness is Dr. Kenneth Thorpe, Professor at the Rollins School of Public Health at Emory. He is Executive Director of the Partnership to Fight Chronic Disease. He has written broadly on health care financing and chronic disease issues. Dr. Thorpe previously served as the Deputy Secretary for Health Policy at HHS.

Our second witness is Dr. James Weinstein, Chairman of the Department of Orthopaedic Surgery at Dartmouth-Hitchcock Medical Center and Director of the Institute for Health Policy and Clinical Practice. In addition to being a spine surgeon, Dr. Weinstein is also a highly regarded researcher and leader in comparative medical studies.

My staff says that I should try to gavel down any witness who tries to get some free medical advice from you today.

Our third witness is Dr. J. Paul Leigh, Professor of Health Economics at the University of California, Davis, Medical School. I want to take particular notice of the fact that he received a PhD in economics from a little known university called Wisconsin. He is primary author of over 140 science papers, as well as two books, including "Costs of Occupational Injuries and Illnesses," and will address the issue of cost to society of workplace injuries and illnesses.

Before I call on the witnesses, let me simply call on Mr. Walsh to make whatever comments he has.

Mr. WALSH. Thank you, Mr. Chairman.

Mr. OBEY. And then we will see how much we can get done before the bells ring.

Mr. WALSH. Thank you, Mr. Chairman.

I would like to welcome our witnesses also. Thank you for coming today. I know you are all busy. This will be helpful to us.

I said yesterday, at our hearing about the economy, that I believe that not only is it critical to our economic well-being to safeguard the health of Americans, but also it is the right thing to do. I know there are philosophical differences with respect to the details on this issue, at least with respect to health insurance. I hope, however, that there is widespread agreement on the need to prevent disease.

I firmly believe in the adage that an ounce of prevention is worth a pound of cure; that it is critical to extend productive years as long as possible. To the extent we cannot prevent disease, we must continue to find new treatments. I think a large part of successful prevention programs relies on personal responsibility, making smart choices throughout one's life. Clearly, the medical community and government can and do play a role in making sure that people have the information they need to make those smart choices. But, at the end of the day, choosing behaviors that reduce the burden of disease is up to the individual.

Of course, there are diseases that cannot be prevented, or circumstances where sickness will occur despite a healthy lifestyle. In these cases, clearly, we must rely on modern medicine and the incredible advances we have made through research conducted in the private sector, as well as supported by the government. I would like to get into that a little more in my questions, particularly as it relates to translating basic research into therapies that are widely unavailable.

Unfortunately, I am going to have to step out briefly due to a commitment. I am going to address a conference on autism in the Canon Building, and I will be right back, if the votes do not intervene. Otherwise, I will be back right after the votes.

Thank you all.

Mr. OBEY. All right.

Thank you, gentlemen. Why do not you each go ahead for about 10 minutes or so, summarize your remarks. We will put the full text of you remarks in the record. Why do not we begin with you, Dr. Thorpe?

Mr. THORPE. Thank you, Mr. Chairman, Mr. Walsh, members of the Subcommittee. Thanks for the opportunity to testify today on the economic and social consequences of what I believe are under-investments in public health programs, particularly those targeting chronic disease.

Among the many serious challenges our Nation faces, few have more grave long-term consequences than under-investment in population-based prevention and clinical management, including research and evaluation into the effectiveness of health care, largely because the programs—as the Chair just mentioned—that you deal with in this Committee have broader implications for the health care system than just the CDC or AHRQ or some of the other organizations and agencies that you look at; they directly affect rates of morbidity, mortality, productivity in the United States economy, and overall health care spending.

I wanted to make just a couple of key points along those lines. First is that we know that chronic illnesses account for most of the mortality in this Country. Nearly 70 percent of deaths are linked directly to chronic illness. Two, we know we have an obesity issue. Over the last 25 years, the rate of obesity has doubled in this Country. Now, over 34 percent of adults are clinically obese, and we know that obesity is directly linked with a variety of chronic health care conditions.

Chronic diseases overall account for nearly 75 percent of what we spend on health care, so virtually the entire book of business in the health care system is linked in one way or another to patients that have one or more chronic health care conditions. I think, most importantly, if you look at the Medicare program, over 95 percent of spending in Medicare is linked to chronically ill patients. They own that population. The same is true with Medicaid, that has a very high share of its overall spending linked to chronic disease.

If you look at the growth in spending, about two-thirds of the growth in spending in the United States over the last 20 years is linked to rising rates of treated prevalence of disease, largely chronic illnesses.

Another statistic that I think is important as well, I mentioned that the rate of obesity in this Country had doubled since 1985. That doubling of obesity by itself accounts for nearly 30 percent of the growth in health care spending, both due to a rise in the incidence of disease, like diabetes, but also due to the fact that we are more intensively treating obese patients and obese adults today, something that we probably need to look at a little bit more clearly in terms of are they cost-effective in terms of the interventions.

Chronic disease and its impact on health care goes beyond just medical care costs; it has an impact on productivity as well. Studies done by the Milken Institute out in California have shown that for every dollar we spend on the medical side linked to chronic illness, that we spend another $3.50 in lost productivity to our American companies. So we can see this overarching issue of chronic disease and obesity has a major impact on spending trends, the affordability of health care in the Medicare program and in the private insurance programs in this Country.

The data also shows that we are spending, obviously, a lot of money, but we are not really spending it very wisely. We have a sick care illness still in this Country, not really a health care system. A health care system would do a better job of integrating prevention, self-management, workplace health promotion programs, along with more traditional health insurance in ways that we do not very effectively do today.

The good news is that there is a lot of room for improvement. We know from data the Centers for Disease Control and Prevention have pulled together that about 80 percent of heart disease, strokes, diabetes, and about 40 percent of incident cases of cancer are potentially preventable if we just did three simple things—some of them are not easy to do: stop smoking, have a better diet, and get in shape. And, as I will talk in a minute, it basically does come down to individual responsibility, but we have a whole host of settings and programs that I think could be effective in working with patients and individuals—in the community, in the schools, in the workplace—that would help facilitate moving in this direction of stopping smoking and getting in better health.

But to make these changes—and I think this is the point probably most germane to your consideration—is that we need to know what works and what does not. The best health and health policy decisions I think are based on data and scientific evidence. Health services research, the field that I work in, provides the data and evidence needed to make decisions and develop policies that optimize health care financing, the access to the delivery system and health care outcomes. I think it provides practitioners and policymakers the tools and information to make health care in this Country more affordable, more efficient, safer, more effective, more equitable, more accessible, and more patient-centered.

I think the Federal Government needs to be a leader in this endeavor. That does not mean they do it by themselves; the private sector makes a substantial investment through their own research in trying to figure these problems out. But if you take a quick look at recent year budgets, I think it shows that we clearly are underinvesting in some of these public health and health services research activities. If you go back a couple of years ago, 2006, and

look at what was spent through the CDC on chronic disease prevention and control, they spent $6.27 for each one of the 133,000,000 Americans that have one or more chronic health care conditions. That same group of individuals spent an average of over $13,000 a year in health care costs. As I mentioned earlier in the testimony, collectively, this group of chronically ill patients accounts for 75 percent——

Mr. OBEY. Would you state those numbers again?

Mr. THORPE. Sure. If you look at the——

Mr. OBEY. Half the time, people do not hear them the first time.

Mr. THORPE. There are a lot of numbers, so sorry for the cornucopia of numbers here.

CDC's spending on chronic disease prevention and control, they spent $6.27 for each of the 133,000,000 Americans that have one or more chronic health care conditions. And if you look at that same group of individuals, their average health care spending was over $13,000 a year.

To look at it another way, we have been pulling together data with our professional organization, Academy Health, to try to figure out just what do we spend overall on health services research—not just at the CDC, but AHRQ and other places, NIH, and places that support health services research at the Federal Government level—and our best estimate is we spend about $1,500,000,000 a year on these types of investments in health services research to try to figure out ways to do a better job of managing chronic disease, preventing the rise in obesity, the real drivers of what is going on in our health care system.

To put it in another perspective, if you look at what Booz Allen Hamilton, every year they have an annual report on investment by the top 1,000 firms globally, and what they found was that private sector health care research and development was nearly $100,000,000,000 in 2006, about 65 times as much as we spend federally on funding health services research in the United States.

I think it is probably safe to say that virtually all of us are affected by common chronic diseases. I usually go into an audience and ask how many people they know or do they themselves personally have high blood pressure, diabetes, heart problems, co-morbid depression, elevated cholesterol, back problems, pulmonary disease. You can go down the list. It affects virtually everybody in the room; they either have it themselves or they know somebody that has it.

My sense and my hope is that, as you look at this portfolio of spending initiatives, that we need better information on how to prevent the rise in chronic disease; how to prevent this persistent rise in obesity in the United States, ranging all the way from kids to adults; and how can we get better value in managing where the money is spent, which is on those patients with multiple chronic health care conditions.

Today we do not do a good job, I think, in managing those patients. It is the key driver of what is going up in terms of health care spending, and my sense is—and this is particularly germane to Medicare—that all these entitlements that many of us are worried about, in terms of their overall share of the GDP that is projected 5, 10, 15, 20 years down the road, unless we get a handle on the basics in terms of pulling excess clinical dollars, more effec-

tive treatment protocols in managing chronically ill patients, preventing some of these things in the first place, it is going to be very difficult for us to get a handle on entitlement spending.

I will leave you with just one more statistic, and I will close. If you look at the lifetime health care spending for a senior, 65 or 70 years old, who is normal weight, no co-morbid conditions—so does not have a chronic disease—compared to that same individual who is obese and has one disability or one chronic health care condition, over the entire lifetime of those patients, of those individuals, the normal weight individual would spend about 20 percent to 30 percent less over their lifetime than that same person who is obese and has multiple chronic health care conditions. So it does make a big difference. We just need the information base, the data, and the research in order to figure out how we can do this better.

With that, I will close. I look forward to answering any questions you may have and, again, I would like to offer my thanks once again for your invitation in working with you in this Subcommittee's longstanding commitment to health and public health.

[The information follows:]

Testimony As Prepared For Delivery

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House Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies

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Mr. Chairman, Mr. Walsh, and members of the Subcommittee, thank you for the opportunity to testify today on the economic and social consequences of inadequate investment in public health programs, particularly those targeting chronic diseases.

Among the many serious challenges our nation faces, few have more grave long-term consequences than under-investment in population-based prevention and clinical management, including research and evaluation into effectiveness, because that under-investment is directly traceable to increased morbidity and mortality, decreased productivity, and higher health care expenditures, in both the public and private sectors.

Chronic diseases are the number one cause of death and disability in the United States. More than 133 million Americans – 45 percent of the total population – have at least one chronic disease. Chronic diseases kill more than 1.7 million Americans yearly, and account for 7 of every 10 deaths.

The toll on health and wellbeing is concerning enough. But the financial costs are also troubling. Chronic diseases account for fully 75 percent of the nation's overall health care spending. In public programs, the proportion is even higher. Virtually all Medicare spending – 96 cents of every dollar – is spent on chronic disease care and treatment. For Medicaid, the cost is 83 cents on the dollar. Of the $1.75 trillion dollars expended on direct health costs in 2006, an estimated $1.3 trillion was spent on chronic disease.

The average annual growth rate in national health expenditures for 2000 to 2008 was 7.5 percent. Much of the increase in spending – by some measures as much as 20 percent – is attributable to the rise in obesity in the U.S. over the past two decades.

According to the Centers for Disease Control and Prevention, more than a third of U.S. adults are now obese, and two-thirds are either obese or overweight – double the proportion 20 years ago. CDC reports that 1998 aggregate adult medical expenditures attributable to overweight and obesity were estimated to be $78.5 billion using 1998 National Health Accounts data. For obesity alone, the estimated costs were still $47.5 billion. Spending increases are attributable not only to rising incidence and prevalence of obesity and its associated sequelae, such as diabetes and heart disease, but also to more intensive treatment of overweight and obese patients. If the prevalence of obesity were the same today as in 1987, health care spending in the U.S. would be 10 percent lower per person, or about $200 billion less each and every year.

Despite these significant and growing expenditures, however, research shows that chronically ill patients receive only 56 percent of clinically recommended health care. In other words, while America is spending a staggering amount on chronic disease care, objective measures indicate we may not be spending wisely or well to treat chronically ill patients. This discrepancy results chiefly from systemic inadequacies: The American health care system was built to deliver health care services to acutely ill patients requiring episodic care, not to patients who are chronically, persistently in need of medical care.

In short, America spends more on health care than any other industrialized nation, but by many measures, our spending is not achieving the results we want and need. Aside from the question of whether our spending is sustainable at 16 percent of GDP and rising, we face the very real question of whether our spending is sensible, given the results it garners.

A study in this month's *Health Affairs*, for example, by my colleagues Ellen Nolte and Martin McKee, compares trends in deaths considered amenable to health care before age seventy-five between 1997–98 and 2002–03 in the United States and in eighteen other industrialized countries. These preventable deaths account, on average, for 23 percent of total mortality under age seventy-five among males and 32 percent among females. As you might expect, the majority of the conditions responsible for preventable deaths are chronic conditions: cancers, diabetes, ischemic heart disease, and other circulatory disorders. In the OECD countries in the study, the decline in amenable mortality in all countries averaged 16 percent. But the United States was an outlier, with a decline of only 4 percent. If the United States could reduce amenable mortality to the average rate achieved in the three top-performing countries – France, Japan, and Australia – there would have been 101,000 fewer deaths per year. That's more than the populations of Superior, Wausau, and Stevens Point combined, Mr. Chairman.

The rate of amenable mortality is an indicator of overall health system performance. America's significant performance gap is a signal our system isn't performing well against a set of relative health measures. What this study doesn't explain is why the system isn't performing up to par, or in what components of health care, or for what patients. Those are critical questions health services research can answer, if America chooses to invest in it. We also need to better understand what population-based prevention strategies work best.

The truth is, the vast majority of chronic disease could be prevented or better managed. We know from estimates from the CDC, for example, that 80 percent of heart disease, stroke, and type 2 diabetes and 40 percent of cancer could be prevented if Americans would do three things: stop smoking, start eating better, and start exercising.

Of particular prevention focus should be our most vulnerable populations, including children and adolescents and racial and ethnic minorities. As with adults, the prevalence of overweight among children aged 6 to 11 more than doubled in the past 20 years, going from 7 percent in 1980 to nearly 19 percent in 2004. The rate among adolescents 12 to 19 years old more than tripled, increasing from 5 percent to 17 percent. Clinically-based reports and regional studies suggest that type 2 diabetes, although still rare, is being diagnosed more frequently in children and adolescents, particularly in American Indians, African Americans, and Hispanic/Latino Americans. Alarmingly, an estimated 61 percent of overweight young people have at least one additional risk factor for heart disease, such as high cholesterol or high blood pressure. In addition, children who are overweight are at greater risk for bone and joint problems, sleep apnea, and social and psychological problems. Overweight young people are more likely than children of normal weight to become overweight or obese adults, and therefore more at risk for associated adult health problems, including heart disease, type 2 diabetes, stroke, several types of cancer, and osteoarthritis – all conditions that can be prevented.

Preventable morbidity and mortality continue to take an unconscionable disparate toll on America's racial and ethnic minority groups. For example, CDC reports that heart disease death rates are more than 40 percent higher for African Americans than for whites. The death rate for all cancers is 30 percent higher for African Americans than for whites; for prostate cancer, it is more than double that for whites. African American women have a higher death rate from breast cancer despite having a mammography screening rate that is nearly the same as the rate for white women. The death rate from HIV/AIDS for African Americans is more than seven times that for whites. Hispanics living in the United States, as well as American Indians and Alaska Natives, are almost twice as likely to die from diabetes as are non-Hispanic whites. Hispanics also have higher rates of high blood pressure and obesity than non-Hispanic whites. These conditions are preventable.

But America's investment in prevention is woefully inadequate – including our investment in understanding what works, for whom, under what conditions, and why. The evidence base for population-based prevention programs as well as for clinical care and treatment is insufficient to make truly sound investments in prevention, even if we chose to do so. We must increase R&D in prevention to ensure we see a better return on both our prevention and health care investments.

Policymakers in both the public and private sector have little information concerning cost-effective prevention programs and approaches for managing chronic disease. Despite the fact America spends more than $2 trillion annually on health care, we do not have even the most basic, up-to-date data at the state level on health care spending. Our health care information system is deficient for decision making.

Critically needed are intervention evaluation and identification of programs that work – those that prevent the rise in obesity and chronic health conditions, such as diabetes and HIV. We also need far more information on how best to manage patients with multiple chronic health conditions – the patients who account for three-quarters of our health care spending. Once effective management plans are identified, we need targeted strategies for providing incentives for employers, schools, and communities to adopt these demonstrated "best practice" programs.

Yet of the $2.1 trillion spent on health in 2006, just 3 percent, or slightly over $63 billion, was allocated to all government public health activities, local, state, and federal. That same year, CDC spent $834 million on chronic disease prevention, health promotion, and genomics, including $63 million on diabetes and prevention and control. In contrast, the total annual economic cost of diabetes last year was estimated to be $174 billion, according to the American Diabetes Association. Indirect costs resulting from increased absenteeism, reduced productivity, disease-related unemployment disability, and loss of productive capacity due to early mortality totaled $58 billion. We spent $27 billion for diabetes care, $58 billion for chronic diabetes-related complications, and $31 billion for excess general medical costs, for a total direct cost of $116 billion. Perverse incentives in our health care system are key drivers of this spending: Private insurers often will not cover a $150 preventive office visit for a diabetic patient to visit a podiatrist, but they will cover a foot amputation at $30,000.

We have to take are hard look at relative investment: In 2006, CDC's spending on chronic disease prevention and control was $6.27 for each one of the 133 million Americans with one or more chronic conditions. The same group accounted for an average of $13, 143 in health care spending that year.

To look at it another way, our nation's estimated investment in health services research last year was just $1.5 billion. Booz Allen Hamilton's annual report of

investment by the top 1000 firms globally shows that private sector health care R&D was $97.8 billion in 2006, or roughly sixty-five times as much.

The best health and health policy decisions are based on data and scientific evidence. Health services research provides the data and evidence needed to make decisions and develop policies that optimize health care financing, delivery, access, and outcomes. It provides policymakers, practitioners, and other decision makers the necessary tools to make America's health care:

- *Affordable*, by decreasing cost growth to levels sustainable by individuals and the country.
- *Efficient*, by decreasing waste and overpayment and monitoring cost-effectiveness of care.
- *Safe*, by decreasing preventable medical errors and adverse drug events, monitoring public health, and improving health system preparedness.
- *Effective*, by monitoring and evaluating health programs and outcomes and improving implementation of evidence-based innovations as part of routine health care.
- *Equitable*, by eliminating disparities in health and health care according to ethnicity, gender, and geographic location, as well as socio-economic and insurance status.
- *Accessible*, by connecting people with the appropriate health care they need when they need it.
- *Patient-centered*, by increasing patient engagement in their care, as well as their satisfaction with the care they receive.

Similarly, public health research and evaluation can help guide population-based prevention services, by ensuring that promising programs are fine-tuned, that successful interventions are scaled up, and that nonperforming programs are redirected.

An overall investment of 3 percent is simply inadequate to provide the information we need.

With that, I'll close, and I look forward to answering any questions you may have. I'd like to again offer my thanks for your invitation, and for this Subcommittee's long-standing commitment to health and public health.

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EDUCATION

1978	Political Science	B.A.	University of Michigan
1980	Public Policy	M.A.	Duke University
1985	Public Policy	Ph.D.	Rand Graduate Institute

FACULTY

1999-Present	Robert W. Woodruff Professor and Chair, Department of Health Policy and Management, Rollins School of Public Health, Emory University
1995-1999	Vanselow Professor, Health Systems Management, Tulane University School of Public Health and Tropical Medicine
1995-1999	Director, Institute for Health Services Research, Tulane University School of Public Health and Tropical Medicine
1994-1995	Professor, Health Policy and Administration, University of North Carolina School of Public Health
1990-1994	Associate Professor Health Policy and Administration, University of North Carolina School of Public Health
1989-1990	Associate Professor, Health Policy and Management, Harvard University School of Public Health
1988-1990	Director, Program on Health Policy and Health Care Financing Management and Insurance, Harvard University School of Public Health

1986-1989	Assistant Professor, Health Policy and Management, Harvard University School of Public Health
1983-1986	Assistant Professor, Health Administration, Columbia University School of Public Health

WORK EXPERIENCE

2007	Executive Director	Partnership to Fight Chronic Disease
2005	Board of Directors	Coalition for Health Services Research
2005	Editorial Board	Health Affairs
2004	Gubernatorial appointee	Governor's Panel on Health Reform, Louisiana
2002	Gubernatorial appointee	Governor's Action Group on Accessibility and Affordability of Health Insurance, State of Georgia
1999	Board of Directors	Louisiana Medical Mutual Insurance Company
1996	Vice Chairman	Louisiana Health Care Commission
1993-1995	Deputy Assistant Secretary for Health Policy	Department of Health and Human Services
1993-1994	Chair, Quantitative Impacts of Health Reform, President Clinton's Health Care Reform Task Force	The White House, Washington,
1991	Member	Institute of Medicine, Panel on 1992 the Future of Employer-Sponsored Health Benefits
1991	Consultant	National Leadership Coalition for Health Care Reform
1990	Member	Advisory Council on Social 1991 Security, Technical Panel on Future of Income Security and Medicare

1990	Gubernatorial Appointee	Massachusetts Commission on Health Care Financing
1989	Member	New York State Universal Health Insurance Advisory Council
1989	Consultant	Council on Health Care Financing, New York State Assembly, provided technical analysis and aided in design of New York's all-payer DRG hospital payment system
1985	Consultant	RAND/UCLA Center for Health Care Financing Policy
1980-1984	Graduate Fellow	The RAND Graduate School, RAND Corporation
1980	Staff Member	Human Resources & Community Development Division, Congressional Budget Office, Washington, D.C.
1979	Summer Staff Member	Office of Congressional Affairs

MAJOR INTERNATIONAL EXPERIENCE:

1995	Developed papers and provided technical assistance, and acted as a resource person for the Regional Conference on Health Sector Reform in Asia, at the Asian Development Bank, Manila, Philippines.
1994	US Representative to the Organization Economic Cooperation and Development (OECD)
	Conference on Health Care Reform. As Deputy Assistant Secretary for Health Policy was one of three US delegates working with OECD countries.

1985-1988	Visiting Professor, St. George's Medical School, St. Georges, Grenada, West Indies. Taught introductory health financing class to medical students. Provided technical assistance to hospitals and nursing homes in Grenada.

MAJOR VISITING APPOINTMENTS:

1981-1984	Adjunct Assistant Professor	Business and Management	Pepperdine University
1985	Visiting Assistant Professor	Graduate School of Business	Columbia University
1991	Adjunct Associate Research Professor	School of Medicine	Duke University

PUBLICATIONS

1. Thorpe KE. *"The Use of Relative Prices in DRG Payment Systems: Distributional Implications"*, Inquiry, 24(1) (Spring 1987): 85-95

2. Thorpe KE, Brecher C. *"Improved Access to Care for the Uninsured Poor in Large Cities-Do Public Hospitals Make a Difference?"*, Journal of Health Politics, Policy and Law 12(2) (Summer 1987): 391-408.

3. Thorpe KE. *"Does All-Payer Rate Setting Work? The Case of the New York Prospective Hospital Reimbursement Methodology"*, Journal of Health Politics, Policy and Law 12(3) (Fall 1987):391-408.

4. Thorpe KE, Cretin S, Keeler E. *"Are the DRG Case Weights Compressed?"*, Health Care Financing Review 10(2) (Winter 1988): 37-46

5. Thorpe KE. *"Why Are Urban Hospital Costs So High? The Relative Importance of Patient Source Admission, Teaching, Competition and Case Mix"*, Health Services Research 22(6) (February 1988): 821-36.

6. Thorpe KE. *"The Use of Regression Analysis to Determine Hospital Payment: The Case of Medicare's Indirect Teaching Adjustment"*, Inquiry 25(2) (Summer 1988): 219-31.

7. Thorpe KE. *"Uncompensated Care Pools and Care to the Uninsured: Lessons from the New York Prospective Hospital Reimbursement Methodology"*, Inquiry 25(3) (Fall, 1988): 344-53.

8. Thorpe KE, Siegel JE, Dailey T. *"Including the Poor: The Fiscal Impacts of Medicaid Expansion"*, Journal of the American Medical Association 261(7) (February 17, 1989): 313-324.

9. Thorpe KE. *"The Costs and Distributional Implications of Employer Mandated Health Insurance and Medicaid Expansion"*, Inquiry 26(30 (Fall 1989): 335-44.

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16. Thorpe KE, Phelps C. *"The Social Role of Not-for-Profit Organizations: Hospital Provision of Charity Care"*, Economic Inquiry 29(3) (July 1991): 472-480

17. Thorpe KE, Spencer C. *"How Do Uncompensated Care Pools Affect the Level and Type of Care? Results from New York State"*, Journal of Health Politics, Policy and Law 16(2) (Summer 1991):363-381.

18. Epstein AM, Bogen J, Dreyer P, Thorpe KE. *"Trends in Length of Stay and Rates of Readmission in Massachusetts: Implications for Monitoring Quality of Care"*, Inquiry 28(I) (Spring 1991):19-28.

19. Thorpe KE. *"The National Health Insurance Conundrum: Shifting Paradigms and Potential Solutions"*, Journal of American Health Policy I(I) (Spring 1991):17-22.

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43. Thorpe KE, Florence,C. *"Health Insurance Among Children: The Role of Expanded Medicaid"*, Inquiry, 35(4) (Winter, 1999): 369-379.

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54. Thorpe, KE. A. Atherly, *"The Medicare+Choice Program: Its Current Role and Near Term Prospects"*, Health Affairs (July 17, 2002).

55. Florence C. , KE Thorpe, *"How Does the Employer Contribution for the Federal Employees Health Benefits Program Influence Plan Selection?* " Health Affairs, 22(2) (March/April, 2003): 211-218.

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62. Thorpe, KE, C. Florence, P. Joski, "*Which Medical Conditions Accounts for the Rise in Health Care Spending?*" Health Affairs, web exclusive, August 25, 2004.

63. Thorpe, KE, "*The Health Policy Debate Over the Uninsured*" New England Journal of Medicine, 2004.

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65. Thorpe, KE, et al. "*The Impact of Rising Disease Prevalence on the Growth in Private Health Insurance Spending*", Health Affairs, web exclusive, (June 27, 2005).

66. Atherly, AA, Florence CS, Thorpe, KE. "*Health Plan Switching among Members of the Federal Employees Health Benefits Program*", Inquiry, 42(3) (Fall, 2005).

67. Thorpe KE, "*The Rise in Health Care Spending and What to Do About it! The Role of Population Based Interventions*" Health Affairs, web exclusive, 2005.

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71. Thorpe KE, "Reframing the Debate over Healthcare Reform: The Role of System Performance and Affordability", forthcoming Health Affairs, fall 2007.

72. Thorpe KE, "Emerging Health Care Reform Issues in the US Presidential Debate" Health Economics, Policy and Law, 3, (2008): 1-5

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2. Dertouzos JN, Thorpe KE. Newspaper Groups: Economics of Scale, Tax Laws and Merger Incentives. R-2878-SBA. Santa Monica, Rand Corporation, 1982.

3. Dertouzos JN, Thorpe KE. Specification Error and the Price Effects of Media Crossownership. P-6776. Santa Monica: Rand Corporation, 1982.

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5. Thorpe KE. Hospital Cost Shifting. New York Business Group on Health. 4(3):1984.

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10. Thorpe KE. Financing Access to Medical Care. Statement before the House Select Committee on Children, Youths and Families, December, 1989.

11. Thorpe KE. Medicaid Expenditures on AIDS: Future Trends and Policy Issues. Statement Subcommittee on Health and the Environment, February, 1990.

12. Thorpe KE. Economic Impacts of S. 1227, Health Care for All Americans Act. Statement Before the U.S. Senate Committee on Labor and Human Resources, Washington, D.C., 24 July 1991.

13. Rice T, Thorpe KE. The Feasibility of Income-Related Cost Sharing in Health Insurance Plan. American Association of Retired Persons, November, 1991.

14. Thorpe KE. Tax Incentives to Purchase Health Insurance. Statement before the Senate Finance Committee, 18 June 1992.

15. Thorpe KE. Structural Reforms in the Medicare Program. Statement before Senate Aging Committee, 19 May 1997.

16. Thorpe, KE. Applying the FEHBP to Medicare. Statement before Senate Finance Committee, 21 May 1997.

17. Thorpe, KE. Why Health Care Costs are Rising -- Again, in Guide to Managed Care Strategies 1998, Washington Group on Health, Washington, DC, 1997.

18. Thorpe, KE. The Health Care System in Transition: Current Costs and Coverage, in Mark Peterson (ed) Healthy Markets? The New Competition in Health Care. Duke University Press, Durham, NC, 1998.

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20. Thorpe KE. Changing the Tax Treatment of Health Insurance: Impacts on the Insured and Uninsured in D. Salisbury (ed) Severing the Link Between Health Insurance and Employment, (Employee Benefit Research Institute, Washington, D.C., 1999).

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RESEARCH AND PROFESSIONAL ACTIVITIES

MAJOR RESEARCH AND TEACHING INTERESTS:

National and State Health Care Policy
Health Care Financing and Organization
Application of Econometric Techniques to Health Policy Issues Covering the Uninsured

FUNDED RESEARCH AS PRINCIPAL INVESTIGATOR OR CO-INVESTIGATOR

Health Policy Options for Georgia, Georgia Health Care Foundation, principal investigator, $120,000, 2004-2005

Accountability and Health Safety-A Statewide Approach, Agency for Health Care Quality and Research, *principal investigator,* $1,606,430 , 2002-2005

"Developing New Options for Financing Cancer Care, Commonwealth Fund, *principal investigator,* $146,565, 2002

"Health Plan Selection for Medicare Eligible Enrollees in the FEHB", co-investigator, Robert Wood Johnson Foundation, $213,262, 2002

"Contingent Workers and the Labor Market. Issues and Implications for Health Care Reform", The Commonwealth Fund, $25,000, 1999

"The Impact of Hospital Ownership Changes in the Hospital Delivery System", Robert Wood Johnson Foundation, $509,156, 1997

"The Impact of Managed Care on the Provision of Uncompensated Care", Kaiser Family Foundation, $150,000, 1997.

"Competitive Bidding in the Federal Employees Health Benefits Program", Robert Wood Johnson Foundation, $363,959, 1997.

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Journal of Policy Analysis and Management
Inquiry
Law, Medicine and Health Care
American Economic Review
Medical Care
The New England Journal of Medicine
Health Services Research
Journal of Human Resources
Health Affairs

MEMBERSHIPS AND LICENSES

PROFESSIONAL SOCIETIES:

American Economic Association
Association for Public Policy Analysis and Management
American Public Health Association
Association for Health Services Research
Delta Omega Society

AWARDS AND HONORS

Herbert Goldhamer Award, Rand Graduate School, 1985
Awarded to top graduating doctoral student.

Young Investigator Award, Association for Health Services Research, 1991

Up and Comers Award, Modern Healthcare, 1993

Philip and Ruth Hettleman Award for Artistic and Scholarly Achievement, University of North Carolina at Chapel Hill, 1994

SERVICE

Worked with the following jurisdictions in developing statewide approaches to universal health insurance:

California
Colorado
Georgia
Kansas
Louisiana
Maine
Massachusetts
Missouri
New York
North Carolina
South Carolina
Vermont

Mr. OBEY. Thank you.

Dr. Weinstein.

It is a miracle we have not had a vote yet. [Laughter.]

Dr. WEINSTEIN. Happy Valentine's Day.

Thank you for allowing us to be here today to speak to you; it is an honor. And thank you for your continued support for research to all the entities—NIH, AHRQ, and others.

As you know, the health care system, by some estimates, has some $400,000,000,000 to $600,000,000,000 in waste. We could certainly do a lot more with that money in research and education of ourselves, our infrastructure for training young physicians—going to be a dying breed—and what I call a research recession. We, as a Nation, are talking about recession, but I worry about how our health care dollars and research dollars are spent that we may lose the best and the brightest, and the unintended consequences of that may be tremendous.

As you mentioned, I am an orthopaedic surgeon and I have a unique career in that I am able to work in many domains in understanding health care delivery. Following in the footsteps of Dr. Jack Wennberg and Elliott Fisher and others, who look at variation in this Country and the kind of money that we spend in end-of-life situations, and the Medicare budget varies by such significant amounts that we, as a Country, think that we are spending probably 20 percent too much even in Medicare, which is about a $26,000,000,000 of monies that could be spent other ways.

Knowing the idea that there is variation in being an orthopaedic surgeon, I sought to try to find some solutions: Having data to support the treatment that we are offering to patients trying to empower our patients who have been left out of the milieu of the decision-making about how health care is offered. If patients are given a choice, they tend to make appropriate decisions. Our study recently funded by the National Institutes of Health, NIOSH, and others demonstrates that for a common condition, back surgery—some of you may have back pain today, listening to me. But the fact is that 80 percent of our population, at some time in their life, experience back pain. If we take that common condition and try to dissect all that is being done for it, understanding the lack of evidence for most of the things that are being done and the costs associated with that, why had not we done clinical trials to understand the effectiveness of various treatments? To me, that was a call for me to try to stand up and do something as a health services researcher and an orthopaedic surgeon who practices spine surgery.

I was fortunate to receive a $15,000,000 grant to do the first-ever randomized trials in this Country about these conditions, again, affecting some 80 percent of our population. Given the results of our trial, it appears that patients do have a choice. Surgical intervention is not always the best option. And, for individuals, choice matters. People who now have data can make these kinds of decisions, as can breast cancer patients or cardiovascular patients. We know from studies in breast cancer that the treatment of lumpectomy versus mastectomy for a woman facing breast cancer ought to be given to the woman to decide, not because a physician decides that one treatment is best for that patient. If the outcomes are the same, who should decide?

In cardiovascular disease, where we have all kinds of new treatments—whether it is drug-eluting stents, Bear stents, bypass surgery, or just drug therapy—if the treatment options are equal, who should make the decision about those choices? We believe in the concept of informed decision-making or informed choice. The doctrine of informed consent—which is traditionally what I do when I am consenting a patient for a surgery—I believe is out of date, arcane, and none of us—that doctrine is about assault—are trying to assault our patients. We are trying to help our patients. I would like to see the doctrine of informed choice.

Given the information we have from SPORT, the trial we have been doing on back pain, what is the cost of not doing these kinds of studies? We know from people that potentially are going to suffer strokes that there was a procedure called ECIC bypass, which was done mostly by neurosurgeons. Until that procedure was subjected to a randomized trial, thousands of patients were having that procedure done. Once the randomized trial was published in the New England Journal, that procedure went away. The thousands of women who face bone marrow transplantation for breast cancer, only to find out in randomized trials that that was not an effective therapy. That is not the way this Country should move forward. As I said in my statement to the group, the enemy of the best is the good enough, and I think we have been doing barely good enough, and certainly not the best.

If we make the kind of investments that we have made in SPORT, our back pain surgery trial, there is the opportunity to save billions of dollars. Imagine patients who have a choice who decide not to have surgery. In our study, that is 30 percent to 38 percent. Imagine if we took the dollars saved from not doing those procedures and applied them to other things that actually worked for patients based on best evidence—diabetes, cholesterol-lowering drugs, hypertension treatment, routine eye examinations—that have the kind of evidence to support the kind of treatments that we do not even well enough in this Country, knowing that they work.

Fusion surgery for spine care is one of the major procedures that is going up at alarming rates. I do that procedure; I am affecting myself by what I am saying here today—but believe we do not have the evidence to support that volume of surgical increase that is occurring in this Country and do not currently have the studies to support it in the way that it is being done. Patients do not have the informed choice about making those decisions today because we lack the evidence to inform our physicians who are offering their patients that kind of treatment.

The issue of comparative effectiveness—brought up in the opening statement by the Chairman—is one that Gayle Walinski has brought forward as an idea that I think is very powerful. In our own studies for people who have faced hip fractures, there are many different types of treatment for hip fractures, meaning very different types of devices. We know that the change in practice in the United States has been almost 100-fold, a crossing over of old technology to new technology that now costs approximately two and a half times more, with greater morbidity and greater mor-

tality. Why are we using these new devices and new technologies without the data to support them?

Who is going to make these decisions? I hope it is us, as researchers, working with clinicians like myself, working with you as Congress and our patients to get to the information to get to informed patient choice. We need to look at cost-effectiveness and we need to be accountable for the things we are doing and the investments we are making. I know that NIH and other agencies are under the gun because of the doubling of the budget and where is the return on the investment. I suggest that SPORT is an example of a tremendous return on investment if we just listen to the results, implement the strategies around informed choice to help patients, change the rates of procedures where patients actually know the risk and benefits, and there is more money to be spent.

Knowledge and evidence versus guesses and the good-enough is not good enough. Don Frederickson, who was Director of the NIH in 1975 to 1981, almost 30 years ago, said field trials—and I assume he was referring to clinical trials—are indispensable. They will continue to be an ordeal, and having done them, they are very difficult. You face a lot of criticism and a lot of difficult issues with colleagues who want to do what they think is best for their patients, despite not having the data. Trials lack the glamour, they strain our resources and patients, and they protract the moment of truth to excruciating limits. Still, if, in major medical dilemmas like we face in many of the issues in health care today, the alternative is to pay the cost of the perpetual uncertainty, have we really any choice? And I would argue the answer is no. A resounding no to continue as we are doing without the evidence to support the treatments that we are offering for patients, for your families, for my families, for patients around the world.

SPORT was a practical clinical trial. It shows that things can be done in clinical practice with working with physicians, not around physicians; working with patients, not around patients; talking to patients, not at patients; and we can gain the kind of outcomes and cost-effectiveness and a comparative effectiveness data that Gayle speaks so highly of. I believe there is a return on investment. I believe there is the opportunity to retain our brightest and best young clinicians and scientists that we may lose to other countries who are certainly willing to invest more today.

We need to know the truth about what works and we need to share that with our communities. We need to alter the incentives that seem perverse in how physicians may be paid for doing more than for doing what is right. Right-sizing our system seems appropriate at this time. And as Elias Zerhouni says from NIH, in his four Ps—being predictive, personalize, preemptive, and participatory—I think for the kind of basic research that we are talking about in the translational research area, the kind of research I am talking about today with clinical trials deals with patients who have problems today. The future of genetics, genomics, proteomics is tremendous, but we have to have the continuum of both of these working together to help our patients today.

I thank the Committee for your time and look forward to your questions.

[The information follows:]

Testimony of James N. Weinstein, DO, MS
Before the House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
February 14, 2008

The best is the enemy of the good.
Voltaire

The enemy of the best is the good enough
JNW

Mr. Chairman, and distinguished members of the subcommittee, "good morning." It is an honor to appear before you today.

In a health care system with an estimated $400-$600 billion in waste, I'm going to talk to you today about a $15 million investment by NIH that has provided us with an opportunity to realize billions of dollars in savings. Supporting NIH clinical trials can offer substantial return on investment and more importantly, can help our patients make better informed choices about their treatment decisions in a complex health care system..

I am here wearing two hats. As Director of the Dartmouth Institute for Health Policy and Clinical Practice, I have worked with my colleagues Jack Wennberg, Elliott Fisher and many others to understand variations in medical practice including but not limited to, disparities in care based on race, ethnicity, and age. Factors related to the variance in utilization of health care resources throughout life and at the end of life as well as the associated cost based on the geography of where one lives has been a focus of our work.

Much of my own work has been supported by federal funding (NIH, AHRQ and others). An important part of my career has been looking at the importance of "**patient preferences**" in choosing their care, what we at the Dartmouth Institute call **"Informed Patient Choice,"** and its effect on costs and outcomes of healthcare.

I am also a practicing spine surgeon and Chair of the Department of Orthopaedics at the Dartmouth- Hitchcock Medical Center. So although research has been an important part of my work, I speak today as someone for whom health care is not simply an academic mission or some abstract entity. It has been my life's work for more than 30 years. I see first hand, and up close its impact on one's every day life, on our patients and my colleagues, and the greater healthcare systems. I have witnessed the importance of our research and its application in the clinical setting, a setting in which nearly all of us as individuals and/or as families, find ourselves at some point in our lives.

You have asked me here today to talk about the importance of research funding, particularly funding for the National Institutes of Health. I want to first thank the members of this committee for your past support of the NIH and what I hope will be your continuing strong

support at a time when it is needed most. In addition to the importance of the clinical trials that NIH supports – and which will be the subject of my comments today -- without adequate funding we are in danger of losing our leadership in global health science research. We are already seeing some of our best and brightest scientists go to other nations competing in the race of discovery. Increased funding for the NIH is necessary if we are to continue to lead and to encourage a new generation of teachers and mentors.

NIH and "Best Evidence"

In all the discussion of how to "fix" health care, we simply cannot lose sight of the critical role that **research** can play in making our system more efficient, more effective, with greater evidence to support **Informed Choice** and the associated greater safety for our patients. Right now in this country, doctors perform procedures and offer treatments in the absence of best evidence. In the face of not knowing, we care for patients the best we can, hoping that what we are doing is right. Arguably, it is only the NIH that can or would sponsor the kinds of large scale trials needed to look at whether current practice is best for our patients.

There are many examples documented by our Institute and others, but because my expertise is in orthopaedics and particularly back problems, let me start there.

In fact, the back is a good place to start for many reasons. As you may know, approximately 80 percent of Americans suffer from back pain at some point in their lives, maybe even some of you sitting here today, listening to me. Next to the common cold, it is the most frequent reason for which people visit their physicians. And it is the most common cause of work-related disability, as well as the most expensive in terms of workers compensation and medical costs. Social security disability associated with back and other musculoskeletal problems is going up at an alarming rate.

Table 1: Number of Disabled Workers Under the Social Security Disability Insurance Program, 1996 & 2005

	1996	2005	% Change
Workers on Disability	4,400	6,519	48.2
Total (men)	2,653	3,517	32.6
Total (women)	1,747	3,002	71.8
Specific Disease Categories			
Circulatory System	518	621	19.9
Mental Disorders*	1,128	1,863	65.2
Musculoskeletal	**907**	**1,657**	**82.7**

All counts in thousands. Source: *Annual Statistical Report on the Social Security Disability Program, 2005* (published 2006). *Excluding mental impairment. *courtesy of Jon Skinner

It has also become an area where we've seen an explosion in new technology, with an associated explosion in costs. And yet the truth is that roughly 85 percent of patients with isolated low back pain cannot be given a specific diagnosis. More important is the fact that

most all improve without intervention. Tincture of time and return to normal activities, as soon as possible, is often the best treatment.

Why then have rates of procedures like spinal fusion increased more than 250 percent in recent years? In 2004, an estimated 327,000 patients underwent this procedure.

Spinal fusion procedures account for one-third of all back surgeries in the U.S. The associated increases in costs are staggering. Estimated cost of the surgery increased 215% between 1998 and 2004; costs were $16.9 billion in 2004 alone. Another $1.2 billion was spent in 2004 on repeat procedures. The cost of the spinal implants – implanted devices used to aid in fusing the spine -- is almost $2.5 billion a year.

This raises a significant red flag for me as a clinician and as a health services researcher– Why, given the paucity of research or evidence to support these treatments are these rates and costs increasing so dramatically? There is actually some evidence that fusion results in more complications and worse outcomes. But what are the alternatives?

Clinical Trials

The gold standard of clinical research, the large-scale, multicenter randomized clinical trials have simply not been done to tell us definitively whether fusion for back pain is effective.

This question and the kinds of answers we need are not simple. Does that mean we shouldn't do the studies necessary to answer these questions? Of course not! I know my fellow surgeons wish to help their patients who come to them in pain and unable to work. But, we cannot, in the face of poor data and insufficient studies continue to do what we think works. We need the evidence to say what works.

The concern is not just the expense of these procedures. It is the consequences, intended and unintended that we as a nation must consider. The impact on one's loving family seeking what is best for their loved one(s) can be onerous and disruptive; time off from work and the impact on the US work force and its productivity; the impact on the employer, rises in insurance and disability premiums, and of course, the impact on the patient who is forever affected by these critical decisions. In addition, doing tests or procedures that patients, given a choice, don't need or want,can be associated with increased rates of medical errors.

Today Congress must not wait to increase the NIH budget, not just for scientists and clinicians like me who are anxious to do the necessary and much overdue research, but for your constituents -- our patients -- who must have the kind of evidence each of you would want and need for you or your family's decision making in such circumstances.

Sheila's Story

A few years ago, a woman came to see me. Her name was Sheila (She has given me permission to share her story.) She was in her late 60's, an artist who had lived a vibrant, joyful life. A few years earlier, she had undergone spinal surgery at another hospital.

Following the operation she didn't do well, in fact, she got worse and her pain was so unbearable that she had become addicted to the pain-killing narcotic drugs prescribed for her.

She was advised that another operation was her only option. She and her husband came to me not knowing what to do and wanting to have another opinion. It was clear to me that Sheila was depressed, appropriately so. She was tearful, scared and just wanted someone to listen to her.. She was understandably apprehensive about undergoing another operation.

We suggested Sheila come off the narcotics and begin an exercise program, exactly the opposite of what she had been told. Months later Sheila came to see me and gave me a beautiful painting, the first piece she had done in a long, long time. She was so happy to be drug-free and getting her life back together. Surgery would not have helped Sheila!

How many more Sheila's do we need to see before we have the funding to do the necessary studies? We can no longer continue to do surgery nor put patients on long term drug programs because of our lack of good clinical research. Patients become addicted in many ways that cost our nation not just in dollars and cents, but undermine our national pride, "hard work," the critical ethos that built the American dream. We must have the research to provide the solid, evidence-based information to guide our patients and our physicians. Patients should not be left to their own defenses or physicians left to make treatment recommendations in a climate influenced by upside down financial incentives that drive us towards the newest and latest – and most expensive -- technologies.

Proactive approach vs. a reactive approach

So what can we do? We must support the research necessary for our patients and their doctors to make better **informed choices**. These "gold standard" clinical studies are complex and expensive. They take time and coordination, multiple institutional resources, physicians willing to say they don't know, and the designs necessary to answer the difficult questions. They can only be conducted by an agency such as the NIH that has the national credibility to assess, award, perform and monitor in an independent and unbiased manner.

I speak from experience as the lead investigator of a 14-center, $15 million research study called SPORT – the Spine Patient Outcomes Research Trial(s). It was largely funded through the National Institute of Arthritis and Musculoskeletal and Skin Diseases at NIH. We wanted to know if surgical interventions for common back conditions involving herniated disc with sciatica and two kinds of spinal stenosis were effective. These are some of the most common reasons for which spine surgery is performed in the US.

NIH was courageous in taking this on. The cost was substantial. This trial only happened because of the doubling of the NIH budget that year. It could not have been done today, with the current NIH funding without sacrificing other important work. And again, only NIH had the motivation and ability to ask whether current accepted practice in treating these conditions was justified by the evidence.

Had SPORT not been done, it would have been a great loss. The results of SPORT will be revealing and important for decades to come, for literally hundreds of thousands of patients and their doctors making these decisions everyday.

For herniated disk patients with sciatica (where a disc in the back presses on nerve that goes down your leg) associated with severe leg pain, we found in our randomized trial that after one and two years, there was very little difference in outcomes whether patients chose surgery or non-surgical treatment. Patients choosing surgery did only slightly better. The most important, often overlooked, finding was how well the non-operative patients did.

Thus, patients with disc herniation, the most common diagnosis for which surgery is performed, now have a choice between surgery and non surgical treatment. In cases like this where the decision can be a toss up or close call, the patients' preferences and expectations clearly matter.

For those with spinal stenosis (a narrowing of the space in the spine where the nerves live; thus a progressive squeezing of nerves, generally seen in patients over 60 years of age), our first paper, published in the New England Journal of Medicine March 2007, showed that unlike the disc herniation study, there was a clear advantage for surgery. Patients who had the operation did much better on all levels. Yet, here again, an important and often overlooked finding was that some 38 % of our stenosis patients continue to be followed without surgery over two plus years. Again, choice and preference matter.

We know from our research at Dartmouth that Shared Decision Making (Informed Choice), or informing patients with the best evidence, does alter their treatment choices. From our prior studies, before SPORT, funded by the former AHCPR in the late 90's we found that herniated disc surgery rates went down 30% when patients were informed by the best evidence at that time.

Cost and Cost Effectiveness

Imagine the impact on cost and cost-effectiveness of our treatments and spending nationally if we were able to give patients this kind of information on a broader scale, across all of medicine, based on more evidence-based research and clinical trials like SPORT. For example, what would a 30% reduction mean, as demonstrated in our prior work, in the number of disk surgeries? Well in 2004 there were some 325,000 disc surgeries performed in this country. If that number were decreased by 30% – we could realize an annual savings of $3 billion. If the same 30 % reduction occurred among the 150,000 patients who had surgery for spinal stenosis in 2004, we would have seen a minimum of $1.2 billion in savings. Just these two procedures alone would realize a $4.2 billion cost reduction. This represents about 14 percent of the current NIH budget or just under 1 percent of the total Medicare budget. That's quite a return on the $15 million investment.

Imagine if we could see such a return on just half of the "preference based", elective procedures performed in this country. In that scenario, patients seen in clinical practice would only have procedures they chose with their doctor and doctors would only perform

procedures on those who participated in an evidence based "Informed Choice" decision process. This is an excellent example where NIH-sponsored research translates directly into clinical practice with broad reaching impact. Assuming we could capture those unspent dollars, we as a nation would benefit with more funds for the uninsured, children, immunizations, and more clinical trials

Return on Investment

Instead of focusing on the cost of research, I believe we should be emphasizing the return on investment. Through SPORT, we have real information we can provide for decades to come to the benefit of patients around the world. The offshoot of this research has led many other researchers in this country and others to emulate the SPORT study for other conditions for which there is little evidence but a great deal of cost.

We must also remember the **costs of not investing in research**. What is the effect on our patient's safety and our health care system when treatments or therapies are adopted without evidence of effectiveness? When drugs or treatments are widely adopted, but then found to be ineffective or harmful to the patients being treated? We can't, afford not to make these kinds of investments in the public good. It is not always about the money, but in this case the money can be well spent and the benefits go to so many and to the detriment of none.

Summary

As you can hopefully see clearly –NIH-supported clinical trials do matter. Yes, they are expensive, but their costs are overwhelmed by the cost of not knowing the truth. And, as in the above examples potential savings demonstrate a return on investment that is hard to beat. Above all else, we should know what is best for our patients **all** of the time, not just **some** of the time.

I believe in all that we do, we must honor those who came before us. In my case I stand on the shoulders of many who have come before me. In closing I would like to invoke the words of Donald Frederickson, who was the Director of the NIH from 1975-1981.

> "Field trials are indispensable. They will continue to be an ordeal. They lack glamour, they strain our resources and patience, and they protract the moment of truth to excruciating limits. Still … if in major medical dilemmas, the alternative is to pay the cost of perpetual uncertainty, have we really any choice?"

As Frederickson did, I believe the answer is **a resounding NO, we have no choice**. Continued increased funding for research at the NIH is critical. The difference it will make for our patients, for the advancement of medical science and medical practice, for the health care profession, and for the health of our nation, is well worth the investment.

Each of us conducts our lives according to an oath we took when entering our professions; you as congressmen and I as a physician. For you, it is to support and defend the Constitution, which as you know calls for the promotion of the general welfare of our nation, including healthcare. For me, it is the Hippocratic principles, including to "do no harm." For NIH, it is to apply all the knowledge gained through research to extend life and reduce the burdens of illness. Thus, for all of us it is a commitment to "promote the general welfare of our nation". To that end, I can think of no better way for us to fulfill these commitments than in the cause of our citizens' health.

Thank you.

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Appendices:

1. United States Trends and Regional Variations in Lumbar Spine Surgery: 1999-2003
2. Racial, Ethnic, and Geographic Disparities in Rates of Knee Arthroplasty among Medicare Patients

3. Trends and Geographic Variations in Major Surgery for Degenerative Diseases of the Hip, Knee, and Spine
4. Surgical versus Nonsurgical Treatment for Lumbar Degenerative Spondylolisthesis

5. Surgical vs Nonoperative Treatment for Lumbar Disk Herniation: The Spine Patient Outcomes Research Trial (SPORT): A Randomized Trial

6. Surgical vs Nonoperative Treatment for Lumbar Disk Herniation: The Spine Patient Outcomes Research Trial (SPORT) Observational Cohort

Dr. James N. Weinstein

Dr. James Weinstein is Director of the Dartmouth Institute for Health Policy and Clinical Practice, formerly the Center for the Evaluative Clinical Sciences, and Professor and Chair of the Department of Orthopaedic Surgery at Dartmouth in Hanover, New Hampshire. He is the Principal Investigator of the Spine Patient Outcomes Research Trial (SPORT), the largest study funded by the National Institute of Arthritis and Musculoskeletal and Skin Diseases at the National Institutes of Health.

He founded the first in the nation Center for Shared Decision-Making at DHMC and the multidisciplinary Spine Center at Dartmouth-Hitchcock Medical Center as a model group practice for health care delivery using real time data collection and shared decision making. Dr. Weinstein is Center Director of the NIH sponsored, Multidisciplinary Clinical Research Center in Musculoskeletal Health Care at Dartmouth (MCRC). He is Editor-in-Chief of *Spine*.

He is the recipient of the Bristol-Myers Career Research Award in pain research and the prestigious Kappa Delta Award. Dr. Weinstein is fortunate to host dozens of visitors from all over the world, eager to learn about the clinical systems for clinical practice and research study designs. He is also a Director for the American Board of Orthopaedic Surgery. Dr. Weinstein was fortunate to receive the Wiltse Lifetime Achievement Award in 2006, Bergen, Norway.

Dr. Weinstein served many national and international committees most recently the NCQA Spine Care Advisory Committee resulting in the Back Pain Early Recognition Program and National Quality Forum (NQF): Episodes of Care Working Group (AMI and Back Pain). He was recently nominated by the Secretary of Health and Human Services to serve a three-year term on the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) Council. For the Institute of Medicine, he was privileged to participate in their roundtable workshops covering evidence-based medicine, identifying highly effective clinical services, and shared decision making.

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National Academies. The National Academies Press, Washington, DC, 2008. **J. Weinstein** –participant.

C. Research Support.

2 U01 AR045444-06 (Weinstein, J) (PI) 4/1/99 - 5/31/09
NIH/NIAMS
Low Back Pain: A Multicenter Randomized Trial
The major goal of this project is to extend the original follow-up of SPORT for an additional five years and provide short and long term scientific evidence as to the relative efficacy/effectiveness of surgical versus non-surgical treatment for the three most commonly diagnosed lumbar spine conditions: intervertebral disc herniation (IDH), spinal stenosis (SpS), and degenerative spondylolisthesis (DS).

1 P60 AR48094-01A1 (Weinstein, J) (PI-Director) 4/1/03 - 3/31/08
MCRC in Musculoskeletal Diseases
The major goal of this center is to promote rigorous clinical research through a focused collaboration of diverse disciplines with an overall objective of improving the health of patients suffering from musculoskeletal diseases.

1 T32 AR049710-01 (Weinstein, J) (PI) 7/1/03-6/30/09
NIH/NIAMS Grant
Orthopedic Resident Clinician/Researcher Program
The major goal of this grant is to support the training of orthopaedic clinician/researchers in good, solid research principles and practices and to assume leadership positions to initiate health care improvement.

(Weinstein, J) (Advisor) 2002-2012
NIH Grant
Rush-Presbyterian St. Luke's (Andersson, G - PI)
MCRC Intervertebral Disc Degeneration and Regeneration: Biomechanical and Biochemical Aspects

COMPLETED

(Weinstein, J) (Mentor) 2002-2007
NIH K-Award (Lurie, J)
Clinical Decision-Making in Low Back Pain

(Weinstein, J) (Advisor) 2002-2007
NIH Grant
University of Washington Seattle (Deyo, R - PI)
Multidisciplinary Clinical Research Center for Musculoskeletal Research

2 RO1 AR44757 DeLeo, J (PI) 9/3/97 – 7/31/06
NIH/NIAMS
LBP with Radiculopathy: An Inflammatory Response
The major goals of this project are to determine the role of neuroimmune activation in low back pain associated with radiculopathy.

Center for Medicare and Medicaid Services (CMS) 1/1/05 - 12/31/05
Shared Decision Making Demonstration Project
Weinstein, J (PI)

The major goal of this project is to extend the shared decision-making process developed at the Center for Shared Decision Making (CSDM) at Dartmouth-Hitchcock Medical Center (DHMC) for choice of treatment for low back pain and breast cancer to include choice of treatment for osteoarthritis of the hip and knee, and the PSA screening decision. The shared decision-making process will also be extended to Lakes Region General Hospital and to Dartmouth-Hitchcock patients using the Concord Hospital, Concord, NH

(Weinstein, J) (Advisor) 2001-2005
NIA Grant (Levinson, W-PI)
Informed Decision-Making in Older Patients and Surgeons
The purpose of this grant is to assess the informed decision making skills of surgeons with patients who are 65 years or older in the office setting.

1 K02 HS11288-01 (Weinstein, J) (Mentor) 9/15/00-8/31/05
Agency for Healthcare Research & Quality (Birkmeyer, N) (PI)
Assessing and Improving the Quality of Care For Low Back Pain
This study has two main goals (1) to evaluate the quality of surgical and non-surgical treatment for low back pain; and (2) to reduce variation in treatment practices and improve the outcomes of treatment for these conditions.

THE DARTMOUTH INSTITUTE
FOR HEALTH POLICY & CLINICAL PRACTICE
Where Knowledge Informs Change

March 3, 2008

The Honorable David Obey
Chairman
House Appropriations Subcommittee
on Labor, Health and Human Services,
Education, and Related Agencies
2314 Rayburn House Office Bldg.
Washington, D.C. 20515

Dear Congressman Obey,

Thank you for the opportunity to testify before the Subcommittee for your hearing: Opportunities Lost and Costs to Society: The Social and Economic Burden of Disease, Injuries, and Disability. It was a great honor.

I am writing to respond to your request for additional comments for the record. You asked for recommendations on how best to strategically distribute the federal funding that is currently available for health care research and reform.

I would focus on four areas:

- **Revise the current payment system that rewards providers for doing more procedures and providing more care, when our evidence from the Dartmouth Atlas shows that more is indeed not better and in fact often results in greater mortality and worse outcomes.** As long as the incentive is to see patients more often and to provide more care, we can never achieve lower costs in our health care system. Worse, we are encouraging a process that actually hurts our patients.

- **Reduce variation in health care delivery.** As documented in the Dartmouth Atlas of Health Care and most recently by the CBO's report, "Geographic Variation in Health Care Spending," there are huge differences in practice and treatment patterns across the country. These exist not only between states, but within states. (I've attached a document showing variations in the states and districts represented by the Subcommittee members, as an example. This particular sampling looks at back surgery, but the patterns persist across health conditions and treatments.)

- **Standardize our information systems to reduce medical errors, lower costs, and improve care**. In an age where the pharmaceutical industry knows the prescription practices of every provider their sales reps call upon, it is incredible that our health care informatics remains fragmented, inconsistent, and dangerously ineffective. According to the Institute of Medicine medical error mortality statistics, more than 100,000 lives could be saved each year with the institution of a common platform for medical records. Imagine, a solution as simple as every hospital and doctor on the same computer system, it should be mandated. The cost savings would be in the billions.

- **Increase investment in practical clinical trials.** These are cheaper and probably more effective in delivering the necessary evidence to improve clinical practice. They will inform the shared decision making process and lead to

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empowered patients who have an "Informed Choice". They will lead to safer, and better treatments, improve outcomes, patient satisfaction, and substantially lower health care costs for the nation.

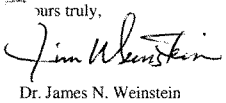
As a beginning to achieving these goals, I would propose funding 1-2 year demonstration projects to show the return on investment each of these initiatives. I, Jack Wennberg and others at the Dartmouth Institute for Health Policy and Clinical Practice have developed models for proving the value and effect of shared decision making, informed by evidence based medicine. These projects would demonstrate a new and exciting paradigm wherein the provider payment system rewards the best practice, not the most practice.

The Dartmouth Atlas Series provides an in-depth analysis of variation and its impact on patient health and costs. We have shown that billions of dollars could be saved annually if high-procedure, high-spending regions were to adopt the practice patterns of more efficient regions. We have a number of proposals to address these discrepancies to improve both the patient health and financial health of our nation. Finally, with colleagues at Dartmouth-Hitchcock Medical Center, we are building what we believe to be a model information system to improve quality and safety, while lowering costs within our two-state health care system (NH and VT).

I welcome the opportunity to discuss any of these issues and approaches that could be implemented to demonstrate the savings and effectiveness of these strategies. If you or your staff would like more information, please do not hesitate to contact me. I am also happy to meet with you at your offices.

Thank you again for the invitation to testify and to share my thoughts on this very important subject.

Yours truly,



Dr. James N. Weinstein
Director

Cc: Members of the Subcommittee
Andria Oliver, Subcommittee Clerk

Enclosures:

Report by the Congressional Budget Office: Geographic Variation in Health Care Spending (Feb. 2008)

Analysis of variation within congressional districts of the Subcommittee members (From the data of the Dartmouth Atlas and the Dartmouth Institute for Health Policy and Clinical Practice.)

Letter to Congressman Kennedy in response to his request for directed language re. CMS allocation of funding.

Executive Summary: The Care of Patients with Severe Chronic Illness: A Report in the Medicare Program by the Dartmouth Atlas Project (2006)

Mr. OBEY. Thank you very much.

Dr. Leigh.

Mr. LEIGH. Thank you, Chairman Obey and members of the Committee for inviting me.

Most Americans between the ages of 22 and 65 spend 50 percent of their waking time at work. Every year, millions of Americans experience injuries, illnesses, and even deaths in the workplace. The cost of occupational injuries and illnesses is nearly as great as the cost of cancer, roughly the same as the cost of diabetes, and greater than the cost of Alzheimer's. This large size is sometimes underestimated since Federal Government statistics systematically under-count occupational injuries and virtually ignore occupational disease.

Despite these large costs, Federal budgets for research and statistics on occupational safety and health are a fraction of those for cancer, diabetes, or Alzheimer's. In addition, most of these costs are not absorbed by the worker's compensation system; they are passed on to other private insurance carriers, to Medicare, to Medicaid, to Social Security disability insurance, and to individual injured workers and their families. Finally, a disproportionate number of Hispanic and low-income persons experience these injuries. But what is especially tragic about this toll is that so many of these occupational injuries and illnesses could have been prevented.

The failure to address these costs has a number of broader economic consequences since an ounce of prevention is worth a pound of cure. First, greater attention to the prevention of occupational injuries would partially restrain the escalating costs of medical care, now 16 percent of gross domestic product and rising. Second, it would decrease the high cost of worker's compensation insurance, which now extracts about $88,000,000,000 annually from business and government. Third, greater prevention would improve productivity, since there would be fewer workers who become disabled.

Let me now address some of these points a little more in detail.

National costs. I use the Cost-of-Illness method that divides costs in direct and indirect categories. Direct categories include hospitals spending and physician spending; indirect refers to wage losses and household production losses.

Let me first address diseases.

The greatest contributors to occupational disease are cancer, circulatory disease, respiratory disease, and job-related arthritis. The number of yearly job-related disease deaths sums to over 66,000. Total costs were $49,000,000,000. Worker's compensation was not likely to cover these fatal diseases since so many of them do not manifest themselves until retirement.

In addition to the fatal diseases, there was job-related arthritis. Job-related arthritis most frequently develops after age 55 and can be attributed to an on-the-job injury. A typical case would involve a worker who seriously injures his or her knee on the job at age 40 and develops severe osteoarthritis in that knee at age 70. In some cases, the knee may have to be replaced, and knee replacement surgery is expensive. Medicare, not worker's compensation, would pay for that surgery.

Turning now to injuries, I estimate over 5,800 injury deaths that cost about $5,000,000,000 annually. I estimate about 8,000,000

non-fatal injuries that cost about $110,000,000,000. If we sum these two, it comes to $115,000,000,000 each year.

Combining diseases with injuries, I estimate a total of $163,000,000,000. About 67 percent of this—$109,000,000,000—is for indirect costs, lost wages; about $55,000,000,000 is for direct costs.

Now, there are other cost estimates, not just mine. Liberty Mutual is an insurance company, one of the largest worker's compensation insurance carriers in the Nation. They also estimate costs of occupational injuries and illnesses. They put the figure anywhere from $155,000,000,000 to $232,000,000,000.

My estimates, as well as those of Liberty Mutual, indicate a higher percentage of indirect costs—that is, lost wages—as a ratio to total costs when compared to other diseases, such as heart disease and cancer. The reason for these high indirect costs is that over 70 percent of occupational costs are due to injuries, not illnesses; and injuries account for more harm to younger persons than they account for by diseases.

Occupational injury deaths, for example, frequently occur among people that are in their twenties or in their thirties, whereas, cancer and heart disease deaths frequently occur among people in their seventies and eighties.

Now, all deaths are losses, but deaths among younger persons result in many more years of economically productive life loss than deaths among older persons. Moreover, deaths among parents with young children are especially tragic. Neither my estimates nor those from Liberty Mutual attempt to account for the emotional cost to children of losing a parent.

These occupational injury and illness costs are large when compared to those for other diseases. My costs were almost as large as the estimates for cancer, on a par with the cost for diabetes, and greater than Alzheimer's. The upper range of Liberty Mutual estimates far exceed those for cancer.

These estimates invite comparisons to Federal Government funding. The National Institute for Occupational Safety and Health (NIOSH) has consistently received among the smallest amounts of funding of all the institutes. The 2006 budget for NIOSH was $254,000,000. This compares to the National Cancer Institute, with 19 times the NIOSH budget; National Institute for Diabetes, Digestive and Kidney Disorders, 7 times the NIOSH budget.

I am not arguing for a chance for any money—I think all of them should be increased—I am just providing a comparison.

The Bureau of Labor Statistics under-count and the disease gap. A number of studies indicate that the Bureau of Labor Statistics may miss from 20 percent to 70 percent of all injuries and illnesses. There are many causes for this omission, but let me mention one: outsourcing to small firms with contingent workers.

In the past 20 years, the American economy has seen greater reliance on big firms outsourcing to small firms who hire contingent workers. We all know that small firms, especially those with contingent workers, are less likely to report injuries to OSHA and BLS. But the greatest gap lies with measuring fatal occupational disease. Less than 5 percent of occupational disease is recorded in Federal statistics.

Regarding worker's compensation. It pays about $55,000,000,000 in medical care and lost wages per year. A comparison to my estimate suggests that 66 percent of these costs—or about $108,000,000,000—is not covered by worker's comp. Well, who pays when worker's compensation does not pay? The short answer is everybody else.

For medical costs, roughly $14,000,000,000 was paid by private insurance; $12,000,000,000 by Medicare; $4,000,000,000 by Medicaid. For indirect costs, that is, lost wages, a significant portion, perhaps $20,000,000,000, was paid by the Social Security disability insurance.

There are economic implications for cost shifting. The health of workers can be viewed as an economic externality, an unwelcome byproduct of production, similar to air pollution. Economic efficiency requires that private costs of production equal social costs. If private costs are too low, the firm will produce an inefficient amount, that is, too much pollution or, in our case, occupational injuries.

Aggregate private costs, reflected by worker's compensation premiums, are too low. If the premiums were higher, the firms would have an economically appropriate incentive to reduce injuries. This reduction would likely involve prevention strategies.

I just have a couple concluding remarks.

Greater investments in preventing occupational injuries and illnesses are needed. Standards to reduce exposures to chemicals and ergonomic hazards would help prevent many occupational diseases and reduce the incidence of musculoskeletal disorders, which are responsible for nearly one-third of all injuries. In addition, an increase in the sizes of OSHA penalties, especially for repeat offenders, would help. For the sake of economic efficiency, employers should face a higher price for their neglect.

Let me offer a low-cost policy suggestion. We should require health and safety information be attached to all job application forms. We know more about the fat content of potato chips before we purchase them before we do about the health and safety content of jobs before we take them. I think every job application form should carry a page of information on statistics, including death rates, particular to the specific occupations and industries relevant to the job applicant. This would permit prospective employees to turn down dangerous jobs, thus providing a free market incentive for employers to improve job safety.

I hope that one question involves Hispanic workers. I wanted to make sure I was under the 10 minute limit. But thank you, Chairman, for inviting me, and I look forward to your questions.

[The information follows:]

The Costs of Ignoring Occupational Injury and Illness

Could An Ounce of Prevention Reduce These Costs?

Written Testimony for Chairman David Obey, US House of Representatives, House Appropriations Committee, Sub-Committee on Labor, Health & Human Services, Education, and Related Agencies

Date: February 14, 2008

Written by : J. Paul Leigh, Professor of Health Economics, Center for Healthcare Policy and Research, Department of Public Health , University of California, Davis, Medical School. One Shields Ave, TB-168 Davis, California, 95616-8638
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Introduction

This testimony will highlight some of the costs associated with the failure of government and society to address the significant problems of occupational injury and illness. The size of the costs is large. I estimate the costs to be nearly 80% as large as those for cancer, roughly the same as those for diabetes, and greater than those for Alzheimer's in 2005. This large size is sometimes underestimated since federal government statistics systematically under-count occupational injury and virtually ignore fatal occupational disease. Despite these large costs, federal budgets for research and statistics on occupational safety and health are a fraction of those for cancer, diabetes and Alzheimer's. In addition, most of these costs are not absorbed by workers compensation insurance carriers; they are passed-on to non-workers compensation private medical insurance carriers, to Medicare, to Medicaid, and to individual injured workers and their families. Finally, evidence also exists demonstrating that a disproportionate number of Hispanics and low-income persons experience these injuries.

The failure to address these costs has a number of broader economic consequences since "an ounce of prevention is worth a pound of cure." First, greater attention to the prevention of occupational injuries and illnesses would partially restrain the escalating costs of medical care, now pegged at 16% of GDP and rising. Second, it would decrease the high costs of workers' compensation insurance which now extracts $ 88 billion annually from business and government. Third, greater prevention would improve productivity since there would be fewer workers who become disabled. (The father of economics, Adam Smith, recognized this productivity consequence and called for government intervention to reduce occupational hazards.). Fourth, the fewer number of disabled workers would result in fewer federal dollars being spent for Social Security Disability Insurance as well as fewer dollars spent by state and local governments for welfare.

This testimony will be divided into six parts. First, I will discuss methods and estimates of the overall costs for occupational injury and illness. Second will be a discussion of under-reporting of cases to the Bureau of Labor Statistics. Third, I will address issues of cost-shifting. Fourth, I will discuss disparities by race, ethnicity, and income; and fifth, the time-trend

in reported injuries will be discussed. . Finally, the main points are summarized and a modest proposal for providing information to improve market efficiency will be suggested in section six.

I. **National costs of occupational injury and illness, 2005**

I used the Cost-of-Illness method that divides costs in direct and indirect categories. Direct costs include medical spending on, for example, hospitals, physicians, drugs, and nursing homes. Indirect costs refer to productivity losses that include wage losses and household production losses; as well as employer productivity losses, which include time spent by supervisors recruiting and training replacements for injured workers. After adjusting for inflation, costs were expressed in 2005 dollars.

I and fellow researchers previously developed rigorous estimates of costs for 1992. For this testimony, I have generated preliminary estimates for 2005 that extrapolated from the 1992 estimates based on the growth or reduction in prevalence or incidence of illnesses and injuries as well as inflation . Despite the preliminary nature of these estimates, I am confident that the conclusions drawn (e.g. comparing these costs to costs of cancer or diabetes) still hold.

Estimates for diseases are presented first followed by injuries and then followed by diseases and injuries combined.

Table 1` lists the costs of diseases attributed to job-exposures. All disease age ranges had a lower limit of age 25. Most had no upper limit with the exception of circulatory disease, which had an upper age limit of 64.

In addition to the fatal diseases there is job-related osteoarthritis and nonfatal illnesses measured in Bureau of Labor Statistics (BLS) files. Job-related osteoarthritis most frequently develops after age 60, and can be attributed to an on-the-job injury. A typical case would involve a worker who seriously injures his or her knee on-the-job at age 40 and develops severe osteoarthritis in that knee at age 70. In some cases, the knee may have to be replaced, and knee replacement surgery is expensive. The BLS illness data included information on, for example, carpal tunnel syndrome, dermatitis and tendonitis.

The greatest contributors to costs in Table 1 are cancer, circulatory disease, respiratory disease and job-related arthritis. The number of yearly job-related deaths in Table 1 sums to 66,239. Total costs including job-related osteoarthritis and nonfatal illnesses total $49.1266 billion in 2005. Workers compensation is not likely to cover many of the fatal diseases or job-related osteoarthritis since so many do not manifest themselves until retirement.

I also updated the 1992 fatal and nonfatal injury estimates to 2005. Adjusting fatalities yielded 5,876 in deaths $5.007 billion in costs. . Adjusting nonfatal injuries yielded 8,181,583 in number of cases and $110 billion in costs. Combining the two injury costs yielded $115 billion.

I estimate the total costs of occupational injuries, illnesses and fatalities in 2005 to be $163.2 billion (Table 2) with 66.6% or $108.8 billion for indirect costs and $54.5 of direct costs.

Liberty Mutual is one of the largest workers' compensation insurance carriers in the US. They estimated direct and indirect costs for all occupational injuries and illnesses (not just those covered by workers' compensation) to be from $155 billion to $232 billion in 1998.

(One reason Liberty Mutual's estimates exceed ours is they allow for more categories of productivity costs to employers such as overtime pay).

My estimates as well as those of Liberty Mutual's indicate a higher percentage of indirect costs to total costs when compared to other diseases such as heart disease or cancer. The reason for these high indirect costs is that over 70% of the occupational costs are due to injuries rather than illnesses and injuries account for more harm to younger persons than are accounted for by diseases. Occupational injury deaths, for example, frequently occur among persons in their 20s , 30s and 40s whereas cancer and especially heart disease deaths frequently occur among persons in their 60s, 70s and 80s. Whereas all deaths are losses, deaths among younger persons mean many more years of productive life lost than deaths of older persons. Moreover, deaths among parents with young children are especially tragic. Neither our estimates nor those from Liberty Mutual attempt to account for the emotional costs to young children of losing a parent.

Table 1
Diseases and Costs, 2005, Preliminary Estimates

	Disease	**ICD-9 Codes**	**Percent Attributed to jobs**	**Estimated Job-Related Deaths**	**Estimated Job Related Costs (Billions$2005)**
1	Cancer	140-209	8%	44,445	$16.3293
2	Circulatory disease (heart and stroke)	410-414, 430-438, 440	10%	7155	$4.5070
3	Chronic obstructive pulmonary disease and asthma	490-496	10%	11,880	$6.4660
4.	Pneumonoconioses	500- 505	100%	1136	$0.1268
5.	Nervous system disorders	323.7, 331, 332, 349.82, 356, 357.7, 359.4	2%	712	$0.1985
6.	Renal disease	580-589	2%	911	$0.4586
7.	Osteoarthritis	715	8%	0	$14.4652
8.	Non-fatal illnesses from BLS	N/A	N/A	0	$6.5752
	TOTAL			**66,239**	**$49.1266**

Table 2

Number and Cost for Job-Related Injuries and Illnesses in US ($ Billions) 2005, Preliminary Estimates

	Number	Costs, billions
I Injuries	8,186,792	$115.0776
A. Deaths	5,876	$5.0070
B. Nonfatal	8,180,916	$110.0706
II. Illnesses		$49.1266
A. Deaths	66,239	$28.0862
B. Nonfatal injuries	726,325	$6.5752
C. Job-related arthritis		$14.4652
III. Grand total		**$163.2042**

These occupational injury and illness costs are large when compared to those for other diseases. The costs of cancer in 2005 were estimated to be $210 billion. My costs estimates ($163 billion) are therefore roughly 78% as large as those for cancer. The upper range of Liberty Mutual's estimates exceeds those of cancer. The costs of diabetes in 2007 were estimated to be $174 billion. Accounting for inflation between 2005 and 2007, my estimates would be on a par with those of diabetes. The upper range of Liberty Mutual estimates would again exceed those of diabetes. A recent estimate of the costs of Alzheimer's disease was $148 billion indicating my estimates of costs of occupational injury and illness exceed those of Alzheimer's.

These costs estimates invite comparisons to federal government funding for health research. The National Institute for Occupational Safety and Health (NIOSH) has consistently received among the smallest amounts of funding compared to other institutes. The 2006 fiscal year funding for NIOSH was $254 million. This compares to: $4,793 million (19 times NIOSH budget) for the National Cancer Institute; $1,844 million (7.3 times NIOSH) for the National Institute for Diabetes, Digestive and Kidney Disorders; and $508 million (2 times) for the National Institute of Arthritis and Musculoskeletal Disorders.

2. Undercount

A number of studies indicate that the BLS's estimates of the numbers of nonfatal injuries and illnesses are significantly below the actual numbers . The BLS may miss from 20% to 70% of all nonfatal injuries and illnesses. In part, this is due to the purposeful BLS exclusion of the self-employed. But more important are the exclusions of cases that private firms do not report to the BLS. First, firms may have an economic incentive to under-report. Some experience-rated workers' compensation systems penalize firms with high premiums if they report high numbers of injuries. Firms may also want government contracts and therefore want to look attractive to government agencies , at least on paper. But it is not just firms. Employees may voluntarily decline to report an injury for fear of being labeled accident-prone or for fear of being denied a promotion. Finally, the undercount may have also resulted from the increasing number of out-

sourcing firms who employ contingent workers (#1 ref. Cummins). These workers and firms may be especially prone to under-report.

This undercount is not unique to the BLS Annual Survey. Any of the major sources of data, such as from the National Institute for Occupational Safety and Health, workers' compensation systems, or National Health Interview Survey, by themselves underestimate the numbers of injuries and illnesses by similar margins.

But the greatest data gap in government statistics lies with measuring fatal occupational fatal disease . Information is available on coal workers' pneumoconiosis, silicosis, byssinosis , and mesothelioma. But these comprise fewer than 5% of all occupational disease deaths. In my view, more resources should be devoted to data-gathering for fatal occupational disease.

3. How much of the costs do Workers Compensation insurers cover ? Who pays for the rest? Implications for cost shifting

Workers Compensation insurers paid $55.3 billion for medical care and indemnity payments in 2005. The comparison to my estimates suggests that 66% of costs, or $108 billion, was not covered by workers compensation.

Who pays when workers compensation does not? The short answer is "everybody else." I can assume that medical costs will be absorbed by existing payment mechanisms outside workers compensation. Using figures from the National Center for Health Statistics (NCHS), roughly 15% will be out-of-pocket, 40% will be private health insurance, 33 % will be Medicare , 10 % will be Medicaid and 2% will be "other." If $108 billion is not covered, and 33% of $108 is direct costs, then $36 billion will be spread across the NCHS categories. Roughly $14.4 billion will be paid by non-workers' compensation private insurance. Roughly $15.6 billion will be paid by taxpayers in the form of Medicare ($12 billion) and Medicaid ($3.6 billion).

The bulk of the uncovered indirect costs ($72 billion) will be absorbed by individual workers and their families but also by the economy at large, since more disabled workers will mean less output. Some indirect costs will also be absorbed by Social Security Disability Insurance. Reville and Schoeni (#2 ref.) find that "among Disability Insurance recipients, 45 percent of men and 26 percent of women are disabled because of workplace accidents, injuries, or illnesses. The annual cost of workplace injuries to Medicare and Social Security Disability Insurance is roughly $33 billion."

There are economic implications for this substantial cost-shifting. The health of workers can be viewed as an economic externality, an unwelcome by-product of production, similar to air pollution. Economic efficiency requires that private costs of production equal social costs. If private costs are too low, the firm will produce an inefficient amount (too much) pollution or, in our case, too many occupational injuries. Aggregate private costs, as reflected by workers compensation premiums, are too low. If the premiums were higher, and if firms were experienced-rated so that they would face the true costs they generate, the firms would have the economically appropriate incentive to reduce injuries. This reduction would likely involve prevention strategies. This prevention would mean a reduction in costs borne by private non-workers compensation medical insurance carriers, Medicare and Medicaid. Given the high and rising cost of medical care (currently 16% of GDP) this trade-off of more prevention spending for less cure spending would be welcome.

4. Disproportionate number of Hispanics and low-income workers

The BLS's Census of Fatal Occupational Injuries indicates that while all other race and ethnic groups were reporting fewer deaths from 1992 to 2005, Hispanics were reporting more. The percentage increase for Hispanics was 73%. . A similar trend was evident for non-fatal injuries and illnesses in the BLS's Annual Survey. While all race/ethnic groups showed a downward trend, the trend for Hispanics was the smallest. From 1992 to 2002 (latest year for which definitions are the same), white non-Hispanic cases decreased by 45%, but Hispanic cases decreased by only 9%. Numerous studies by researchers at BLS confirm these findings. A 2005 study concluded that "Hispanic workers tend to be disproportionately represented in higher-risk, lower-wage jobs." And these findings apply to both male and female Hispanic workers.

There are two relevant points regarding low wages and occupational injuries and illnesses. First, when economists consider the relation between wages and occupational hazards, they almost always exclude white-collar workers. The reason is that it is widely believed that there are too few serious injuries and illnesses among white-collar workers to allow for a meaningful analysis. But it is also widely recognized that white-collar workers, in general, are paid more than blue-collar workers. Second, the list of 10 occupations in the BLS data with the greatest numbers of nonfatal cases of injuries and illnesses includes a disproportionate number of low wage occupations. The list of ten (number of cases and average wage, for 2005 and 2006) are as follows: laborers and freight, stock, and material movers(92,240, $11.08), truck drivers, heavy and tractor-trailer(65,930, $17.46), nursing aides, orderlies, and attendants(52,150, $11.04), construction laborers(39,270, $14,39), truck drivers, light and delivery services(32,740, $13.23), retail salespersons(32,300, $11.51) , janitors and cleaners, except maids and housemen(31,440, $10.45), carpenters(31,270, $19.20), maintenance and repair workers, general(23,170,$16.11), stock clerks and order filers(23,060, $10.79) . With the exception of carpenters' wages, the remaining nine of these "top 10" wages are well below the average for the nation, $18.84.

Again, BLS researchers confirm these findings. One report states "...the risk of nonfatal workplace injury and illness declines as estimated family income rises. Male workers with an estimated total family income under $20,000 face a risk of nonfatal workplace injury or illness that is nearly 3 times higher than it is for male workers with an estimated total family income of $80,000 or more." Similar findings were found for women.

5. Trend

There has been a downward time trend for numbers and rates of occupational injury (but not disease). A roughly 8% reduction for injury deaths occurred from 1992 to 2005 and a 38% reduction for nonfatal cases from 1994 to 2005. This has lead some observers to suggest that "nothing more needs to be done," since time will obviate the need for additional resources devoted to occupational safety and health. There are at least three responses to these observers. First, academic researchers question whether and how much reduction there has actually been, especially given the controversy above about the BLS undercount. One study found that 83% of the BLS reported decline is due to changes in OSHA record-keeping rules. Second, for other diseases, just because there is a downward trend does not mean we quit. Breast cancer mortality for white women has been slowly but steadily dropping, perhaps 25%, since 1984. Yet the NCI funding for breast cancer research has been increasing. The same is true for heart disease. The age-adjusted death rate for heart disease dropped 42% from 1980 to 2002 but funding for the National Heart Lung and Blood Institute has expanded from 1980 to 2002. As breast cancer and

heart disease deaths drop we tend to congratulate the funding agencies and reward them with more resources. I believe we should do the same for occupational safety and health. The third response is simply this: there is no evidence that the total numbers of fatal occupational diseases (66,239 in 2005) are falling over time.

6. Summary and Proposal

- The toll of occupational injuries, illnesses and deaths is great.
- The costs are almost 80% as large as those for cancer and on a par with those for diabetes yet the resources and research devoted to occupational injury and disease is a fraction of those devoted to cancer or diabetes.
- The BLS injury and illness survey underestimates the problem by as much as two-thirds.
- Workers compensation covers less than half of the costs. A large portion of the remainder is shifted to Medicare, Medicaid, and Social Security Disability Insurance.
- A disproportionate number of Hispanics are in high-risk, low-wage jobs.

Greater investments in preventing occupational injuries and illnesses are needed. Standards to reduce exposures to chemicals and ergonomic hazards would help prevent many occupational diseases and reduce the incidence of musculoskeletal disorders which are responsible for nearly one-third of all injuries. In addition, an increase in sizes of penalties, especially for repeat offenders, would help. A recent PBS Frontline investigation revealed that the penalty for employers who "willfully" ignore safety hazards that result in a worker death is only a misdemeanor.

Let me offer a low-cost policy suggestion: require that health and safety information be attached to all job application forms. Like most economists, I am a believer in free markets. As all economists acknowledge, free market efficiency is enhanced with better information. Today, information on job hazards that workers can easily grasp is sadly lacking. For example, I do not believe that most clerks in convenience stores realize that their risks of murder are higher than those for police officers. I do not believe that most women seeking jobs as aides in nursing homes realize that nursing home aides experience more serious injuries than women in any other job in the country. We know more about the fat content of potato chips before we purchase them (thanks to federally-mandated nutrition notices) than we do about the health and safety content of jobs before we take them. This is unfortunate since most of us between the ages of 22 and 65 spend 40-50% of our waking time at work. I think every job application form should carry a page of information and statistics---including death rates--- particular to specific occupations and industries relevant to the job applicant. This would permit prospective workers to turn down dangerous jobs, thus providing a free market incentive for employers to improve job safety.

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Biography: J. Paul Leigh is Professor of Health Economics, Center for Healthcare Policy and Research, Department of Public Health, University of California, Davis, Medical School. He received a PhD in economics from the University of Wisconsin, Madison in 1979. His research interests include estimating costs of diseases, econometric applications in medical research, effects of education on health, and occupational safety. He has received funding from the National Heart, Lung and Blood Institute, the National Institute for Occupational Safety and Health, and the National Science Foundation. Dr Leigh served as Economics Consultant on numerous arthritis grants with Stanford University Medical School from 1986 through 2003. He is primary author of over 140 scientific papers as well as two books, including *Costs of Occupational Injuries and Illnesses*, published by the University of Michigan Press in 2000.

BIOGRAPHICAL SKETCH

NAME	POSITION TITLE
Leigh, J. Paul	Professor

EDUCATION/TRAINING *(Begin with baccalaureate or other initial professional education, such as nursing, and include postdoctoral training.)*

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	YEAR(s)	FIELD OF STUDY
University of Oregon, Eugene, OR	B.A.	1973	Economics
University of Wisconsin, Madison, WI	Ph.D.	1979	Economics

A. Positions and Honors

1979 - 1981	Assistant Professor, California State University, Los Angeles, California
1981 - 1984	Assistant Professor, San Jose State University, San Jose, California
1984 - 1986	Associate Professor, University of Kentucky College of Medicine, Kentucky
1986 - 1998	Professor, San Jose State University, San Jose, California
1986 - 2003	Economics Consultant, Stanford Medical School, Stanford, California
1998 - present	Professor, University of California Medical School, Davis, California

B. Selected peer-reviewed publications (selected from 150 peer-reviewed publications)

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C. Research Support

ACTIVE

1 R01 HS013603 (Anthony Jerant, M.D.) 7/1/03-12/31/07
Agency for Health Care Research and Quality, AHRQ
A Randomized Trial of Home Self-Efficiency Enhancement
Study will compare effectiveness and incremental cost-effectiveness of different home-based care models and usual care designed to improve chronic illness outcomes and to increase understanding of the mechanisms of effective home care. Role: consultant

1 R01 OH008248(Paul Leigh, PI) 6/1/05 – 5/31/10
National Institute for Occupational Safety and Health, NIOSH
Costs of Occupational Injury and Illness
Study will estimate costs of injuries and illness for nation, across industries, demographic groups. Study will also forecast costs for 2015. Role: Principal Investigator

'RPFZNB (Richard Kravitz MD and Nicole Bloser, PIs) 4/1/07-12/31/08
zer Pharmaceuticals Inc.
Cost-Effectiveness of N-of-one Trials
Study will conduct cost-effectiveness studies on n-of-one trials involving selected pharmaceuticals.
Role: Consultant

Mr. OBEY. Well, thank you. Thank you all very much. Let me simply say that we are in the last year of this Administration's tenure, and I think, as the last year's appropriation cycle indicated, we do not have a whole lot that we agree with in terms of the Administration's budget policies; and I think that was demonstrated by the fact that the President vetoed the bill produced by this Subcommittee last year.

I do not particularly see any sense in chewing the same cud twice, as we say in farm country, and so I really regard this year, and our actions during it, as simply being preparatory to the new administration, whichever party it is; and I think everyone recognizes that there is a major chance that the next Congress and the next president will tackle the issue of universal health coverage. If we do, that has profound consequences all throughout the economy. It has profound consequences in terms of the way we distribute and deliver health care.

And I view this Committee as having a responsibility to try to respond to this question: If we thought that, within two years, Congress will have passed legislation creating universal health care—forget the theological debate about what shape that will be—if we do that, where should we be putting money in this Subcommittee in order to try to prepare our health care system and our medical system for the implications of finally passing that kind of legislation?

And let me ask each of you to respond. I have got a lot of other questions, but, because of time, I will then pass the witnesses down to the other members.

Mr. THORPE. I think, as I started out in my testimony, to me, the real critical part of a broader health care proposal, in addition to the uninsured, is the issue of affordability. If we do not find ways to make health care more affordable in the public and private marketplace, doing a universal insurance proposal may or may not be sustainable over the long haul. So we have got to find more effective ways of bending the cost curve on the per capita growth in Medicare spending, Medicaid, and private insurance pocket.

Now, having said that, I think there is a lot of agreement that we need to do that in the business community and the labor community, and so on. You have to have a clear understanding of the issue. And if you look at the two facts that I raised—one is that 75 percent of spending is linked to chronically ill patients, where the money is; and, two, a very substantial amount of the growth in spending is linked to the rising incidence of disease. Diabetes itself has gone up 70 percent over the last 20 years. So in terms of an investment portfolio, it seems to me that we have got to find better ways of managing chronic disease in the system and preventing its rise over time. So I would point to just three or four areas in terms of thinking about where to make investments.

One is that I think we need to change the way that we pay for health care. The Medicare benefit model was a great model for patients in the 1950s, what it was based on and designed after. The clinical characteristics of patients in the system today, and who are driving spending, are very different than they were 40 years ago. So we are going to need research into what makes sense in terms of restructuring our payment model.

What makes sense in terms of restructuring how we deliver services, building into a more proactive delivery model: working with patients outside of the traditional physician's office; providing patients appropriate information on financial incentives to self-manage their condition.

And prevention. What can we do that is cost-effective to slow the rise in obesity and, with it, slow the rise in chronic disease prevalence.

I think that those are not only important because, you know, to me it is the centerpiece of making the whole system sustainable, but it is also areas I think, if you think about it, are just common sense initiatives. They deal with prevention and more effective clinical management. I think an opportunity, I would hope, in 2009 that we can build a bipartisan approach for moving forward with this as really a cornerstone of how to position the debate.

Mr. OBEY. Thank you.

Dr. Weinstein.

Dr. WEINSTEIN. Thank you. I think there is some evidence out there of things that we can do in chronic disease management, as well as in end-of-life types of decisions, where we are spending a lot of money. I think if we take the chronic disease management programs, like Brent James has developed in Intermountain Health, and allow the Nation to benefit from those programs with what some of the plans are calling for, a new IT strategy. And, of course, Dr. Braylor's attempt at that was not successful, but I think that the idea that every hospital system has a different computer system and every patient does not have a transfer of information across this Country seems like an inordinate type of expense that ought to be changed.

Imagine if we all had the same computer system that our patients were having their records kept on. It seems today that is possible. Maybe it is even Google. I am not supporting anybody, I do not own stock in it, but maybe there are better ways to do this.

The idea of practical trials, like SPORT, where we actually get good information to empower our patients in making choices. We know every time we have done that we have seen changes in the rates of procedures, the cost of procedures, the outcomes of procedures, and the utilization of health care more appropriately.

I agree with the ideas of prevention, but implementing those strategies, even back to when John Kennedy was President and we actually worked on physical fitness as a major program in our school system in the grade schools and high school, maybe we just need to go back to just simple things like that and getting back into physical education.

The payment models are all backwards, as I said in my opening statement. The incentives for me are to do more. The more surgery I do, the more complicated the procedure is, the more I am reimbursed. I do not think that is the appropriate model for our health care system.

The issue of episodes of care, which the NQF and others, NCQA and others, are working on—which I have been involved with with Dr. Fisher and others—looking at how you take an acute myocardial infarction patient or somebody with back pain and work through that episode in a payment mechanism that actually gets

the highest quality care, while limiting the payment structure to that episode, maybe be an interesting model to pursue.

I think the opportunities for end-of-life care. Again, do patients want to die in an intensive care unit? Certain studies by Joann Lynn and others have suggested that patients want to die at home. Yet, if you look in the California system, which I know some of you are from, especially in the UCLA area, most patients end up dying in the hospital. That is an extremely expensive way to die, especially, again, if patients were informed with informed choice and didn't desire to.

A few ideas.

Mr. OBEY. Dr. Leigh.

Mr. LEIGH. Well, I agree with a lot of what has been said, especially with Dr. Thorpe, the emphasis on prevention, and I think that improvements or increases in the NIH budget, in the NIOSH budget. I am a believer in the economic efficiency in the sense that I think that the price of production for an employer ought to reflect the true costs associated with that. So if somebody is injured—back injury, hip injury—this should be figured into the production of the product. So this gives the appropriate incentive to the employer, then, to look for prevention strategies; not that one size fits all. Let's have individual employers find where the best prevention strategy might be to reduce these back injuries, reduce the hip injuries, again, encouraging prevention.

It turns out that, with the obesity epidemic, I have a grad student now that we are doing some research on wages and obesity; and, as probably most of you know, obesity is much more prevalent among lower income people, so it might be a substantial increase in the minimum wage would result in fewer people with low income. An increase in the minimum wage would result in higher prices for soda pop and, as we have seen with cigarettes, when you put a tax on the cigarettes, people do in fact smoke less. So this may be a policy way to approach the obesity epidemic.

But, in general, I agree with all the strategies related to prevention.

Mr. OBEY. Thank you.

Mr. Walsh.

Mr. WALSH. Thank you, Mr. Chairman.

Sorry I had to leave, but everyone is expected to do lots of things at once here.

I was able to pass a bill here in the Congress that provided for hearing testing for all newborns, and it really has an impact, as you can imagine, on that child's ability to learn. And the idea of screening I think everyone accepts as a good concept for cancer and a host of others that focus on the individual, but there is another type of prevention program that I really think gives us a good bang for the buck, and that is population-based prevention, which develops and delivers interventions that reach large groups of people.

I raise this issue in large part because of the explosion in the health entitlement programs and the cost of those programs that we have seen in the last couple of years. In fiscal year 2007, we spent over $600,000,000,000 on mandatory programs at the Department of Health and Human Services—largely Medicare, Medicaid, and S-CHIP. In fiscal year 2009, just two years later, that

number is expected to be about $680,000,000,000. That is pretty astonishing, that it would increase that much in a two-year period.

We have to find ways, I think, to impact on health and cost. You do not want to focus on one or the other. So what types of studies have been done to evaluate the value of population-based prevention programs as a whole in terms of savings across the entire health care spectrum, particularly with respect to Federal entitlement programs?

Any of you care to respond?

Dr. WEINSTEIN. I guess I would respond in a way that you might not expect. I am not sure that screening is always the right thing. Screening——

Mr. WALSH. I was not suggesting that that is the only approach to prevention. I was suggesting that that is one, but a larger spectrum of individuals would be gathered in different prevention programs.

Dr. WEINSTEIN. I understand, I believe.

Mr. WALSH. Okay.

Dr. WEINSTEIN. But I think the idea of screening is an important one to talk about because, you know, should we have PSA tests for men? Should we have colon cancer screening? Should we have mammography for women? What are the most cost-effective? What is diabetes? You know, imagine if you changed the you know, if somebody says your blood sugar is 200, that is diabetic. If they change it to 210, we increase the number of people that are diabetics in this Country by maybe two million. I mean, so we have to be careful what we call disease versus pseudo-disease.

So if we screen people for prostate cancer—and I do not know if any of the men here have had that screening, but if you have a positive PSA test, then you have to consider whether you are going to have a biopsy or not. And it is not just a needle stick, it might be 20 needle sticks. You might not know that. Probably not too comfortable. What if it is positive for cancer cells? Then you have a decision about treatment—radiation, chemotherapy, surgery. And the outcome of that treatment may be no different than having not been screened.

So the issue is cost, which you are talking about the $600,000,000,000 to $680,000,000,000 change. As we screen more and we find more, there are consequences to that. As we do genetic testing, how are we going to respond to that, women with the genetic predisposition for breast cancer? Do we offer our daughters, at 16, mastectomy? I mean, realize the ramifications of what we are talking about.

I agree with your concept, but I just want to suggest that the hearing test was wonderful, and obviously children need to hear to learn, and we have all kinds of wonderful medical devices to allow people to hear today that could not hear today. Great success in medical therapies. The population-based prevention, though, and based on screening, I think has some risks to it. That is all I am pointing out. So we have to be careful about what we recommend in the screening field around prevention.

Mr. THORPE. Let me just take a little different cut on this. In addition to what I do at Emory, I am also the Executive Director of this organization called the Partnership to Fight Chronic Disease.

It is a group of nearly 100 organizations ranging from the Chamber of Commerce to the labor unions and virtually everybody in between.

We have been focusing a lot of our time figuring out ways to make health care more affordable, focusing on some targeted prevention interventions specifically dealing with people who are overweight—there is this, Dr. Weinstein mentioned, pre-diabetic, prehypertensive patients and so on—to see how we can intervene to make sure that they do not switch over into those more extreme clinical categories, you know, going from 200 to 600 in terms of blood sugar levels. Because, when it happens, you have a big spike in spending.

So if you can find effective interventions targeted right there, we know the return on investment can be very substantial.

We are scouring, with our 100 groups, looking at best practices in work site health prevention, school-based programs, community-based interventions, and what we have found is—I mean, it is somewhat frustrating that in the published literature—very little in terms of what is out there doing formal evaluations of programs that are up and running. We have found some good programs in the workplace. I think that those are promising. There are very few of them. If you think about it, there are seven million plus business establishments; there are probably a handful of big companies that really do this effectively.

But in that data we have got published information that shows that we can get a positive return on investment if they are designed appropriately. And that is a lot of what we are trying to understand, is how the design of this really mattered in producing outcomes.

On your Medicare question, I think that having this information on best practices is going to be essential for Medicare, because if you look at the cohort of 65-year-olds coming into the Medicare program today, they have two characteristics compared to that same cohort 15, 20 years ago: they cost a lot more; they have more of an elevated chronic disease profile. The only good news is that they are less likely to be disabled. So the disability rates have gone down a little bit.

But if you look at the wave of people——

Mr. WALSH. More chronic health issues in that cohort now than there were 15 years ago?

Mr. THORPE. Yes. If you look at Medicare, 75 percent of what we spend in Medicare is linked to patients that have five or more treated chronic conditions; it is diabetes, it is heart disease, it is pulmonary problems, it is co-morbid depression, it is asthma, arthritis, back problems. That is where the money is. So I think that there is a real opportunity for us to look more broadly to figure out prevention programs at the work site or in the community that we could put into place now that would improve the health profile of seniors coming into the program.

I think while you were doing your talk, one of the things that I mentioned was that if you look at lifetime health care spending for a senior who is age 65, who is normal weight with no chronic conditions, compared to a 65-year-old who is overweight, has one or more disabilities and some chronic conditions, that healthier pa-

tient will spend about 20 percent or so less over the course of their lifetime. They live longer, true, but they spend less. So I think there is an opportunity, as we think about the entitlement issue, to tee it up a little bit differently than the usual way we have been dealing with it, which is increasing co-pays, reducing benefits, reducing payment levels, increasing the eligibility age, you know, paying around the board but not really fundamentally changing the level of spending among that population.

Mr. WALSH. That is helpful. Thank you.

Thank you, Mr. Chairman.

Mr. OBEY. Ms. McCollum.

Ms. MCCOLLUM. Thank you, Mr. Chair, and thank you, gentlemen for your testimony. I am going to switch to Professor Leigh.

Your comment focused on government's failure to address occupational injuries and illness, and I am currently working on legislation that would ban the re-importation of asbestos into the United States. The legislation would also require research on the health hazards of naturally occurring asbestos and invest research and treatment of asbestos-related illnesses. And in the President's budget, he cuts a lot of the research opportunities for occupational safety.

As you may or may not be aware of, mesothelioma is not diagnosed until extraordinarily late. They have seen some successes with people being given this diagnosis and now living, a few people, years longer, but for the most part it is, as my predecessor found out, Congressman Vento, once diagnosed, it is pretty much you have X number of months to live.

So could you talk a little more about the Government's role, its responsibility in regards to finding out more and understanding more about asbestos in the workplace, especially seeing as how many of us—I am 53—and older have been exposed to it throughout our lifetime? Why would it be important to know about this issue as it affects workers in the workplace and why it would be important to do the research in order to not only maybe find a cure, but to find early diagnosis.

Mr. LEIGH. Well, a lot of people have been exposed to asbestos and may not even know it. I think I was exposed years ago when I worked at Manpower Corporation and they had me work with mobile homes, and we were moving a lot of equipment around, and they had the one job, which was basically moving fiberglass and asbestos, which was in the back part of the lot. Thank goodness for the union there, because they would not let me work over three days. I was kind of upset because I wanted to keep working; it was a decent wage. But I was told, well, the union is not going to allow you to work more than three days. At the time, I was kind of upset about it, but I am very happy now that the union had that rule, because I didn't know—I was 22 years old—I didn't know what I was being exposed to.

So I think it is important for us to—and, of course, as you know, the cost of asbestos is growing, or asbestosis and mesothelioma, as all the pneumoconiosis. So it is important for us to know how to treat this, and greater research would help in terms of where the asbestos is now and how to reduce it.

So it is a large problem, a significant economic problem. I welcome more investments in the research.

Mr. OBEY. Would the gentlewoman yield? And I promise it will not come out of your time.

Ms. MCCOLLUM. I trust the Chair.

Mr. OBEY. The very first day I served on this Subcommittee, back in the early 1970s, I walked into the room and Dr. Dave Roll was testifying for the National Institute of Environmental Health Sciences, and as I walked in I heard him explain to the Committee what percentage of British shipyard workers who had been exposed to asbestos in World War II had died of mesothelioma, and it stunned me because, in my father's business, I had worked with asbestos products. So that got my attention in one whale of a hurry, which I think is the principal reason that, in my earliest years on this Subcommittee, I focused so much on occupational health and safety.

But I am glad you asked that question.

Ms. MCCOLLUM. Thank you, Mr. Chair.

Mr. OBEY. And it will not come out of your time.

Ms. MCCOLLUM. Thank you, Mr. Chair.

Another statistic that stood out to me—and you all touched on this in your testimony one way or the other about chronic disease and how it accounts for 75 percent of our Nation's health care spending. Now, I authored a bill, it was a constitutional amendment—I do not think we are going to amend the constitutional, get my language forward, but my intent was, by having a constitutional amendment to provide health care and preventative care for Americans, was to have a different discussion than the one that we are having.

The discussion I believe that we should have should be what is the bottom basic set of access to health care should Americans expect in an industrialized country. It goes to the question of screening; it goes to the question of treatment; it goes to the question of prevention.

What are you seeing missing from the current debate on health care that would address what should an American, in the most technologically advanced country in the world, expect their government to come together in the common good to make sure that they have access to truly good health care?

Mr. THORPE. That is a good and tough, difficult question, but I will go ahead and take a shot at it anyway.

My sense is that—and this sort of comes from what I see some of the more innovative large, self-funded employers are putting in place now—that if we really focused on early detection, early diagnosis, and appropriate evidence-based treatment of care, you know, that is a model that I think would be very effective in terms of preventing disease and more effectively managing it when we diagnose and detect it. Let me give you an example.

There are some very good health risk appraisals, very simple benchmarks that one could do to get a risk profile of an adult or an adolescent or a kid in school. And based on that risk profile, whether you are in normal health, good health, fine, you know, there are care programs and ways to make sure that you keep in good and normal health.

If you are a diagnosed diabetic with some of these multiple chronic health care conditions, we want to make sure that we enroll you as quickly as possible into a plan, an evidence-based plan to make sure that that disease is appropriately managed; and in most cases it is not. We know nationally that chronically ill patients get about 56 percent of the clinically recommended primary preventive maintenance services that they should get to manage their disease and prevent them from going into the emergency room, having amputations, losing a kidney, or going blind.

So I think if you think about it in terms of not so much insurance benefit design discussions, but more on the primary population health risk appraisal type approach, where we are diagnosing and detecting disease earlier on in the stage of a particular problem, and then making sure that they get the right—and it is largely primary health care to appropriately manage it, those would be a bundle of services that I think most would agree on makes sense. It makes clinical sense; it makes good public health sense.

Mr. OBEY. Mr. Kennedy.

Mr. KENNEDY. Thank you.

If we are spending so much money—Dr. Thorpe and Dr. Weinstein, you have both talked about this—in Medicare, Medicaid on all these treatments, but we do not know effectively what is the best treatment, wouldn't you suggest that we spend more of our dollars in CMS doing comparative analysis effectiveness in terms of before we start—I mean, I know in the mental health field there is a variety of different ways of addressing mental illnesses—pharmacologically, behaviorally, and the like—and some are far more expensive and, yet, do not show that much more effectiveness in terms of a result.

And, yet, as you said, there has not been the kind of data-mining or research and, yet, if there was, for a very little set-aside up front, we could be saving ourselves a lot of money on the payment side. What do we need to be doing to get to direct? Could you comment on the need for us to get CMS to do more in terms of internally directing some of their internal dollars to that comparative analysis effective research within their own budget before they start spending all this money just going out the door without knowing whether all of it is the best, most effective money spent? Could you comment on that?

Dr. WEINSTEIN. I would agree. I think there are lots of opportunities there for CMS to do such things. They have, as you know, supported some trials work. I think, for lung reduction surgery, they actually paid for the procedures being done to get the answer in a trial type way. So I would think this is a tremendous opportunity. As you think about what the costs are for what we pay in America versus what we might pay in Canada for drug issues and things like that, why are not we doing some comparative effectiveness of those things in this Country so that our citizens, you and I and our families, can get the cheapest drug with the highest quality, best outcome?

You know, there is little incentive for people to test things that—I am for the free market, do not misunderstand me, but we need to allow people to understand, when we are doing trials, how you

design a trial often can determine the results you are going to get. So if you want to test aspirin against drug X that is very expensive, you might find out that aspirin is really good. But if you do not want to know that the really cheap aspirin is really good, you will not test against aspirin.

So I think there is an opportunity in CMS to do that kind of work. We have the opportunity to sort of do competitive purchasing. Why do we have to buy the most expensive things if there is not the data to support those technologies, there is not the increased survival? I mean, I mentioned the breast cancer bone marrow transplant program. Very expensive.

Mr. KENNEDY. Well, maybe you could give us this in a memo, because maybe we can, as a Committee, figure out a way to do some directed language, because there is an awful lot of money in that CMS. Obviously, it is obligated entitlement spending, but if they could save a lot more in the future, when the debate comes up on entitlement spending, in the way they direct it by doing more of the initial cost analysis on how it can be best spent, then, boy, we could get that entitlement spending to go a lot further than it is going.

Dr. WEINSTEIN. I agree, but I want to also throw out the fact that there are many things that we do well. For example, nonwhite males, black males are not getting the rates of total knee replacement—that is an effective treatment—for reasons we do not understand. And, yet, many people may be getting rates of those kinds of procedures more than they need. So there are lots of opportunities to deal with the whole population through that budget and deal with issues of disparity variation in ways that we have not thought about.

Mr. KENNEDY. Can you just explain why the public health schools have not intersected with your economic sections of your universities to come up with how you refigure these reimbursement systems? I mean, how come you guys cannot get together and figure out if we can buy futures in pork bellies, why cannot we buy futures in people's health and get a new economic system that will incentivize people's health and well being and market that? I mean, why cannot we redevelop an economic capitalist system to incentivize health, as opposed to sickness?

Mr. THORPE. I think it is an outstanding question, and I think some of it goes back to the fact that, really, until about two or three years ago, I think, the prevailing view in the economics world was that 70 percent, 80 percent, 90 percent of the growth in health care spending was all due to new technology; that we were powerless over it, that it was just this flood of new technology coming online; and that these other things that are more controllable, perhaps, in the near-term—demographics, cost-sharing and so on—accounted for very little.

Work we have been doing over the last five years I think sort of debunks a piece of that. Technology is a big part of this puzzle, but what we did in our work is introduced economist epidemiologists. Epidemiologists have, for years, been looking at rising rates of disease prevalence without figuring out the financial implications of it, and in economics the word epidemiology never comes up anywhere in any course, any term. I think I would be banned from the

profession if you even talk about it. They just do not think about it in that way.

So some of it is making sure we have the database and the problem appropriately framed, which we now do. And I think we are now in the process of saying, well, gee, prevention really is important; and that we really do need to think about more effective payment models. Dr. Weinstein mentioned some of the work they are doing on episodes of care. We need more research and work thinking through how we can buy more effective health care services for people who have ongoing, established medical conditions that perpetuate throughout the year, at the very least, and we just do not have that models as widely known as we should.

There are good pilots, we know a little bit about them, but the fundamental research base in terms of how they work, how they change outcomes, how they affect cost, we have some data from, as was mentioned, Intermountain Health and from Kaiser and other places, but the research base in terms of thinking this through is quite limited.

Mr. OBEY. I am sorry to interrupt, but the gentleman's time is up. We have a vote coming up, so we have got a choice to make. We can either go vote and come back—we have the next hearing beginning at 2—or we can try to split the time, about two minutes apiece, with each of the three remaining questioners. How would you prefer it?

Okay, then the gentlewoman is recognized for two minutes.

Ms. LEE. Thank you.

Thank you, panelists, for being here today.

Dr. Weinstein, very quickly. How do you ensure that minority groups are well represented in clinical trials? Just last year we talked about—and I spoke with Dr. Griffin Rogers with regard to the hemoglobin variant using the A1C test for diabetes with regard to some ethnic minorities is just not a valid test in many ways, and we didn't know this until this hearing, and we followed up, and thank goodness we were able to get this straight.

Second question. Informed decision-making is very important, but as a person who does a lot of medical research—I am not a physician, but I have aging and disabled family members, so I know a little bit about it. I had a family member who had to have carotid artery surgery. A physician gave me the pros and cons of the stent versus the surgery. Very thorough, but I had a hundred more questions to ask. At the end of that, he says, so what do you want to do? I waited, well, what do you recommend?

Bottom line is, yes, informed decision is very important, but for people who may not have access to the type of information, say, for instance, that I had access to, or are less educated and have not come up with all these questions, don't we need go to one step further and allow for the—and, again, in your research, I do not know if you did this—but have people feel that, once they have the information, ask the physician for their recommendation? Because I could not even figure it out.

Dr. WEINSTEIN. Well, the first question about enrollment of non-white patients in the trials, and I think all ages as well, so gender, race, and age are important. In fact, in our trial for back pain, we had one of the largest non-white enrollments of any trial done

using the informed choice shared decision-making tools, and it was remarkable.

One of the diseases we actually studied, degenerative spondylolisthesis—a mouthful—is much more common in females and black females. So we actually had a higher enrollment than we even anticipated, which is really nice.

So you are correct that clinical trials need to be looked at very carefully when you are saying what this is good for. It is just a clinical study, it is not necessarily about you.

So then we need to empower you with information—which gets to your second question—that allows you to make a decision. And as Congresswoman McCollum was talking about what do we need to do, you know, we need access. So you needed access for your family member who had the carotid disease. You needed a decision tool. What would have been helpful for you is getting all this information in some unbiased way. I am a surgeon. What I like to do is surgery. If I am a physical therapist, I like to do physical therapy. So that is what I offer.

I would like to suggest—and our data would suggest it is true—when we use these tools, we see different decision-making processes occur. They are written at a level so that the understanding of the person looking at it can be clear, their questions can be answered; they feel that they are knowledgeable, that we understand their values about their decision and their preferences.

Those turn out to be very important variables in a health care system that is now drowning in cost, where we need to find simple tools that help people make those decisions. Not everybody with carotid stenosis or carotid disease necessarily has to have surgical intervention. What are those risks and benefits? What is my risk of stroke from that procedure? Memory Loss? What kind of cognitive disability might I have? Which might be more important to you than the risk of the actual infection from a surgery or whatnot. So those tools can be very helpful. And, in fact, from our trial, we are putting those kinds of tools on the Internet free to help people make those decisions.

Mr. OBEY. The gentlewoman's time has expired.

Ms. Roybal-Allard.

Ms. ROYBAL-ALLARD. Professor Leigh, thank you very much for your testimony, particularly for highlighting the fact that low-income and Hispanic workers have a significantly higher on-the-job injury and mortality rate. You also mentioned during your testimony that much of those injuries and deaths are preventable, and that is one reason that I was happy that after seven years, legislation sponsored by myself and Congressman Miller and a lawsuit finally brought OSHA to the point where they did in fact issue the rules on personal protective gear, which the employer has to pay for. Unfortunately, during that seven-year interim period, there were many injuries and deaths.

During your testimony you mentioned that you wish you had had some additional time to highlight the Hispanic population and the health and safety measures and on-the-job problems that they face, and I would like to give you the opportunity now to do that.

Mr. LEIGH. Thank you very much. Yes, I would like to mention. There was an earlier question about prevention strategies, and

there are many that are in the workplace. For example, with nursing aides who are tending to elderly people in nursing homes, a lot of people are surprised. It turns out this is one of the most dangerous jobs a woman can take anywhere in the economy, because you can have a woman, let's say, who is 120 pounds trying to lift a 200-pound man who has Alzheimer's from one bed to a gurney, and the man can slap her. A lot of violence happens in these nursing homes.

Anyway, they have now passed legislation in Texas where they have lift teams and lift tables, and groups of people who now are authorized to lift patients from beds to gurneys that are in nursing homes; and this has cut way down on the injuries, and this has saved on worker's compensation. It is just an example of where an ounce of prevention is worth a pound of cure.

Regarding the Hispanic point, there are many studies done by the Bureau of Labor Statistics that indicate that Hispanics have a higher fatality rate and a higher non-fatality rate compared to all other groups. Let's see, there was one report that from 1992 to 2005 Hispanics were reporting more injuries. The percentage increase for Hispanic fatal injuries was 73 percent. This trend was not evident for any other ethnic or racial group. And the same trend occurred for non-fatal injuries.

Now, it also turns out not just Hispanics, but low-wage workers in general are subject to greater incidents for injuries.

If you look on the BLS Web site, you will find the 10 occupations with the greatest number of non-fatal cases, and these occupations include laborers, material movers, truck driver, heavy tractor trailer drivers, nursing aides, construction laborers, light truck drivers, retail salespersons, janitors and cleaners, carpenters, maintenance and repair workers, stock clerks, and order filers.

Now, it turns out that except for carpenters——

Mr. OBEY. I apologize for interrupting, but we have only got about three minutes left if we are going to vote, and I have got two more members who need to ask a question. So I am going to ask you to supply the rest of that answer for the record or privately.

Mr. Udall.

Mr. UDALL. Thank you, Mr. Chairman.

Dr. Thorpe, I guess my question is directed to you, but I am interested in what the others have to say. You say in your written testimony the truth is the vast majority of chronic disease can be prevented or better managed, and then you have the statement "these diseases could be prevented if Americans would do three things: stop smoking, start eating better, and start exercising."

These things seem so simple, but people do not seem to be getting the message. I mean, clearly, we are moving in the wrong direction when you look at all these diseases. How do you explain this phenomenon. Is the right information getting to people on smoking, eating better, and exercise? What is really going on here?

Mr. THORPE. Excellent question. I will try to make it quick. Just to give you a sense, I mentioned diabetes up 70 percent since the mid-1980s. Over 90 percent of that growth is due to rising rates of obesity, pure and simple.

I think the challenge is that we almost have to sort of start in multiple jurisdictions to find programs that are effective in helping

people change behavior. It is not easy to do. I think you have to start in schools. There are some great examples of different States. Arkansas has perhaps a controversial program, but it is one that has taken the rates of childhood obesity in the Arkansas schools down, at the same time period when rates of obesity among kids are going up dramatically.

There are good models at the workplace, where we have had a substantial impact on the weight distribution of workers and productivity. Unfortunately, we do not have a good dissemination or research base to sort of take those results and quickly diffuse them into other settings. I know in the other chamber Senator Harkin has been looking at this for some time to figure out what are the key design features of those programs that work; how can we encourage their diffusion.

And community-based interventions. We are just starting to learn in a very scattered way about what works in the community to change behavior. Those are all areas that we should be making investments in to find best practices and find places where we can replicate good programs.

Mr. UDALL. Thank you.

Mr. OBEY. Ms. DeLauro.

Ms. DELAURO. I will be brief.

We have the Rudd Center in New Haven, Connecticut, which I represent and Kelly Brownell is doing a lot of work there on this issue; it is a very important issue. But I noted your testimony, Dr. Thorpe, though, you say CDC's spending on chronic disease prevention and control was $6.27 for each one of the 133 million Americans with one or more chronic conditions. The same group accounted for $13,143 in health care spending that year.

You probably do know that, with CDC, there is a $475,000,000 cut in their budget, so we need your help and your support in that effort.

Just quickly, Dr. Leigh, I will not go through the whole issue, but where do we get a better picture of direct Federal investment to have an accurate picture, if you will, of the costs associated with occupational injury and illness—because it is not coming out in the data that we are looking at—in terms of bringing down those costs? If you cannot answer it now, you can get it back to me for the record.

And I would like to have you look at, if you would, and get back to us on the impact of the regulatory inaction we have seen at OSHA and tell us what that has caused.

Okay, we do not have time. We have two minutes, right, Mr. Chairman?

Mr. LEIGH. Well, I would like to mention that the Bureau of Labor Statistics has two wonderful data sets: The census of fatal occupational injuries and also the annual survey for non-fatal injuries. Now, a lot of people, including myself, have criticized that survey, but it is to say that we can improve upon it, and there are many ways that the Bureau of Labor Statistics can improve upon those data to have wider—

Ms. DeLauro. We would welcome your help on how to do that, because we can help to design their program.

Mr. OBEY. Gentlemen, let me apologize for the abbreviated nature of this hearing, but it is a miracle we got it in at all, given what is going on on the House Floor. So thank you very much and we will see you back.

We will reconvene at 2:00 with the Secretary.

U.S. Rep. Rosa L. DeLauro
Opportunities Lost and Costs to Society:
The Social & Economic Burden of Disease, Injuries and Disability
Questions for the Record

1) Public Health – CDC
Dr. Thorpe: I read a recent CDC study that analyzed the decrease in death rates from coronary heart disease between 1980 and 2000, and according to the study, had death rates from 1980 remained the same by 2000 – taking into account population growth – an additional 341,745 deaths from coronary heart disease would have occurred. Instead, we saw a significant decline. The authors determined that about half of the decrease can be attributable to changes in medical treatments and approximately half are due to risk factor changes. They conclude, "Future strategies for preventing and treating coronary heart disease should therefore be comprehensive, maximizing the coverage of effective treatments and actively promoting population-based prevention by reducing risk factors."

With this in mind, Dr. Thorpe, what will the impact of the President's FY 2009 budget have on the author's conclusion? Specifically:

For the 6th year in a row funding for NIH-supported heart and stroke research is below medical research inflation under the president's budget,

And the President also proposes to cut the CDC's Heart Disease and Stroke Prevention Program by nearly $1.3 million, while currently only 13 states receive sufficient resources to implement its Heart Disease and Stroke Prevention Program.

Response:
Heart disease, stroke, and other cardiovascular diseases remain America's leading causes of death. They affect nearly 81 million Americans and cost this nation more than any other disease. Despite the enormous burden these diseases place on our nation, NIH heart and stroke research remains disproportionately under-funded, especially in light of the many promising scientific opportunities that could advance the fight against these diseases. The currently NIH invests only 7% of its budget on heart research and just 1% on stroke research. When adjusted for medical research inflation, the NIH budget for CVD research is estimated to be 15% lower in 2008 than 2003. According to NIH, budget shortfalls mean a projected decline in the success rate of new research project grant applications to 18% in 2007.

Cuts in NIH funding will slow research progress, including:

- Clinical trials to decide how much to lower cholesterol in patients at high risk for CVD.
- Efforts to translate basic research into evaluation, treatment and care of patients directly after stroke onset.
- Ground-breaking research, such as exploring the prospect of repairing tissue damaged in a heart attack.

NINDS projects that $406 million is needed in FY 2008 to fill vital gaps in stroke knowledge. The FY 2008 estimate for its stroke research is $182 million – more than 50% below the professional judgment amount.

As the baby boomers age, heart disease deaths are projected to increase 2.5 times faster than the population overall , and the prevalence of heart disease is projected to increase by 16% each decade. CVD will cost our nation an estimated $449 billion in medical expenses and lost productivity in 2008, making it the most costly disease. Treatment costs for CVD are expected to rise 64 to 84% by 2025. Stroke treatment alone is projected to exceed $2 trillion from 2005-2050. There is no doubt that the population-based primary and secondary prevention programs funded by CDC are essential to reducing morbidity and mortality associated with coronary heart disease. But they are similarly under-funded.

CDC's Heart Disease and Stroke Prevention Program began in 1998, and was funded in only 8 states. Currently, 33 states and the District of Columbia have a Heart Disease and Stroke Prevention Program at either the Basic Implementation funding level (13 states) or the lower Capacity Building funding level (20 states + DC). With the appropriations provided for FY 2008, it is anticipated that 7 additional states will be funded for Capacity Building and 1 additional state will be funded for Basic Implementation.

Even with an increase in appropriated funds, however, 10 states will still be unfunded for heart disease and stroke prevention – the number one and number three killers in America. In FY 2007, Basic Implementation funding averaged approximately $1.2 million to implement statewide activities addressing priority areas such as controlling blood pressure and raising awareness of the signs and symptoms of heart disease and stroke. Capacity Building states received an average award of $350,000 to build capacity for heart disease and stroke prevention programs; this seed money does not enable comprehensive implementation of interventions.

The proposed $1.3 million cut in funding for CDC's Heart Disease and Stroke activities would only exacerbate this lack of program dissemination and impact. To accommodate this cut in funding, CDC would have to eliminate or reduce funding to some states, decrease the level of supporting activities provided by the agency, or both. Given the increasing medical costs and the aging of the population, and given the clear and demonstrated potential of public health strategies to promote cardiovascular health and control risk factors such as hypertension and cholesterol, it is imperative that CDC's State Heart Disease and Stroke Prevention Program be strengthened and not weakened.

CDC's Heart Disease and Stroke budget should not be cut for 2009. In fact, funding for the Heart Disease and Stroke Prevention Program should be increased by $20 million for the next fiscal year. With a $20 million increase in CDC's Heart Disease and Stroke budget line, CDC could accomplish the following:

- Add new Capacity Building Programs in order to ensure that all 50 states as well as the District of Columbia are funded with State Heart Disease and Stroke Prevention Programs.

- Increase funding for a number of states with pre-existing Heart Disease and Stroke Prevention Programs by moving them up to a Basic Implementation level or providing them with Optional Funding to implement demonstration interventions.

- Increase the capacity for surveillance (monitoring and tracking disease) at the national, state, and local levels in order to provide the best possible cardiovascular disease and risk factor data for policymakers and health care providers.

- Provide greater assistance in evaluation to heart disease and stroke prevention programs as well as engage in more evaluation research.

- Increase the internal capacity of CDC's Division for Heart Disease and Stroke Prevention to allow the Agency to provide more technical assistance to states and communities, engage in more public health research, and create more tools and strategies for heart disease and stroke prevention.

THE DARTMOUTH INSTITUTE
FOR HEALTH POLICY & CLINICAL PRACTICE

Where Knowledge Informs Change

Responses from Dr. James N. Weinstein to Questions for the Record
from Congresswoman Rosa L. DeLauro

In re: House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies 2-14-08 Hearing
Opportunities Lost and Costs to Society:
The Social & Economic Burden of Disease, Injuries and Disability

1) Investing in Biomedical Research
Dr. Weinstein, you present a powerful case for continued increases in funding for the NIH – not only from the cost and cost-effectiveness angle, but also from the perspective of reducing human suffering by providing patients with the best options available so they can make informed choices for their treatment. Yet, we are facing an Administration that does not get it. For the fourth year in a row, the NIH budget request is flat. The FY09 Bush budget provides roughly $29.3 billion for NIH, $630 million below the amount needed to maintain purchasing power at this year's level.

Can you talk some more about the real costs of not investing in research?

America can do Better
Failure to invest in our research infrastructure will weaken our economy, bring to a sudden stop our leadership role as innovators for the world and cause us to lose the brightest and best researchers to other nations with more competitive and supportive economies for scientific investigation. In this global economy, shifts occur at speeds that challenge our most innocent of ideas. To see the rapid fall of our economy today is such an example. The difference between the haves and have nots is widening at an alarming rate.

If we ignore the world economy and the competition for the brightest and best we will lose our preeminence in the scientific world. India, China, Hong Kong, and Europe are already looking to attract our best scientists. I am now on my third trip to China and they are anxious for more and more collaboration. I have turned down more than a dozen offers to go to India.

Lack of Evidence
One of the most important and often unseen costs is the impact of applying therapies or treatments to our patients that have not been vetted through the kind of large scale clinical trials that only NIH can do, independent of intended or unintended bias that are often seen with industry sponsored trials.

Media news stories abound about the latest "breakthrough" drug or device and or new treatment algorithm(s) that, when subjected to appropriate trial design, with appropriate subject populations, and realistic endpoints, turn out to have little clinical benefit or even worse, to have a detrimental effect on patients studied. The unstudied populations then receive these treatments by acclamation rather than real evidence. The underserved and unstudied are offered treatments 'off label' or without appropriate testing in these disparate populations.

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The most recent case of this involved the cholesterol drug Vytorin. Over 1 million prescriptions are filled per week at a cost of $5 billion annually. Yet when industry study results were finally released, it turned out that not only did the drug fail to clear plaque from the arteries, it actually may have increased plaque formation. And there are many questions about why it took so long for the trial results to be published.

Congressman Dingell held a hearing on this case earlier this year to examine whether the study outcomes were deliberately suppressed and delayed by the pharmaceutical companies involved. This again raises the issue of the need for unbiased trials, which can only happen with oversight or involvement of institutions like the NIH or a more modern idea of the 'Altruistic Clinical Trial' concept discussed in the attached article. Clearly, legislation could be enacted to change or at least offer another less expensive and more effective solution to the current dilemma.

Research must not be influenced by financial interest in the drug/device being tested, but should be all about credible and rational use of new and improved treatment options, that are safe and effective.

Of course there are many other examples, where conflict of interest may have caused a conflict of the mind e.g., the case of Jesse Gelsinger who died after being treated with an experimental drug. It turned out that the physician and the university had some ownership and stock options in Genovo, the manufacturer of the drug. These are scientists trying to save lives, but our system and lack of models for funding such work causes the best and brightest to seek other pathways. America can do better!

In my testimony, I spoke of another example that comes from the heart, the triple digit rise in spinal fusion procedures; rates have risen more than 250 percent in recent years. Yet there is no evidence base for these procedures. In fact, to my chagrin there is some evidence that fusion results in more complications and worse outcomes. But as a nation, we are spending more than $20 billion per year on spinal fusion. Legislation must call for clinical trials in these highly used and unproven, elective procedures, wherein well informed patients would very likely choose less invasive, less costly treatment options.

One additional illustration involves the widespread use of high dose chemotherapy with bone marrow transplant (HDC/ABMT) for women with advanced stage breast cancer. This is a grueling procedure for patients. Very high doses of chemotherapy drugs are administered to destroy the cancer cells, but in the process, they also poison the bone marrow, putting the patient at severe risk, so the aggressive chemotherapy must be followed by bone marrow transplant. More than 30,000 women received this treatment in the 1990's before 4 clinical trials revealed that there was no difference in survival between these women and those who had standard chemotherapy. It was more toxic, in some cases deadly, and at a cost of $3.4 billion over 10 years, it was twice as expensive as conventional treatment. The costs to the patients in needless suffering are incalculable.

I lost a daughter undergoing chemotherapy and radiation for her cancer. I know the pain and suffering associated with such treatments. I know America can do better!

Unexpected Consequences
Returning to your question, I see three main costs of not investing in NIH research.

First, the constant rush to have the newest drug or device, what I call, the "latest and greatest phenomenon" is not in America's best interest. Advanced technology, without the appropriate evidence, is driving costs higher, often at some risk.

Second, we know that when we have "the facts," real evidence, to engage our patients in **informed decision making** – something that happens most effectively when we have clinical trial evidence to share – they will make choices that result in lower costs and better outcomes. As I indicated in my testimony, in one of our trials,

fully 30 percent of patients with herniated disk chose not to have surgery after hearing the best evidence about outcomes. If, in this single diagnosis, those percentages were applied nationally, we would see a savings of $4.2 billion annually in lumbar disk and stenosis surgeries alone. **Imagine** how we could put those savings to good use. How many vaccinations could we provide, how much influence could we have on public health by preventing disease and effectively treating chronic disease? **Imagine** if we applied this methodology to other "toss up" healthcare decisions, how much money could go towards NIH to help our nations HEALTH. **Imagine**.

A **third,** and important cost argument is that we are needlessly putting Americans at risk (consistent with the Institute of Medicine reports, re: quality) by failing to do the due diligence to make sure these therapies and procedures are safe, effective, and warranted. We must have the funding to increase the numbers of unbiased, gold standard trials and accelerate the advancement of knowledge about what works and what doesn't. How can we afford not to?

In that same vein, the **comparative effectiveness** initiative is also merited as we have seen several examples where less expensive treatments and or devices are safer, as effective or more effective and cheaper. All of these can be grouped in legislative activity and certainly support increased NIH funding.

How do we make the case to the American public?

America has systems in place to protect our citizens' health and safety. Examples include the food we eat, cars we drive, and other consumer products we buy. Yet often, therapies do not undergo the same kind of rigorous testing. And our current arcane doctrine of "informed consent" rather than a more appropriate and timely doctrine of "informed choice" does not always make this clear to patients and their families. It is time to legislate **"Informed Choice,"** wherein patients are partners in their health care decisions and those decisions are based on best evidence supported by work done in the NIH model and/or combined with the Altruistic Clinical Trials model described in the attached article. FDA labeling of drugs should be no less than we do for our foods e.g., cereal boxes. Why do we know and understand better what is in a cereal box than what is in a drug and what the side effects are in ways in which our citizens can understand. America can do better!

Informed Choice
Shared decision making and or "informed choice" aim to make patients better, smarter consumers of medical care. We know that when we can tell people objectively what the risks and benefits of a procedure or treatment might be, they often choose their treatment course correctly. That means they understand the risks and benefits and their outcomes are better, and often at lower risk. This is especially true when we have evidence from comprehensive clinical trials, e.g., the NIH sponsored SPORT Trial, to share with them.

We have to help people understand that clinical trial research is not something abstract and only of interest to scientists. It directly affects one's health and that of their loved ones. It is both a consumer protection issue and a necessity if we are to improve health care and make the kind of *proven* medical advances our citizens deserve. It is these clinical trials that inform the decision tools, e.g., informed choice (shared decision making) that will improve our healthcare system by providing "best care." not just the latest and most exciting care.

Moving people away from believing that newest is best and more health care is better will not be easy. As a culture, we are firmly in the camp that says that the latest version of anything – be it computer, flat screen TV, I Pod – must be superior. Perhaps that is true in electronics, but it is not true in medicine. At the Dartmouth Institute for Health Policy and Clinical Practice, we continuously work to educate the public and the media about understanding and evaluating medical treatments and reported "advances." The importance of that educational effort cannot be overstated. Congress should play a key role in helping to educate our citizens,

nationally and at a state and constituent level. We would be happy to work with you on this kind of effort. A starting place might be in your own constituent newsletters or through constituent meetings in your district.

What in your view are the two or three bullet points that best make the case for continued increases?

- Investing in research *saves* not only money but, as in the cases above, can save lives. The return on investment can be enormous as demonstrated by the example of spine surgery.

- We must have research that is objective, unbiased, and untainted by market or financial interest. As a publicly-funded organization, NIH can perform the kinds of rigorous, well-designed trials we need. In addition, NIH will fund studies with important public health implications (e.g. combination drug therapies for common diseases such as osteoporosis) that the private sector will not pursue.

- As research dollars and opportunities decline, more and more young investigators – the best and brightest of the next generation of scientists – are becoming discouraged and disillusioned. Many are seeking other career paths. At the same time, promising early research is languishing for lack of funding to carry it to the next step. Momentum created by the doubling of funding in the 90's is being lost as laboratories around the country have to scale back or close down promising research initiatives, that not only bring hope but create jobs, careers and new opportunities. Without sustained investment in NIH, we are at risk of losing our brightest and best young researchers and relinquishing our position as the world leader in advancing discovery and offering new, evidence-based treatments to our population.

- America can do better.

Enclosure: *An Altruistic Approach to Clinical Trials; The National Clinical Trials Consortium.* Spine, Vol 31, Number 1

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An Altruistic Approach to Clinical Trials

The National Clinical Trials Consortium (NCTC)

Dr. James N. Weinstein, Editor-in-Chief, Spine

We find ourselves working in a healthcare system in which $1.9 trillion dollars are spent to have the U.S. rank 37th in world health.[1] Clearly, our health expenditures don't necessarily coincide with better outcomes. There is evidence to suggest our healthcare system is fundamentally broken. The Dartmouth Atlas studies have provided ample evidence that our healthcare is irrationally distributed, and that patients in high utilization areas had more inpatient treatment, more diagnostic tests, and increased use of specialists.[2] Frequently, technologies or diagnostic tests are brought to market (increasingly, directly marketed to patients) despite a paucity of good studies providing solid evidence of proven efficacy and or effectiveness. We continue to bring new technologies into practice with studies that are often underpowered and without clearly defined endpoints. Unfortunately these studies can provide a false sense of security to our practicing physicians and to the patients to whom these treatments are directly marketed. Inadequate follow up and failure to report negative findings can undermine the very scientific process that has advanced medicine.

Naturally, given their investment, industry-supported trials are driven by the need for swift FDA approval in order to get a device or drug to market. However, we know that industry-supported projects yielded a nearly 73% positive result, whereas unfunded research had a much more even distribution of results, with positive at 46.2%, neutral at 45.6% and negative at 8.2%. Therefore, we should also pay close attention to the affiliations of those in academia that perform research. At university campuses around the country we are seeing a greater influence of large corporations in the naming of science centers, departments, professorships, and, ironically, schools of ethics. So carefully reading the disclosure statements of articles reporting the results of a trial is imperative to interpreting and understanding the results. Thus, caution is justified in adopting new technology that has not been evaluated with the rigor that affords us more than a modicum of confidence that we are doing what is best for our patients.

Dr. Elias Zerhouni has outlined a new initiative at the NIH called the Clinical and Translational Science Awards (CTSA), targeting some of the most basic systemic barriers in medicine as practiced today.[3] Recognizing that we currently depend on two problematic systems to perform scientific research–the first being companies with much to gain financially from a positive result that their trials of effectiveness should be critically assessed and the second being that many overworked clinicians and basic scientists are being asked to cram the three careers of teacher, practitioner, and researcher into one lifetime. The CTSA hopes to partner with institutions who are already "grappling with the complex challenges posed by the clinical and translational science of the 21st century." This program is an acknowledgment that the changes necessary to reform all aspects of health care are profound, difficult, and complex.

Such change doesn't involve easy or quick fixes, or shiny new technology. Only the earnest collaboration of everyone who cares deeply about the state of our health care environment will bring this about. To this end, I'm recommending formation of a National Clinical Trials Consortium (NCTC) (Figure 1). This should be formed and run by physicians and surgeons and their PhD colleagues. It should have an oversight board from independent professional societies, and appropriate specialty societies as well as public members. This consortium would be supported by industry, payers, FDA, NIH, and others, including the public, with vested interest in the clinical research enterprise. There should also be a data safety and monitoring board with public members. The primary function of the consortium would be to promote and direct high-quality clinical trials less susceptible to conflict of interest, affording them more face validity and almost certainly less bias.

Such a structure would be both tangibly and conceptually constructive. Funding of an independent consortium cannot and will not eradicate all conflicts, but would provide checks and balances to minimize true as well as apparent conflicts. Answering the most pressing and relevant clinical questions would be the priority. The NCTC would fund innovative practicing physicians and PhDs with collective expertise in those aspects of clinical trials most prone to weakness: study design consistent with ones' stated hypothesis and specific aims; protocol development; data collection and data monitoring; complex longitudinal statistical analysis; intention-to-treat analysis and appropriate adjustments in an as-treated analysis; and appropriate oversight by an independent data and safety monitoring board. Another advantage of such a well-organized consortium would be more rapid enrollment and completion of projects with required open dissemination of results to all relevant public and private groups. This structure would serve to increase credibility and validity and possibly lessen medical liability.

We must avoid using a technique or device on our patients only to find out weeks, months, or years later that it failed to achieve what we had understood from available literature. The NCT consortium could also be

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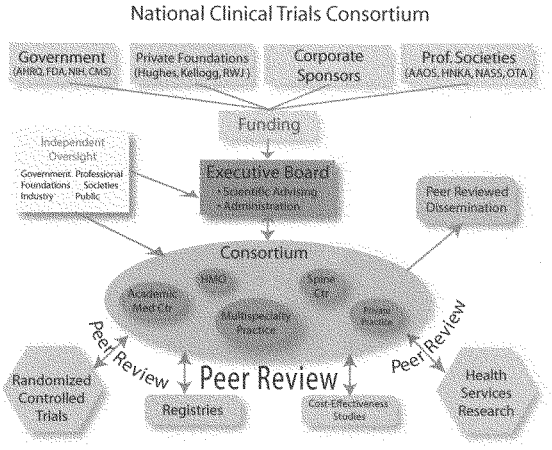

Figure 1. Clinical Trials Consortium.

used for postmarket surveillance in collaboration with our industry partners, FDA, Medicare, Medicaid, and independent private payers. The hope remains that a National Clinical Trials Consortium with broad geographic representation would allow us to bring the focus of our profession back to serving our diverse patient needs while minimizing the costs incurred by the current extensive network of various individual(s) trial group(s) conflicted in mission and purpose.

Barriers

There are many potential barriers to establishing the utopian clinical trials consortium. First, we must have the will to do this. We must avoid further fragmentation. We must trust one another and we must commit the time and resources necessary to accomplish this most important endeavor. Second, we must proactively change the current process by which technology is adapted by surgeons and colleagues to the benefit of our patients without any unintended detriment. In so doing we will be empowered to regain our focus, diminishing the noise of reimbursement and medical liability demands that currently drown out everything else. Breaking down barriers is not easy. Knowing the right thing is hard enough; doing the right thing is even harder. Most of us find reasons to avoid it: "I'm too busy" is a common complaint. "This will cut into my practice." "This interferes with my physician/patient relationship." "My results are already good and I don't need more data."

Reality

External forces are now coming to bear on these issues. Ford automotive company and General Motors stock has been relegated to "junk bond" status, in part related to the high cost associated with their medical benefits. Recently, the American automobile industry has changed its strategy for long-term benefits–employees now share in their long-term health expenditures. Failure to do so would be prohibitive for the U.S. auto industry and its capacity to remain competitive in world markets. United Airlines, a leader in air transportation, is another example where the toll of ever increasing healthcare cost is pushing their company and this industry toward bankruptcy with a corporate pension plan at risk. Today, fuel cost is partly responsible but escalating healthcare costs have been omnipresent and loom larger each year. Clearly, our major industries can no longer afford to pay for health care that doesn't work, and we can't afford to provide care without scientific evidence to support our work. Medicare and other large private payers can no longer afford to pay for medications, diagnostic tests, surgeries, or other treatments that are not proven to be effective.

Winston Churchill said "Americans do the right thing after they have tried everything else." I hope in our case that will not be true. There are many examples today in which well-designed clinical trials have benefited our profession and more importantly our patients. One recent example is in patients with persistently active rheumatoid arthritis, the combination of etanercept and methotrexate was safe and well tolerated and provided significantly greater clinical benefit than methotrexate alone.[5]

Being transparent in our mission, vision and our research is the best medicine we can give to society. A

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National Clinical Trials Consortium offers industry, our profession and our patients the results we all want, an altruistic, selfless means to determine the most effective treatment alternatives. Our patients are having to take more and more responsibility for their own healthcare. As true partners, we along with our patients, industry, government and the private sector can have a major impact in moving our nation's health forward.

Acknowledgments

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THE DARTMOUTH INSTITUTE
FOR HEALTH POLICY & CLINICAL PRACTICE

Where Knowledge Informs Change

March 3, 2008

The Honorable Patrick J. Kennedy
407 Cannon House Office Building
Washington, D.C. 20515

Dear Congressman Kennedy,

It was an honor to appear before you at the recent hearing of the Appropriation Subcommittee on Labor, Health and Human Services, Education, and Related Agencies. The subject of the hearing, Opportunities Lost and Costs to Society: The Social and Economic Burden of Disease, Injuries, and Disability, is of great importance, as I indicated in my testimony.

During the question and answer period, you asked me to get back to you and the Subcommittee on the issue of CMS spending on research. Specifically, you requested some directed language to spell out how CMS should allocate money for research projects. As you said, "We could make the funding go a lot farther if we knew we were spending money on things that worked." You implied and I agree, there is a need to bring all the parties together in order to rationalize (vs. ration) what we are doing. As you know, right now we are in a never-ending shell game of moving the pieces from one place to another and never actually solving any one problem.

As you may recall, much of my testimony revolved around the issue of shared decision making and how patients who have good information upon which to make an "informed choice" often decide to forgo surgery or other expensive interventions and further diagnostic procedures To recap only briefly; our research has shown for a person diagnosed with a herniated disk, the most common back operation in America, surgery rates went down 30 percent when patients were given good information, shared decision making, to help them make their decision about treatment, an "informed choice

If that 30 percent reduction were extended to the population as a whole, we would have had 97,500 fewer disk surgeries in 2004, at a savings of $3 billion. Shared decision making in cases like disk surgery, where there is no clear-cut "right" choice, makes a difference. In addition to substantial savings, patients who participate in shared decision making, experience better outcomes and express greater satisfaction with their treatment.

Consequently, an investment in a shared decision making pilot by CMS would be money well spent; improving health, lowering costs, and making a tangible advance for our health care system. This could be done within a one-year demonstration project at designated hospitals across the country. Participants would share in the process developed by the Dartmouth Institute for Health Policy and Clinical Practice and implemented at Dartmouth-Hitchcock Medical Center, home of the first-in-the-nation Center for Shared Decision Making.

The specific objectives of this one-year project would be to:

1. Demonstrate how to integrate decision aids into practice in a variety of settings for a variety of conditions. We can start with back conditions, as the increase in Medicare spending for spine surgery

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has been about $500 million in the last 10 years with little evidence to support the 47% increase in rates of spine fusion surgery. We can than address other costly interventions, such as breast cancer, cardiovascular disease, and joint replacement where, informed choice has been shown to be effective. The simple introduction of informed choice can forever change the dynamics in the delivery, cost and safety of health care.

2. Demonstrate the value and feasibility of putting a data collection protocol into office practices. Show a concrete path forward in the implementation of these effective tools nationally, with their associated impact on outcomes and cost.
3. Demonstrate one way in which patient data can improve patient-physician communication about decisions. Clear the way to incorporating patient knowledge, values and preference about their healthcare decisions in a truly patient-centered model of care.
4. Implement a patient-physician data collection and feedback process that captures the differences in measures of decision quality without and with a decision aid intervention. This would allow for the scientific discourse to occur while empowering our patients in a way that addresses gender, race and educational differences.
5. Collect data that would demonstrate the degree of match/mismatch between stated values/preferences/treatment choice and actual treatment. The data from this project would enlighten us to the differences between what appears to be appropriate care and what the patient actually wants.
6. Collect data that would lay the groundwork for thinking about "standards" for providing decision support in medical practice. With this project we can begin to lay down the necessary and long overdue foundation for a nation struggling with conflict and disparity. both of which need to be addressed.
7. Collect data from providers and patients using debriefing interviews and focus groups about the benefits and problems from their points of view.
8. Demonstrate that the implementation of this process leads to:
    a. *high quality patient decision making*: mastery of knowledge questions and treatment choices that are consistent with a patient's values.
    b. *appropriate utilization of surgical and other resources:* rates of surgery that coincide with patients' expressed preference for surgery as a treatment choice.
9. Estimate the population-based impact on rates of surgery and Medicare program spending prior to and after implementation of shared decision making for target treatments.
10. Develop a process for assuring the "quality" of shared decision-making procedures. A national certification process by NCQA or NQF or JCAHO for using these tools effectively, tying reimbursement to the use of "informed choice"
11. Based on (8) and (9). develop a model "pay for performance" reimbursement strategy to facilitate the wider implementation of shared decision making.

For CMS, this Demonstration Project would address several of the agency's stated goals and objectives:

<u>CMS Goals</u>

- Protect and improve beneficiary health and satisfaction
- Promote the fiscal integrity of CMS programs
- Foster excellence in the design and administration of CMS programs

- Provide leadership in the broader health care marketplace to improve health

CMS Program Objectives
Access to Quality Care:

- Expand health care choices and further strengthen programs and services to adapt to beneficiary needs.
- Improve quality of care and health outcomes for the beneficiaries of CMS programs.
- Protect beneficiaries from substandard or unnecessary care.

Costs of this demonstration project would vary depending on the number of hospitals involved and the conditions included. However, it could and should be done cost-effectively and with an enormous return on a modest investment.

I welcome the opportunity to discuss this with you more fully. Should you find this of interest, we would be happy to develop a more fleshed-out and specific proposal that could be the foundation of the directed language you request.

Again, thank you for the opportunity to testify before the Committee and to share these additional thoughts with you. I look forward to hearing from you.

Yours truly,

Dr. James N. Weinstein

Director,
The Dartmouth Institute for Health Policy
and Clinical Practice

Chairman,
Department of Orthopaedics, Dartmouth-Hitchcock Medical Center
and Dartmouth Medical School

cc: Congressman David Obey, Chairman

Enc.

Health Affairs November/December 2007
Extending the P4P Agenda, Part 1: How Medicare can Improve Patient Decision Making and Reduce Unnecessary Care

Health Affairs September/October 2004
Trends: Trends and Geographic Variations in Major Surgery for Degenerative Diseases of the Hip, Knee, and Spine

Center for the Evaluative Clinical Sciences

Executive Summary

The Care of Patients with Severe Chronic Illness:

A Report on the Medicare Program by the Dartmouth Atlas Project

The Medicare program could reduce current spending by at least 30%, while improving the medical care of the most severely ill Americans.

More than 90 million Americans live with chronic illnesses such as diabetes, cancer and heart disease; and seven out of ten American deaths are caused by chronic illnesses. The care of people with chronic illness accounts for more than 75% of all U.S. health care expenditures, but Medicare spends much more per enrollee in some states and regions than it does elsewhere. The differences in spending provide important insights into the causes of waste in our current health care system – and the opportunities to improve both the quality and the efficiency of care.

The differences in spending are not because there are more sick people in high spending regions; while the prevalence of chronic disease varies among regions, differences in illness levels are virtually unrelated to the differences in spending. And while variation in the price of care explains some of the differences in spending among states and regions, what matters most is the variation in the amount of care provided on a per person basis. Chronically ill patients living in high spending regions have more visits, hospitalizations, stays in ICUs, and diagnostic tests. Behind the striking variations in spending and utilization are equally striking variations in the resources — the numbers of beds and clinically active physicians — that providers use in managing chronic illness. A similar pattern of variation is evident among leading academic medical centers with strong national reputations for high quality care, as well as among the hospitals in major metropolitan markets such as Manhattan, Miami, Los Angeles, Minneapolis and Seattle.

The bottom line diagnosis: The extra spending, resources, physician visits, hospitalizations and diagnostic tests provided in high spending states, regions and hospitals doesn't buy longer life or better quality of life. In fact, those with chronic illnesses who live in high rate regions have slightly shorter life expectancies and less satisfaction with their care than those in regions with lower rates of spending. When it comes to managing chronic illnesses, greater use of hospitals and physician labor doesn't result in additional health; the problem is waste, and over-use in high rate states, regions and hospitals — not under-use and health care rationing in low rate areas and institutions.

This edition of the Dartmouth Atlas shows how to identify high quality, high efficiency providers and how to measure the potential savings that could be achieved if all providers met these benchmarks. **If the resources and utilization of efficient providers were realized by all providers managing the care of people with severe chronic illnesses during the last two years of their lives, Medicare spending for this group could be reduced by 30%.** The challenge is to realize these savings and reallocate resources to build and maintain integrated community-based systems for managing chronic illness.

An important task in meeting this challenge is transparency in measuring quality and efficiency. The performance measures described in this edition are now available on the Dartmouth Atlas Website for 4,346 hospitals. The measures will be updated and added to on a timely basis and posted on the website, which can be accessed without restriction. The data can be used to identify providers who are relatively efficient in managing severe chronic illness compared to others, including hospitals located within the same community.

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Highlights on a Chapter-by-Chapter Basis

Chapter One:
Chronic Illness and the Problem of Supply-Sensitive Care

Why spending and utilization varies: unmanaged supply of resources, limited evidence and optimistic assumptions (that turn out to be false). The first chapter explains why differences in per capita resources drive differences in utilization and spending in managing patients with severe, life threatening chronic illness. A hospital bed, once built, will be occupied. A medical specialist, once trained, will see patients, order tests, and make referrals to other specialists. But evidence-based medicine plays virtually no role in governing the frequency of use of these supply-sensitive services. In the absence of strong evidence (such as clinical trials comparing one kind of care management to another), other factors drive clinical decisions – including the widely held assumption that for patients with severe chronic illness, more medical care means better care. This assumption is reinforced by fee-for-service payment systems and by physician fears of malpractice lawsuits.

The critical question is whether more supply-sensitive care results in better health outcomes. The chapter reviews the research demonstrating that greater use of supply-sensitive services appears to be associated with worse outcomes, poorer quality and lower satisfaction. Although higher-spending regions spend more, use more resources, and have higher hospitalization rates, the technical quality of care and patient reports concerning access to care are marginally worse, and patients with the same disease have higher mortality rates, very likely because of medical errors associated with the increased use of acute care hospitals. Comparisons of major academic medical centers revealed the same pattern; higher spending was not associated with better quality of care or outcomes.

Implications: high performing health systems can be used as benchmarks of efficiency. The evidence that the outcomes and quality of care tend to be better in regions with lower resources shows that providers serving such regions are not rationing care. On the contrary, they are more efficient; they achieve equal and often better outcomes with fewer resources.

Chapter Two:
Variations Among States in the Management of Severe Chronic Illness

Patients are treated very differently, depending on the state where they live. This chapter illustrates striking variations among states in Medicare spending, resource inputs and utilization. It illustrates the importance of the mix of physician specialties, as well as the per capita numbers of physicians, in achieving low cost/high quality health care. It shows that states that rely more on primary care physicians than on medical specialists in managing chronic illness tend to have lower Medicare spending and use fewer ICU beds. They also have less overall physician labor and fewer referrals to multiple physicians — and have better quality of care as measured by standard process of care measures. The hospital-specific data now available can help states address practice variation in their various roles as purchasers (Medicaid and state employees), regulators (decisions on need to construct hospital beds and other capacity-influencing decisions) and educators (decisions to expand medical schools or other policies that promote growth in the supply of physicians).

Chapter Three:
Treatment of the Chronically Ill at Academic Medical Centers

Academic medical centers vary remarkably in the way they manage chronic illness. Readers of this chapter should come away with the clear impression that there is no consensus among academic medical centers on the clinically appropriate way to manage chronic illness. Academic medical centers differ dramatically in their patterns of practice and resource use. For example, during the last six months of life, patients using New York University Hospital had 76 physician visits per person; Mayo Clinic patients had only 24 visits. Academic medical centers differ in the way they use physicians. Over the last two years of a patient's life, the University of California teaching hospital in Los Angeles (UCLA) uses twice as much physician labor — measured as full-time equivalent physicians — as does the Mayo Clinic. UCLA is very medical specialist oriented; they use 2.5 times more specialists than primary care physicians. UCLA's sister academic medical center, the Uni-

versity of California teaching hospital in San Francisco, favors the use of primary care physicians: they use 1.2 times more primary physicians than medical specialists.

The chapter shows the importance of the choice of benchmark in establishing the need for physician labor. Depending on which region or academic medical center is chosen as the benchmark for physician supply, very different conclusions can be reached about the adequacy of the current supply of physicians. Benchmarks based on regions where large group practices or integrated health care systems dominate practice — such as the Rochester, Minnesota region (where most care is provided by physicians associated with the Mayo Clinic) — indicate that the country has a current surplus of physicians and is likely to have enough physicians to meet U.S. needs thorough 2020, when the Medicare population is swollen by the baby boom generation. In view of the close association between physician supply, the utilization of supply-sensitive care in managing chronic illness, and the evidence that more intensive care may have worse outcomes, we believe that policy makers should respond to the current calls for increasing the supply of physicians by 15-30% with caution.

Chapter Four:
How to Use the Dartmouth Atlas to Compare Performance in Managing Chronic Illness

Hospitals, even those in the same region, vary remarkably in the way they manage chronic illness. Hospitals, even those with same region, often differ remarkably in utilization, Medicare spending and resources allocated to manage chronic illness. For example, Medicare spending for inpatient care and physician visits varies more than twofold among the hospitals in Miami. The major contributor to variation in per person spending within a region is usually variation in the volume of care (i.e., the utilization rate), not variation in the price of care (i.e., reimbursements per day in hospital or physician visit). *Identifying efficient providers depends on being able to measure the volume of care* (patient days and visits per person, for example) as well as unit price; the hospital-specific methods used in this edition of the Atlas provide this critical population-based information. The chapter describes in detail the routine population-based performance reports for evaluating the relative efficiency of regions and hospitals. The reports can be downloaded from the Dartmouth Atlas web site.

Chapter Five:
The Problem of Overuse of Acute Care Hospitals in Managing Chronic Illness: A Regional Analysis

The problem of overuse of acute care hospitals in managing chronic illness. The final chapter draws attention to the over-dependency on acute care hospitals, with their emphasis on "rescue medicine," in the management of chronic illness. As discussed in Chapter One, it can no longer be assumed that this management approach results in better outcomes. Chapter Five presents evidence that the differences in Medicare spending among regions are not a consequence of greater need for care (there is no correlation between the prevalence of severe chronic illness and spending). What matters in predicting Medicare overall spending is how much is spent per patient for those who have a chronic illness. The subsidies between regions, which are based on the way Medicare is financed, have no justification either in terms of differences in illness or in terms of the potential benefit to the populations of living in high spending regions. The only significant benefit of the federal subsidies to high spending regions is in their contribution to the local economy in high cost regions.

The problem of overuse of acute care hospitals in managing chronic illness is not only a Medicare problem. Although there is no systematic national database available for analysis, studies in Michigan have shown striking correlations between variations in Medicare utilization and variations in Blue Cross Blue Shield utilization. The Michigan analysis also traced the variations to the "system effect of capacity," namely variations in the per capita numbers of hospital beds in Michigan communities.

The problem of overuse of acute care hospitals and medical specialists in the management of chronic illness is rapidly getting worse. Over the four-year period 2000-2003, per capita labor inputs of medical specialists, as well as the number of ICU beds per capita, increased more than 13% in the United States. The growth in utilization was greater in regions with higher baseline spending rates. In other words, the disparity between regions in spending and utilization appears to be increasing. For example, per patient rate of use of intensive care units during the last six months of life increased more than 15% in the highest rate regions, compared to 9.7% in the lowest rate regions.

Reducing variation toward the benchmarks of efficient practice would mean large Medicare savings. Utilization and resource use patterns in regions where care is better organized provide promising benchmarks of the fiscal benefits that would accrue by reducing overuse of acute care hospitals and medical specialists. For example, if utilization rates of acute inpatient care and physician visits were reduced to benchmarks provided by Salt Lake City, a region where more than half of health care is delivered through an integrated health care delivery system provided by Intermountain Healthcare, inpatient reimbursements would be reduced 32% and reimbursements for physician consultations and visits by 34%.

Toward a Solution

The reallocation of resources from the acute care sector to create a population-based, community-wide integrated system for managing severe chronic illness is today only a thought experiment. It should become a national goal. Realizing the savings that better organized care can bring requires building community-wide systems of coordinated care. In most communities, such systems do not now exist. The benchmarks from efficient practice indicate that Medicare already invests more than enough money to build and maintain such a system. The problem is that the resources are now largely locked in by Medicare's reimbursement policy. To meet their payrolls and amortize their debts, acute care hospitals are dependent on utilization; reduced utilization results in loss of income. In many regions the reduction in utilization required to meet efficiency benchmarks would have serious — indeed, devastating — consequences for acute care hospitals. Finding a solution will require payers, particularly Medicare, to develop new methods of financing care that provides a fiscal "safe landing" for hospitals and retained savings for use in building community-based systems for managing severe chronic illness. It will also require accountability for system integration. With proper reform of financial models, large group practice and integrated care systems should be able to provide this accountability for the populations they serve in regions where such practices exist. Through economic incentives, existing large group practices might be persuaded to accept responsibility for organizing such care in regions where it does not now exist. Traditionally, hospitals have served as the focus for coordinating community resources. They are the only locus of organized care available throughout the United States; perhaps acute care hospitals could take on the mission of integrating providers into community-based systems for managing chronic illness.

About the Dartmouth Atlas Project

The Dartmouth Atlas Project (DAP) began in 1993 as a study of health care markets in the United States, measuring variations in health care resources and their utilization by both geographic areas. More recently, the research agenda has expanded to reporting on the resources and utilization among patients at specific hospitals. DAP research uses very large claims databases from the Medicare program and other sources to define where Americans seek care, what kind of care they receive, and to determine whether increasing investments in health care resources and their use result in better health outcomes for Americans.

The study was funded by the Robert Wood Johnson Foundation, in partnership with a funding consortium including the Wellpoint Foundation, the Aetna Foundation, the United Health Foundation and the California HealthCare Foundation.

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Subcommittee on Labor, Health and Human Services, Education & Related Agencies

February 14, 2008

Opportunities Lost and Costs to Society: The Social & Economic Burden of Disease, Injuries and Disability
Questions for the Record

Questions from Chairman David Obey:

1. Dr. Leigh, I note that your testimony refers to factors that may add to an undercount of occupational injuries, including both employee concerns about advancement and issues such as out-sourcing and contingent workers. In our overview hearing yesterday, we heard about how the decline in union membership affects wage inequality and health and pension benefit coverage. Is the decline in unionization also a factor in the reporting of workplace injury? Has the culture of the workplace changed in a way that impacts how workers deal with both occupational injuries and health and safety hazards in the workplace?

Yes,in my opinion, the decline in unionization is an important factor. There are no definitive studies, but indirect evidence indicates strong correlations between unionization and injury-reporting, other things equal. My opinion is that the presence of a union allows workers to feel more comfortable reporting injuries than they would without a union. They feel less intimidation. Moreover, many unions have Health and Safety Committees that encourage accurate record-keeping. Prof Medoff and colleagues from Harvard have repeatedly emphasized the importance of unions in altering the culture of the workplace. And part of this culture involves openness regarding understanding and reporting injuries. This would be especially true for low-income persons who may not be aware of the laws governing workplace safety and health. So as unions have lost members, I would expect that the union culture would also recede.

But the definitive research has yet to be completed regarding this important question of unionization and reporting.

On a related point, there are many studies that show unions improve public health. First, union members are paid higher wages and higher wages are associated with better health. Second, union members are more likely to receive medical insurance and pensions, both of which have been linked to better health. Third, unionized workplaces are safer, other things equal, and reduce "job strain"--- a technical medical term referring to arrangements at work that raise blood pressure. In my view, unions may be viewed as a form of preventive medicine for union members and their families. To the extent that

unions raise wages for non-union workers and reduce economy-wide inequality, unions provide a public health benefit for all Americans.

2. Dr. Leigh, as your testimony indicates, the extent and cost of occupational injuries and illnesses is enormous, placing a significant burden on employers, workers, and the taxpayers. Of particular concern are musculoskeketal disorders caused by ergonomic injuries, a topic also covered by Dr. Weinstein. Last year BLS found that these types of injuries accounted for 30 percent of all reported lost-time injuries, and that these cases had a median of 9 days away from work, two days longer than the median, resulting in a greater impact on employers in lost productivity.

A 2005 study by researchers at the Rand Institute and University of Michigan found that among men, 36 percent of Social Security Disability cases were related to a work disability; and the annual cost of these workplace injuries to Social Security and Medicare is $33 billion. That study also found that that 78 percent of these cases were due to a muscoloskeletal disorder, which would put the annual cost to the government and the tax payers at about $26 billion.

Yet, despite the enormity of this workplace safety and health issue, the first act by the Bush administration in 2001 was to have Congress kill the OSHA ergonomics standard that was finalized at the end on the Clinton administration. In lieu of regulations, Secretary Chao promised to develop voluntary guidelines on an industry by industry basis. Nearly six years later not much has happened to implement even this weak plan, as these voluntary guidelines would not be used for enforcement. Only <u>three</u> voluntary industry guidelines (for poultry processing, retail stores, and nursing homes) of the <u>sixteen</u> recommended by the Secretary's hand-picked advisory group have been issued, and this past year one additional draft guideline, for shipyards, was published.

Questions from Chairman David Obey (continued):

- If the government wanted to prevent one of the leading causes of workplace injuries and illnesses, wouldn't it make sense to focus a lot more attention on ergonomic hazards that are responsible for nearly one-third of serious workplace injuries and wouldn't these preventive efforts not only benefit workers and employers, but significantly reduce Workers Compensation and Social Security Disability costs?

Response:
The answer is "yes" to each of your questions. We are "penny-wise and pound-foolish." The biggest mis-conception of advocates of rescinding rules on ergonomics is that they "save money." They only save money to the particular businesses involved and only in the short-run. We know that workplace musculoskeletal injuries are not fully compensated by workers compensation. First, many of these injuries are never reported to workers comp insurers and among those that are, there is evidence that only some short-run medical and lost productivity costs are covered. In the long-run, these body parts can be re-injured. In fact, the best predictor of any injured body part is whether that body part was injured before. When a second injury occurs, it may be off-the-job and private insurance or Medicare, Medicaid, etc, will have to pay for it. This means that "everybody else" has to pay these costs. And , in the long-run, this would include the business that might originally save some money in the absence of the ergonomic standard. Time and again research demonstrates that what medical researchers call "primary prevention" in the community (i.e. outside the medical sector) is more likely to be cost-effective than prevention within the medical sector or medical spending on cures or care-taking of persons with disease.

- Are the numbers of reported injuries even accurate? As I understand it, the Department of Labor eliminated the separate column for employers to identify Musculoskeletal Disorders on the OSHA 300 log, making these cases more difficult to track.

Response:
They are the best data we have . I have used them extensively. The data can be used effectively if researchers know the limitations of the data.So, for some purposes, especially when comparing across some categories, they are reasonably accurate. For example, I recently wrote a paper on needlestick injuries with William Wiatrowski at BLS. We were able to document that significant numbers of these injuries occur outside the medical care sector. This is "news" to the research community. But we also know that there are serious deficiencies. I believe the data-gathering system could be greatly improved.

I did not know that they eliminated the column about musculoskeletal disorders. I am shocked. As you know, this is an especially large category of injury and one that is amenable to prevention. This can only harm us in the long-run. We need to prevent these injuries to save money for everybody in the long-run.

Questions from Rep. Rosa DeLauro (continued):

3) Occupational Health & Safety
Professor Leigh, what I understand from your presentation is that job-related fatalities are stable;

Response:
No, if that was your recollection, I mis-spoke. Fatalities have dropped roughly 10% over the last 15 years.. I believe that this 10 % drop is reasonably accurate. injuries and illnesses are down according to the statistics, and we have made significant progress in this area.

Response:
Reported nonfatal injuries have dropped perhaps 30%. I do not believe this number. It is too high.

Yet, the costs of occupational injury and illness are "nearly 80% as large as those of cancer, roughly the same as those for diabetes and greater than those for Alzheimer's." In addition, there are real problems with the accuracy of the numbers, with the BLS under-reporting up to 70% of all nonfatal injuries and illnesses. I find this shocking. Because in the final analysis, we do not have an accurate picture of what is going on. This, at the same time, that we face an agency in the Occupational Safety & Health Administration which has basically stopped issuing new standards, except those mandated by court order. **So my question is this, given that resources are limited, where do we direct the federal investment to first have an accurate picture of the costs associated with occupational injury and illness,**

Response:
1. Here some relatively cheap ones....a.Start asking the Agency for Healthcare Research and Quality(AHRQ) to start collecting data on workers comp as an insurance category, similar to Medicare of Medicaid. AHRQ has many beautiful data sets. One is the H-CUPnet (http://www.google.com/search?hl=en&q=h-cup-net&btnG=Google+Search) which collects lots of data on hospitalizations all around the US. The H-CUPnet has info on Medicare, Medicaid, etc, but no category for workers comp ! b. ask the National Center for Health Statistics to start getting better data on "injury at work" in their National Health Interview Survey. (http://www.cdc.gov/nchs/nhis.htm) . They need to start asking about back pain, shoulder pain, connections to the job, etc. c. There are many national longitudinal data sets available....NLS, PSID, MEPS , we need to have these data sets start collecting better data on job injuries and hazards and workers comp payments.

2.We need substantial improvements in the BLS Annual Survey of Occupational Injuries and Illnesses(SOII) We need to test pilot projects regarding how best to improve the Survey. These projects need to somehow involve workers in data collection. We could administer sureys to workers themselves and compare to what BLS records are. We

could, for example, survey doctors in a given region regarding carpal tunnel syndrome(CTS) and compare to CTS reported to BLS. We could expand analysis of the Emergency Room data NIOSH has .(NEISS). Conduct investigations of firms that may be under-reporting. Issue fines for under-reporting. OSHA already audits records of some firms. These audits need to be expanded.

3. The Census of Fatal Occupational Injury(CFOI) is terrific. But it, too, could be improved. W e need to experiment with requiring only 1 rather than 2 official documents to determine if deaths were truly occupational.

4. We need to start collecting data on deadly occupational illnesses. We could begin with CFOI. In the early years of CFOI some data were collected on disease deaths, **This effort** needs to be expanded. Using Social Security records,we could match cancer patients with employments (years ago) that likely resulted in exposure to cancer-causing substances. NIOSH has attempted to produce mortality risks for cancer, COPD, etc based upon prior employments in hazardous industries.

5. Job-related arthritis data sets need to be developed. Medicare has data on hi and knee replacements. We could do a pilot study of these Medicare patients to determine if they had experienced a knee or hip injury at-the-job years before. We could then try to find a workers comp record of the injury. This might be especiallyeasy with the federal government's own workforce since the federal government has its own workers comp records. Alternatively, we could try to get records from Washington state which has a single-payer workers comp insurer. MEPS, NLS , PSID might be especially useful for this also.

5. We need to collect(at the federal level) as much workers comp data from the different states as possible. State agencies and insurers have huge amounts of data. There need to be national data sets on workers comp data. These data would have an advantage over BLS since they would also contain info on costs. NIOSH has tried this, I believe. Several states have single-payers.(Washington Wyoming, Ohio and others). These data could be easily collected and merged at the federal level. Many states, including California, have very large semi-public insurance carriers. We could ask these carriers to submit data.

6. I have many more ideas on data-collection, but you wanted this brief.

and second, bring down those costs?

Response:
The answer, I believe, is prevention. Medical costs will be soaring no matter what. This is not the problem of workers comp systems or OSHA or employers or unions, but is the result of the general rapid increase in all medical costs nationwide (16-17% of GDP). But with prevention, costs can be reduced. Paul ONeill (Bush's former economic advisor) proved prevention could work at Alcoa Aluminum http://www.businessweek.com/2001/01_06/b3718006.htm

Finally, can you discuss the impact of the regulatory inaction we have seen at OSHA?

The greatest effect is on culture at the job. Employers see that OSHA is no longer much of a force, and they simply place issues of occupational safety on the back burner. It is not that firms intentionally trade-off more production for less safety it is just that over time with fewer people asking questions about safety, fewer news reports, fewer OSHA visits, etc, safety just slips out of people's minds. OSHA's biggest effects, I believe, are in changing the culture at work. The fines, penalties, regulations are too low and weak and need to be strengthened. Repeat offenders need to face much stiffer penalties (see PBS Frontline "Dangerous Business" http://www.pbs.org/wgbh/pages/frontline/shows/workplace/) . But the bottom line is whether and how much occupational safety is taken seriously .

Questions from Rep. Lucille Roybal-Allard:

1) Professor Leigh: Thank you for highlighting during the hearing the fact that low income and Hispanic workers have a significantly higher on-the-job injury and mortality rate.

You say in your testimony that 66% of costs for work related injuries and illness are not covered by workers compensation insurance and therefore must be paid by out-of-pocket costs, private health insurance, Medicare, Medicaid or Social Security disability benefits.

Since the majority of these illnesses and injuries are borne by low-income(yes) and minority workers(technically, no, there are a disproportionate number of Hispanics and African Americans, but they are not the majority) who do not have private health insurance, and who can't afford the out of pocket expenses, these costs are most likely covered by the government programs. Will you please elaborate on how burdensome you think this is for the system as a whole?

Response:
If injuries were more frequent among high-income persons and a disproportionate number of whites, consequences would be different. 1. High income people are more likely to have medical insurance and less likely to rely on Medicaid. This means that because, in reality, injured people are low-income, a greater burden falls on taxpayers So because injured people are more likely to be low-income means that we are transferring money from the private sector to the government sector.2. Many researchers and others believe that Medicaid, because it reimburses doctors less than private insurance, actually provides poorer quality medical care than what would be provided by private insurance. This results in a disparity: Hispanics and African Americans are receiving poorer quality medical care, on average. This is not the result of overt discrimination, but the result of institutional discrimination since Hispanics and African Americans experience a disproportionate number of occupational injuries. 3. It is likely that illegal immigrants are also disproportionately employed in hazardous jobs. Here we have new implications: a. as illegal immigration may have expanded in the 1990s, BLS "reported" injuries may have fallen because illegal immigrants are afraid to report a job-injury. b. Seriously injured illegal immigrants likely return to , for example, Mexico (as an example in California). This means that the burden is then absorbed by a different country. c. This creates an incentive for employers to hire illegal immigrants because their workers comp rates will be lower and they do not have to spend to improve safety standards at-the-job. This would result in a general reduction in safety at-the-job for all workers, whether or not illegal.

2) Professor Leigh: You also mentioned in your testimony that the Bureau of Labor Statistics may miss 20% to 70%

Response:
A better estimate is 33% to 70%

of all nonfatal injuries and illnesses. As a researcher, how do you factor in the unreliability of the BLS statistics, and what recommendations do you have to make them more reliable?

Response:
I factor these in by creating a mathematical model which captures likely values for firms under-reporting and employees under-reporting as well as accounting for firms and governments that are not required to report. . My paper "An estimate of the US Government's undercount of nonfatal occupational injuries" in Jo Occupational and Environ Med, January 2004 explains the model. If you do not already have a copy of this one I will be happy to send it to you.

Please see my point # 2 above under from Rep. Rosa DeLauro ():**3) Occupational Health & Safety**

2. We need substantial improvements in the BLS Annual Survey of Occupational Injuries and Illnesses(SOII) We need to test pilot projects regarding how best to improve the Survey. These projects need to involve workers in data collection.). We could administer sureys to workers themselves and compare to what BLS records are We could, for example, survey doctors in a given region regarding carpal tunnel syndrome(CTS) and compare to CTS reported to BLS. We could expand analysis of the Emergency Room data NIOSH has .(NEISS). Conduct investigations of firms that may be under-reporting. Issue fines for under-reporting. OSHA already audits records of some firms. These audits need to be expanded. More firms need to be audited.

TUESDAY, FEBRUARY 26, 2008.

OPPORTUNITIES LOST AND COSTS TO SOCIETY: THE SOCIAL AND ECONOMIC BURDEN OF INADEQUATE EDUCATION, TRAINING AND WORKFORCE DEVELOPMENT

WITNESSES

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THOMAS W. RUDIN, SENIOR VICE PRESIDENT FOR ADVOCACY, GOVERNMENT RELATIONS AND DEVELOPMENT, THE COLLEGE BOARD

HARRY J. HOLZER, PROFESSOR OF PUBLIC POLICY, GEORGETOWN PUBLIC POLICY INSTITUTE AND SENIOR FELLOW, THE URBAN INSTITUTE

WILLIAM E. SPRIGGS, PROFESSOR AND CHAIR, DEPARTMENT OF ECONOMICS, HOWARD UNIVERSITY, WASHINGTON, DC

Mr. OBEY. If the committee will come to order?

As members know, this subcommittee has jurisdiction over a great many programs that deal with people who often begin life behind life's starting line, and the purpose of these programs is to try to equalize people's opportunity to make a full and decent life for themselves and their families and their loved ones.

We often hear congressional debate about the cost of making certain appropriations. We don't often hear much said about the cost of not making those appropriations.

It always bothers me, for instance, when people say that each and every American has X thousand dollars share of the national debt. That's true. But what we don't often see is a description of what the value of the assets are which are owned by the United States government as a representative of the taxpaying public.

Example: what is the value to each citizen of Glacier National Park, or Yellowstone? They're often very hard to quantify. But I would venture to say that the value of assets owned by the American people are at least equal to the value or to their share of the nation's outstanding debt.

Another example that I've tried to use: Lou Gehrig's Disease. We spend roughly $43,000,000 to try to find a cure for that disease, nationwide.

This committee does not specifically appropriate to deal with diseases. It shouldn't. But that is the effective amount that's spent nationwide to try to discover the causes and the cures of that disease, so we know what the cost to us is if we double that funding.

But we don't know what the cost of the disease itself is to this society when you total up the cost of hospitalization, the cost of doctors' visits, the cost of lost income from the disease, the cost of medical services to patients as they progress through the disease.

So what we are trying to do here today, we heard this morning from the Secretary of Education, we'll hear tomorrow from the Sec-

retary of HHS, and we'll hear later on from the Secretary of Labor, and we will have tough discussions about what it costs to provide increased services for OSHA or increased funding for the National Institutes of Health, or increased funding for Pell Grants, but today I want the witnesses to deal with the cost of not moving ahead to make progress in all of these areas.

We have with us four distinguished witnesses.

First is Dr. Robert Lynch, Professor and Chair of the Department of Economics at Washington College; Dr. Tom Rudin, Senior Vice President for Government Relations and Development at the College Board; and Dr. Harry Holzer, Professor of Public Policy at Georgetown Public Policy Institute and a Senior Fellow at the Urban Institute, and Dr. William Spriggs, Chair of the Department of Economics at Howard University and formerly a senior economist for the Joint Economic Committee of the National Urban League.

Before I call on the witnesses for their testimony, I'd like to ask Mr. Walsh for whatever remarks he would care to make.

Mr. WALSH. Mr. Chairman, I'd just like to thank you for holding this hearing. I look forward to hearing from the witnesses. I welcome them here today, and I hope to get a few questions in when they complete their testimony.

Thank you. I yield back.

Mr. OBEY. Thanks.

Well, gentlemen, why don't we proceed first with Dr. Lynch.

Mr. LYNCH. I want to thank Chairman Obey, Ranking Member Walsh, and all the other members of the subcommittee for giving me this opportunity to discuss with you my research on early childhood education.

I will describe for you what we know about the benefits of public investment in early education programs, including Head Start, and some of my own research on the costs and benefits of extending and enhancing Head Start.

A key message that I want in part is that public investment in the education of young children is an outstanding use of the taxpayers' money.

Research is increasingly demonstrating that the policy of investing in early childhood education is one of the best ways to improve child well-being, increase the educational achievement and productivity of children and adults, and reduce crime.

Assessments of high quality programs have established that investing in children has a large number of lasting, important benefits for children, their families, and society as a whole, including its taxpayers.

In general, participating children are more successful in school and in life after school than children who are not enrolled in such programs.

In particular, children who participate in early education programs tend to have higher scores on math and reading achievement tests, have greater language abilities, require less special education, and are less likely to repeat a grade.

They have lower dropout rates, higher levels of schooling attainment, and graduate from high school and attend college at higher rates.

These children experience significantly less child abuse and neglect.

Both as juveniles and as adults, they are less likely to engage in criminal activity.

Once these children enter the labor force, their employment rates and their incomes are higher, along with the taxes that they pay back to society.

Parents of children who participate in early education programs also benefit. They benefit both directly from the services they receive and indirectly from the subsidized child care provided by publicly funded programs.

For example, parents are less likely to abuse or neglect their children and are more likely to be employed and have higher earnings.

Careful long-term analyses of three high-quality early childhood education programs have found benefit/cost ratios that varied from a minimum of 4:1 to a high of more than 17:1, which means that every dollar invested in these programs returned between $4 and $17 in total benefits.

In addition to providing benefits to participating children and their families, early education programs lead to government budget benefits by generating savings in government spending on K–12 education, on child welfare, and on the criminal justice system, and by increasing tax revenues.

It is noteworthy that while participants and their families get part of the total benefits, the benefits to the non-participating public and government are large, and in and of themselves, tend to far outweigh the costs of these programs.

For example, when all the costs are borne by taxpayers, and when we take into account only the benefits that generated budget savings for government, benefit/cost ratios for early education programs have been calculated to equal about 3:1.

That is, every tax dollar spent on these programs generated about $3 in budget revenues and budget savings.

Thus, it is advantageous even for nonparticipating taxpayers to help pay for these programs because the costs to government are outweighed by the positive budget impacts that these investments eventually produce.

Now, with respect to Head Start specifically, most studies have found that the immediate impacts of Head Start, whether measured in terms of achievement test scores or the behavior, motivation, and health outcomes of participating children have been positive.

There have been only a few studies of the long-term impacts of Head Start and these, too, generally show small to moderate positive effects.

A carefully controlled, large-scale randomized study of the outcomes of Head Start is currently underway, the National Head Start Impact Study. It has published its first year findings from a study that plans to follow children for four years.

After just one year of Head Start, there were small to moderate statistically significant positive impacts for three- and four-year-olds on several measures of cognitive achievement, social, emotional behavior, access to health care, and health status.

In addition, from the parenting programs, we find that there were small, statistically significant improvements in the parenting practices of parents of children who had attended Head Start.

In my own research, I analyze the costs, and many, but not all, of the benefits of public investment in prospective high quality prekindergarten programs.

In other words, I look at what would happen if we extended and further enhanced Head Start.

I find that a larger and improved Head Start program would generate growing annual benefits that would surpass the cost of the program in six years. The annual budgetary, earnings, and crime benefits eventually exceed the cost of the program by a ratio of more than 12:1.

The net annual effect on government budgets alone—that is, excluding the crime benefits and the earnings benefits that go to citizens—the net annual budget benefits alone turn positive within nine years.

That is, starting in the ninth year, and every year thereafter, annual government budget benefits due to an enhanced the Head Start would outweigh annual government costs of the program, and do so by growing margins over time.

For every tax dollar invested in high quality Head Start, we would eventually experience more than $3 in government budget benefits.

And of course, on top of the budget savings, an enhanced Head Start program would substantially increase the earnings of workers, grow the economy, and reduce the cost to individuals from crime.

So what research demonstrates is that investment in early education, even when its benefits are not fully accounted for, is an effective public policy strategy for enriching children and enriching the nation.

A nationwide commitment to high quality Head Start would cost a significant amount of money up front, but it would have a substantial payoff in the future, as it will reduce costs for remedial and special education, for criminal justice and child welfare, and it will increase income earned and taxes paid.

Over time, government budget benefits alone outweigh the costs of Head Start. That is, a high quality Head Start would pay for itself.

The consequence of not extending and further improving Head Start is more crime and poverty and a weaker, less globally competitive economy with less skilled workers earning lower incomes.

Thus, we should be investing in high quality early education to improve the quality of life of millions of our children, to reduce crime, to make the workforce of the future more productive, and to strengthen our economy. It is one of the wisest investments our nation can make.

Thank you very much.

[The information follows:]

The Benefits of Public Investment in Early Childhood Education Programs

Testimony before the U.S. House Appropriations Subcommittee on Labor, Health and Human services, Education, and Related Agencies,
Tuesday, February 26, 2008, 2:00-4:00 PM,
Room 2359 Rayburn House Office Building

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Public investment in early childhood education is an effective strategy for enriching our nation, strengthening our communities, and improving the quality of life of our children and their families. Although not all the benefits from public investment in early childhood education can be measured and quantified, many can be calculated. The costs of public investment in early childhood education are relatively easier to capture fully and accurately. Hence, the quantifiable benefits and costs can be compared and, even when the benefits are not fully accounted for, such a comparison can inform the public debate on the merits of public investment in early childhood education by illustrating its substantial net benefits.

Economic research is increasingly demonstrating that investment in early childhood education is one of the best ways to improve child well-being, increase the educational achievement and productivity of children and adults, and reduce crime. Such investment is also one of the best ways to help us attain numerous other socioeconomic goals. It is interesting to note that the conclusions of economists about the effectiveness of investment in early childhood education are buttressed and strongly supported by the findings of scholars in several other fields of inquiry. Consider the following from Knudsen et al (2006):

A cross-disciplinary examination of research in economics, developmental psychology, and neurobiology reveals a striking convergence on a set of common principles that account for the potent effects of early environment on the capacity for human skill development. Central to these principles are the findings that early experiences have a uniquely powerful influence on the development of cognitive and social skills, as well as on brain architecture and neurochemistry; that both skill development and brain maturation are hierarchical processes in which higher level functions depend on, and build on, lower level functions; and that the capacity for change in the foundations of human skill development and neural circuitry is highest earlier in life and decreases overtime. These findings lead to the conclusion that the most efficient strategy for

strengthening the future workforce, both economically and neurobiologically, and for improving its quality of life is to invest in the environments of disadvantaged children during the early childhood years.

Within the discipline of economics there has long been near universal agreement that educational achievement and attainment are fundamental elements of success in the labor market. Education provides skills, or human capital, that raises an individual's productivity and future earnings.[1] Findings from economics and other fields, such as medicine, neurobiology, and developmental psychology, increasingly indicate that "prevention is more effective and less costly than remediation, and earlier is far better than later" (Knudsen et al 2006). Thus, there is growing consensus that investment in the education of young children, especially disadvantaged children, is one of the most effective strategies to develop the workforce of the future, ameliorate the quality of life, and enhance the wealth of nations, societies, communities, families, and individuals.

Overview of the benefits of early childhood education programs:

Consensus about the effectiveness of investments in high-quality early childhood education (ECE) programs has not always existed. Initially, there was great optimism about the benefits of ECE programs. Early studies showed that children in ECE programs performed significantly better on IQ tests in the first few years after program participation than did comparable children who did not participate in the programs (see, for example, Deutsch 1967). However, follow-up studies of ECE participants found that their advantage over non-ECE participants in terms of IQ test scores tended to fade as they progressed through school so that by the end of third grade there were no significant IQ test score differences (see, for example, a Westinghouse Learning Corporation study

[1] For a review of this literature see Ashenfelter and Rouse (1999).

by Cicirelli 1969). The initial optimism turned to pessimism and some scholars concluded that investment in ECE was a waste of money, producing few if any lasting benefits but costing thousands of dollars per participant.

Subsequent and better quality research has shown that this pessimism about the longer-term effects of ECE investment is unwarranted for several reasons. First, there was an undue focus on IQ scores at the expense of other cognitive and socio-development outcomes. In general, research has shown that gains in IQ due to ECE program participation are short term and tend to gradually fade and even disappear (Barnett 2004). However, many other important outcomes, such as improvements in achievement test scores and graduation rates, and diminished grade retention, special education placements, and crime and delinquency persist. So, even if gains in IQ fade over time there are numerous other long term educational and social benefits from ECE program participation.

Second, several studies that found a "fadeout" effect of the educational benefits of ECE participation were methodologically unsound. For example, the famous Westinghouse study mentioned above that continues to be widely cited by non-experts, was seriously flawed for a number of reasons. Below, a few of these flaws are explained.

Children in first, second, and third grade who had attended Head Start were compared to classmates in the same grades who had not attended Head Start. But, children in both groups who were placed in special education were not included in the samples. Since the non-Head Start comparison group had a higher percentage of special education placements, a higher percentage of lower performing children were excluded from the comparison group. In addition, while the two groups of children were

appropriately matched on a number of criteria, they were not matched on age. Children retained in grade were included in the samples and mixed in with the younger children in the grade to which they were retained. Again, the non-Head Start comparison group had a higher percentage of children who were retained in grade. Thus, an increasing age gap developed between the comparison group and the Head Start children as they advanced from first to third grade. As a consequence, the third grade comparison group was significantly older than the third grade Head Start group (Barnett and Hustedt 2005). So, what the Westinghouse study found was not fadeout, but that a relatively larger subset of the highest performing Head Start children (those Head Start children not placed in special education) did as well as a relatively smaller subset of the highest performing non-Head Start children (those not placed in special education). In addition, the study found that younger third graders who had attended Head Start performed as well as older third graders who had not attended Head Start, a positive reflection on Head Start given that achievement test scores of children are positively correlated with age. The findings that Head Start participants were less likely to be placed in special education or retained in grade are examples of the lasting educational benefits of prekindergarten that were inappropriately used to suggest the opposite.

Third, studies that report fadeout effects often fail to control for the quality of ECE programs. Numerous studies have found that quality matters: higher quality predicts higher test scores in language and math, fewer behavioral problems, and better work habits *that last over time* (Peisner-Feinberg et al 2001; Broberg ,Wessel, Lamb, and Hwang 1997; Howes 1988; Vandell, Henderson, and Wilson 1988; NICHD 2005). A recent and large National Institute for Child Health and Development study (NICHD

2005) found that children who experienced better quality child-care manifested greater achievement through the third grade without any fadeout effects. Hence, poor-quality ECE programs may generate small educational benefits that diminish over time, but high-quality programs produce larger benefits that endure.

Thus a strong consensus has developed among experts who have studied high-quality early childhood education programs that these programs have substantial and enduring payoffs. Long-term studies of ECE participants have consistently found that investing in children has several lasting, important benefits for the participants, their families, and society at large including taxpayers. These benefits include:

- Higher levels of verbal, mathematical, and general intellectual achievement
- Greater success at school, including less grade retention, less need for special education, and higher graduation rates
- Higher employment and earnings
- Better health outcomes
- Less welfare dependency
- Lower crime rates
- Higher government revenues and lower government expenditures

More specifically, assessments of well-designed and well-executed programs in early childhood development, have established that participating children are more successful in school and in life after school than children who are not enrolled in high-quality programs. In particular, children who participate in high-quality ECE programs

tend to have higher scores on math and reading achievement tests and greater language abilities. They are better prepared to enter elementary school, experience less grade retention, and have less need for special education and other remedial coursework. They have lower dropout rates, higher high school graduation rates, and higher levels of education attainment. They also have better nutrition, improved access to health care services, higher rates of immunization, and better health. Additionally, they experience less child abuse and neglect, and they are less likely to be teenage parents.

As adults, high-quality preschool program participants have higher employment rates, higher earnings, greater self-sufficiency, and lower welfare dependency. They exhibit lower rates of drug use and less frequent and less severe delinquent behavior, engaging in fewer criminal acts both as juveniles and as adults and having fewer interactions with the criminal justice system, and lower incarceration rates. The benefits of ECE programs to participating children enable them to enter school ready to learn, helping them achieve better outcomes in school and throughout their lives.

Parents and families of children who participate in ECE programs also benefit—both directly from the services they receive in high-quality programs and indirectly from the subsidized childcare provided by publicly funded ECE programs. For example, mothers have fewer additional births, have better nutrition, and smoke less during pregnancy, and are less likely to abuse or neglect their children. They complete more years of schooling, have higher high school graduation and employment rates, have higher earnings, engage in fewer criminal acts, have lower rates of drug and alcohol abuse, and are less likely to use welfare.

Investments in ECE programs pay for themselves over time by generating very high rates of return for participants, the non-participating public, and government. Good programs produce $3 or more in present value benefits for every dollar of investment. While participants and their families get part of the total benefits, the benefits to the rest of the public and government can be larger and, on their own, tend to far outweigh the costs of these programs. Thus, it is advantageous even for non-participating taxpayers to help pay for these programs.

Several prominent economists and business leaders (many of whom are skeptical about government programs generally) have recently issued well-documented reviews of the literature that find very high economic payoffs from ECE programs. For example, Nobel Prize–winning economist James Heckman of the University of Chicago has concluded:

> Recent studies of early childhood investments have shown remarkable success and indicate that the early years are important for early learning and can be enriched through external channels. Early childhood investments of high-quality have lasting effects… In the long run, significant improvements in the skill levels of American workers, especially workers not attending college, are unlikely without substantial improvements in the arrangements that foster early learning. We cannot afford to postpone investing in children until they become adults, nor can we wait until they reach school age – a time when it may be too late to intervene. Learning is a dynamic process and is most effective when it begins at a young age and continues through adulthood. The role of the family is crucial to the formation of learning skills, and government interventions at an early age that mend the harm done by dysfunctional families have proven to be highly effective (Heckman 1999, 22 and 41).

The director of research and an associate economist at the Federal Reserve Bank of Minneapolis, Arthur Rolnick and Rob Grunewald, have come to similar conclusions:

> …recent studies suggest that one critical form of education, early childhood development, or ECD, is grossly under-funded. However, if properly funded and managed, investment in ECD yields an extraordinary return, far exceeding the return on most investments, private or public…. In the future any proposed economic development

list should have early childhood development at the top (Rolnick and Grunewald 2003, 3 and 16).

Likewise, after reviewing the evidence, The Committee for Economic Development (CED), a nonpartisan research and policy organization of some 250 business leaders and educators, concluded that:

Society pays in many ways for failing to take full advantage of the learning potential of all of its children, from lost economic productivity and tax revenues to higher crime rates to diminished participation in the civic and cultural life of the nation. ...Over a decade ago, CED urged the nation to view education as an investment, not an expense, and to develop a comprehensive and coordinated strategy of human investment. Such a strategy should redefine education as a process that begins at birth and encompasses all aspects of children's early development, including their physical, social, emotional, and cognitive growth. In the intervening years, the evidence has grown even stronger that investments in early education can have long-term benefits for both children and society (Committee for Economic Development 2002).

In its most recent review of the evidence, CED further concluded that:

...it has become generally accepted that preschool programs play an important role in preparing children—both advantaged and disadvantaged – to enter kindergarten. There is also a consensus that children from disadvantaged backgrounds in particular should have access to publicly supported preschool programs that provide an opportunity for an "even start." The social equity arguments for preschool programs have recently been reinforced by compelling economic evidence, which suggests that society at large benefits from investing in these programs. Broadening access to preschool programs for *all* children is a cost-effective investment that pays dividends for years to come and will help ensure our states' and our nation's future economic productivity (Committee for Economic Development 2006).

Reviewing the benefit-cost ratios calculated for three high-quality prekindergarten programs illustrates the net benefits of investment in ECE programs.

Estimates of benefit-cost ratios for prekindergarten investment

Three prekindergarten programs have had carefully controlled studies with long-term follow-up of participants and a control group of non-participants: the Perry

Preschool Project, the Abecedarian Early Childhood Intervention, and the Chicago Child-Parent Center Program (CPC).[2] All of these studies, described in more detail later in this paper, have found that enormous payoffs result from investments in early childhood development. Specifically, as illustrated in **Figure A**, analyses of the three programs for disadvantaged children have found benefit-cost ratios that varied from a minimum of 3.78 to 1 to a high of 17.07 to 1 (expressed in net present value). Investment in a project is justified if its benefits are greater than its costs or if its benefit-cost ratio exceeds 1 to 1. Moreover, in the benefit-cost analyses of all three of these programs, the costs may have been fully described, but the benefits were certainly understated.[3] Thus, the benefits of these prekindergarten programs probably exceed the costs by margins greater than those indicated in Figure A.

From the perspective of public policy, investments in prekindergarten programs pay for themselves by generating very high rates of return for participants, the nonparticipating public, and government (in the form of either reduced public service costs or higher tax payments by participants and their families). While participants and their families get part of the total benefits, it is noteworthy that the benefits to the non-participating public and government are larger and, in and of themselves, tend

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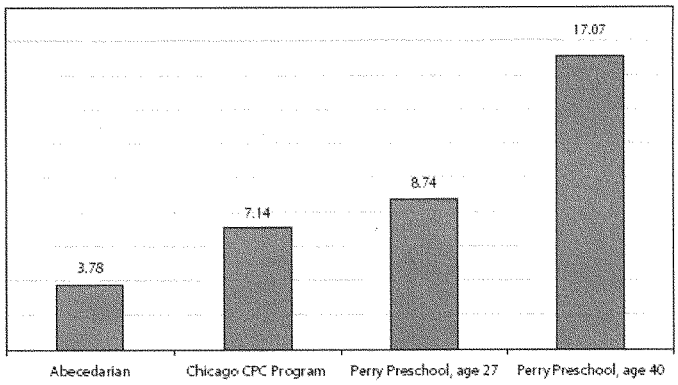
[2] All but the Chicago Child-Parent Center program had random assignment of potentially eligible children into the intervention program or the control group. The analysis of the Chicago CPC program began after the children had been accepted into the program. The outcomes for the treatment group were then compared to the outcomes for a control group of children selected from Chicago neighborhoods that met the eligibility requirements but did not have a CPC prekindergarten program. Thus, the Chicago Child-Parent Center program did not use randomized assignment into intervention and the control group, but the control group did closely match the intervention group on age, eligibility for intervention, and family socioeconomic status. However, only 60% of the Chicago CPC children subsequently attended full day kindergarten whereas *all* the control group children did, possibly introducing a conservative bias in the outcome effects of the CPC program.

[3] It was not always possible to monetize the benefits that were identified (such as the monetary benefit of reduced illegal drug usage) and not all the likely benefits were identified and monetized (such as the increased employment and earnings of parents who had children enrolled in prekindergarten programs).

FIGURE A Ratio of benefits to costs



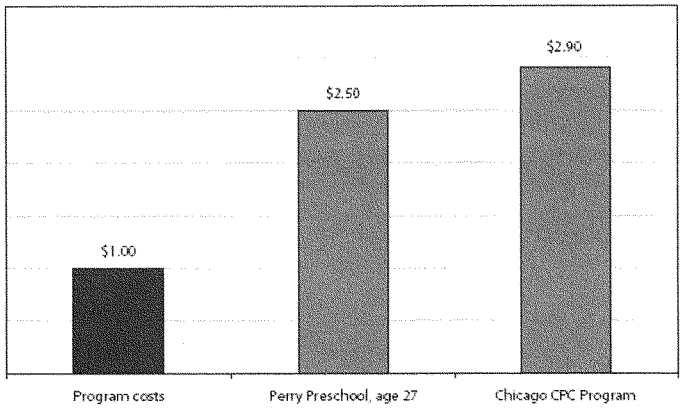
Source: Barnett (1993); Masse and Barnett (2002), Reynolds et al (2002), Schweinhart et al (2005).

to far outweigh the costs of these programs. For example, a Federal Reserve Bank of Minneapolis (Rolnick and Grunewald, 2003) study determined that annual real rates of return (i.e., adjusted for inflation) on public investments in the Perry Preschool prekindergarten program were 12% for the non-participating public and government, and 4% for participants, so that total returns exceeded 16%. Thus, it is advantageous even for non-participating taxpayers to pay for these programs. To comprehend how extraordinarily high these rates of return on prekindergarten investments are, consider that the highly touted real rate of return on the stock market that prevailed between 1871 and 1998 was just 6.3% (Burtless 1999).

Even from the narrow perspective of budgetary policy, investments in prekindergarten programs pay for themselves because the costs to government are outweighed by the positive budget impacts that the investments eventually produce. **Figure B** illustrates the benefit-cost ratio for two of the three prekindergarten programs described in Figure A assuming that all the costs are borne by government and taking into

account only the benefits that generate budget gains for government.[4] These ratios vary from 2.5 to 1 for the Perry Preschool program to 2.9 for the Chicago CPC program.

FIGURE B Government benefits for each dollar invested



Source: Barnett (1993), Masse and Barnett (2002), Reynolds et al (2002), Schweinhart et al (2005).

The long-run benefits of investments in early childhood education:

The long-run benefits of investment in four prekindergarten programs are presented below: the Perry Preschool Project, the Abecedarian Early Childhood Intervention, Head Start, and the Chicago Child-Parent Center program. Head Start is by far the largest of the prekindergarten programs. The other three prekindergarten programs described below were selected because they represent examples of very high-quality,

[4] Masse and Barnett (2002) did not calculate government savings for the Abecedarian program. They did indicate budgetary impacts for government in the form of lower public education spending, lower welfare outlays, and increased outlays for public higher education. But Masse and Barnett did not estimate the tax revenues that would derive from the additional earnings that they calculated would be generated by participants and their families. Nor did they calculate criminal justice system savings because their data on the Abecedarian program showed reductions in crime that were not statistically significant. If we ignore criminal justice system savings and apply a 33.3% marginal tax rate (e.g. 8% federal, 15.3% payroll, and 10% state and local taxes) to the additional earnings of participants and their families, then the benefit-cost ratio for government from the Abecedarian program would be 1.1 to 1.

well-conceived programs. Perhaps more importantly, these four programs all include long-term follow up studies that analyzed the outcomes of the programs after following the children to the age of 21 (the Abecedarian Early Childhood Intervention), 24 (Chicago Child-Parent Centers), 31 (Head Start), or 40 (Perry Preschool). In addition, these programs took place in a wide variety of settings from small town (Abecedarian and Perry Preschool) to large, urban inner-city (Chicago Child-Parent Centers).

1. Perry Preschool Project *(Ypsilanti, Michigan 1962-1967)*

Description: One hundred twenty-three African-American children with low IQ's (in the 70 to 85 range) from families with low socio-economic status were randomly assigned to one of two groups: one enrolled in a prekindergarten program and one not. Those enrolled in prekindergarten attended for two school years at ages three and four. Services included daily two-and-a-half-hour classes and weekly one-and-a-half-hour home visits with mother and child. Both groups of children were evaluated annually until they reached the age of 11, and then again at ages 14, 15, 19, 27, and 40.

Results: **Table 3** summarizes some of the statistically significant outcomes of the preschool program. Researchers observed additional positive outcomes from the program, but these benefits are not included in the table or described in the following discussion because it cannot be asserted with a high degree of certainty that they resulted from the ECE investment.

TABLE 3 Statistically significant benefits of the Perry Preschool Project

	Preschoolers	Non-Preschoolers
Grade retention or special education, age 10	17%	38%
High school graduation, age 27	71%	54%
Arrested for drug-related offenses by age 27	9%	25%
Arrested, age 27	48%	57%
Average number of arrests by age 27	2.3	4.6
Earn $2,000 or more per month, age 27	29%	7%
Employment rate, age 27	69%	56%
Average monthly earning, age 27	$1,219	$766
Homeownership, age 40	37%	28%
Car ownership, age 40	82%	60%
Received welfare or social services by age 27	59%	80%
Receiving public assistance, age 27	15%	32%
Single mothers, age 27	57%	83%
Employment, age 40	76%	62%
Median annual earnings, age 27	$12,000	$10,000
Median annual earnings, age 40	$20,800	$15,300
High school graduation, age 40	77%	60%
Earn over $20,000, age 40	60%	40%
Arrested by age 40	71%	83%

Source: TK

Each time the children were evaluated, important benefits of the prekindergarten program emerged. For example, by age 10 only 17% of the preschool children had been held back a grade or placed in special education compared to 38% of children who had not been placed in prekindergarten. By age 14, the preschoolers had significantly higher achievement scores, and by age 19 they had higher literacy scores and grade-point averages.

The differences in achievement have persisted and in some cases have grown over time. By age 27, 71% of the preschoolers had graduated from high school versus 54% of those not placed in preschool. By age 40, the graduation rate reached 77% for the prekindergarten program group versus 60% for those not in the program. The children in the program had significantly better earnings: at age 27, 29% of preschoolers earned

$2,000 or more per month compared to 7% of the non-preschoolers. At age 40, median annual earnings were $20,800 for the program group and $15,300 for the non-program group, or 36% greater, whereas at age 27, the median earnings of the preschoolers were only 20% greater than those of the control group ($12,000 versus $10,000). The employment rate was 69% for the preschoolers at age 27 compared to just 56% for the non-preschoolers and 76% versus 62% at age 40. At age 27, average monthly earnings were 59% higher for the program participants than for non-participants ($1,219 versus $766 in 1993 dollars).

At age 40, 37% of preschoolers owned their own home, and 82% owned a car, whereas only 28% of non-preschoolers owned their own home, and 60% owned a car. At age 27, just 59% of preschoolers had received welfare or other social services in the past 10 years versus 80% of the non-preschoolers. More dramatically, only 15% of preschoolers were receiving public assistance at age 27 compared to 32% of the nonpreschoolers. Finally, at age 27, 57% of the female Perry Preschool participants were single mothers compared to 83% of the non-preschoolers.

The effects of the Perry program on crime are substantial. By ages 27 and 40, significantly fewer preschoolers had ever been arrested (48% versus 57% of the control group at age 27 and 71% versus 83% at age 40) and the average number of arrests was about half that of the control group (2.3 lifetime arrests versus 4.6 for the control group at age 27). Nine percent of the preschoolers had been arrested for drug-related offenses compared with 25% of the non-preschoolers.[5]

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[5] As noted in the text, numerous other benefits were identified, but the differences between program and non-program groups were not always statistically significant. For example, rates of tobacco and marijuana/hashish usage were much lower among program participants than non-participants at age 40 (42% versus 55% for tobacco and 45% versus 54% for marijuana/ hashish). By age 27, 7% of the

A benefit-cost analysis by Barnett (1993) found $108,002 in net present value benefits and $12,356 in net present value costs per preschool participant (in 1992 dollars), a benefit-cost ratio of 8.74 to 1. Of the total benefits, the public received $88,433 and $19,570 accrued to the program participants. The benefits to the public included $70,381 saved by potential victims of crimes never committed (based on typical settlements for such crimes) and in reduced justice system costs; $8,846 in higher taxes paid because of higher participants' earnings; $7,155 saved in education costs due primarily to lower grade retention and use of special education; and $2,918 in lower welfare costs. These benefits were partly offset by $868 in increased costs for the public funding of higher education. The benefits to the program participants included $21,485 in higher earnings and fringe benefits and $738 in childcare offset by a loss of $2,653 in welfare payments.

Another benefit-cost analysis of the Perry Preschool Project found large net benefits. Karoly et al (1998) found $49,972 in net present value benefits and $12,148 in net present value program costs in 1996 dollars—a benefit-cost ratio of 4.1 to 1. Karoly et al's estimates of benefits differ from those of Barnett mostly because they exclude the benefits that derive from reductions in the intangible losses due to crime: the pain and suffering that crime victims experience. Thus, Barnett calculates $70,381 in benefits from less crime, while Karoly et al estimate the benefits from less criminal activity at just $20,885. The benefits from reductions in the intangible losses due to crime do not, for the most part, go to government. Thus, while there is a large difference in the overall benefit-cost ratios calculated by Barnett (1993) and Karoly et al (1998), the benefit-cost ratios

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preschoolers had been arrested five or more times as compared to 29% of those who had not participated in preschool. By age 40, 28% of program participants had been sentenced to prison compared to 52% of non-participants

they calculate for government savings are very similar: 2.5 to 1 for Barnett and 2.1 to 1 for Karoly et al.

The most recent cost-benefit analysis of the Perry program (Schweinhart et al 2005), based on the outcomes of participants at age 40, found net present value benefits of $258,888 and net present value costs of $15,166—a benefit-cost ratio of 17.07 to 1. The growth in the benefit-cost ratio over time for the Perry program reflects in part that the benefits of the program persist and even increase as the study participants age.

The economic benefits of the Perry Preschool program were probably underestimated by Barnett (1993), Karoly et al (1998), and Schweinhart et al (2005). For example, given that the prekindergarten program was a form of childcare, some of the guardians of program participants were probably able to increase their employment and earnings relative to what they would have been without the program, thus increasing their tax contributions and decreasing their welfare consumption (Karoly et al 1998). But these benefits were not included in any of the analyses. In addition, none of these analyses calculates the likely positive effects on the children born to participants who have higher earnings and employment and lower incarceration rates (Rolnick and Grunewald 2003). Other savings to government budgets, such as reductions in public health care expenditures, likely resulted from the program, but these benefits were not calculated either.

An analysis of Barnett's (1993) benefit and cost estimate for the Perry Preschool program conducted by the Federal Reserve Bank of Minneapolis estimated the real rate of return for the Perry School program at 16%—12% to society generally, and an additional 4% to the program participants (Rolnick and Grunewald 2003). As the

Minneapolis Federal Reserve noted, compared to other public investments and even those in the private sector, such a rate of return on an investment is very high. Indeed, it compares very favorably to the 6.3% real rate of return on the stock market that prevailed between 1871 and 1998 (Burtless 1999).

2. The Abecedarian Early Childhood Intervention

(North Carolina, 1972-85)

Description: One hundred eleven children believed to be at high risk for hindered intellectual and social development based on the low socioeconomic background of their families were enrolled in the program when they were between six and 12 weeks old. The children were randomly assigned to a preschool or a control group. The preschool ran full day, five days a week, and 50 weeks per year. The curriculum stressed language development but attempted to address the social developmental needs of the children, as well. Children in the preschool and in the control group also received medical and nutritional services. At age five all the children were reassigned to either a special school-age intervention program through age eight or to a control group. The intervention program involved having parents engage in specific supplemental education activities for the children in their homes. The parents were given educational material and training roughly every two weeks, with which to engage their children. Data were collected at ages three, five, eight, 12, 15, and 21.

Results: **Table 4** summarizes some of the statistically significant outcomes of the program. Note that these results are from a preschool program that lasted five years from

ages zero up to age five. Thus, these results are from the combination of a preschool program for children aged zero to two and a high-quality prekindergarten program for children aged three up to age five. Researchers observed additional positive outcomes from the preschool program, but these benefits have not been included in the table or described in the following discussion because it cannot be asserted with a high degree of certainty that these additional benefits resulted from the ECE investment. The subsequent school-age treatment program from ages five through eight provided some additional benefits, although these effects were weaker than those of the preschool program (see Campbell et al 2002).

The children who had attended the preschool, whether or not they had participated in the post-age-five intervention program, had significant cognitive achievements relative to the control group children. For example, at ages three, five, eight, 12, and 21 the

TABLE 4 Statistically significant benefits of the Abecedarian Early Childhood Intervention

	Preschool	Control
IQ test, age 21	89.7%	85.2%
Special education, age 9	25.0	48.0
Grade retention, age 15	31.0	55.0
Years of education, age 21	12.2	11.6
Employed in high skilled jobs, age 21	47.0	27.0
Enrolled in four-year colleges, age 21	36.0	14.0
Marijuana use in last 30 days, age 21	18.0	39.0
Mother additional births	23.0	40.0

Source: TK

preschoolers scored significantly higher on IQ tests than did the control-group children. The preschoolers also scored substantially higher on both math and reading achievement tests at ages eight and 15. By age nine, only 25% of the preschoolers had required special education services compared to 48% of the control-group children. By age 15, only 31%

of the preschool participants had ever been retained in grade compared to 55% of those in the control group. By age 21, those who had attended preschool had significantly higher scores on an array of cognitive tests and earned grade equivalent scores in math and reading that were almost two years higher than those of the control group (Campbell et al 2002). Also by age 21, the preschool attendees had completed significantly more years of education (12.2 years versus 11.6 years) and were more likely to be employed in high-skill jobs (47% versus 27%). Finally, by age 21, 36% of the preschoolers had enrolled in a four-year college versus just 14% of the control group.

In addition to improving measures of intelligence and achievement of the preschoolers, the program had other benefits for the preschoolers as well as benefits for their mothers. For example, at age 21, the preschool participants reported significantly lower rates of marijuana use within the past 30 days (18% versus 39% for the control group) and were less likely to have become a teenage parent (26% versus 45% for the control group). When the preschoolers were approximately four and a half years old, data were collected on the mothers who were under age 18 at the time they gave birth. These young mothers were more likely to have graduated from high school, attained post high school education, been employed, and been self-supporting if they were in the intervention group.[6]

Masse and Barnett (2002) conducted a benefit-cost analysis of the Abecedarian Early Childhood Intervention Program in which they calculated $135,546 in benefits and $35,864 in total costs (2002 dollars)—a benefit cost ratio of 3.8 to 1. As was the case for the other benefit-cost analyses discussed above, the benefits were surely underestimated

[6] Although the results were not statistically significant, on average, these young mothers had more education (11.9 years versus 10.3 years) than did the control group young mothers. Moreover, only 23% of these young mothers had an additional birth compared to 40% of the young mothers in the control group.

as the researchers limited themselves to benefits for which it was possible to obtain monetary estimates. Thus, Masse and Barnett left out benefits such as the intrinsic value of lower marijuana use, the value of fewer teenage parents, and the value of greater self-sufficiency among the mothers of the preschoolers (Masse and Barnett 2002). In addition, Masse and Barnett did not calculate the government savings in welfare outlays due to the higher earnings of the mothers of participants. Nor did they calculate the added earnings of mothers during the preschool years.

3. Head Start *(1965 to present)*

Description: Head Start is the best-known and largest early childhood intervention program in the United States. It provides early childhood education and development services, health services, and nutrition services to preschool children from low-income families as well as education services for their parents. The program is administered at the local level, with over 1,400 local programs. There is substantial variation in how the program is carried out, but all local programs must comply with federal performance standards and quality guidelines. The typical program runs full-day during one school year for children aged four, but other programs run half-day and accept three-year-olds as well (and two- and five-year-olds in some cases). There are about 900,000 children enrolled annually in the program (less than two-thirds of those who are eligible) at a cost of over $6 billion.

Results: Before discussing the outcomes of the Head Start program, two caveats are in order. First, one should not expect the results of the Head Start program to be as

impressive as those of the other programs discussed. While the Head Start program is of good quality, it is generally ranked lower in quality than the other programs in terms of teacher/pupil ratios, class size, teacher education and experience, and teacher pay. This relatively lower quality is certainly in part due to the fact that the Head Start program is funded at much lower levels than the other programs discussed in this chapter. For example, Karoly et al (1998) estimated that the Perry Preschool Project costs about $7,000 per child annually (for a half-day program), and estimated that the Abecedarian program costs about $15,000 per child annually (for a full-day program), compared to about $5,000 per child annually (for mostly full-day programs) for the Head Start program (all amounts expressed in 1996 dollars).

Second, it is difficult to evaluate the overall effectiveness of Head Start. The 1,400 local programs are not uniform (although they must all follow federal guidelines), and there have been no carefully controlled, large scale, long-term randomized studies of the outcomes of the local Head Start programs (although such studies are underway).

Nonetheless, the following outcomes can be reported. In general, most studies have found that the immediate impact of Head Start, whether measured in terms achievement test score or the behavior, motivation, and health outcomes of participating children up to the start of elementary school, has been small but positive. In terms of IQ test scores, the results of Head Start programs have been found to be quite variable. Specifically some studies found that Head Start had no effect on IQ test scores, many found positive initial effects that faded by ages seven through 11, and a few studies found longer-term positive effects on test scores.

Long-term studies of Head Start suggest that some of the positive and immediate cognitive effects, although they may not fade out altogether, do diminish over time. But other effects such as reductions in grade retention and special education persist over time.

Currie and Thomas (2000) found that the fading of Head Start gains may be due to the fact that Head Start students, particularly non-white children, are more likely to attend inferior schools subsequent to the Head Start program than are non-Head Start children. Indeed, white Head Start students who attend schools of similar quality to other white students maintain the initial gains in test scores. This suggests that in order to prevent the fade out of the gains of Head Start, the quality of subsequent schooling must be improved. And, of course, the fact that the Head Start children are more likely to attend inferior schools subsequent to the Head Start program than are non-Head Start children may make comparisons between the groups inappropriate. If we want to understand the effects of Head Start versus non-Head Start (including any fade out effect) then we should compare students who have subsequent access to schools of similar quality.

Barnett (2002) argues that the fade out of Head Start-induced achievement test score gains found in some studies may not be occurring at all. He points out that Head Start students' achievement test scores have been improperly compared to non-Head Start students' scores because of high attrition in the samples and other methodological design flaws. The flaws discussed earlier with respect to the Westinghouse Study (1969) of Head Start—where the scores of children held back or placed in special education were not properly included in the samples—are a prime example of this problem. Barnett notes

that studies that do not have these design flaws have been more likely to find persistent positive effects of Head Start on achievement test scores.

Only one Head Start study (of the program in Rome, Georgia) followed the children through high school. It found that Head Start had a large positive effect on high school graduation rates. Head Start participation was also associated with higher immunization rates.

There is some evidence of the long-term benefits of Head Start. A comparison (Garces et al 2000) of Head Start participants to non-participants between the ages of 18 and 31 found that white and Latino participants had a significantly higher probability of completing high school and attending college. In addition, white participants had elevated earnings in their early 20s. For white children whose mothers had less than a high school education, attending Head Start led to a 28% increase in high school graduation, a 27% increase in attending college, and a 100% increase in earnings in their early 20's. African-American participants had a significantly lower probability of ever being charged or convicted of a crime and African-American male participants were more likely than their siblings to have completed high school.

Oden, Schweinhart, and Weikart (2000) also found some evidence of the long-term benefits of Head Start. They analyzed 622 22-year-olds, 17 years after their participation or non-participation as children in Head Start programs at two sites (one in Florida and one in Colorado). In the samples from Florida, 95% of the female Head Start participants had obtained a high school diploma or General Education Development (GED) diploma compared to just 81% of the female nonparticipants. In addition, only 5% of the female Head Start participants had ever been arrested compared to 15% of the

female non-participants. They further found that the children who had attended Head Start classes using an enhanced curriculum rather than the standard Head Start curriculum had significantly higher grades throughout their schooling and less than half as many criminal convictions by age 22 as the non-participants.

Ludwig and Miller (2005) found that Head Start had a large impact on the mortality rates of children aged five through nine as well as positive effects on educational attainment. They suggest that a 50% to 100% increase in Head Start funding for their high-poverty treatment group could reduce the child mortality rates of this group by 33% to 75%. They also found that children exposed to Head Start, regardless of race, had statistically significant improvements in high school completion and college attendance.

As mentioned above, it would be unreasonable to expect Head Start to generate the same positive results as the other model ECE programs, in part because the Head Start programs are funded at much lower levels per student than are the other programs. Currie and Neidell (2003) provide strong evidence that funding levels matter. They found that Head Start children in higher per student spending programs have significantly larger gains on reading scores and a lower probability of grade retention than do Head Start children in lower spending programs.

Finally, the National Head Start Impact Study has recently published its first year findings (Puma et al 2005) from a study that plans to follow children for four years. Approximately 5,000 three- and four-year-old children were randomly assigned to Head Start or a non-Head Start group (whose members could enroll in programs other than Head Start). After one year of Head Start, there were small to moderate statistically

significant positive impacts for both three- and four-year-olds on several measures of cognitive achievement. In addition, there were small statistically significant impacts on social emotional behavior for three-year-olds but not for four-year-olds. In terms of access to health care and health status there were small to moderate improvements for three-year-olds. For four-year-olds, there were moderately positive impacts on access to health care but significant impacts on their health status. Lastly, there were small statistically significant improvements in the parenting practices of parents of both three and four-year-olds who had attended Head Start.

Again, it should be noted that it would be unreasonable to expect the same outcomes from Head Start that are observed in the high-quality prekindergarten programs described here. As Barnett and Hustedt (2005) argue, "...it seems highly plausible that programs such as Head Start lack the type of funding necessary to produce the levels of intensity and quality achieved in better funded model programs with the direct result that they are less effective."

4. The Chicago Child-Parent Center program

(Chicago, Illinois, 1967 to present)

Description: Established in 1967, the Child-Parent Center Program (CPC) provides center-based, comprehensive educational and family-support services to economically disadvantaged children from prekindergarten (ages three or four) to early elementary school (up to grade three/age nine). The program was initiated with funding from Title I of the Elementary and Secondary Education Act of 1965, and its prekindergarten and kindergarten components are still supported by those federal funds. After Head Start,

CPC is the oldest federally funded prekindergarten program in the nation and the oldest extended early-childhood program.

To be eligible for enrollment in the CPC, children must live in school neighborhoods that receive Title I funding. In contrast to Head Start, neighborhood poverty, rather than individual poverty, is the first criterion for program eligibility, though both practices result in an intake of a high proportion of children living in poverty. However, CPC prekindergarten programs exist only in some of the neighborhoods that receive Title I funding. To encourage the enrollment of high-need youngsters in the neighborhoods where the programs exist, school-community representatives who work in the centers conduct a variety of outreach activities, even going door-to-door. Eligible children must not be enrolled in another preschool program, and their parents must agree to participate in the program at least one-half day per week in classroom activities, field trips, or adult education classes; in practice, participation tends to be lower.

The CPC programs are conducted under the auspices of the Chicago Public School system, operating either in a separate building in close proximity to the local elementary school or in a wing of the elementary school. A head teacher directs each center and coordinates the child education program, parent involvement, community outreach, health, and nutrition services. The centers have their own budgets and administrative operations, but each head teacher reports directly to the principal of the associated elementary school.

Teachers in the CPC program have at least a bachelor's degree, with certification in early childhood education (Graue et al 2004, 8). This is in sharp contrast to Head Start

and many other preschool programs, which, unlike the public school system, can hire "teachers" without a minimum of a four-year college degree. Relative to Head Start and most preschool programs, staff stability and compensation are high (i.e., the salary schedule of the public schools), with the latter strongly contributing to the former (Masse and Barnett 2002).

Aside from qualified teachers, individual classrooms are staffed by teacher aides (one per classroom) and, often, parent volunteers. Centers also have the services of a clerk and a janitor, as well as nurses (who provide health screenings), speech therapists, and other staff from their associated elementary schools. Each center includes a parent-resource teacher who implements the parent program in the parent resource room, with the input of the participants. In addition to conducting outreach activities in the neighborhoods, the school-community representatives associated with each center also make home visits. The Chicago CPC program also provides funds and time for the ongoing professional development of head teachers, classroom teachers and aides, the parent-resource teachers, and the school-community representatives.

Children typically enter the program at age three for a half-day of prekindergarten (morning or afternoon sessions of three hours). Kindergarten is offered at most sites and is either half-day or full-day. The school year follows the regular nine-month school calendar. Beginning in 1977, an elementary school component (grades one through three) was added to the CPC program.[7]

In the prekindergarten program, maximum class size is 17. With a teacher and aide for each classroom, the child/staff ratio is no more than 17 to 2. In the kindergarten

[7] This and the above three paragraphs are drawn from http://www.waisman.wisc.edu/cls/History.htm; http://www.waisman.wisc.edu/cls/eligibil.htm; http://www.waisman.wisc.edu/cls/component.htm; and Reynolds 2000.

program, maximum class size is 25. With a teacher and aide for each classroom, the child/staff ratio is no greater than 25 to 2. In both prekindergarten and kindergarten, parent volunteers further lower the child/staff ratios.

According to information updated in January 2006, 1,383 children in 48 classrooms across 15 schools/locations were enrolled in the CPC prekindergarten program in 2005.[8] At its height, the CPC prekindergarten program operated in 24 schools/locations. Nineteen of these centers also provided half-day or full-day kindergartens and 13 of the centers provided additional educational services through the third grade when children typically reach nine years of age. Between the prekindergarten programs, the kindergartens, and the elementary school component, over 5,000 children annually are attending the centers.

The centers emphasize basic language and reading skills as well as social and psychological development. The centers also provide free breakfasts, lunches, and health services.

The Chicago Longitudinal Study (1999) has been following a sample of 1,539 children born in 1980 from families of low socioeconomic status. All 989 children who completed the Chicago CPC prekindergarten program and kindergarten were compared to a control group of 550 children who did not attend the preschool program but had participated in full-day kindergarten. Of the 550 children in the control group, 161 attended a CPC kindergarten program even though they had not attended the CPC prekindergarten program. Data on both the intervention and control groups are collected periodically, with the most recent published results having analyzed data for over 20 years, or until the students were 24 years old (Reynolds et al 2006).

[8] http://www.ecechicago.org/about/glance.html, retrieved 6/1/06.

Results: **Table 5** summarizes some of the statistically significant outcomes of the CPC preschool program as reported by Reynolds et al (2002). The results shown here are only for the education program that served three- and four-year old children in the prekindergarten program. Numerous other statistically significant outcomes have been observed along with positive impacts that were not statistically significant. In addition, other benefits were observed for children who attended the program from preschool through the third grade. In other words, there are good results from the prekindergarten program alone and outcomes continue to improve with later intervention. Many of these other outcomes have been reported in Reynolds et al (2002) and Reynolds et al (2006).

TABLE 5 Statistically significant benefits of the Chicago-Parent Center Prekindergarten Program

	Center students	Non-center students
Special education by age 18	14.4%	24.6%
Grade retention, age 15	23.0	38.4
Years in special education, from ages 6-18	0.73	1.43
Arrested by age 18	16.9	25.1
Arrests for violent offenses by age 18	9.0	15.3
High school graduation, age 20	49.7	38.5
Highest grade completed, age 20	10.55	10.23
Victim of abuse or neglect, ages 4-17	5.0	10.3
Petitions to juvenile court	0.45	0.78

Source: Reynolds et al (2002).

The Chicago Longitudinal Study (CLS) has demonstrated that numerous benefits have been generated by the centers. For example, the study found that the center children had significantly higher achievement test scores at ages five, six, nine, and 14 than noncenter students. Center students also spent less time in special education through age 18 (0.7 years versus 1.4 years) and had lower grade retention at ages nine and 15 (19% and 23% versus 26% and 38%, respectively). Between the ages of four and 17, 5% of the

prekindergarten attending children had been victims of abuse or neglect compared to 10% of the comparison group. Delinquency rates were significantly lower for the center children through ages 13 and 14. By age 18 only 17% of center prekindergarten children had been arrested compared to 25% of the non-center children, charges for violent offenses were brought against 9% of center children but 15% of non-center children, and the number of petitions to juvenile court were 0.45 for the prekindergarten children versus 0.78 for the non-program children. By age 20, the high school graduation rate for center children was 50% compared to just 39% for non-center children.

Reynolds et al (2002) carried out a benefit-cost analysis of the Chicago Child-Parent Center program. For the prekindergarten program alone, they identified $47,759 in net present value benefits and $6,692 in net present value costs in 1998 dollars—a benefit-cost ratio of 7.1 to1. The benefits derived mainly from reduced public education expenditures due to lower grade retention and use of special education, reduced costs to the criminal justice system and victims of crime due to lower crime rates, higher projected earnings of center participants, and increased income tax revenue due to projected higher lifetime earnings of center participants. When the benefits from reduced pain and suffering on the part of crime victims were included, the benefit-cost ratio for the Chicago CPC prekindergarten program rose to 10.15 to 1.

Once again, the benefits of the program were underestimated. For example, the savings from reduced adult welfare usage on the part of center participants was not calculated. In addition, the likely gains from improved health, changes in fertility behavior, and other life changes were not monetized. Moreover, the likely benefits to the

offspring of center participants were not calculated nor was the value of the likely increase in parental earnings, due to the childcare provided by the preschool, included.

The costs and benefits of enhancing Head Start and converting it into a high-quality prekindergarten program:

By enhancing and extending its reach, Head Start can be converted into a very high-quality prekindergarten program. Public investment in such a high-quality prekindergarten program can help the United States achieve a multitude of social and economic development objectives. These include stronger economic growth, income growth, job creation, poverty and inequality reduction, education and health care improvement, and crime reduction. Moreover, high–quality pre-K can help to create the conditions that enable people to achieve their potential, live lives of dignity and maximize their choices.

A high-quality, nationwide commitment to early childhood education would cost a significant amount of money upfront, but it would have a substantial payoff in the future. The U.S. political system, with its two- and four-year cycles, tends to under-invest in programs with long lags between when investment costs are incurred and when benefits are enjoyed. The fact that state and local governments cannot capture all the benefits of pre-K investment may also discourage them from assuming all the costs of pre-K programs. Yet, the economic case for public investment in prekindergarten is compelling.

I estimate that providing a voluntary, high-quality, publicly funded, *targeted* prekindergarten program for the poorest 25% of three- and four-year-old children would

generate annual budgetary, earnings, and crime benefits that would surpass the annual costs of the program within six years.[9] By the year 2050, the annual budgetary, earnings, and crime benefits would total $315 billion: $83 billion in government budget benefits, $156 billion in increased compensation of workers, and $77 billion in reduced costs to individuals of crime and child abuse. These annual benefits in 2050 would exceed the costs of the program in that year by a ratio of 12.1 to 1. Broken down by state, the total annual benefits would outstrip the annual costs of the program by a minimum of 8.1 to 1 for residents of Alabama and by as much as 29.1 to 1 for the residents of Delaware.

A high-quality, targeted pre-K program would cost nearly $6,300 per participant and could be expected to enroll just over 2 million children when it is fully phased in. Thus, the targeted program would initially cost taxpayers about $13.2 billion a year or, with offsets for current commitments to prekindergarten for at-risk children, an additional $8.2 billion per year once it is fully phased in. Such a program would ultimately reduce costs for remedial and special education, criminal justice, and child welfare, and would increase income earned and taxes paid. Within nine years, the net annual effect on government budgets would turn positive (for all levels of government combined). That is, starting the ninth year and every year thereafter, annual government budget benefits due to the program would outweigh annual government costs of the program. Within 44 years, the offsetting budget benefits alone would total $83 billion, more than three times the cost of the program. Thus by 2050, every tax dollar spent on the program would be offset by $3.18 in budget savings and governments collectively would be experiencing $57 billion in surpluses due to the pre-K investment. On top of the budget savings, by the

[9] For a more complete discussion of the costs and benefits of public investment in high-quality pre-k and the methodology used to arrive at the estimates described in this paper, see Lynch 2007.

year 2050, a targeted program is estimated to increase the compensation of workers by $156 billion and reduce the costs to individuals from crime and child abuse by $77 billion.

A voluntary, high-quality, publicly funded, *universal* prekindergarten program for all three- and four-year-olds would produce even greater annual budgetary, earnings, and crime benefits than would a targeted program. The annual benefits of the program would begin to outstrip its annual costs within nine years and would do so by a growing margin every year thereafter. By the year 2050, the annual benefits would total $779 billion: $191 billion in government budget benefits, $432 billion in increased compensation of workers, and $156 billion in reduced costs to individuals from less crime and child abuse. These annual benefits would exceed the costs of the program in 2050 by a ratio of 8.2 to 1. Broken down by state, in 2050 the total annual benefits would outstrip the annual costs of the program by a minimum of 6.1 to 1 for residents of Alabama and by as much as 11.4 to 1 for the residents of Wyoming.

A high-quality, publicly funded, *universal* prekindergarten program would cost nearly $6,300 per participant and could be expected to enroll almost 7 million children when it is fully phased in. Thus, the program would initially cost taxpayers $43.2 billion or, with offsets for current prekindergarten commitments, an additional $33.3 billion per annum once it is fully phased in. Within 17 years, the net annual effect on government budgets alone would turn positive, and by 2050 the budget savings would be $191 billion, double the total costs of the program in that year. Thus, in 2050, every tax dollar spent on a universal program would be offset by $2.00 in budget savings and governments would be enjoying $96 billion in surpluses as a consequence of their pre-K investment. In

addition to the budget savings, by the year 2050, a universal program is estimated to increase the compensation of workers by $432 billion and reduce the costs to individuals of crime and child abuse by $156 billion.

A case for public investment in either a targeted or a universal prekindergarten program can be made with the best policy depending in part on whether a higher value is placed on the ratio of benefits to costs (which are higher for a targeted program) or the total net benefits (which are higher for a universal program). However, when policy makers weigh the benefits of investment in a targeted versus a universal program other criteria should be taken into consideration. For example, if public funds are limited, a targeted program may be more attractive as it is less expensive to implement. Likewise, if a large priority is placed on narrowing the achievement gap between children from low-income and upper-income families, then the targeted program may be more effective in achieving this goal. On the other hand, a universal program available to all children may garner greater public support and thus be more likely to achieve the high-quality necessary for optimal results. Also, children who are not eligible for a targeted program can benefit from high-quality pre-K and targeted programs are likely to fail to reach many of the children they are designed to serve. A universal program not only benefits middle- and upper-income children but may also have larger effects than a targeted program for the most at-risk children.

Conclusion:

The economic and social benefits from public investment in high-quality early education programs include, but amount to much more than just, improvements in public

balance sheets. Investing in young children has positive implications for the current, future, and earlier generations of children. The current generation of children will benefit from higher earnings, higher material standards of living, and an enhanced quality of life. Future generations will benefit because they will be less likely to grow up in families living in poverty. And earlier generations of children, who are now working or in retirement, will benefit by being supported by higher earning workers who will be better able to financially sustain our public retirement benefit programs such as Medicaid, Medicare, and Social Security. The pending retirement of the baby-boom generation will put enormous pressure on the federal budget in coming decades as more retirees draw from these benefit programs, and investing in high-quality prekindergarten education will provide much-needed future budge relief. In other words, strengthening the economic and social conditions of our youth will simultaneously help provide lasting economic security to future generations, to us, and to our elderly.

Investing in young children is likely to have enormous positive effects on the U.S. economy by raising GDP, improving the skills of the workforce, reducing poverty, and strengthening U.S. global competitiveness. Crime rates and the heavy costs of criminality to society are likely to be substantially reduced, as well. Additionally, given that the positive impacts of prekindergarten may be larger for at-risk than for more advantaged children, a pre-K program, whether targeted or universal, may help to reduce achievement gaps between poor and non-poor children, ultimately reducing income inequality nationwide.

Clearly, no single public policy can bring about the rapid and simultaneous achievement of *all* of our development goals, but just as clearly, policies do matter. And

at a time of sharp disagreement over solutions to the many social and economic problems we confront, we should take particular notice when a consensus emerges across the political spectrum that the policy of investing in early childhood development in general, and in high-quality prekindergarten in particular, has the ability to powerfully impact many of our development goals and positively influence the pace of the development process. Investing in high-quality early childhood education programs is an effective public policy strategy that produces a wide array of significant benefits for children, their families, and society as a whole (including its taxpayers).

Although investment in early childhood education has the ability to positively impact many socioeconomic development goals, such investment has a particularly potent and direct bearing on the well-being of children, the educational achievement and productivity of children and adults, and crime. All three of these are areas where we have not only failed to achieve our potential, but also fallen short relative to other economically advanced nations. The United States should be investing now in high-quality prekindergarten to improve the quality of life of millions of American children, to make the work force of the future more productive, to strengthen the economy, and to reduce crime. If the ultimate aim of public policy is to promote the wealth of nations, communities, families, and individuals, then investment in early childhood education is clearly a most effective strategy.

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Mr. OBEY. Thank you.

Why don't we proceed with you for five minutes, and then we'll go vote and come back and hear the others too.

Mr. RUDIN. Great. Thank you, Mr. Chairman. Appreciate the opportunity to be here, ranking Member Walsh.

The College Board is the organization I represent, and we're a national non-profit membership organization, and our members are schools, colleges, and universities that focus on connecting more students to college.

So we appreciate the opportunity to be part of this conversation. Thank you.

Mr. Chairman, I can summarize my presentation. I would like to take the full five minutes, but I can summarize it in three words, and that is, higher education pays.

From lifetime earnings, to increased access to pension and health plans, to being a healthier citizen, to overall community vigor, higher education yields significant benefits for both individuals and for society as a whole.

Now, I have given you a couple of materials in advance. One is this publication, "Education Pays," and another is a publication that summarizes some of the key points from our 2007 Education Report, and I'll just summarize a few key points from that report.

We know, and I think it's pretty well understood, that access to a college education does lead to higher earnings for individuals, a 60 percent premium on your earnings if you've graduated from college versus just graduating from high school.

People with a Master's Degree earn twice as much over their lifetime as people with a high school degree, and people with professional degrees earn almost three times as much over their lifetime in terms of earnings.

Even people who have attended college for some time, not even finishing the degree, earn on average 19 percent more than high school graduates.

And access to pension plans and health care is at least twice as high for people from college graduate groups than for people who have no high school degree or perhaps even dropped out of high school.

So the individual benefits to having a college degree are quite significant.

But what about the question of whether government, foundations, scholarship organizations should invest in education of individuals? What's the payoff to society for that?

Well, we think it's significant, and I'll cite just a few key pieces of data.

The typical college graduate working full-time for a year pays 134 percent more in federal taxes than the high school graduate, and pays 80 percent more in all taxes—federal, state, and local.

College graduates are more likely than high school graduates to donate blood, to vote.

And in one interesting chart that is in front of you, it shows that college graduates are more likely to value and understand, be willing to accept the opinions of others who have different views than them than high school graduates.

And perhaps one of the more compelling pieces of information that we've uncovered and that is in our report is that the benefits of higher education extend to those who don't even have a college degree.

A recent study showed that, for example, people who work in a metropolitan area, who do not have a college degree, still benefit if those around them, and if an increasing number of those around them, have a college degree.

For example, a 1 percentage point increase in the proportion of the local population holding a four-year college degree leads to a 1.9 percent increase in the wages of a worker without a high school diploma and a 1.6 percent increase in the wages of a person with a high school diploma.

So there are significant benefits when the overall community is better educated that accrue even to those who haven't gone to college.

Now, what about other benefits, to health and parenting?

Low income Bachelor's Degree recipients are more likely than high school graduates of any income level to report excellent or very good health. They have better access to health care and better understanding of how to take advantage of it, and more money to pay for improved health care.

Another interesting point that illustrates the societal and social impacts of a college degree: 61 percent of four-year graduates ages 25 to 34 exercise vigorously once a week. That's twice as much as high school graduates.

And by 2005, the smoking rate in this country had dropped to about 20 percent, but among college graduates, that had fallen to 9 percent.

And even if you look at the data from 50 or 60 years ago, when about 40 to 45 percent of the people in this country smoked, it was the same for college graduates and non-college graduates, but once the awareness became pretty widespread that smoking was bad for you, smoking dropped overall, but among college graduates, it dropped quite significantly compared to others.

So we have data for particular states. The data for Wisconsin mirror the data across the country in terms of wages and in terms of overall societal benefits.

I'll cite one piece of data from Wisconsin: 28 percent of people who do not have a high school degree in Wisconsin, Mr. Chairman, are Medicaid participants, but only 5 percent of Bachelor's Degree recipients in Wisconsin are Medicaid recipients.

So the benefits are substantial.

We believe an investment in education pays great dividends, both for individuals and for society in general, and I'd be happy to talk with you further about some of the work that's underway to try to close the achievement gap in terms of access to education and some of the work that this committee is supporting and that we're helping to implement across the country.

Thank you.

[The information follows:]

Higher Education Pays

The Benefits of Connecting More Students To College Success

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The College Board

Labor-HHS-Education Appropriations Subcommittee
U.S. House of Representatives

February 26, 2008

Introduction – Higher Education Pays

Higher education pays—for individuals and for society. Students who attend institutions of higher education obtain a wide range of personal, financial, health, and other lifelong benefits. Likewise, taxpayers and society as a whole derive a multitude of direct and indirect benefits—some monetary and some non-monetary—when citizens have broad access to postsecondary education. Accordingly, uneven rates of participation in higher education across different segments of U.S. society should be a matter of urgent concern not only to the individuals directly affected, but also to public policymakers at the federal, state, and local levels.

People generally think of college education in personal terms. Public opinion polls reveal a widespread understanding of the role of education in opening the door to a middle-class lifestyle. Yet, as the price of a college education continues to rise more rapidly than the prices of other goods and services, more students and families are facing difficult decisions about the sacrifices involved.

Education does pay. It has a high rate of return for students from all racial/ethnic groups, for men and for women, and for those from all family backgrounds. It also has a high rate of return for society. Higher education has transformed the lives of many people—especially those from groups historically underrepresented in higher education. College-educated citizens' level of participation in civil society, their openness to new ideas and experiences, and the opportunities and choices they face in the workforce are all significantly improved by their educational experiences.

Also, the broader societal benefits of investment in higher education are fundamental to the well being of our nation. In 2007, the College Board published the second edition of *Education Pays: The Benefits of Higher Education for Individuals and Society.* In the testimony that follows, I draw on that report to provide information on some of the specific benefits we reap from widespread access to higher education—and from the costs we bear as a result of gaps in that access.

It is difficult to determine precisely how much of the variation observed in the patterns reported here is directly attributable to education and how much is actually the result of other factors. Individual characteristics that influence the probability of enrolling in and graduating from postsecondary institutions may have a direct and systematic influence on other outcomes in peoples' lives. In general, while simple descriptions of correlations provide useful clues about causal effects, they do not reliably indicate the size of those effects, and instead are best interpreted as providing broad-gauged evidence of the powerful role that higher education plays in the lives of individuals and in society.

Individual students and their families reap much of the benefit of higher education. For members of all demographic groups, average earnings increase measurably with higher levels of education. Salaries are not the only form of compensation correlated with education level; college graduates are more likely than other employees to enjoy employer-provided health and pension benefits. People with more education are less likely to be unemployed and less likely to live in poverty. These

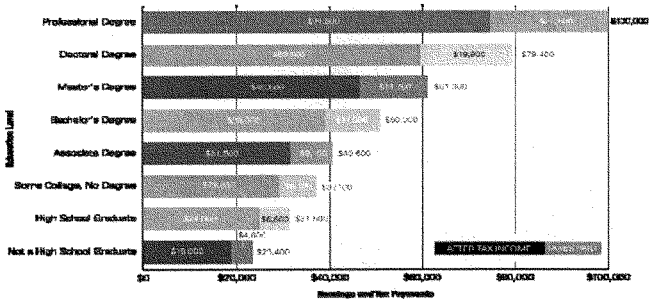
economic returns make financing a college education a good investment. Although incurring debt should always be approached with caution, even students who borrow a sizable share of the funds required to pay for college are likely to be financially better off relatively soon after graduation than they would be if they began their full-time work lives immediately after high school.

Society as a whole also enjoys a financial return on the investment in higher education. In addition to widespread productivity increases, the higher earnings of educated workers generate higher tax payments at the local, state, and federal levels. Consistent, productive employment reduces dependence on public income-transfer programs and all workers, regardless of education level, earn more when there are more college graduates in the labor force.

Beyond the economic return to individuals and to society as a whole, higher education improves the quality of life in a variety of other ways. The economic advantages already mentioned have broader implications. For example, a reduction in poverty increases material standards of living and improves the overall well being of the population; the psychological implications of decreased unemployment are also significant. In addition to their non-monetary benefits, poverty and unemployment affect spending on public assistance programs. Moreover, participating in postsecondary education improves the quality of civic society. Adults with higher levels of education are more likely to engage in organized volunteer work, to vote, and to donate blood; they are also more likely to have much lower rates of incarceration and have healthier lifestyles. College-educated adults are more likely than others to be open to differing views of others, and the young children of adults with higher levels of education engage in more extracurricular, cultural, athletic, and religious activities than other children.

Earnings and Tax Payments

Median Earnings and Tax Payments of Full-Time Year-Round Workers Ages 25 and Older, by Education Level, 2005

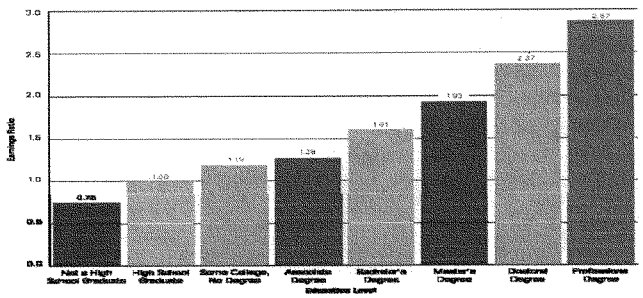


Higher levels of education lead to both higher levels of earnings for individuals and higher tax revenues for federal, state, and local governments. In 2005, the typical full-time year-round worker in the United States with a four-year college degree earned $50,900—62 percent more than the $31,500 earned by the typical full-time year-round worker with only a high school diploma. Median earnings for those with some college but no degree were 18 percent higher than those for high school graduates, and adults with associate degrees earned 29 percent more than high school graduates.

Not all of these differences in earnings may be attributable to education level, since education credentials are correlated with a variety of other factors that affect earnings. However, careful academic research on the subject suggests that the figures reported here do not measurably overstate the financial return of higher education. Moreover, there is evidence that the pay-off is highest to students who come from disadvantaged backgrounds and are likely to end up in very poor economic circumstances if they do not go to college. Higher education can make a particularly significant impact in the future prospects of these students—particularly if they complete their degrees.

Another way to compare the earnings prospects for people with different levels of education is to examine expected earnings over a lifetime. The typical bachelor's degree recipient can expect to earn about 61 percent more over a 40-year working life than the typical high school graduate earns over the same period. Median lifetime earnings for individuals with some college but no degree are 19 percent higher than median lifetime earnings for high school graduates with no college experience, and those with associate degrees earn about 28 percent more than high school graduates.

Expected Lifetime Earnings Relative to High School Graduate, by Education Level



Notes. Based on the sum of median 2005 earnings from ages 25 to 64 for each education level. Future earnings are discounted using a 3 percent annual rate to account for the reality that, because of foregone interest, dollars received in the future are not worth as much as those received today.

Sources. U.S. Census Bureau, 2006, PINC-03, calculations by the authors.

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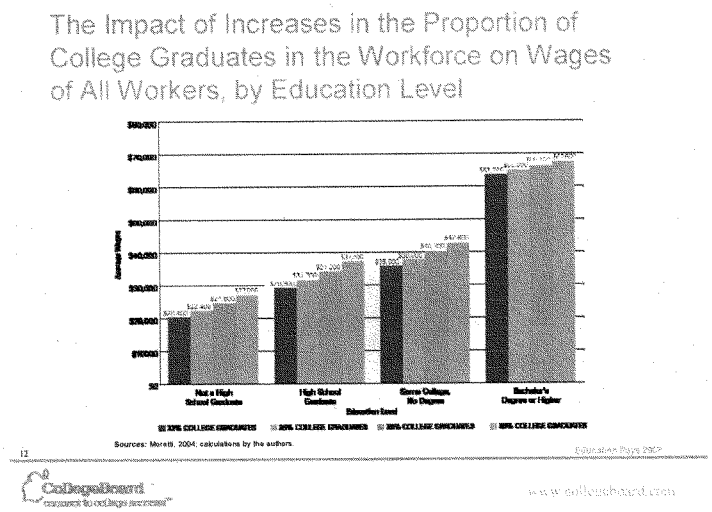
The typical expected earnings over the working lives of four-year college graduates add up to $800,000 more than the expected earnings of high school graduates. If college graduates who also earn higher degrees are included, the lifetime earnings

premium is over $1,000,000. Accounting for the fact that some of the higher earnings are many years in the future, the increased earning power of a college education is worth about $450,000 in today's dollars. If college graduates who also earn higher degrees are included, the lifetime earnings premium is over $570,000.

Society shares in the higher earnings of college graduates through the tax system. In 2005, the typical college graduate working full-time year-round paid 134 percent more in federal income taxes and almost 80 percent more in total federal, state, and local taxes than the typical high school graduate. The bachelor's degree recipient paid about $12,000 in total taxes, compared to almost $26,000 for the median professional degree holder and under $7,000 for the typical high school graduate.

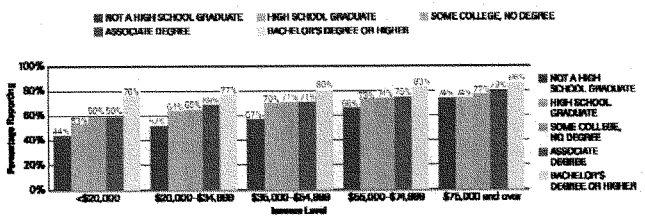
Higher Education Raises Earnings for All



It is well known that college graduates earn significantly more than individuals with lower levels of educational attainment. Less well known is the fact that even those with lower levels of education earn more if they are in a working environment with more educated people. Those with more education spread their knowledge, organize workplaces more efficiently, and are more receptive to new ideas and more encouraging of innovation. Estimates suggest that controlling for other factors, a one percentage point increase in the proportion of the population holding a four-year college degree leads to a 1.9 percent increase in the wages of workers without a high school diploma, a 1.6 percent increase in the wages of high school graduates, and increases of 1.2 percent in the wages of workers with some college and 0.6 percent in the wages of college graduates.

Higher Education is Linked to Better Health

Percentage of Individuals Ages 25 and Older Reporting Excellent or Very Good Health, by Income and Education Level, 2005



Sources: National Center for Health Statistics (NCHS), 2005 *National Health Interview Survey*; calculations by the authors.

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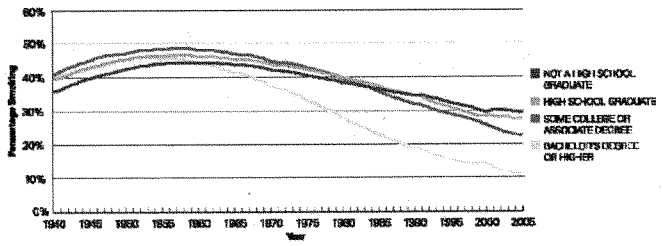
People with higher incomes tend to be healthier than less affluent people, in part because they are likely to have more access to health care. However, even controlling for income levels, people with more education report better health. For example, 83 percent of four-year college graduates with incomes between $55,000 and $75,000 in 2005 reported being in excellent or very good health, compared to 75 percent of associate degree recipients, 74 percent of those with some college but no degree, 73 percent of high school graduates, and 66 percent of those who did not complete high school. There has been considerable research on the determinants of health, and studies show convincingly that higher education really does lead to better health. Much of this difference appears to be related to people following directions more responsibly and engaging in behaviors that lead to better health outcomes.

Smoking patterns, for example, provide a vivid example of differences in behavioral patterns corresponding to differences in education levels. This is important because of the social costs of medical care associated with smoking, but also as an indication of the behavioral impact of education. College graduates are more likely to process information about health and alter their behavior accordingly, including exercising more regularly.

Smoking Rates of Individuals Ages 25 and Older, by Education Level, 1940–2005



Notes: Data for 2001-05 are three-year moving averages (i.e., the average of the current year and the two previous years)
Sources: De Walque, 2004; NCHS, *National Health Interview Survey*, various years

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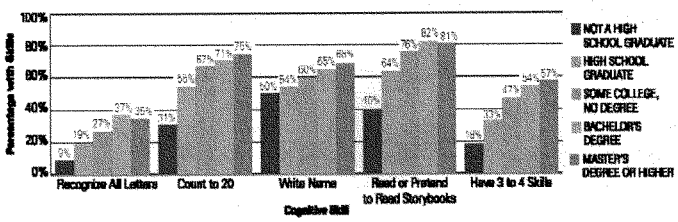
The Next Generation

Cognitive Skills of Preschool Children Ages 3–5, by Mother's Education Level, 2005



Sources: U.S. Census Bureau, 2007, Table 224 (based on 2005 *National Household Education Survey*)

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Investments in education have a long-term impact that goes beyond the current students to the next generation. Children of parents with higher levels of educational attainment are better prepared for school and are more involved in all types of extracurricular activities than other children. In 2005, more than half of the children

between the ages of 3 and 5 whose mothers had four-year college degrees and almost half of those whose mothers attended some college had at least three of the following skills that made them more ready to succeed in school: recognizing all letters, being able to count to 20, reading or pretending to read books, or writing their name. Only a third of the children of high school graduates and fewer than 20 percent of the children of mothers who did not complete high school had these skills.

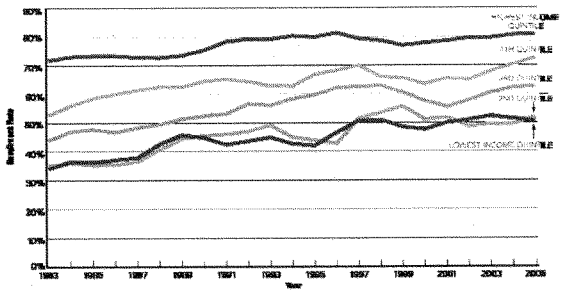
It is important to recognize that the relationship between the mother's level of education and children's cognitive skills is not entirely causal; it is difficult to know what is nature and what is nurture. Moreover, people who are raised to value learning are more likely to go to college. That said, these relationships are very important. We know that expectations and aspirations matter a great deal. We also know that the higher earnings associated with higher levels of education have a significant impact on the opportunities available to children. These data highlight the increased potential for the children of college-educated parents to become educated productive citizens.

College Enrollment is Increasing—But Gaps Remain

College enrollment rates have increased significantly over the past three to four decades, both overall and for all demographic groups. However, this good news is dampened by the persistent gaps in participation in postsecondary education among people from different backgrounds. People from low-income families, those whose parents did not attend college, and African Americans and Hispanics are much less likely than more affluent people, those whose parents have college degrees, and Whites and Asians to enroll in college and to earn degrees. In recent years, increased participation has been almost exclusively in the upper half of the income distribution.

Many factors contribute to the variation in postsecondary participation rates. Financial constraints, as well as wide disparities in elementary and secondary educational opportunities, academic preparation, aspirations, and expectation all play a role. The evidence does, however, clearly indicate that financial constraints create barriers. There are significant differences by family income level in college enrollment and success rates among high school graduates with very high test scores, and among those whose parents have similar education levels. A strong academic background is not always sufficient to allow students to overcome financial barriers. It does, however, significantly improve postsecondary opportunities. Within income groups, students with high achievement levels are significantly more likely to go to college and to graduate, as are those whose parents have high levels of education.

Postsecondary Enrollment Rates of Recent High School Graduates by Family Income, 1983–2005



Notes. Based on enrollment in college within 12 months of high school graduation. Income quintiles are defined in terms of all households. In 2005, the upper income limits of the quintiles were: lowest, $16,799; 2nd, $31,998; 3rd, $50,380; and 4th, $80,982. High school graduates are not evenly distributed among income quintiles. In 2005, 13 percent of high school graduates were in the lowest income quintile; 15 percent were in the 2nd; 16 percent were in the 3rd; 24 percent were in the 4th; and 31 percent were in the highest income quintile.

27 Sources: NCES, unpublished tabulation using data from the *Current Population Survey*.

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Only about half of the college graduates from the bottom 40% of the income distribution go to college within a year after graduation from high school, compared to about 80% of those from the most affluent families. Money is, of course, not the only issue. But even if we control for academic preparation, low-income students are much less likely than others to enroll in college. The gaps in degree completion rates are even larger than the gaps in enrollment rates.

It is clear that while money is not the whole story, financial barriers are diminishing educational opportunities in the U.S. The significant costs of public and private investments in higher education are very visible. It is important that the successes of these investments be equally visible.

The clear story told by the information reported here and a vast amount of other available information is that *higher education does pay*. It has a high rate of return for students from all racial/ethnic groups, for men and for women, and for those from all family backgrounds. It also has a high rate of return for society. We all benefit from the higher tax revenues, the greater productivity, the lower demands on social support programs, and the greater levels of civic participation of college-educated adults. Even if the number of college graduates in our labor market were adequate, in order to have an efficient and equitable society those individuals most likely to benefit from college need to be able to attend.

Connecting More Students to College Success

What steps can be taken, both in the short-term and the long-term, to open the door to college access and success for many more of our nation's citizens? As mentioned previously, academic preparation is vitally important, especially for minority and underrepresented students. The College Board, which is a membership association of more than 5,400 schools, colleges and universities, has undertaken a number of significant steps in this regard. Let me highlight just three of our current initiatives.

CollegeKeys

The Board of Trustees of the College Board recently convened a *Task Force on College Access for Students from Low-Income Backgrounds* with the dual goals of creating a commonly accepted definition of "low-income student" and then seeking to remove all identifiable barriers, financial and non-financial, to college access for those who meet the definition. The task force has challenged educators nationwide to begin a collective effort to expand educational opportunities for low-income students. Already more than 250 schools and colleges have pledged to join with us to remove these barriers and to implement programs that increase the academic preparation, college recruitment and admission, and college retention of low-income students—and we anticipate another 300-500 institutions will join with us in this effort by summer 2008. Among the steps that these institutions are committed to pursuing are the following:

- Creating a college-going culture in all secondary schools by establishing a college-preparatory program as the "default" secondary school curriculum.
- Ensuring that rigorous high school courses are available in every secondary school. The College Board believes it is important that college-preparatory courses and programs be offered in all high schools and that these courses reflect high standards of academic achievement; that is, they must be rigorous, time-tested, and evidence-based. For example, Advanced Placement (AP) courses are widely accepted for college credit by institutions of higher education and have demonstrated success in raising student achievement in a variety of school settings. Such courses must become the norm rather than the exception in all high schools—particularly those that serve high numbers of low-income students.
- Establishing college and university partnerships with local schools to offer a continuum of college and career exploration programs, including campus visits, college awareness programs, and assistance completing admissions and financial aid forms.
- Creating changes in financial aid policy and practice that reflect increased institutional commitment to meeting students' full need. This includes the simplification of aid eligibility criteria for low-income students, the expectation that low-income students' financial needs can be met without an over-reliance on loans or jobs, and institutional grants that finance summer school for low-income students to accelerate their chances of academic success.
- Offering tutoring, supplemental instruction, study skills programs, and small learning communities established on campus to integrate academic instruction—especially during the freshman year.

- Mandating statewide articulation agreements between two- and four-year institutions that enable community college students to enroll at four-year institutions without needlessly duplicating course work.
- Providing need-based financial aid that accurately assesses full costs and realistically meets full need (through a combination of grants, loans, and jobs), which can be a powerful tool that encourages student persistence through graduation.

Community College Initiative

To expand the key role of community colleges in connecting more students to college success, the College Board recently convened a group of leading educators, the National Commission on Community Colleges, to form a set of national recommendations and to strengthen the College Board's work with this increasingly critical sector.

More than 46 percent of those who attend college are enrolled in two-year institutions, an increase of 18 percent over the last decade. Especially for underrepresented and low-income students, community colleges often provide the first entry to the opportunities of post-secondary education. Yet community colleges have not been at the center of national debates about the future of education. The commission believes that if the United States is to achieve its educational and economic development goals goals, both in terms of quality and equality, community colleges must be a central component of the nation's educational agenda.

Among the primary recommendations of the commission is the creation of the federal *Community College Competitiveness Act of 2008*, which would provide federal support for a strong role for community colleges. Provisions of this legislation would include:

- A statement that in an era of global competition, it is the policy of the U.S. government to encourage universal public education through at least 14 years of schooling as the minimum educational requirement.
- A new Department of Labor program centering on community college-level training for emerging workforce development needs—especially in the employment areas anticipating the greatest job growth over the next decade (including biotechnology, nanotechnology, genetics, environmental engineering, energy, health care, and new manufacturing technologies).
- Funding Pell Grants for community college students at 70 percent of the average cost of attending a public four-year institution of higher education.
- Supporting students enrolled for at least one-third of a full course load with all federal aid programs.
- Support for facilities construction and modernization through a matching grant program to states to encourage facilities construction, remodeling, and modernization.

EXCELerator Schools

The College Board has partnered with the Bill and Melinda Gates Foundation to create the EXCELerator program, a comprehensive school improvement initiative launched in 2006 in selected urban high schools. The EXCELerator program is designed to help underrepresented groups enter the pipeline to higher education by means of a comprehensive educational program in middle and high school based on academic rigor, student counseling, and extensive teacher training and support.

There are currently more than 60 schools across the country implementing the College Board EXCELerator model, with plans to expand the program in the coming years. Currently participating are school districts in Chicago, IL; Washington, DC; Duval County, FL; Hillsborough County, FL; and Denver, CO. These pilot districts were selected from a pool of applicants after demonstrating an urgent need and a strong commitment to reform.

Characteristics of every College Board EXCELerator School include:

- Implementation of **rigorous academic programs** for all students aimed at increasing the literacy levels of underachieving students, leading to accelerated and enriched learning programs in mathematics, science, English, and social studies.
- **Extensive and ongoing professional development** for superintendents, principals, teachers, and counselors. This highly trained cadre of administrators and teachers will guide the school in change while providing intense instructional leadership.
- **Extensive use of data** to inform and drive teaching, learning, and assessment within each school, with a particular focus on using data to examine the extent to which students are mastering mathematics, science, reading, writing, and critical thinking skills, and the extent to which schools modify their instructional programs and strategies to meet the needs of every student in all core subjects.
- **College planning and preparation,** including counseling and advisory programs that support students' efforts to better prepare for enrollment and success in college, beginning as early as middle school.
- **Developmental supports to** create a personalized learning environment and community for every student.

We believe it is time to make good on the promise first made by President Abraham Lincoln when he signed the Morrill Act during the Civil War, and restated in some fashion by every post–World War II president of the United States: The American Dream will be kept alive and well when no student is turned away at the college door because his family is poor…because each American has a right to expect that if she works hard she will be able to obtain a first-class college education…because access to the fruits of a college degree remains a defining element of American life.

THOMAS W. RUDIN

Thomas W. Rudin is senior vice president for advocacy, government relations and development at the College Board. As the organization's chief representative in Washington, he works on behalf of the 5,200 institutional members to promote public policy, legislation and education programs that connect students to college success and opportunity.

Specifically, Rudin implements a federal and state government relations agenda that includes the promotion of increased student enrollment and success in advanced-level courses, including Advanced Placement; advocacy for greater access to financial aid for college students and their families; and the implementation of rigorous reading, writing, and mathematics programs in U.S. middle and high schools to raise standards and achievement. He is also responsible for the implementation of the College Board's advocacy initiatives related to student aid, college admissions, access and diversity, school counseling, and teaching. As the College Board's development officer, he is responsible for securing foundation and government grants for public service programs and research projects.

Previously, Rudin served as executive director of grants planning and management at the College Board, and before that he spent four years as coordinator of special projects for EQUITY 2000, the College Board's national education reform program. He joined the College Board in 1992 from the National Institutes of Health in Bethesda, MD, where he was a senior policy analyst.

Rudin has also spent time in the classroom, having worked as a visiting instructor at the Middle East Technical University in Ankara, Turkey, where he taught courses in U.S. public policy, human rights and organizational management.

Before this, he directed the Task Force on Science and Technology within the office of North Carolina Governor James B. Hunt, Jr., where he was also involved with state initiatives such as the North Carolina Biotechnology Center and the North Carolina School of Science and Mathematics.

Additionally, Rudin has consulted for nonprofit organizations such as Amnesty International USA and ASPIRA, Inc., as well as institutions of higher education, including North Carolina Central University and Morgan State University.

Rudin received a bachelor's degree in communications from Purdue University. He holds master's degrees in public administration and in social work from the University of North Carolina at Chapel Hill.

June 2007

Mr. OBEY. We have a floor action. This first vote, there are eight minutes left. Almost nobody has voted yet. Then we have another five-minute vote. Then we have 10 minutes of recommit debate. Then a 15-minute vote on recommit. And then five for final passage.

So the floor action is pretty well screwing up this hearing.

What I'd like to do if I can is to try to squeeze another witness in before we go to vote.

Dr. Holzer.

Mr. HOLZER. Thank you, Mr. Chairman, Mr. Walsh, and other members.

I want to talk today about the economic costs of inadequate investments in workforce development, not just for individuals, but for the whole economy.

In my statement, I have four points to make, although I'll focus primarily on one of them, because of the reduced time.

First of all, the very low earnings and employment of millions of Americans generate not only high poverty rates but they impose huge costs on the U.S. economy overall.

Secondly, federal investments in workforce training to raise these earnings have declined quite dramatically over time.

Third, the research evidence and the evaluation evidence, while somewhat mixed, does show that many of these public investments are cost effective at raising the earnings of these workers, and many more newer approaches are very promising.

And fourthly, therefore, the federal government should make major new investments in workforce development while also undertaking many new evaluation studies to improve our knowledge of exactly what works.

I want to focus primarily on the first point about the costs of low earnings.

Roughly 10 million Americans, 10 to 15 million Americans live in low-income families and have very low wages. Many have poor basic skills, no high school diplomas, but very few of them have any serious post-secondary education or training.

Now, what costs do they impose, not only on themselves and their families, but also on the overall economy?

Well, since worker earnings generally reflect their productivity in the labor market, low earnings of the poor directly reflect 10s of billions of dollars of lost productivity to the U.S. economy.

These poor workers also generate large budgetary costs to the federal government. We spend roughly $600,000,000,000 each year in means tested programs for the poor. Now, at least half of that is Medicaid alone. But remember, these programs mostly treat the symptoms of poverty, not its causes.

Furthermore, low potential earnings tend to discourage many workers and drive many of them out of the labor force altogether, and here especially, I'm talking about low-income minority men, whose employment rates have been declining over time.

Young men with low earnings potential are much more likely to engage in behaviors that are very costly to society, like participation in crime and fathering children outside of marriage.

Crime, in particular, imposes enormous costs on the United States, estimated by some analysts to be in the value of

$1,000,000,000,000 to $2,000,000,000,000 a year in administrative costs and lost output and costs to victims.

The cost of fathering children outside of marriage is also extremely costly to the economy and society, because the children who grow up in these families are more likely themselves to have very low education, to engage in crime, and to suffer from bad health, generating this ongoing cycle of costs across many generations.

But the costs to the U.S. economy go well beyond the poor themselves and their families.

For instance, employers often report difficulty filling not only their high skilled jobs but jobs in the middle skill categories that don't require a college degree, but certainly require some training beyond high school. Sometimes they have those difficulties even when they're paying reasonably high wages.

Positions remain vacant for significant periods of time, especially in tight labor markets. Their recruitment costs rise, their compensation costs rise, and many employers report having to accept less qualified and less productive employees than they have in the past.

These difficulties and costs for employers will likely grow when the baby boomers begin retiring, and especially in those sectors of the economy like health care and elder care, where labor demand is likely to grow very substantially.

And these concerns may ultimately raise the rate at which employers choose to offshore their production or to recruit immigrants from abroad to fill the jobs remaining in the United States.

So this vast range of costs imposed by poor skills and poor earnings is borne not just by the poor, but by employers and the economy overall.

Now, in my statement I make other points about the dramatic declines in investment spending over time.

Investment spending in workforce training peaked in 1979. It's declined by roughly 70 percent in real terms. It's declined by about 85 percent relative to the size of the economy.

We spend a smaller share of our economy than virtually any other industrialized nation on workforce training programs for less educated workers.

One might say, well, if these programs aren't effective, maybe it's reasonable that we spend less money on them.

I think the evaluation evidence on these programs is somewhat mixed, but there's many, many examples for rigorous evaluations of cost-effective programs, and I could detail those during the question and answer session.

So finally, what I think all this implies is that we do need to invest more in the most promising new kinds of job training and workforce development, the kind that involve partnerships between the private sector, community colleges, state and local agencies and intermediaries. This involves not only training, but a range of financial supports and services to low-income workers.

And while we're making those investments, we certainly need to invest also in rigorous evaluation to improve our knowledge over time about exactly what's cost-effective in this realm.

But certainly, while we get that information, we need to improve the size of those investments, given the costs associated with those very low earnings.

Thank you.

[The information follows:]

Testimony by Harry J. Holzer to the Subcommittee on Labor, Health and Human Services, Education and Related Agencies, Committee on Appropriations, U.S. House of Representatives

February 14, 2008

Economic Costs of Inadequate Investments in Workforce Development

I am very pleased to testify today on the economic and social costs to the U.S. associated with investing too little public funds in workforce development efforts.

I'd like to emphasize the following four points today:

1) The very low earnings and employment of millions of Americans generate high poverty rates and impose huge costs on the U.S. economy;
2) Federal investments in workforce training to raise the earnings of these low-income Americans have declined dramatically over time;
3) The research evidence, while somewhat mixed, does show that many public investments in workforce development are cost-effective at raising the earnings of low-income workers, and many more are very promising; and
4) The federal government should make major new investments in workforce development, while encouraging greater efforts by state/local governments and the private sector, and evaluating newer approaches to improve our knowledge of exactly what works.

1. Low Earnings, Poverty, and their Economic Costs

Roughly 10-15 million American workers are in low-income families and earn very low wages (Acs and Nichols, 2007). Many suffer from very poor basic skills and/or no high school diploma; among the latter, some have GED degrees which only partly compensate for their lack of a real high school diploma.

But, even among those with at least a minimal level of basic skills and a GED or real diploma, a lack of any serious postsecondary education or training often causes major labor market difficulties. Roughly 70% of low-income parents in any year have no postsecondary education or training (Holzer and Martinson 2008); among the long-term poor, that percentage is no doubt much higher. Lacking this type of training or productive early work experience, many poor adults lack access to jobs that pay wages above the poverty level.

At the same time, the demand in the labor market for workers in "middle-skill" jobs remains fairly strong, and is likely to remain so in the future. These are jobs that require some significant postsecondary education or training but less than a bachelor's degree; though their educational requirements are not very high, most low-income workers currently cannot meet them. The jobs are frequently found in health care, construction, manufacturing, transportation and many other sectors of the economy; they include

technician, maintenance and repair, and many other occupations (Holzer and Lerman, 2007).

What costs are imposed on these workers, their families, and the overall economy because of the limited skills and low earnings of these workers? Since worker earnings generally reflect their productivity in the labor market, the low earnings of the poor directly reflect tens of billions of dollars of lost productivity to our economy.[1] This is a huge loss of output that our economy can ill afford. High poverty rates also generate large budgetary costs to the federal government, through expenditures on Medicaid and other means-tested programs that mostly treat the symptoms of poverty but not its causes (Congressional Research Service, 2006).[2]

Furthermore, low potential earnings tend to drive many workers – especially low-income minority men – out of the labor market altogether. Employment rates and labor force participation among less-educated black men, in particular, have been trending downwards for several decades now; among those out of school, employment rates for those in their late teens or early 20s rarely surpass 50% (Holzer and Offner, 2006).

Young men with low earnings and employment rates are much more likely than others to engage in crime, less likely to marry, and more likely to father children outside of marriage. Crime, in particular, imposes enormous costs on the U.S. – as much as $1-2 T per year, by some estimates (Ludwig, 2006). Likewise, the savings that can be incurred from preventing crime and delinquency among youth are extremely high (Cohen and Piquero, 2007).

And the fathering of children outside of marriage is costly to our economy and society as well. Children growing up in poor or single-parent families are more likely themselves to have low education and earnings, to engage in crime, and to suffer from bad health as adults, thus generating an ongoing cycle of enormous economic costs for the U.S. over many generations (Hill et al., 2008; Holzer et al., 2007).

But the costs to the U.S. associated with low skills and limited training among so many workers go well beyond those associated with poor individuals and their families. For instance, employers often report difficulty filling jobs in the "middle-skill" category, even at reasonably high wages (Holzer and Lerman, op. cit.). Positions sometimes remain vacant for significant periods of time, especially in tight labor markets. Recruiting and compensation costs rise, while employers might have to accept less qualified and productive employees (Holzer et al, 2006).

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[1] For example, the income shortfall each year (relative to the poverty line) is over $8000 for the average poor family (mostly with one or two workers) and over $5000 for unrelated poor individuals. Since earnings shortfalls are at least as large as these income shortfalls, and with at least 10M poor workers in the labor force at low wages, these numbers imply earnings and productivity shortfalls of at least $40-50B annually associated with poverty. Using a higher poverty threshold would generate much larger estimated shortfalls.

[2] CRS reports that means-tested federal expenditures each year amount to roughly $600B, of which about half is accounted for by Medicaid.

These difficulties and costs for employers may well grow when "Baby Boomers" in these jobs retire in large numbers over the next few decades, especially in sectors like health care and elder care where labor demand is likely to grow substantially over time. And these concerns may ultimately raise the rate at which employers choose to "offshore" their production activities or recruit immigrants from abroad to fill jobs remaining in the U.S.

2. Declining Federal Investments in Workforce Training

One of the great ironies of workforce policy in the past few decades has been the extent to which *federal investments in training have consistently and dramatically declined, even while the labor market places an ever-higher premium on skills.*

For instance, investments in comprehensive employment and training policies peaked in real terms in 1979 under the Comprehensive Employment and Training Act (CETA). Since that time, CETA has evolved into the Job Training Partnership Act (JTPA) and more recently the Workforce Investment Act (WIA). But, since 1979, expenditures on these programs have declined in real terms by nearly 70%; and, relative to the size of the U.S. economy, they have declined by 85%. The declines in actual expenditures for training of low-income workers are no doubt higher, as more of the current expenditures are allocated to administration and universal (non-training) services than in earlier years. Some, but not all, of this shortfall has been offset by increasing expenditures on Pell grants and other federal programs; and not all of the needs served by workforce development expenditures are met by Pell grants and the other programs.[3]

Current expenditures on programs covered by Title I of WIA for adults and youth are just over $3B annually. Even if one adds in the Job Corps and a range of other workforce programs at the U.S. Department of Labor and elsewhere, these expenditures amount to about .1% an economy with an annual Gross Domestic Product (GDP) of nearly $14T (USGAO, 2003). This share is far lower than what is spent on "Active Labor Market Policy" by virtually any other industrialized nation (Heckman et al., 1999).

In certain specific areas, our declining policy interests and expenditures are quite striking. For instance, federal expenditures in the area of "Career and Technical Education" (or CTE) through the Perkins Act have remained flat in actual dollars, and have fallen in both real and relative terms. Since the expiration of the School to Work Opportunity Act (STWOA) in 2002, no new federal policy initiatives in this important area of workforce development have been undertaken. And both expenditures and staffing in the Labor Department's Office of Apprenticeships have fallen dramatically over time, with appropriations at under $22M in FY 2008 and less than 1/3 of the staff that served there in 1978.[4] Here again, expenditures in the U.S. on CTE (relative to GDP) lag behind those observed in most other industrialized nations.

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[3] For instance, Pell grants are generally not available to those taking classes less than half-time, as are most working poor parents; and they can be spent only at accredited colleges and universities.

[4] I thank Robert Lerman for sharing these numbers with me from the Apprenticeship office of the U.S. Department of Labor.

III. Evidence of Cost-Effectiveness: Does It Work?

Declining federal expenditures on workforce development might be justified if these programs are largely ineffective in achieving their goals of raising earnings and employment among less-educated workers. Indeed, the perception of program ineffectiveness is widespread . But is this perception accurate?

Many evaluations have been undertaken in the past few decades of worker training programs that are federally funded, and also of other programs that have operated at small scale in various locations. Some evaluations have used rigorous methods, such as experimental designs with "random assignment" to treatment and control groups, or various nonexperimental methods that are respected by researchers; in other cases, evaluations have used much less rigorous methods, often lacking control groups that can really be considered in any way comparable to those getting the treatment. In the latter, we learn more about program "outcomes" than "impacts," though the former sometimes suggest promising approaches that merit further study.

The lessons learned from evaluation literature on workforce development programs can be summarized as follows (Holzer, 2007):

- Programs funded under JTPA were highly cost-effective for adults though not for youth. Evidence to date on WIA programs for adults is very limited, but what does exist suggests positive impacts on earnings of similar magnitudes.[5]
- Job Corps training for disadvantaged youth has been cost-effective in the short term but apparently less so over the long-term, as some initially positive impacts fade with time. But, for some groups (like those aged 20-24 rather than teens), positive impacts are maintained over the longer term.[6] Outcomes observed for programs like Youth Build and the Youth Service and Conservation Corps suggest that these programs for at-risk youth are very promising as well.
- The returns to a year or more of community college training for youth or adults appear to be quite strong, particularly for those at-risk or with low incomes. Recent evidence from the Opening Doors demonstration project also shows the feasibility of increasing community college attendance and achievement for low-income young adults with appropriate financial supports and services.[7]
- Training programs that involve private sector employers and prepare workers for specific jobs in the labor market are particularly promising. For adults, "sectoral"

[5] For instance, the National JTPA study showed 5-year returns of over 150% per dollar spent for adult women and men, despite some fading out of impacts over time (USGAO, 1996). Rigorous nonexperimental evaluations of both JTPA and WIA since that time for specific states show strong returns as well – see Mueser et al. (2005) and Raphael et al. (2003).

[6] See Schochet et al. (2003). The most recent evaluation of long-term Job Corps impacts are based on administrative data rather than survey data, though the latter showed somewhat larger impacts in earlier evaluations.

[7] See Lerman (2007) and Brock and Richburg-Hayes (2006).

training programs have shown positive results in one experimental study and very promising outcomes in various nonexperimental studies.[8]

- Studies of incumbent worker training programs also show improvements in employee earnings as well as in workplace productivity.[9]
- Studies of high-quality Career and Technical Education programs that link young people with good jobs in key sectors of the economy - such as Career Academies - show very impressive results.[10]
- Combining training with job placement assistance and other financial supports and services can be effective for low-income populations.[11]
- Community college training for dislocated adult workers, especially in technical more, fields, generates positive returns as well.[12]

It is clear from this summary that not everything funded with federal dollars has been effective. Some things work in the short term but fade out over time; others work very well in small settings but fare less well when they are replicated across the country. And much remains unknown, as the many of the most promising efforts to date (especially in the areas of sectoral training, "career ladder" building and the like) have not yet been rigorously evaluated.

Still, many successes have been uncovered in the evaluation literature. Given that fact, *the dramatic declines in spending on federal workforce development programs cannot be justified.* But improvements in the system, through more funding and also better use of what is actually spent, are certainly in order.

IV. Future Directions: Greater Investments, Incentives, and Evaluation

The weak education and training of so many millions of American workers limit their earnings and impose great costs – not only on themselves but on the U.S. economy and society as well. These costs include low productivity, low employment, high crime and out-of-marriage childbearing. The costs borne by employers who have difficulty recruiting and hiring sufficiently skilled workers, and the potential responses of these employers (through greater offshoring or recruitment of immigrants), should be considered as well.

The labor market demands greater skills than ever before as a precondition for higher earnings, but the federal government invests vastly less in workforce skill development

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[8] See Holzer (2007). An experimental evaluation of the Center for Employment Training in San Jose CA showed positive impacts on the earnings of disadvantaged workers. A nationwide replication effort failed to show these impacts, since earnings growth for both the treatment and control groups in this study seemed unusually strong.

[9] Ibid.

[10] See Kemple (2004) on Career Academies and Lerman (2007) on Tech Prep and other CTE programs.

[11] Examples of rigorously evaluated programs that combine training or employment services with other supports and services that have generated positive impacts include Jobs Plus, the Portland site in the National Evaluation of Welfare to Work Strategies, and some sites in the Employment Retention and Advancement project.

[12] See Jacobson *et al.* (2004).

than it did 30 years ago. Indeed, in a nearly $14T economy, our annual federal investment are pitifully small, especially in comparison with virtually every other industrial country in the world. And, while our knowledge of "what works" in workforce development clearly has limits, we certainly know enough to do better than we do now.

At a minimum, significantly greater federal investments in workforce development are warranted. But the federal government cannot generate the needed investments all on its own. Indeed, public investments in training will always be very small relative to those that of the private sector, though the latter are highly skewed towards highly-educated employees. Given that most state and local areas have strong interests in workforce development as part of their economic development strategies; and given that employers would benefit substantially from these investments; it seems appropriate that federal investments should be structured in ways that incent state/local governments and the private sector to contribute more.

The most promising models of workforce development today involve partnerships between industry/employer groups, community colleges, state/local agencies (including workforce boards), community groups, and intermediary organizations that can bring them all together. In addition to funding for training, a range of other financial supports and services workers might also be needed by low-income workers.
And an effective workforce "system" should also provide performance incentives, oversight, technical assistance, and serious evaluation requirements to achieve maximum success.

Elsewhere, I have outlined what such an "advancement" system might look like (Holzer, 2007). That proposal calls for a set of competitive grants to be awarded to states to build these systems in local regions. These grants would be expandable and renewable, conditional on performance. They would match new state/local public expenditures as well as private ones, but they could be used to directly finance training and other supports and services. This program or its various components could be implemented as part of WIA, or in addition to it.

However we proceed, it is important that we raise federal investments in workforce development, use our resources as efficiently as possible and with maximum leverage on other sources of funding, and improve our overall knowledge of what actually works in this area.

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Mr. OBEY. Thank you.

Let me suggest that we go vote. We will have this vote and then a five-minute vote.

And so I would suggest that we cast these next two votes, and then if we come back here, we will have a 25-minute window before we have to go and vote on the next two items.

I'm sorry to do this to you, Bill.

[Recess.]

Mr. OBEY. Well, as you were about to say before we were rudely interrupted, Dr. Spriggs, please proceed.

Mr. SPRIGGS. I want to thank you, Chairman Obey, and I want to thank the ranking member, Mr. Walsh, for inviting me to speak.

I'm not going to be speaking on investments in people or those programs, but actually, investments in making people get connected to the program so that these programs can be effective.

In particular, I want to talk about the social services block grant and the community block grant programs.

These are programs that give states a great deal of flexibility in figuring out how to connect people who need services to the services, and to close the gap for people who need services but aren't connected because they aren't part of a program, as an example, TANF.

The vast majority of the direct recipients of the social services block grants that states use are children; 63 percent of those who benefit are children.

If we were to cut the program in this current environment, it would be doing it in the face of a growing need on the part of attaching children to services.

The number of poor children in this country since 2001 is up 1.1 million. That's roughly the population of the state of Rhode Island. And these needs are likely to grow, as the economy looks like it is slowing down.

A cut from $1,700,000 to $1,200,000 would be a cut very close to 30 percent, and that would mean roughly 2.7 million fewer children could be attached to important services like day care, which we just heard was an important investment that the government should be making.

These services are provided normally in partnership between services directly provided by the state and with community partners. A big part of that takes place through the community block grants, agencies that are vital, especially in rural areas.

In many cities, there are lots of different social service agencies, but in many rural areas, there aren't, so the community partnership in Lewiston, Idaho, for example, is very important for connecting people to getting help on weatherization, on housing counseling, as we know is a very important thing right now.

It's very important in Indian Head and Russ County in Wisconsin, for instance. That's the way that children get their access to Head Start and to Fresh Start, Wisconsin Fresh Start.

So those grants are important devices for connecting people to the services that they need to receive and keep the investments going.

I want to talk about a problem that we have with the safety net, and that funds to SSBG and the community grant can help with.

This last expansion that we had was very unique, because as opposed to having poverty decline since 2001, as I mentioned earlier, poverty actually increased.

Part of this anomaly is that even though low-income workers, those who actually were in poor households, saw their wage earnings increase, their sources of income from the safety net actually went down, and this was most dramatic when you look at issues of access to TANF, access to food stamps, access to unemployment insurance, so that those automatic stabilizers which we would have anticipated being kicked in to help people through the recession and keep their consumption high actually didn't reach the people we thought that they should have reached.

The block grants were frozen in amounts so that even though there was a rising demand for services, states were not given more resources to actually help make that connection take place, so things like job training and like child services tended not to reach the people we would want to reach.

There is data collected by the Center for Economic Policy Research and the Center for Social Policy Research at the University of Massachusetts, Boston that help to highlight this gap between needs, those who get service, those who are eligible for service, and then those who actually get service. These gaps can be rather huge.

For instance, if we just look at housing assistance, something that we clearly need at the moment, 10.2 percent of folks in Illinois are eligible, but only 2.1 percent actually receive housing assistance among those who are eligible.

Here in Washington, D.C., 19.3 percent of the population is eligible for housing assistance, but only 6.1 percent actually received the assistance that they were eligible for.

And as we look at a downturn in the labor market and think about something as fundamental as food stamps, there can be huge gaps. In Texas, for instance, almost 23 percent of families in Texas are eligible for food stamps, but only 2.7 percent of the families who are eligible actually receive the food stamps.

These grants, these social services block grants, give states the flexibility to fashion as they see the needs in their state how to connect people to the needed services, to child care, to foster care, how do we get them to job training, and get them the right job training, and their partners and the community action agencies and through the community block grants add that extra amount for making sure that services are provided.

We should make sure that states have those resources and can connect people to the programs that you have actually appropriated funds for, to make sure that they are doing the job, the programs are doing the job that you want to have done, and that the people you want served are being served.

And it's very important that, especially in our rural areas, where these community block grants are really essential to making sure that they're going to service providers, so that child care takes place, so that job training takes place.

So these investments you heard are great investments, but they have to be connected to the people who need the services. Cutting those monies to social service and to community service block grants is a way of making those programs less effective.

[The information follows:]

Testimony before the U.S. House of Representatives' Committee on Appropriations

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Concerns with the President's Proposed Cut in Funding for Community Social Service Block Grants

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I would like to thank the Chairman of the Committee for this opportunity to share my concerns with proposed cuts in the Social Services Block Grant (SSBG) and elimination of the Community Services Block Grant Program (CSBG). The Social Services Block Grant Program was created by the Social Security Act, Title XX, as amended, in 1981. The purpose of the act was to create a fund allocated among the states to freely design the provision of social services best targeted for the needs of their state. Originally, the grant was capped at $2.9 billion, and has subsequently been cut to a cap of $1.7 million in the last fiscal year. So, in real terms the funding for this program has declined dramatically.

Program recipients are overwhelmingly children, either in foster care or in poor families that do not receive funding directly from the Temporary Assistance for Needy Families program. States are allowed to provide a range of services, but the largest single service provided is child day care, and 63% of the 16.8 million people states reported receiving assistance from a Social Service Block Grant program were children.[1] In 2001, there were 11.175 million poor children in the United States, and the latest data for 2006 puts the number at 12.29 million, an increase of 1.1 million—or roughly the population of the state of Rhode Island. At the same time there was an increase in the number of poor children, there was a decline in the number of children helped by TANF; falling from 4.1 million in 2001 to 3.7 million in 2005, meaning the percentage of poor children being helped by TANF fell from 35% to 29%.[2] This means there was an increase in the number and share of poor children in need of services provided by the Social Services Block Grant at a time the real funding for the program was being cut. So, this is a program with a growing need but limited funding, and further cuts in the program could only exacerbate the gaps between needs and the provision of services.

While the largest share of expenditures by states using the Social Service Block Grant go to child day care services, states also use other funds to provide that service. So, SSBG funds an average

[1] Administration for Children and Families. U.S. Department of Health and Human Services. Social Services Block Grant 2005 Annual Report, http://www.acf.hhs.gov/programs/ocs/ssbg/reports/2005/chapter3.html

[2] Child Trends Data Bank, http://www.childtrendsdatabank.org/tables/50_Table_1.htm

of about 4 percent of state expenditures on child care. However, SSBG funds provide over half of state funding on adult foster care services (57%) and family planning services (50.1%); and, they are substantial portion of state funds for special services for youth at risk (45%), protective services for adults (42%), day care for adults (42%) and education and training services (41%).[3] So, while the program cuts would adversely affect poor children in need, cuts and elimination of the program would have devastating effects for senior citizens and adults and those state programs designed to meet their needs that depend heavily on SSBG funds to provide the services.

SSBG funds are most often expended in partnership between the state and private service providers. In particular, youth at risk programs, which rely heavily on SSBG funding are done by most states through private service providers or in partnership. And, about two-thirds of states use their SSBG child care funds in a state-private mixture.[4] A key component to making those partnerships work are the agencies funding through the CSBG. So, elimination of the CSBG would be an additional cut to the programs and services provided through the SSBG.

I want to concentrate my testimony on the general failure of the safety-net to assist families to suggest a deeper set of concerns that a cut in SSBG funds, and an elimination of the CSBG, would hurt the response of states to the needs of families. The first concern is that the failure of states to connect services to families undermines the efforts by Congress to create and fund programs designed to meet those needs. So, for instance, I estimate from data in the March 2007 Current Population Survey of the Census Bureau, that among households in the bottom 15 percent of the income distribution that have children, only 55 percent report getting Food Stamps, and 52 percent report being helped by Medicaid. The low penetration of these programs in reaching the neediest households is not without consequences for the rest of the economy in the immediate term, and the lack of investment in our children's healthy development has obvious long term consequences.

In the immediate term, this last economic expansion was unique because it produced extremely few jobs and has yet to boost the median income of families back to their 2001 level, adjusting for inflation. During this recovery, U.S. Census data show that income for those in the bottom twenty percent, those in the middle twenty percent and those in the top twenty percent have all fallen. Yet, aggregate consumption has increased. This anomaly has occurred, because the aggregate savings level of Americans has become negative, and household debt has risen dramatically. But, a closer look at the data shows that those in the bottom twenty percent have in fact suffered from a drop in consumption. Real wages for them have fallen, and because they are credit constrained, they have not borrowed to maintain consumption. Those with middle incomes have apparently maintained consumption, with some modest borrowing, and some

[3] Administration for Children and Families. *Op. cit.,* http://www.acf.hhs.gov/programs/ocs/ssbg/reports/2005/chapter2.html
[4] *Ibid* http://www.acf.hhs.gov/programs/ocs/ssbg/reports/2005/chapter4.html

modest benefit from lower taxes. The big gains in consumption have come from those at the top of the income distribution, where incomes in the highest ranges have gone up, and by borrowing, and from larger benefits from tax cuts. The relative gains in consumption by those in the top twenty percent were more rapid than during the 1980s or 1990s recovery. By 2005, the top twenty percent of the income distribution accounted for almost 40 percent of all consumption. The bottom twenty percent consumed only 8.2 percent.[5] That is, our failure to support the incomes of the bottom twenty percent created a drag on consumption and the robustness of the recovery. And, now we are seeing that the escalating debt the middle class took on is not sustainable as the news grows of housing foreclosures and record delinquencies in automobile debt.

A portion of the decline in the fortunes of those at the bottom is accounted for by the failure of our safety net programs to catch people that fell into poverty in 2001. Far less dramatic than those caught in the flood waters of Lake Ponchartrain and the Mississippi River in New Orleans, nonetheless, we left those in need behind as the 2001 recession sank many families below poverty. In work I have done with Susan McElroy, of the University of Texas at Dallas, we have shown how by 1993 the safety-net response helped poor families more than in 2003, both at similar points in the recovery.[6] Our research looked through the lens of women, because there are more safety-net programs that directly speak to the needs of families and women. The robust labor market of the 1990s meant that poor women had higher inflation adjusted earnings in 2003 than they did in 1993. However, despite higher earnings, the family incomes of poor women were lower in 2003 than in 1993.

In particular, Professor McElroy and I found that while unemployment insurance contributed 3.3 percent of family income to white families below poverty in 1993, it only contributed 2.1% in 2003, with the drop being most pronounced for married poor families. There was a similar drop for Black families, from 3.0 percent of income in 1993 to 2.5% in 2003, with a similar dramatic drop for married families below the poverty line. While the market value of food stamps contributed the equivalent of 12.4 percent of income to poor white families in 1993, food stamp help dropped to the equivalent of 7.3 percent in 2003, with the most dramatic drop for single-female headed families, from 15.7 percent of income in 1993 to 9.2 percent in 2003. The result was similar for Black families, where food stamp assistance dropped from 22.8 percent in 1993 to 15.1% in 2003, but with dramatic drops for both married couple families in poverty (from 12.2 percent down to 6.1 percent) and Black single-female headed families (dropping from 15.7 percent in 1993 to 17.3 percent in 2003).

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[5] Jared Bernstein and Jason Furman, "A Tough Recovery by Any Measure: New Data Show Consumer Expenditures Lag for Low- and Middle-Income Families," CBPP and EPI (November 28, 2006). [http://www.epi.org/issuebriefs/230/ib230.pdf]

[6] Susan McElroy and William Spriggs, Journal of The Center for Research on African American Women, 2006 (Winter/Spring).

We found the most dramatic drop in help was from public assistance, the largest program being Aid to Families with Dependent Children in 1993, and the Temporary Assistance to Needy Families in 2003, though states can use funds from their SSBG to provide small cash grants for emergency shelter and other immediate family needs, as well. In 1993, poor white families received 16.8 percent of family income from public assistance, but that dropped to 4.1 percernt in 2003, with the most pronounced drop in help for white single-female headed families dropping from 26.3 percent of income to 6.0 percent of income. Poor Black families also had a dramatic drop in help from public assistance from 27.5 percent of income in 1993 to 5.6 percent in 2003, and a similar dramatic decline for Black single-female headed families dropping from 32.5 percent of income from public assistance to 6.6 percent of income in 2003.

The drop in assistance to poor families contributed to the drop in consumption of those families in the bottom twenty percent of the income distribution. In part, as with the change from the AFDC to the TANF program, the change was designed by Congress. But, for some programs, like Food Stamps, these are gaps in the ability of states to administer the programs and get the help to those who are eligible. The substantial gaps in those eligible for assistance and those who got help, therefore, hurt the economy by lowering consumption below what Congress intended, and for some programs lowering the investment in the healthy development of our children below what Congress intended.

Work by the Center for Economic Policy Research and the Center for Social Policy Research at the University of Massachusetts—Boston, show substantial gaps between needs and services, and between those who are eligible and the take-up rate for services.[7] Take up rates for Medicaid or SCHIP range from a low of 60.4 percent in Massachusetts and 63.0 percent in Washington state to a high of 89.5 percent in New York state and 79.2 percent in Minnesota among the ten states that the report examines. National data suggests the take-up rate for eligible children is around 56 percent.

Given the current problems in our housing markets, it is disturbing to note the gap between those who are eligible for housing assistance and those who receive help. This gap highlights the leakages that could take place as Congress tries to respond to the current housing market crisis. The report shows that while 19.3 percent of Washington, DC's population is eligible for housing assistance, only 6.1 percent receive assistance, 10.2 percent of Illinois' population is eligible for housing assistance, but only 2.1 percent receive housing assistance.

And, in the face of a downturn in the labor market, Congress' to fashion an appropriate stimulus package could also be hampered. A key element of an effective stimulus would include expanding the food stamp program, yet Congress' reach with food stamps also faces the challenge of matching eligible families to those who are helped. In Texas, for instance, while

[7] Randy Albeda and Heather Boushey, Bridging the Gaps: A Picture of How Work Supports *Work* in Ten States, http://www.bridgingthegaps.org/publications/nationalreport.pdf

22.9 percent of families are eligible to receive food stamps, only 10.7 percent actually receive food stamps.

The SSBG program is meant to give states maximum flexibility in meeting their social service needs. The recent slowdown in the labor market and the sharp downturn in the housing market suggest states will face rising demand to fashion programs to fight homelessness, expand child care to keep parents in jobs, offer transportation assistance to help workers connect to job opportunities and help the "sandwich" generation of women in the work force balancing care for children and senior citizen parents. So, at best, it is odd to propose cutting the SSBG program and eliminating its partner agencies funded through the CSBG.

The SSBG program does allow states to use the grants for administrative purposes, and Congress should continue to be concerned that states are not doing enough to solve the problems created by the gaps between families that are eligible for assistance and the take-up of help by those families. States with significant take-up rate gaps should be required to use their SSBG funds to both study their low take-up rates, and to expand case management, information and referral expenditures to close take-up rate gaps.

I think in the interest of efficiency with respect to federal programs, the immediate concerns with the economy and insuring a robust recovery from the current slowdown, and the long run interest in investing in the healthy development of our children, the SSBG program should continue to be fully funded, and it is necessary to maintain the community based partners funded by the CSBG. I thank you for this opportunity to share my concerns, and look forward to answering any questions.

Mr. OBEY. Thank you very much.

Mr. Walsh.

Mr. WALSH. Thank you, Mr. Chairman.

I'd like to direct questions to, first to Dr. Lynch, and then to Dr. Holzer.

Regarding Head Start, you talked about short-term analysis, short-term results, positive. I've heard that historically. Long-term study generally shows small to moderate improvement.

The point, I guess, is that kids, once they get ahead from Head Start, and they get into a not quite so pro-education an environment, let's say, they start to lose that.

Is that true? And what do you see causing this, and how do we deal with that?

Mr. LYNCH. Well, there is some accuracy to what you're saying, in that if you have children who go through a Head Start program and then subsequently go on to schooling that's of inferior quality, you see some of the initial benefits that they get start to fade.

On the other hand, if we see those children going into reasonable quality schools to good quality schools, we see that those benefits last, the cognitive benefits.

Some of the other benefits seem to last, regardless. For example, grade retention and need for special education seem to last, in either case.

So it is important, therefore——

Mr. WALSH. Grade retention?

Mr. LYNCH. In other words, the reduction in repetition of grades, so kids who were held back, that declines, and that seems to persist, regardless of the kind of quality school they go on to.

But in general, if you want to maintain the gains that initially happen in Head Start, it is important to also invest in the quality of the subsequent schooling that children go to.

Mr. WALSH. You mentioned that, after nine years, savings to the government of programs amounted to a 3:1 investment, positive return to the government.

How do you—how do those savings come? How does that benefit accrue?

Mr. LYNCH. Yes. The savings are in about seven or eight different areas.

One is, children who go through these programs are less likely to need special education, which is very expensive.

They are less likely to be retained in grade. And every time a child is retained in grade, we're spending an extra $10,000, approximately, per year.

Third, children who, and parents who go through these programs, they're much less likely to be involved in child abuse and neglect, and we save a lot of money in our child welfare system.

Fourth, the children, as juveniles, and subsequently as adults, they're much less likely to be involved in criminal activity, saving us an enormous amount of money in the criminal justice system.

Fifth, the parents who go through these programs, who have children in these programs, get the subsidized child care, and therefore they're more likely to go out and get a job and earn income and pay taxes.

Sixth, the children who go through the program, they graduate from high school at higher rates, they go on to college at higher rates, they have higher earnings, and they pay a lot more in revenue to the government, as well.

So all these different forms, these are enormous savings that we get. They don't all happen in year one, but they happen over time, and over the time they grow larger each and every year.

Mr. WALSH. Thank you.

Dr. Holzer, regarding workforce development, you said research was mixed on raising incomes, and yet you call for major new investment. Why? How do you explain that?

Mr. HOLZER. Well, very simply, a lot of the research evidence today is outdated.

People still cite, and even in my statement, I still cite a random assignment study of JTPA, for instance, that's roughly two decades old.

The program has likely changed quite dramatically since it morphed into WIA, and in fact, the evidence that we have on WIA, some of its non-experimental is really quite positive, especially on displaced workers and on adult services.

And on many, many other——

Mr. WALSH. So you anticipate that current programs are much more effective than past?

Mr. HOLZER. That's my guess. If you look at the whole new generation of programs, many of them focus much more on community college training, where there is evidence of effectiveness.

Mr. WALSH. Right.

Mr. HOLZER. They engage the private sector more, sectoral programs, career ladder programs.

So my anticipation is that the evaluation evidence will be more positive, but I also emphasize at the same time that we make these investments that we also invest heavily in evaluation, rigorous evaluation, so we get a better sense over time exactly of what works and maybe reallocate resources accordingly.

Mr. WALSH. Okay. You also made the statement that we spend, it was something like, we spend a smaller amount as a percent of our federal budget—well, we spend a smaller amount as a percent of budget than all other countries, developed countries; was that the statement?

Mr. HOLZER. Virtually all other industrial countries, as a percentage of GDP.

Mr. WALSH. Now, is that federal budget to federal budget? Or does that include BOSEs, community college, vocational high school? Does that include all of those things?

Mr. HOLZER. That includes—the figure comes from a study that USGAO did in 2003, and they went across all agencies in the federal government.

Mr. WALSH. Just federal?

Mr. HOLZER. Just federal.

Mr. WALSH. So it doesn't include state, doesn't include local, doesn't include community colleges, BOSEs, vocational high schools?

Mr. HOLZER. No, it does include some of them. It includes the portions of those programs that actually fund employment services, and as a percentage of GDP.

Now, I'm quite certain that if you added in those other components, the state components and other things, that number would go up a small amount. It might be 2/10ths of a percent of GDP. It wouldn't dramatically change the qualitative result.

Mr. WALSH. Okay. Thank you, Mr. Chairman.

Mr. OBEY. Ms. McCollum.

Ms. MCCOLLUM. Thank you, Mr. Chair.

To kind of follow up on that, I was with some German parliamentarians this weekend, and we were talking about Transatlantic trade and global competition and that.

And what they were—what I was most surprised to hear, and I shouldn't have been, is that in Germany, they thought their commitment to worker training and retraining was 3:1 to where ours was, maybe 2:1 in some other parts of Europe, but a real high emphasis into lifelong learning skills for all workers.

So if there's anything that you could follow up more and comment on that, I'd appreciate it.

Another issue that I've been—and it kind of goes back to adults and it also goes back to young adults not necessarily making good decisions, young adults thinking that they aren't going to go to college or that they aren't going to need college, or people who have been out of high school maybe for 10, 20 years needing math and science to go back in.

They go to the community colleges. They spend a lot of time and energy doing remedial work to get up to a standard in order to start taking classes.

I wonder if there's been any discussion about even to make it more cost effective and user friendly, especially in rural areas, to look at the way we view community education.

In Minnesota, community education can also sometimes mean math, science, and writing classes for adults going back.

If you have any comments you'd like to make on that.

And then thirdly, and this isn't as related, but the housing foreclosures.

One of the most important things, I can tell you as a teacher, is stability in a child's life.

What brings a child the most stability is knowing that there's going to be a roof over their head and there's going to be a parent there, and there hopefully will be something nutritious on the table, and if you're from a cold weather climate like the chairman and I, that there's some heat in the house.

What do you see the effect or are you concerned about the effect of what we're seeing with some of the foreclosures, especially in the areas that we're seeing now, and what should we be doing to prepare ourselves and our schools and these students, to give them an opportunity during what proves to be very, very tough times, especially for these families?

Mr. SPRIGGS. If I can take a first stab at one of your concerns, and that is, the community block grants provide help for a lot of the agencies that do weatherization in rural areas and provide housing counseling.

So now would not be the time to want to cut those programs, because a lot of those families that may be facing foreclosure need the housing counseling advice, and they need it from someone who will be impartial.

One of the big problems out there is finding a paid-for housing counseling service that isn't tied to the industry.

And weatherization is one of those great services that takes place, particularly in Minnesota and Idaho and Wisconsin, that these community action agencies provide. So keeping them in place would be very important.

Mr. HOLZER. I'll take a stab at least at the first question you raised about these international comparisons.

And I agree totally. If we define more broadly, as Mr. Walsh suggested, that we should also include expenditures on vocational educational for high school students, college students, community college students, adult displaced workers, that's a broader concept, but if you defined it that way, the gaps between us and many of these other industrial nations would likely be even larger.

And there we actually have quite strong evidence, high quality career and technical education for young people, so I'm not talking about old, old-fashioned voc ed. I'm talking about career academies, tech prep, those kinds of models. Those are very cost-effective. And yet we invest very little in them, and those investments have, if anything, diminished over time.

So again, defining it more broadly that way makes the point, I think, even more valid.

In terms of your point about community education, and I'm trying to think of other examples that would fit that model, I think there are some states, and I'm familiar with the state of Kentucky, that has developed a statewide model for all of its community colleges, to make that education much more accessible to low-income adults, as well as young people in all their sites across the state, and to link those training programs with employers.

So they have these so-called bridge programs to try to remediate the basic skill deficiencies, and then to move those into more occupational based training.

And without rigorous evidence on effectiveness, they look quite impressive, just in terms of what they've managed to achieve statewide. So one of many models that we might try to emulate in other places.

Mr. OBEY. We have this vote.

[Recess.]

Mr. OBEY. Mr. Honda.

Mr. HONDA. Thank you. Thank you, Mr. Chairman, and the ranking member.

Let me just say to the chairman, I appreciate having these witnesses today, because it validates the kind of things we sense education can really be, in the early childhood and workforce.

The question I had was about early childhood or Head Start and its performance across the country. Although it's good, it's uneven, and I was hoping that you might be able to explain whether it's uneven through states or regions, and perhaps some of the dynamics that might contribute to the unevenness.

Mr. LYNCH. One of the issues is that, with Head Start, there are about 1,500 programs across the country, and while they all have to follow federal guidelines, they vary in terms of what they specifically do.

And among important issues that we see is that in some areas, the requirements, for example, for teachers are much higher than in other areas, so in some areas, all the teachers have Bachelor's Degrees, and even maybe certification in early childhood education, and we know from the research that that's extremely helpful in terms of improving the outcomes, versus in other areas, many of the teachers only have a high school degree.

So there's going to be a variation across the programs, because while they follow the federal guidelines, there's a lot of internal differences in what they're actually doing.

Mr. HONDA. The guidelines don't require a certain level of preparation before you teach or before you're involved in it?

Mr. LYNCH. No, they require just a high school degree.

Mr. HONDA. Okay. So that sort of suggests the need for some sort of in-service training for upgrading the training?

Mr. LYNCH. Absolutely. That certainly would suggest—one of the things that we find is that if you were to improve the qualifications and training of the teachers and staff, that does generate enormous benefits to the children.

Mr. HONDA. This difference in preparation or requirements, is that a phenomenon by regions or is that something that's just scattered?

Mr. LYNCH. It varies by state, often, because of state requirements.

While again, everyone follows the federal requirements, every state has their own specific requirements that may or may not go beyond the federal minimum requirements.

Mr. HONDA. Okay.

Mr. LYNCH. So some states have much more rigid requirements than others.

Mr. HONDA. In the discussion about the children's continuing success as they go on, and when they don't have a program that has had Head Start in it, what is the impact of parents being exposed to Head Start, and are there components of Head Start that have parent education, that would suggest that their participation does help youngsters' continuous growth?

Mr. LYNCH. Well, we know that when parents participate in the education of their children, in these early education programs, that, again, there too, the outcomes tend to improve for the children.

And we also know that many of the Head Start programs have classes for parents, specifically have training for parents specifically, and that improves a number of things, for example, the incidence of hitting or slapping, the kind of discipline that parents use.

So there are benefits directly to the kids from their parents participating, and there's benefits to the parents themselves, in terms of being better parents by participating in the programs.

Mr. HONDA. You mentioned that when a youngster is involved in Head Start, there's less need for special education.

Do they assess youngsters for special education at the third and fourth year or is this just because of the program or the strategies that the kids go through?

Mr. LYNCH. What we find is that when the children enter the public school system, K through 12, that fewer of them are found to require special education if they had quality preschool before they go into the K through 12.

So it seems to be an outcome that's a consequence of the education and the training and the emotional development that happens in the early, in the third and fourth—excuse me—when they're three and four years old.

Mr. HONDA. So it's not so much academic preparation, it's more socialization and——

Mr. LYNCH. This is one of the key things that I think is often misunderstood, is that among the benefits of early education are, some of it is definitely the cognitive outcomes, you know, achievement test scores and things like that, but many other benefits are the social and emotional development, less aggressivity, more persistence.

And we know that this ability to control your emotions and be persistent, stick to it, have enormous benefits, and indeed, are more predictive of outcomes over life than are things like IQ test scores.

And there is some evidence, of course, that IQ test scores do—improvements in IQ test scores tend to fade over time, but these other benefits persist.

And it's a little bit like saying that antibiotics don't cure the common cold, and therefore the antibiotic is worthless. No, that's nonsense. Antibiotics may not cure the common cold, but they generate enormous other benefits in terms of lung infections, sinus infections, et cetera.

And it's the same thing here. We know that the early education may not a huge impact in terms of IQ test scores, but in all these other areas, they do, and these have long-lasting, lifelong consequences, and that's very important.

Mr. HONDA. Thank you.

Mr. OBEY. A lot of questions, very little time.

Dr. Lynch, you talked about Head Start and the economic value of providing more support for it.

Based on your work, my staff estimated that the $164,000,000 cut from the Head Start program could cost as much as $1,200,000,000 over 40 years in lost government tax revenue, reduced individual earnings, and increased costs from crime and child abuse.

Is that a reasonable estimate, and if not so, why?

Mr. LYNCH. Oh, it's definitely a reasonable estimate, and indeed it could be larger than that.

One of the issues is that that estimate is based on the things that we know that we can quantify, but there are also a number of other benefits that are very difficult for us to quantify in monetary terms.

For example, children who go through Head Start and other early education programs are less likely to be teenage parents. What's the monetary value of that? They are less likely to abuse

alcohol and drugs. What's the monetary value of that? That's not included in that estimate.

So that is a reasonable estimate for the things that we know that we can quantify, but it does not include all the benefits.

Mr. OBEY. Mr. Rudin, we often hear the argument that it's wrong to tax lower income people or middle income people in order to pay for increased college benefits for people who will wind up in the higher end of the income ladder.

Yet your statement indicates that there's a ripple effect which increases income for non-college people as well as people who go to college, and you indicate that I think you said there's a 1.9——

Mr. RUDIN. Percent increase.

Mr. OBEY. Explain that.

Mr. RUDIN. Yeah. That's a——

Mr. OBEY. What I'm getting at is, I'm very suspicious of numbers. I think almost anybody can put together any numbers they want.

How do you arrive at that specific conclusion?

Mr. RUDIN. The economists that did this study, what they did is they looked at whether the spillover effect, they called it, of having more college-level educated people in a community would affect the earnings of low-income citizens, and in fact, it did. It drove up their earnings. For each 1 percent more college graduates in the community, it increased the earnings of non-high school graduates by 1.9 percent.

Mr. OBEY. How did they reach that conclusion? What's the mechanism by which that occurred?

Mr. RUDIN. Yeah. They did a study of several cities, and they looked at both the productivity, and therefore the—first, they looked at how many students were—how many of the workers were college educated, and then they tried to measure the productivity in terms of the wages of both the college graduates and the high school and non-high school graduates.

What they found, and we think this is important, it does illustrate that the broad benefits of an investment in higher education are significant. You can get benefits that accrue to people who don't go to college when you increase the percentage of college graduates in the workforce.

The reason why is there's an increase in productivity, there's a likelihood that you have better and more efficient use of new technologies, the likelihood of increased opportunity to be innovative and creative, and the likelihood of greater communications between and among workers in a workforce.

And finally, when a community suffers an economic shock from the closure of a plant or the closure of a business or an economic downturn like we're in today, you have workers who are probably more likely to have the flexible work skills to absorb that, that economic shock in the community, maybe start their own businesses, maybe ease into another job because of their college degree, and that can raise the overall economic productivity of a community, large or small.

Mr. OBEY. Your statement indicates that in recent years, increased college enrollment has been almost exclusively in the upper half of the income distribution.

The administration is recommending that we zero out the SEOG student aid program. That's what, a $757,000,000 reduction.

Is it fair to say that the elimination of funding for that program is likely to add to the education disparity, and also, therefore, add to the income disparity in this society?

Mr. RUDIN. Well, we think that is a fair statement.

That program serves the people who need access to financial aid the most, the neediest students, particularly at a time when Pell grants, the purchasing power of a Pell grant has declined in the last 20 years from about half of the cost of college to about a third of the cost of college. To suggest further cuts, we think would be pretty devastating to the people who need the greatest access to financial aid.

Mr. OBEY. Dr. Holzer, you indicated that we are investing today in job training programs, that we've had about what, about a 75 percent reduction from the high point? That's in job training programs.

The administration is now recommending that we zero out the vocational education program.

What conclusion do you reach about the advisability of that decision, and what effect is it having on the quality of America's workforce and the ability of families to become economically upwardly mobile, shall we say?

Mr. HOLZER. I think that's ill-advised. I think the area of vocational education is one of the areas where we have—is it on now?

I think the area of vocational education is one of the few areas where we have very solid, rigorous evidence on what works, what's cost effective, and I think those federal funds do help to fund career academies, tech prep programs, and a variety of newer models that are really much more effective than the older generation of vocational education was, and these are programs that not only benefit lower income Americans, but some of our most at risk populations, while they're still in school benefit in terms of higher earnings once they graduate, and these benefits persist for at least four years after they graduate, so this is really a penny wise but pound foolish approach, I think, to cut in areas where the need is great and where the evidence of what works is very clear.

Mr. OBEY. Dr. Spriggs, the administration is also asking for a reduction in the low-income heating assistance program of roughly 22 percent.

I have constituents in my district—two weekends ago it was 28 below zero. I'm talking about real temperature, not the chill factor. Ten days earlier, it was 38 below zero.

And the problem in our state is that right now the state forbids energy companies from cutting off people's heating supplies, even if they haven't paid their bills, but that expires in April.

I've got constituents who make 15,000, 18,000 bucks, who have a $4,000 heating bill. I don't know how in hell they're going to pay that.

And we have such a small percentage of people who are eligible for LAHEAT, who are in fact collecting.

You talked about using programs like the community service block grant in order to plug people into information about what

they're entitled to, where they can get help. How do you tie those two together?

You've got a lot of people in this Congress who think that programs like CSBG are just liberal social fantasy programs, it's money down a rathole.

Are there any specific examples you can give about the direct benefit of those programs to low-income people?

Mr. SPRIGGS. Well, specifically, in the case that you just raised, about access to LAHEAT, and in particular the CSBG agencies themselves overwhelmingly are the major source of weatherization help for low-income families.

Mr. OBEY. Can you give me examples of how they might help to plug people into health care networks that they otherwise would not plug into?

Mr. SPRIGGS. One of the things that the community action partnerships do and the community action agencies do is tie the, especially the old age and children, directly into programs that they need.

The mother who is trying to keep a job, isn't on TANF but needs to connect to child care services, or the mother who is taking care of an elderly parent and needs assistance in getting adult day care and access to that, that's what these programs do. They connect the individuals to these types of services.

So withdrawing those services means that you would lose a potential worker. She would have to stay home in order to take care of her parents, or she might have to stay home to take care of her children. So these are the kind of gaps that are filled.

And foster care—most of the hard-to-place children receive assistance through the foster care programs, again done either by the state or in partnership through the CSBG agencies.

So you have young men who present severe mental problems because of all the stress and strains they've been put through, and those families couldn't take on the burden of dealing with a foster care child with those issues, if they didn't have access to these programs.

So it's really filling the holes for folks who would otherwise fall through the cracks of programs we are already funding, but they can't connect to the programs.

Mr. OBEY. One last question.

We have a lot of concern in this society about abortion. We have a lot of political controversy about it. But I don't know of very many people, if any, who are thrilled by the idea of abortions.

We always look for ways that we can minimize the pressure on women to have an abortion.

How do you think these programs fit into that? Of what utility is a program like community service block grant, for instance, in taking the pressure off women, economically, to have an abortion and not carry their fetus to full term?

Mr. SPRIGGS. Well, even before that stage, many of the CAA agencies are the way in which family planning gets funneled, not family planning in that sense, but family planning in sense of encouraging marriage. This is where marriage counseling takes place, and that sort of thing.

So the route through which people could get help who might not otherwise have the money for getting that kind of counseling, that's how we funnel that money.

And at the local level, to provide the safety net that lets the women know that there would be access to child care, that there would be access to other support systems, that's how she knows that's going to take place.

So it's the existence of these programs that can reassure her that there will be help, that she won't be on her own, and that there will be services that could help her through the problem.

Mr. OBEY. Thank you. Just one other thing with respect to health care.

In Portage County, in the southern part of my district, the local CAP agency works with programs like the community service block grant in order to provide access to dental care for thousands of poor people who otherwise would have no ability to get it.

I've been told of several cases of people who have actually died because of dental problems that have gotten out of control.

So I think there are many indirect benefits for funding of programs like that, that aren't generally recognized.

Mr. Walsh, any other questions?

Mr. WALSH. No, thank you, Mr. Chairman.

Mr. OBEY. Anyone else?

[No response.]

Mr. OBEY. All right. Thank you all very much. It's a miracle we managed to finish before the next roll calls.

Thanks again.

Congresswoman Barbara Lee

LHHS Subcommittee Overview Hearing titled, "Opportunities Lost and Costs to Society: The Social and Economic Burden of Inadequate Education, Training and Workforce Development."

Tuesday, February 26, 2008

Questions for the Record

People of Color and Unemployment

I am concerned about the impact of the Administration budget on people of color in the United States. According to the Bureau of Labor Statistics, in January, the:

National unemployment rate was 4.9%
African American community 9.2% - almost double
Hispanic or Latino community 6.3%
Asian community 3.2%

1) What impact do you think the Administration budget will have on people of color in the United States?

Answer: The proposed cuts in Department of Education funds are likely to have a disproportionate effect on people of color. Many of the programs listed in your next question below, provide health, nutrition, education, and after school care to children from low income families. These children are disproportionately children of color. The proposed cuts are also likely to exacerbate the well-documented problem of educational achievement gaps between relatively poor and non-poor children.

Investments in Early Childhood Education Programs

Mr. Lynch, I am particularly interested in your testimony on the Benefits of Public Investment in Early Childhood Education Programs.

This morning, we held a LHHS hearing where I asked several questions of Secretary of Education Margaret Spellings about the severe cuts in programs that benefit our children and students. Her response, which was wholly and completely inadequate, was that it was a trade off and that the Administration wanted to make larger investments in larger programs. Basically, the smaller programs did not matter.

An analysis of the FY09 budget submission of the Department of Education reveals:

- Elimination of the Healthy Start program
- A 26% cut in the 21st Century Community Learning Centers (after school centers)

- Elimination of the advanced placement program
- A 66.1% cut in the Safe and Drug Free Schools State Grants
- Elimination of the Mentoring Programs
- Elimination of School Counselors under NCLB
- Elimination of Civic Education
- Elimination of Vocational Education State Grants

In addition the budget includes a 22.2% cut in funding for Hispanic Serving Institutions; and a 35.7% cut in funding for Historically Black Colleges.

1) What impact do you think the Department of Education FY 09 budget will have on our children and students in the US?

Answer: What we know from decades of careful research is that public investment in the health and education of our children, particularly young children, is one of the wisest investments our nation can make. Children who do not have access to good health and nutrition programs, high-quality school programs, and adequate care in after school programs do less well in school and in life after school. These children are more likely to require expensive remedial education, repeat a grade, suffer from child abuse and neglect, become teenage parents, drop out of school, and be engaged in juvenile crime. In terms of government budgets, these proposed cuts in the Department of Education are likely to be penny wise but pound foolish. That is, they may save us small amounts of money in the short-run but force us to expend much larger sums over time as we will have to spend more money on expensive remedial education, child welfare, and the juvenile justice system.

2) Do you think that these severe cuts in much needed education programs will impact our student's ability to move into higher education, compete, and get good jobs that will allow them a decent standard of living?

Answer: Children with inadequate access to good health and nutrition programs, high-quality school programs, and after school programs are more likely to drop out of school and less likely to graduate from high school and attend college. Once these children enter the labor force their employment rates and incomes will be lower, along with the taxes they will eventually pay back to society. As adults they will be more likely to engage in criminal activity. Thus, the consequence of inadequate public investment in education is more poverty and crime and a weaker, less globally competitive economy with less skilled workers earning lower incomes.

Living Wage

You are familiar with the term "living wage" – is that correct? *Yes.*
Possible definition:

> *A wage that sustains a standard of living: a wage that will allow a worker to support a family in reasonable comfort; or*
>
> *A wage sufficient to provide the necessities and comforts essential to an acceptable standard of living.*

1) What is your definition of a living wage?

Answer: A living wage is the amount a full-time worker would need to earn to support a family at or slightly above the federal poverty line. In other words, a living wage is roughly equal to what a full-year, full-time worker would need to earn to support a family of four at the poverty line ($20,650 a year, or about $9.90 an hour, in 2007). It may be reasonable to set a living wage rate equal to 130% of the poverty line, which is the maximum income a family can have and still be eligible for food stamps. The rationale behind these definitions of a living wage is that jobs should pay enough so that full-year, full-time workers and their families do not need government assistance to obtain the necessities and comforts essential to a life-style free of poverty.

2) Do you think that paying employees in the Unites States a living wage would be beneficial to the overall economy?

Answer: Yes, a living wage would provide several important benefits to the overall economy. A living wage would significantly reduce poverty and all of its negative attendant consequences such as poor health and crime. In addition, a living wage would improve the quality of life of millions of workers and their families, thereby promoting economic development. Finally, a living wage would reduce income inequality by helping to reverse the downward trend in wages for low-wage earners. Wages for the lowest-paid 10% of workers fell between 1979 and 2007. During the same time period the number of jobs in which wages were below what a worker would need to support a family of four above the poverty line grew.

Investing in People

It is clear to many of us on this committee that we as a nation reap huge dividends when we invest in our people, whether through workforce initiatives, healthcare or education programs. The money we invest at the federal level is repaid back many times over in terms of sustained economic growth.

It is also clear to many of us that our nation is at a critical juncture in history. We face many challenges as a nation in terms of globalization, outsourcing, and an aging population and infrastructure.

1) How then would you rate the Bush budget in terms of these two guiding criteria, and how would you differently allocate federal spending to get the best return on our investments to meet the future challenges we will face as a nation?

Answer: The Bush budget is failing to address our nation's long-run economic challenges. By under-investing in the health and education of our greatest asset, the American people, we fall short of maximizing the skills of our workforce thereby undermining our global economic competitiveness, and diminish our capacity to maintain the solvency of our public health care and retirement benefit programs such as Medicare, Medicaid, and Social Security. To get the best return on our public investments we should be spending more on high-quality early childhood education programs. In particular, we should enhance and extend federal programs such as Head Start and share in the cost of providing for state prekindergarten programs. Investments in high-quality prekindergarten programs are likely to generate benefits that eventually exceed the costs of the programs by margins of more than 12 to 1. Thus, the United States should be investing in high-quality early childhood education programs to improve the quality of life of millions of our children, make the workforce of the future more productive, strengthen the economy, reduce poverty, decrease crime, and provide future budget relief.

March 6, 2008

Responses to Questions from Rep. Barbara Lee

Harry J. Holzer

1. People of Color and Unemployment

I am concerned that the Bush Administration's budget proposals for FY 2009 might cause serious harm to people of color in the U.S.

The Administration calls for major cuts in programs at the Departments of Labor, Education and HHS. These programs serve lower-income people, among whom people of color are no doubt disproportionately represented. These include the cuts to WIA training, the Community Services and Social Services Block Grants, and Career and Technical Education by the states. Of course, many of these programs have already been slashed over the past seven years, especially after controlling for inflation and economic growth.

2. Living Wages

I have no particular definition of a "living wage." It is always tricky to define one, especially since what is necessary for a comfortable standard of living for a family will depend heavily on the size of the family, and on how many earners are in the family, and whether or not they work full-time or full-year.

In general, I would love to see everyone in the US earn a living wage. But I don't think this can be simply mandated by the government. Wage payments to workers have to be in line with the productivity that employers anticipate by hiring them. If employers perceive that at least some of these workers have might have insufficient productivity to justify these high wages, their employment rates might suffer accordingly.

To date, many cities and counties in the U.S. have passed living wage ordinances that cover municipal employees and those who work for companies receiving municipal contracts and/or financial assistance from municipalities. These ordinances generally cover very small numbers of people, and so their impacts might be positive but they are always very modest. If they were extended to cover many more workers, I would begin to worry about possible effects on employment or municipal services.

Having said this, I do favor modest or moderate increases in the federal minimum wage, along the lines of what was enacted into law in 2007.

3. Investing in People

I agree that, given the challenges we face as a nation over the coming years and decades (including globalization, offshoring, aging population and infrastructure, etc.), we should

be investing considerably more than we do in the productivity of our workers. Given the costs of low productivity to the US economy (as outlined in my testimony on 2/26/08), it is very costly to our economy when we fail to make such investments.

The Bush budget for FY 2009 fares very poorly in my judgment, according to these criteria. It shortchanges critical programs in education and job training that likely contribute to worker productivity, especially among the disadvantaged. It proposes many further cuts on top of those already administered over the past seven years and earlier.

If one believes that these programs are not cost-effective from a social point of view, then there might be some justification for cutting them. But many of the programs funded in the areas where cuts are proposed have been rigorously evaluated and are surprisingly cost-effective. In other cases we don't have sufficient evidence to make this judgment, but at a minimum funding should be maintained (or increased) while we generate more evidence of what does and doesn't work and then reallocate accordingly.

If it were up to me, I would spend considerably more on education and training in these budgets, with appropriate incentives for performance, and I would finance these increases either with somewhat reduced spending elsewhere in the budget or with higher taxes on our wealthiest Americans.

Congresswoman Barbara Lee

LHHS Subcommittee Overview Hearing titled, "Opportunities Lost and Costs to Society: The Social and Economic Burden of Inadequate Education, Training and Workforce Development."

Tuesday, February 26, 2008

Questions for the Record

Response by Thomas W. Rudin
Senior Vice President for Advocacy,
Government Relations & Development

The College Board
March 19, 2008

People of Color and Unemployment

I am concerned about the impact of the Administration budget on people of color in the United States. According to the Bureau of Labor Statistics, in January, the:

National unemployment rate was 4.9%
African American community 9.2% - almost double
Hispanic or Latino community 6.3%
Asian community 3.2%

1) **What impact do you think the Administration budget will have on people of color in the United States?**

Although the budget does propose some increased funding for programs such as the Advanced Placement Incentive Program (APIP)—which we believe would have considerable positive impact on students of color because of the program's focus on expanding access to AP courses in low-income communities—we are nevertheless concerned with proposed cuts to several programs, including:

- Aid to historically Black colleges and aid to Hispanic-serving institutions.
- Supplemental Educational Opportunity Grants and Perkins loans.
- The LEAP program.

The budget does propose increases in Pell Grants, although not as large as many people would wish. We are pleased with the increase for next year that was negotiated by the House, Senate and White House, but we definitely will be advocating for more Pell Grant funding in the future, because the overall purchasing power of the Pell Grant has declined over the past 20 years. For example, in 1986-87, the maximum Pell Grant covered 52 percent of average tuition and fees and room and board at public four-year colleges and universities, and 21 percent at the average private four-year institution. These figures had declined to 32 percent and 13 percent, respectively, by 2007-2008.

Proposed cuts in the Administration's budget for career and technical training at community colleges would also be likely to fall disproportionately on students of color, and this has the potential to negatively impact employment rates in the future.

Living Wage

You are familiar with the term "living wage" – is that correct?
Possible definition:

> ***A wage that sustains a standard of living: a wage that will allow a worker to support a family in reasonable comfort; or***
>
> ***A wage sufficient to provide the necessities and comforts essential to an acceptable standard of living.***

1) **What is your definition of a living wage?**

2) **Do you think that paying employees in the United States a living wage would be beneficial to the overall economy?**

This is a complicated issue on which the College Board does not take a formal position. We are in absolute agreement that all people should be paid a living wage according to the definitions you have outlined, and we are supportive of efforts to increase the minimum wage.

Investing in People

It is clear to many of us on this committee that we as a nation reap huge dividends when we invest in our people, whether through workforce initiatives, healthcare or education programs. The money we invest at the federal level is repaid back many times over in terms of sustained economic growth.

It is also clear to many of us that our nation is at a critical juncture in history. We face many challenges as a nation in terms of globalization, outsourcing, and an aging population and infrastructure.

1) **How then would you rate the Bush budget in terms of these two guiding criteria, and how would you differently allocate federal spending to get the best return on our investments to meet the future challenges we will face as a nation?**

The budget does acknowledge the need for increased federal support of higher education, advocating a higher Pell Grant maximum and maintaining TRIO and Gear Up. However, the Pell increase is funded at least partially by proposed elimination of other student aid programs, including SEOG and Perkins Loans. The Perkins career and technical education funding for community colleges is cut in the budget, although some other retraining money is proposed.

One proposal that sounds good (but would be unlikely to be very effective) is tax credits for 529 savings contributions for low- and moderate-income (not defined) parents. Of course, these citizens are unable to accumulate substantial savings, so the plan is not likely to be very helpful.

At the K-12 level, we would advocate strongly for increases in support for teacher professional development, dropout prevention, increased counseling services, and a commitment to more rigorous academic standards. In particular, the College Board is actively advocating in support of new funds for the following initiatives:

- Through a combination of federal, state and private funds, an immediate 15 to 20 percent hike in teachers' salaries (and rising to 50 percent in the foreseeable future), with provisions for an 11-month contract and a differential pay system based on teaching at the most challenging schools, shortages in specific disciplines, and outstanding teaching.
- Increased support for hiring new middle and high school level counselors, aimed at reducing the student-counselor ratio; and increased support for professional

development for counselors that focuses on creating a college-going culture in every school.

- Additional funding for teacher, counselor and principal professional development that focuses on increasing academic rigor in all classrooms and on providing the necessary support for students to excel in more rigorous environments.
- Increased support for community colleges, including a federal commitment to invest in new facilities (to be matched by states and local communities).

As noted in our testimony, we strongly believe that increased federal support should be considered for programs that increase college access and success for many more U.S. citizens. Students who attend institutions of higher education obtain a wide range of personal, financial, and other lifelong benefits; likewise, taxpayers and society as a whole derive a multitude of direct and indirect benefits when citizens have access to postsecondary education. Accordingly, uneven rates of participation in higher education across different segments of U.S. society should be a matter of urgent interest not only to the individuals directly affected, but also to public policymakers at the federal, state, and local levels.

Congresswoman Barbara Lee

LHHS Subcommittee Overview Hearing titled, "Opportunities Lost and Costs to Society: The Social and Economic Burden of Inadequate Education, Training and Workforce Development."

Tuesday, February 26, 2008

Questions for the Record – Responses from Dr. William Spriggs

People of Color and Unemployment

I am concerned about the impact of the Administration budget on people of color in the United States. According to the Bureau of Labor Statistics, in January, the:

National unemployment rate was 4.9%
African American community 9.2% - almost double
Hispanic or Latino community 6.3%
Asian community 3.2%

1) What impact do you think the Administration budget will have on people of color in the United States?

Given the difficulties in the labor market of the last two recessions, it would not be unreasonable to assume that the national unemployment rate will rise to the range of 6.3 to 6.7 percent. That would mean that the unemployment rate in the African American community would end up near 13 percent, and around 9 percent in the Hispanic community.

The Administration's budget, and the stimulus package, ignore the strain a prolonged weakness in the labor and housing market would play on state and local governments. Primarily, the strain will be felt deeply in the African American community with the limits states will be forced to take on the SCHIP and Medicaid programs that provide a very disproportionate share of health insurance for African American children. States will also be strained in supporting state colleges and universities and community colleges, which will put pressures on those schools to make up for lost revenues with higher tuition costs. Community colleges provide a disproportionate share of the education opportunities for African American students beyond high school.

The lack of extended unemployment benefits will greatly affect African Americans who tend to have longer spells of unemployment, and are more likely to exhaust regular unemployment benefits; particularly during a

recession, the African American unemployment rate is higher than the national average because it is harder for unemployed African Americans to find jobs. The unemployment rate for African Americans is stays at roughly twice the national unemployment rate regardless of educational attainment or job experience, so the gap is far more likely the cause of hiring discrimination than issues of less skill.

The current impasse on adequately addressing the housing crisis will also have a disproportionate impact on African American and Hispanic households. Both African American and Hispanic households have been disproportionately harmed by the sub-prime mortgage crisis, having continued to suffer discrimination in access to conventional home lending. Currently, African American homeownership has returned to its level of before the Bush Administration took office, and is likely to fall back to its level of the mid-1990s before this crisis ends, meaning this will be the largest loss of African American wealth since the Great Depression.

Living Wage

You are familiar with the term "living wage" – is that correct?
Possible definition:

A wage that sustains a standard of living: a wage that will allow a worker to support a family in reasonable comfort; or

A wage sufficient to provide the necessities and comforts essential to an acceptable standard of living.

Yes. A "living wage," as defined by many local ordinances, sets a wage for public contractors to pay their employees to insure that a full-time worker would be above the federal poverty line, sometimes as much as 30 percent above the poverty line.

A related concept is that of family budgets. Family budget guidelines examine local living costs to determine how much income it would take to provide moderately priced safe housing, quality day care, health insurance, food (based on the cost of preparing food at home for a family of four, as opposed to the base for the federal poverty threshold which was an emergency level food budget), transportation, basic living expenses (telephone service, clothes, personal care, banking fees, school supplies,etc.) and taxes. Family budgets are often twice the federal poverty line.

1) What is your definition of a living wage?

I think that employers should pay a wage that would at least let a full-time worker support a family of three above the federal poverty line.

2) Do you think that paying employees in the Unites States a living wage would be beneficial to the overall economy?

I think that it is essential that all employees in the United States have a wage floor to insure that a full-time worker can accept the responsibility to support their family. This will lower labor turnover rates among low-wage employers, it will stabilize low-wage neighborhoods and lead to greater employment opportunities in those neighborhoods as a result of small businesses that will be more sustainable in those neighborhoods, and greatly reduce child poverty rates. Higher wages for low-wage workers will lower public expenditures designed to support the consumption of low-wage workers—food stamps, housing subsidies, reduced and free lunch, etc.

Investing in People

It is clear to many of us on this committee that we as a nation reap huge dividends when we invest in our people, whether through workforce initiatives, healthcare or education programs. The money we invest at the federal level is repaid back many times over in terms of sustained economic growth.

It is also clear to many of us that our nation is at a critical juncture in history. We face many challenges as a nation in terms of globalization, outsourcing, and an aging population and infrastructure.

1) How then would you rate the Bush budget in terms of these two guiding criteria, and how would you differently allocate federal spending to get the best return on our investments to meet the future challenges we will face as a nation?

I think the Bush budget rates a failing grade for insuring that we have adequate investment in our people. It fails to recognize the people of America as a shared and common resource. When we have a large pool of skilled workers it allows American companies to grow easily without forcing wage inflation—simply bidding up the salaries of small number of higher skilled workers, and avoids the necessity to out-source jobs to find skilled workers. Education and training have positive externalities (benefits to society that are greater than those received by the individual), and as such, unless we intervene at the societal level to reduce costs of acquiring skills and training, we get individuals investing in less skill and education than would optimal for society. In a globally competitive world, this means that our investment level in education, skill and training must be at ever higher levels. For years, the United States could rest on having built a work force that almost universally had completed high school compared to most nations where universal elementary and secondary education were rare. But, today, that level of education is no longer unique to the United States. To get our previous relative advantage in maintaining a high

skilled work force we will have to extend our goal to having a work force that is almost universally college educated.

Generally speaking, the Bush budget under-invests in the United States, in skills and in physical infrastructure. I would not waste as much on tax cuts, which will lower national savings and investment, and put that money into higher investments in skills and infrastructure to keep America competitive.

WEDNESDAY, MARCH 5, 2008.

EXPANDING HEALTH CARE ACCESS

WITNESSES

JEANNE LAMBREW, PH.D., ASSOCIATE PROFESSOR OF PUBLIC AFFAIRS, UNIVERSITY OF TEXAS, AUSTIN, TEXAS

DEBORAH CHOLLET, PH.D., SENIOR FELLOW, MATHEMATICA POLICY RESEARCH

GREG NYCZ, EXECUTIVE DIRECTOR, FAMILY HEALTH CENTER OF MARSHFIELD INC.

RICHARD POPPER, EXECUTIVE DIRECTOR, MARYLAND HEALTH INSURANCE PLAN

Mr. OBEY. We are missing one witness, but I think we will get started anyway.

As I have noted several times before in these hearings, we are taking a lot of testimony. We will be having a lot of debate and discussion about where we ought to be putting our money in terms of programs under the jurisdiction of this Subcommittee, and that discussion usually takes place in terms of what does it cost to do this, what does it cost to do that, what does it cost to do that. We do not very often have a focus on what it costs not to A, B, or C, and that is basically what I want to get into today.

We have a lot of subjects before this Subcommittee. One of them that I am most interested in is the question of access to health care. I do not care about people's political theology. I do not care whether health care services are delivered at the local level, State level, Federal level. I do not care. I could care less if we have a system that is seen as largely a government-oriented system or a privately-oriented system.

What I care about is whether every blessed human being in this Country has access to the health care they need without sweating. So we have a number of witnesses here today, I think, who can walk us through the cost of not meeting these needs.

There is one other aspect that I would like to focus on, because I believe that regardless of what the rhetoric is in the Congress or in this town, I believe that whoever is elected president next time is going to have no choice but to deal with the question of universal health care, and if that is the case, then the question is since we do not have jurisdiction over that issue—but we do have responsibilities with respect to a large variety of health programs in this bill—the question is what efforts should we be focusing on, what programs should we be focusing on; what programs should we be expanding or changing in order to try to prepare the health care system for the day when we will have universal coverage and universal meaningful access.

So that is basically what I want to talk about today.

Before I call on our witnesses, let me simply ask Mr. Walsh for any comments he might have.

Mr. WALSH. Thank you, Mr. Chairman. Thank you for holding this hearing. I very much appreciate your comments regarding universal health insurance, universal access to health care. I think that you are right, I think whoever is the next president will need to deal with this in a realistic way during the campaign and as president, and I think it is a debate that the Country is ready for.

I very much appreciate the opportunity to hear from our witnesses today, all from the different perspectives on health care and access to health care. I think your views are very important to us in our consideration of this important issue.

I do note that Dr. Chollet has a degree from Maxwell School at Syracuse University, which is a great school. It is the number one school of citizenship and governance in the Country. My son has a degree from there also, for which I am very proud.

So we welcome you today and——

Mr. OBEY. What a case of rampant conflict of interest. [Laughter.]

Mr. WALSH. She was not my witness, Mr. Chairman, but I am delighted that she is here.

This is a key issue for us going forward, and we welcome your testimony and look forward to asking a few questions and delving into your expertise.

Thank you, Mr. Chairman.

Mr. OBEY. Thank you.

Dr. Jeanne Lambrew is a professor at the Lyndon B. Johnson School of Public Affairs at the University of Texas at Austin; Dr. Deborah Chollet is Senior Fellow at the Mathematica Policy Research; Mr. Greg Nycz—in the interest of full disclosure, I should confess that I have known Mr. Nycz for many years. I regard him as a good friend—he is Executive Director of the Family Health Center at Marshfield, Wisconsin; and we do not have him here yet, but I expect he will be here shortly, Richard Popper, Executive Director of the State of Maryland Health Insurance Plan.

So let me ask each of you—we will put your statements in the record—if you would summarize your statements, then we will get to the questioning.

I want to begin with you, Dr. Lambrew.

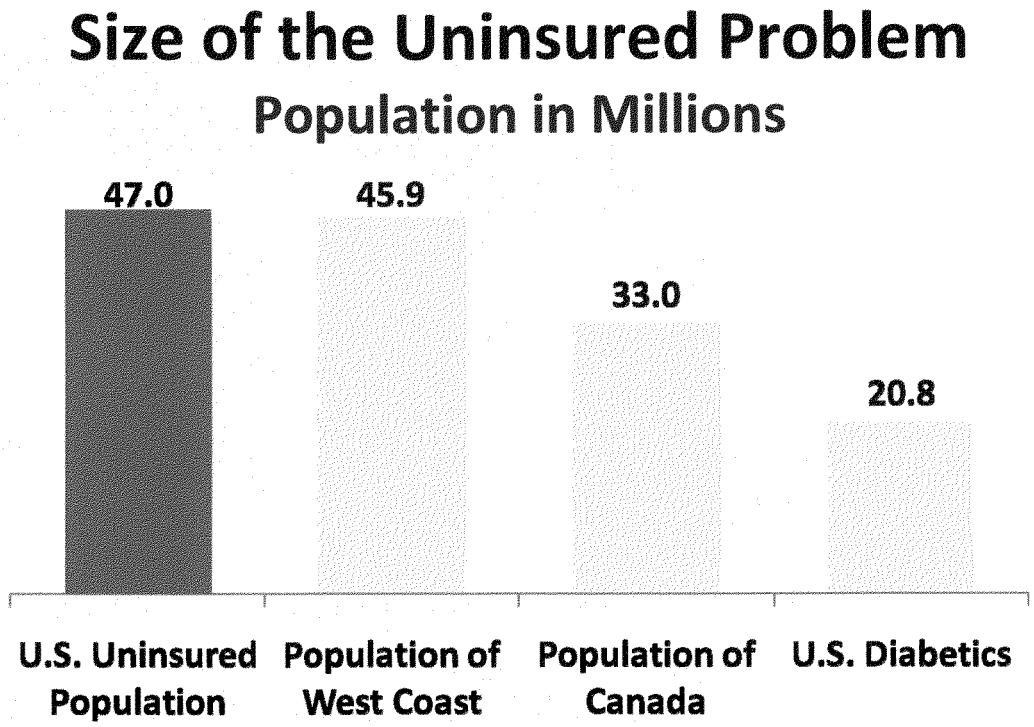
Ms. LAMBREW. Chairman Obey, Ranking Member Walsh, and other members of the Committee, I thank you for the opportunity to testify today on expanding access to health care. I do need to apologize; I lost my voice. I sound worse than I feel, but I will try to get through this. And I also have some figures I will be referring to that are in my submitted statement.

I also want to thank you for your contributions to improving the health of vulnerable Americans. Your jurisdiction over programs that have served as a literal lifeline to people have really made a difference, the access in our Nation, and I also think it is commendable that the way you are looking at the broader issues of health access today.

What I would like to do in my testimony is review the evidence that suggests that health reform should be at the top of the next Congress's agenda. I will do that by looking at a snapshot of the

system, looking at trends, reviewing the research and the implications of our broken systems. In addition, I will offer several observations about solutions that are being considered.

Figure 1



Source: Census Bureau 2007 Current Population Survey, CDC estimate of prevalence of diabetes in 2005

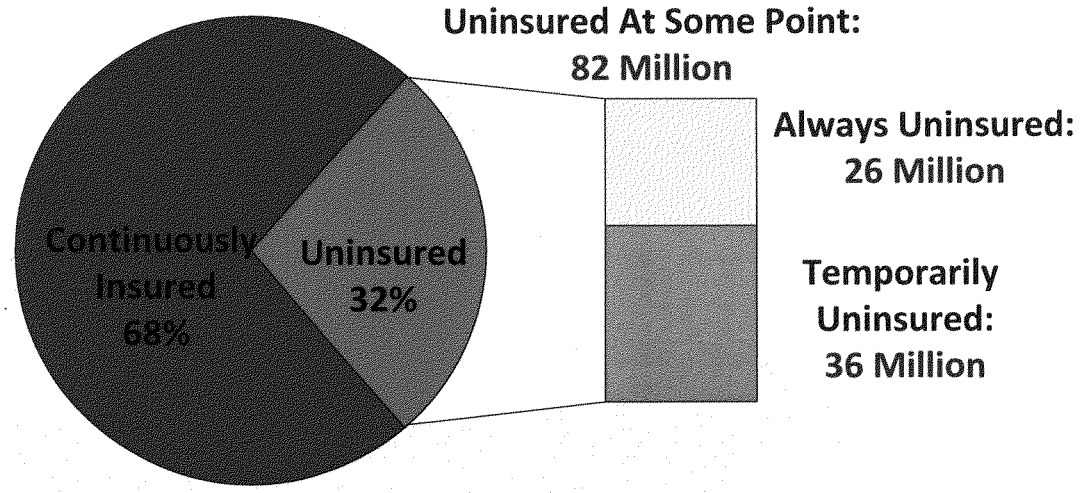
Ms. LAMBREW. But, to start with, nearly one in five of all Americans reports some sort of access problem, meaning that they cannot access health care because of cost. This largely results from lack of health insurance coverage. We have 47 million Americans who lack health insurance at a point in time, but to put this into perspective, as you can see in Figure 1 in the testimony, that is more than the whole population of the West Coast of the United States, it is more than the population of Canada, and it is double the number of people who have diabetes in this Nation. It is a large problem.

[The information follows:]

Figure 2

Health Care Coverage

Nearly One-Third Have Gap in Coverage, 2005-2005



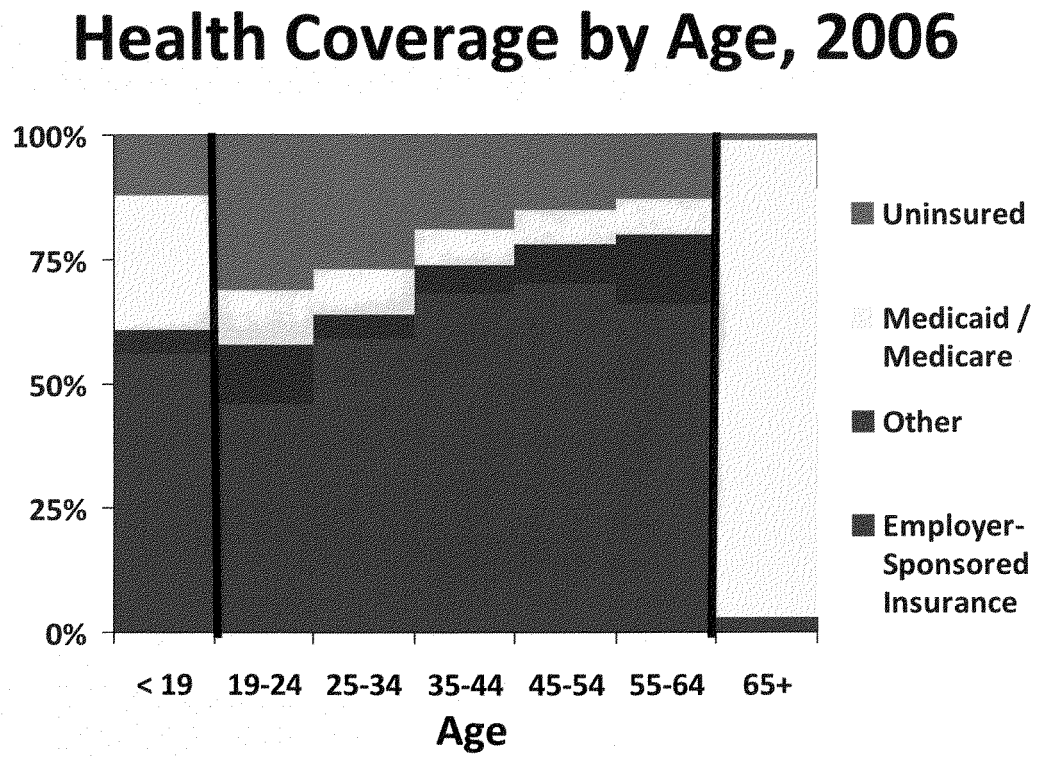
3

Source: Rhoades and Cohen. (August 2007). *The Long-Term Uninsured in America, 2002-2005.* U.S. DHHS, AHRQ, Statistical Brief #183.

Ms. LAMBREW. But even looking at those statistics is misleading and kind of understating the problem. As you can see in Figure 2, fully one out of three Americans, 82 million Americans, has some gap in coverage over the course of two years; and even having a small gap in coverage means a person behaves more like an uninsured person than an insured person in terms of their access patterns.

[The information follows:]

Figure 3



Source: Census Bureau 2007 Current Population Survey

Ms. LAMBREW. While it is a common problem, we also know that there are patterns among the uninsured. Age matters. When you look at Figure 3, which kind of shows your insurance status from age and the different types of insurance, we see that Medicare does provide universal coverage for our seniors. We have virtually no uninsured seniors. Look at the other end of the spectrum. We have very few uninsured children. Clearly, 9 million uninsured children is a lot, but the rate of uninsured children is less than that of any other non-elderly population.

Young adults have the highest uninsured rate, primarily because they are losing access to their family coverage and they experience significant work transitions. And then we see older adults who are not yet eligible for Medicare have a low uninsured rate, but they are at risk for all sorts of health problems and cannot easily access health coverage when they need it.

So we have age patterns. We also have work patterns. What we do know is that, contrary to popular perception, about four in five uninsured Americans are in working families. About 83 percent of people who have access to employer-based insurance enroll in it, but we see a lot of people who do not have access to employer-based coverage. Why is that? Part of it is because small firms are not likely to offer health insurance coverage. Only 45 percent of firms with fewer than 10 employees offer health insurance today.

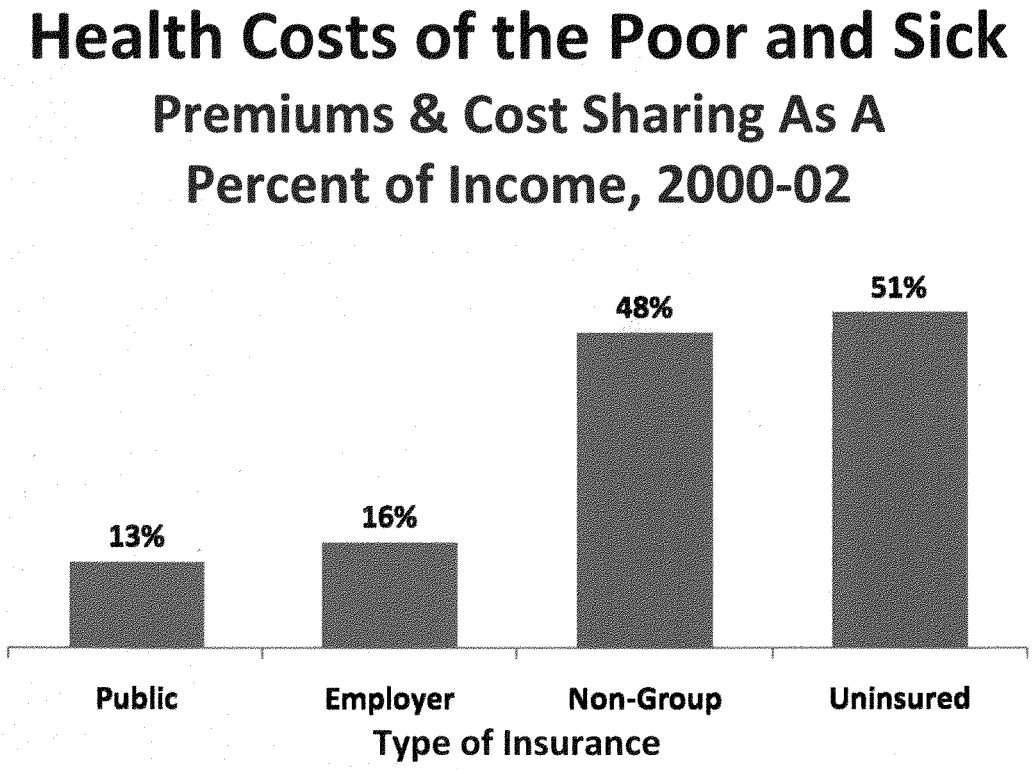
Firm type matters as well. As you can see in Figure 4, we have different patterns. Retail firms are much less likely to offer health insurance coverage than manufacturing or State or local governments.

In addition to work and the work patterns we see in our uninsured problem, we also have income patterns. About two-thirds of our uninsured Americans have income below 200 percent of the poverty threshold, which is about $21,000 for a family of four. Only about 36 percent of low income workers have ever even been offered health insurance, even though they are more likely to take it when they get it, and they have few affordable options in the individual market. So we all know income matters in our health insurance system.

But before I kind of turn to the trends, I do want to say un-insurance is one problem, but under-insurance is another one. Because the costs of premiums and health care cost sharing have risen faster than wage growth, we see that about 16 million people are under-insured, meaning they are paying a large fraction of their income out of their pocket even though they have a health insurance card. This is a big problem for personal bankruptcies. We know that in 2001 about half of all personal bankruptcies were caused by medical debt.

[The information follows:]

Figure 5

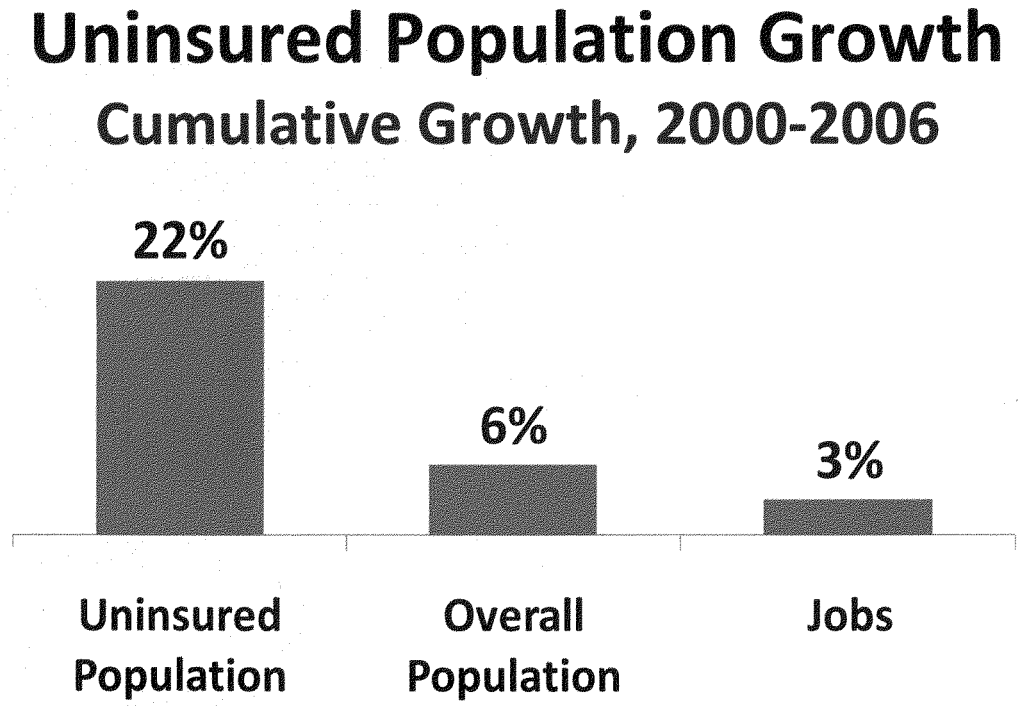


Source: Blumberg et al., Urban Institute, 2005

Ms. LAMBREW. In addition, when you look at Figure 5, you see that when we look at people who are in the individual market who have low income and high costs, they are paying as much out-of-pocket as uninsured people. Their health spending comprises about 50 percent of their income, which is pretty startling for somebody who actually has health insurance.

[The information follows:]

Figure 6



Source: Census Bureau, Bureau of Labor Statistics

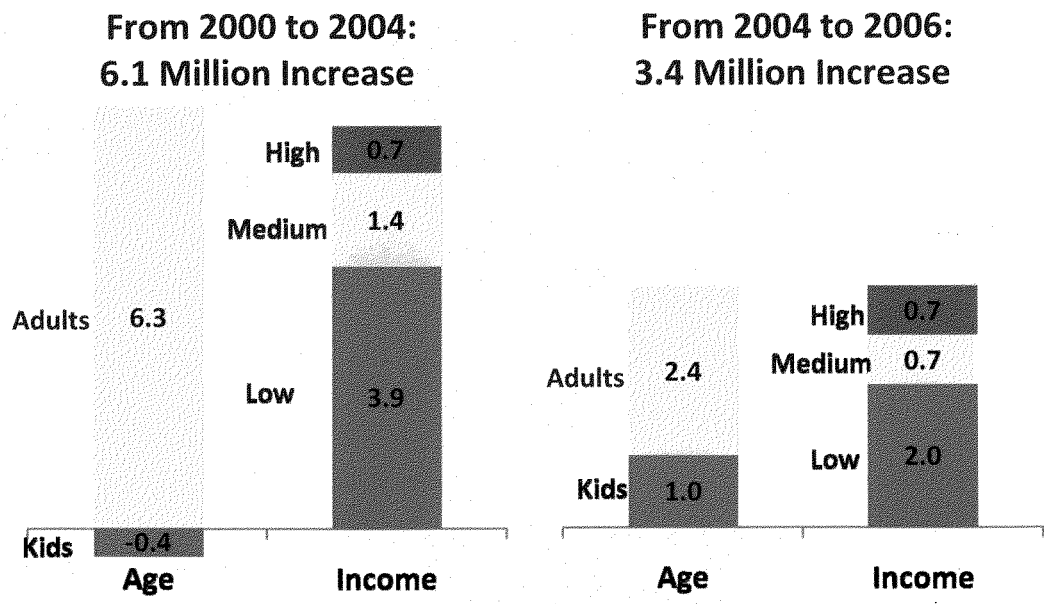
Ms. LAMBREW. So looking at these grim statistics, people wonder is it getting better or worse. Unfortunately, we see in Figure 6 that we have had a significant growth in our uninsured population. The number of uninsured Americans has growth at a rate that is three times that of population growth and seven times that of job growth.

We also have seen that the profile of the uninsured has changed recently. Almost all of our uninsured growth is amongst adults, not children, and that is thanks to the children's health insurance program and Medicaid that have served as a Safety Net.

[The information follows:]

Figure 7

Change in the Uninsured
By Age and Income (Millions)



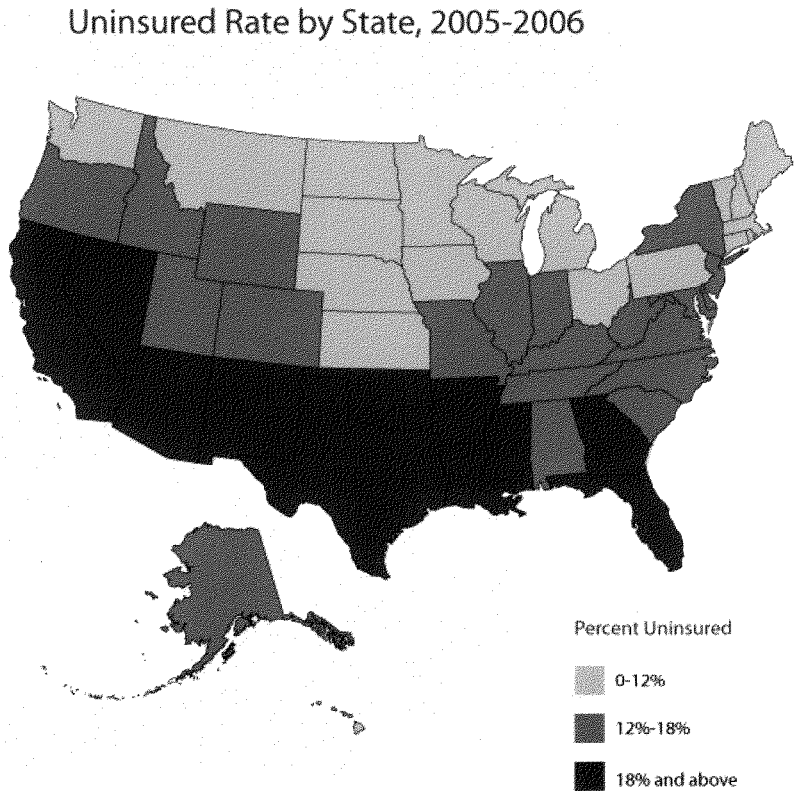
Source: Holahan and Cook, *Health Affairs,* February 2008

Ms. LAMBREW. In addition, we have seen the uninsured kind of creeping into the middle income distribution. When you look at Figure 7, you can see—and it is a little bit of a complicated chart—that we are seeing kind of constant growth of the uninsured amongst medium-and high-income people; was, the low-income population kind of ebbs and flows with the economy, depending on how we are doing. So we actually can anticipate, with the economic downturn, we will see more low-income uninsured, but t has been a steady erosion of coverage among middle-income Americans.

Why is this happening? We all know it is because employer coverage is declining. The rate of firms offering coverage has dropped from 69 percent to 60 percent just since the year 2000, more precipitous decline among small firms. This is because costs are climbing. Again, since the year 2000, we have seen premiums cumulatively increase by 98 percent; was, wages have only grown by 22 percent, eating away at our wage base as well as diminishing our employers' competitiveness.

[The information follows:]

Figure 10



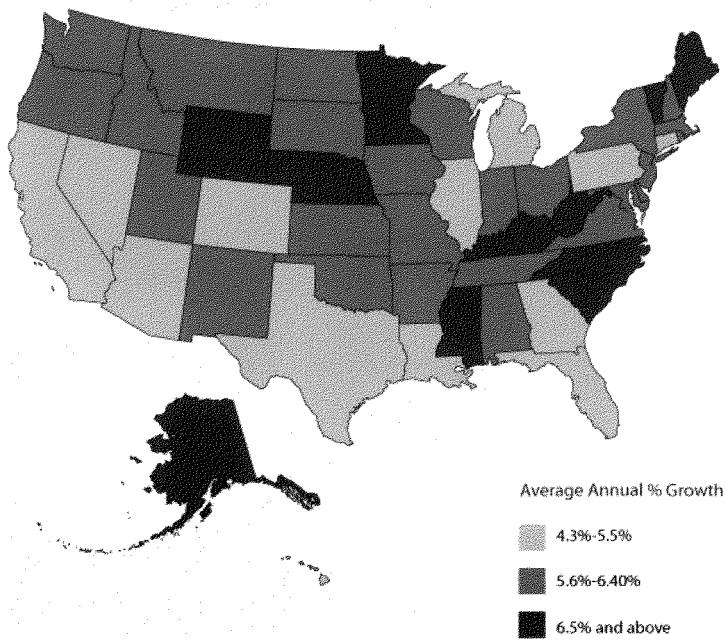
Source: Census Bureau as tabulated by Kaiser StateHealthFacts.org

Ms. LAMBREW. Looking at patterns across States, you see one State and we see patterns across all States, but the uninsured population is concentrated primarily among low-income States; not a surprise when health insurance is so expensive. So if you look at the map that we have shown you on Figure 10, what we see is we have lot of uninsured people in the South and Southwest. Being from Texas, we have the highest rate of uninsured in the Nation, and you can see it is partly because of the job structure: fewer manufacturing jobs, more service industry jobs, more part-time work.

[The information follows:]

Figure 12

Average Annual Growth in Health Spending Per Capita by State, 1991-2004



Source: Centers for Medicare and Medicaid Services data as tabulated by Kaiser StateHealthFacts.org

Ms. LAMBREW. In addition, we cannot correlate that with high health care costs. The next chart shows that we basically have different patterns for high health care spending. We have higher health care spending in the Northeast primarily, with a swath kind of in the middle part of the Country. How does that relate to things? We know that there are higher costs of living and higher aging populations in those States.

But it does not quite correlate with everything else we think. We do not have a good relationship between costs and quality. So, for example, even though you can see high costs areas in the Northeast, we do not necessarily see better outcomes in the Northeast. So we have a cost problem that is in a different place than our uninsured problem.

But if you look at the third map on Figure 12, what we see is that when we look at cost growth the whole Nation is affected. We really kind of see that every State has this problem of high health care cost growth, so the States that are low now are going to catch up to the other ones quite quickly.

Before talking about the consequences of these patterns, though, I have to say that racial variation is as important as geographic variation. We have large serious racial disparities in our coverage patterns so that we know that African-Americans are uninsured at a rate of 22 percent and Hispanics at a rate of 36 percent compared to 13 percent for white Americans. This contributes, but does not fully explain, why we have racial disparities in our health system.

Why do these statistics and trends matter? We know that being uninsured is associated with worse access. Uninsured people are 25 percent more likely to report delaying or foregoing needed care. We know that about 22,000 people die each year because of lack of health insurance. To put that into perspective, that is more than the number of homicide deaths in the U.S. in the same year. We also know it affects health and financial security; that it is a family problem, it is a business problem. We know it is an economic problem. Having these uninsured people diminishes our economic prosperity by $65,000,000,000 to $130,000,000,000 each year.

But I do want to say, as I think Chairman Obey indicated, that access to coverage is important, but it is not sufficient, because we do need to have high quality coverage and a Safety Net that makes sure that people can get access to the care that they need. We are lacking an adequate supply of primary care providers, as this Committee knows. For example, between 1997 and 2005, the number of medical school graduates entering family practice dropped by 50 percent.

We also have non-financial barriers to access that persists, anywhere from lack of information about when and how to access the system to subtle forms of discrimination that still pervade our system. So a health reform plan designed to improve access should start with expanding coverage and improving efficiency, but cannot end there. It really has to do more to succeed in promoting access to valuable health care.

I will end by just making three comments about the solutions that are out there. Clearly, we are hearing a lot about health reform in this particular presidential election, but I think it is also something that the Congress has consistently put on the table

every year, including members of this Committee. Rather than discussing these ideas in depth, I think there are three comments that I would make for each of these proposals.

One is that it is important to recognize we cannot address one without the other. We have to address the costs and quality of access problems simultaneously because, if we do not address costs, the access problems will persist.

Second, we really have to look at, probably, national solutions. States have and can provide us with frameworks and feasibility of different ideas and solutions. They really are responsible for local quality and kind of innovation. At the same time, we have to recognize the fact that we cannot construct an effective and efficient system State-by-State. There are different challenges that the States face, both structural—like balanced budget requirements—as well as challenges that Deborah Chollet will talk about. It also, going State-by-State, tolerates similar inequality. If we have more uninsured people in low-income States, by definition those low-income States cannot do much about them. So if we are really going to try tackling this problem, we have to do it nationally.

I will say, lastly, that in this time of debate—and I think, Chairman Obey, you said this at the start—we cannot let the perfect be the enemy of the good. There are solid ideas out there that can be crafted. I think we see a lot of commonality among some of the proposals that have been put on the table. But, most importantly, I think that the need for action is now.

So I will stop, and thank you again for the opportunity to testify.

[The information follows:]

Testimony

Hearing on Access to Health Care

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University of Texas at Austin

Senior Fellow
Center for American Progress

Before the

Subcommittee on Labor, Health and Human Services, and Related Issue
Committee on Appropriations
United States House of Representatives

March 5, 2007

I thank you for the opportunity to testify on expanding access to health care. This Subcommittee has jurisdiction over programs that have served as a literal lifeline for millions of Americans. These activities range from immunizing children to distributing AIDS drugs to placing health workers in underserved communities. Your interest in the broader context within which these programs operate is commendable and consistent with a record of advancing the nation's health.

The evidence suggests that health reform should be at the top of the policy agenda. In this testimony, I will review this evidence by offering a snapshot of the system, a description of key trends, and a review of the research on the implications of our broken health system. In addition, I will offer several observations on the solutions that are being debated.

But before doing so, I want to note that you are in good company in focusing on this challenge. Economists from the Congressional Budget Office (CBO), the Governmental Accountability Office, and most major think tanks agree on the imperative of tackling the health system problems. The Director of CBO recently noted, "No other single factor will exert as much influence over the federal government's long-term fiscal balance as the future growth rate of costs in the health care sector."[1] Addressing health costs requires addressing access, as another economist observed: "Covering nearly all Americans is a precondition for effective measures to limit overall health care spending."[2] This is echoed by business leaders ranging from the CEOs of General Motors to Wal-Mart and organizations from the Business Roundtable to the National Federation of Independent Businesses. Patient groups have picked up the refrain. For example, the American Cancer Society has dedicated its entire advertising budget this year to ads on the importance of coverage. And, public opinion is strong: addressing health care is a top, if not the top, domestic policy priority among voters.

Snapshot

Nearly one in five of all Americans reports needing health care but not being able to access it due to cost.[3] This largely results from lack of health insurance. About one in six Americans lacks health insurance at a point in time. To put this into perspective, 47 million uninsured Americans is double the number of people with diabetes. It is also more the number of people who live on the entire west cost of the United States or in Canada (Figure 1). This estimate does not capture the all the people affected by gaps in coverage. Looking over a two-year period, a government study found that 82 million – one-third – of all non-elderly Americans experienced a gap in coverage (Figure 2). Research suggests that access for people with short gaps in coverage is more similar to the long-term uninsured than insured population.

Even though the lack of coverage is common, certain populations are at greater risk of being uninsured than others. Health coverage varies by age (Figure 3). Medicare provides universal coverage for our nation's seniors, while Medicaid and the State Children's Health Insurance Program (SCHIP) have given children the second-lowest rate of uninsurance. Young adults have the highest uninsured rate, largely because they experience significant work and family transitions. While older adults have a relatively low uninsured rate, they face a different risk. They have less employer-sponsored insurance and greater difficulty accessing affordable insurance in the individual market.

Contrary to popular perceptions, about four in five uninsured are in working families. The majority of people with access to employer-based health insurance – 83 percent – enroll in it. However, this access to job-based health insurance depends on a number of factors. Only about 45 percent of firms with three to nine workers offer health benefits compared to 99 percent of those with 200 or more workers.[4] The type of firm affects is health benefits as well as its size. Firms in the retail industry are half as likely to offer health insurance as state and local governments (Figure 4). While manufacturers were one-third more likely to offer health benefits than service industry employers, service-providing industries are projected to generate approximately 15.7 million new jobs over the 2006 to 2016 period. Goods-producing industries are expected to experience overall job loss during this same period.[5] In addition, part-time and temporary workers are less likely to have job-based coverage. The uninsured rate among part-time workers – 29 percent in 2006 – was the same as that of non-workers.[6]

People's insurance status is related to their income. About two-thirds of the uninsured have income below 200 percent of the poverty threshold ($21,200 for a family of four in 2008).[7] Low-income workers are less likely to be offered health insurance. Only about 36 percent of low-wage firms (defined as having 35 percent or more of workers earning $21,000 or less annually) offered health benefits, nearly half the rate of firms with higher-wage workers.[8] Additionally, when offered it, low-wage workers are less likely to take it up. The alternative, purchasing coverage in the individual (i.e., non-group) market, is infrequently used by low-income people. Only from four to 11 percent of low-income people without access to job-based coverage or public programs purchase individual coverage.[9]

It is also important to recognize that "under"-insurance has become a serious problem along with uninsurance. The family share of premiums plus cost sharing have been rising faster than inflation, causing access problems for some. Researchers generally consider people under-insured when their health spending comprises a large fraction of their income (e.g., greater than 10 percent). One study found that 16 million Americans face serious medical costs even though they have insurance.[10] Half of all bankruptcies in 2001 were caused, in part, by medical debts, which averaged nearly $12,000. Three-fourths percent of those bankrupted by medical debt had health insurance at the start of their illness or injury.[11] In addition, a recent study that examined health spending for low-income and high-cost people found that people in the individual market spent as much on health care as a percent of their income as did the uninsured (Figure 5).[12]

Trends

These grim statistics result from several years of deteriorating access and climbing costs. Between 2000 and 2006, the number of uninsured Americans rose by six to seven million – at a pace three times that of population growth and seven times that of job growth (Figure 6). The uninsured rate today is higher than it was in 1993, the last time that the nation engaged in a debate over health reform. But, the profile of the uninsured population has changed. Until recently, all of the growth in the uninsured has occurred among non-elderly adults. Medicaid and SCHIP have decreased the rate of uninsured children in the last decade. In addition, the income distribution of the uninsured is shifting. During the recession from 2000 to 2004, the growth in the uninsured primarily grew among low-income Americans. However, from 2004 to

2006, this growth has occurred among higher-income Americans (Figure 7). This makes the problem harder to solve.

A main reason for the rise in the uninsured is the fall of employer-sponsored insurance. The proportion of firms offering health insurance dropped from 69 to 60 percent between 2000 and 2007, with even more rapid declines occurring among small businesses (Figure 8). The proportion of non-elderly Americans covered through employers declined from 67.8 to 63.0 percent between 2000 and 2006.[13] Dependent coverage has also been declining although public programs have prevented this from resulting in an increase in the rate of uninsured children. Workers with low-income have been particularly hard hit by the erosion of employer coverage. Between 2001 and 2005, employer-based coverage rates dropped from 37 to 30 percent among the poor and 59 to 52 percent among the near-poor.[14]

The deterioration of employer coverage is largely a response to the rapid rise in health costs. Since the year 2000, employer-based insurance premiums have cumulatively risen by 98 percent, five times higher than wage growth (Figure 9). If trends persist, health benefit costs of Fortune 500 companies could exceed their profits this year.[15] Health costs are a percent of our gross domestic product rose from 13.8 percent in 2000 to an estimated 16.6 percent this year. If trends persist, CBO estimates that the fraction of the economy dedicated to health spending will be 25 percent in 2025 and 49 percent in 2082.[16]

Differences Across States

Both the snapshot of health coverage and costs as well as the trends vary by state. There is no simple pattern to state variation. In general, states with lower-than-average income have higher-than-average uninsured rates (Figure 10). These tend to be concentrated in the south and west. Such states also tend to have more jobs in the service, agriculture, and other industries that are less likely to offer health benefits than manufacturing or government jobs. State resources, delivery systems, and political cultures also affect the uninsured rate. Some states invest in public hospitals and clinics while others use Medicaid and SCHIP to ensure access.

States with high uninsured rates are generally not those with high health care spending per capita (Figure 11). High spending is partly driven by underlying variation in the cost of living, which tends to be higher in the north east. It also reflects demographics; states with higher-than-average senior populations tend to have higher health spending per capita as well. However, research has documented that there is no strong correlation between cost and quality. In fact, there is some evidence that some outcomes in high-cost areas are worse than those in low-cost areas.[17] This point-in-time pattern on health care costs masks the breadth of the cost problem. High average annual growth in health costs extend to states across the country (Figure 12). Explanations for why some states have experienced spending growth that is even faster than the already-high national average are hard to find.

It is also important to look at variation within states to get an accurate picture of the coverage challenges. People who live in rural areas away from cities are less likely to have job-based insurance and more likely to have low income, explaining why their uninsured rate is significantly higher.[18] They also face physical barriers to care: access is impeded in areas with

few health care providers. Similar problems exist in certain urban areas. The increase in the uninsured has strained public hospitals and clinics. The same holds true for emergency departments in hospitals. Between 1994 and 2004, emergency department visits rose by 26 percent while the number of emergency departments dropped by 9 percent.[19]

Lastly, geographic variation pales in comparison to the racial variation in heath outcome and coverage. Compared to whites (12.6 percent), the uninsured rate for African Americans is nearly twice as high (21.8 percent) and for Hispanics is nearly three times as high (35.7 percent).[20] This contributes to – but doesn't fully explain – the lower use of prevention, delayed use of needed care, and worse outcomes for racial and ethnic minorities.[21]

Consequences

These statistics, trends, and patterns help describe the landscape for access to care in this country. They do little to explain why it matters. A decade's worth of research since the last health reform debate underscores the value of health coverage. Numerous studies have documented that being uninsured is associated with delayed prevention, low adherence to recommended care, and worse outcomes. For example, about 25 percent of uninsured adults report delaying or forgoing needed health care due to cost, five times higher than the rate among insured people.[22] Uninsured people who were injured or developed a chronic illness were less likely to receive initial and follow-up care, impeding recovery and accelerating the worsening of the condition.[23] One study found that the risk of death is typically 25 percent higher for uninsured versus insured patients. Roughly, 22,000 people die each year due to lack of coverage.[24] This is higher than number of people who died of homicide in 2006 (17,034).[25]

The health system problems affect financial as well as health security. As described earlier, rising costs and underinsurance diminish families' resources. Counting employer contributions, the typical person or family with employer coverage pays 12.3 to 15.1 percent of income on health care costs.[26] This also affects businesses that finance roughly a quarter of our health system. The "old-line" industries are struggling to maintain coverage; new industries and businesses are struggling to offer coverage in the first place. Health care costs are limiting firms' competitiveness domestically and globally. The coverage gaps also have implications for our economy. The Institute of Medicine estimated that the lost productivity of uninsured Americans costs our economy from $65 to $130 billion.[27]

It is important to note that coverage is necessary but not sufficient for access. The quality of the coverage matters: if it fails to cover a pre-existing condition or critical service, financial barriers will persist. An adequate supply of high-quality doctors, nurses and other providers matters as well. The nation faces a primary care shortage. For example, between 1997 and 2005 the number of medical school graduates entering family practice residencies dropped by 50 percent.[28] This decline is occurring in a country that already has a mal-distribution of health care resources. And other non-financial barriers to access persist, from lack of information about when and how to access the system to subtle forms of discrimination that perpetuate racial disparities. A health reform plan designed to improve access should start with expanding coverage and improving efficiency, but cannot end there if it is to succeed in promoting access to valuable health care.

Solutions

A wide range of visions and detailed plans have been developed to fix the broken health system. The 2008 election is likely to focus on some of them; others have been proposed in Congress and by Members of this Committee. With my colleagues at the Center for American Progress, I also have outlined a way to improve and expand health coverage.[29] But rather than discussing these ideas in depth, I would like to end by making three comments on approaches to reform.

The first is the importance of addressing the coverage and cost problems simultaneously. Coverage will continue to erode, even with expansions, if the cost of coverage continues its rapid increase. This is evident in the recent experience with children's health: some of the gains in kids' coverage have been lost due to the unrelenting cost increases that have eroded employer coverage as well as states' ability to Medicaid and SCHIP. The same is true in reverse: the unsustainable cost curve cannot be bent without ensuring coverage for all Americans. The United States spends nearly $500 billion more than peer nations, adjusting for wealth, in part due to its complexity.[30] Not only do we pay seven times more per capita on administrative costs as a result, but we pay "hidden taxes" from cost shifting. Some fraction of uncollected bills for care for the uninsured gets added to the bills for the insured. One analysis estimated that this added $922 to the premium for a privately-insured family in 2005.[31] Moreover, gaps in coverage limit the potential of policies to bend the growth curve in health costs. There is widespread, bipartisan agreement that improved prevention, chronic disease management, health information technology, and similar policies could reduce the nation's health costs. However, the full potential of these policies to realize savings may be constrained or even reversed if one-third of the population cycles in and out of insurance over the course of two years.[32]

Second, solutions must be national in scope. States can and should help develop the framework and feasibility of solutions. This Committee's creation and support of state planning grants has made a real difference in both local health systems and the national knowledge of how to make systemic change. But, an effective and efficient U.S. health system cannot be constructed one state at a time. States face structural barriers such as balanced budget requirements and ERISA that are formidable. And, a state-by-state approach tolerates inequity in the system. Poor states have more uninsured and can't afford to do much about it. And 50 separate reform efforts complicate our already complicated system and inhibit efforts to simplify it.

Third, the perfect should not be the enemy of the good. It would be hard to create a more irrational health care system than the one we have. Plans for a well-functioning system are, by definition, radical and have a role in the debate. However, when advocates of market-based solutions and single-payer systems put purism ahead of pragmatisms, we get gridlock. More of the same means that people die every day in the wealthiest nation on earth due to lack of financial access to care. The solution will, by necessity, be a hybrid: a mix of public and private coverage, and individual and employer responsibility. This is the framework we have seen from Republican governors and Democratic presidential candidates. It is what many Members of Congress have proposed. And, hopefully, it will be inherent in the legislation that you consider in the near future to address the health crisis in the United States.

Notes:

[1] P.R. Orszag, "Testimony: Growth in Health Care Costs," United States Senate Committee on the Budget, January 31, 2008.
[2] H. Aaron, "Budget Crisis, Entitlement Crisis, Health Care Financing Problem – Which Is It?" *Health Affairs*, 26(6): 1622-33, November / December 2007.
[3] National Center for Health Statistics, *Health, United States, 2007*. (Atlanta: Centers for Disease Control and Prevention, 2007).
[4] Kaiser Family Foundation & Health Research and Educational Trust. *Employer Health Benefits 2007 Annual Survey*. (Menlo Park, CA: Kaiser Family Foundation, 2007).
[5] Bureau of Labor Statistics, "Tomorrow's Jobs", in *Occupational Outlook Handbook (OOH), 2008-09 Edition*. (Washington, DC: U.S. Department of Commerce, 2007).
[6] Kaiser Family Foundation, *The Uninsured: A Primer, Key Facts about Americans without Health Insurance*. (Menlo Park, CA: Kaiser Family Foundation, October 2007).
[7] Kaiser Family Foundation, *The Uninsured: A Primer, Key Facts about Americans without Health Insurance*. (Menlo Park, CA: Kaiser Family Foundation, October 2007).
[8] Kaiser Family Foundation & Health Research and Educational Trust. *Employer Health Benefits 2007 Annual Survey*. (Menlo Park, CA: Kaiser Family Foundation, 2007).
[9] Kaiser Family Foundation, *How Non-Group Coverage Varies by Income*. (Menlo Park, CA: Kaiser Family Foundation, February 2008).
[10] C. Schoen et al., "Insured but Not Protected: How Many Adults are Underinsured?" *Health Affairs*, W5-289-302, June 14, 2005.
[11] D.U. Himmelstein et al., "Illness and Injury as Contributors to Bankruptcy," *Health Affairs*, Web Exclusive, W5-63-W5-73, February 2, 2005.
[12] L.J. Blumberg, L. Clemans-Cope, and F. Blavin, *Lowering Financial Burdens and Increasing Health Insurance Coverage for Those with High Medical Costs*. (Washington, DC: The Urban Institute, December 2005).
[13] J. Holahan and A. Cook, "The U.S. Economy and Changes in Health Insurance Coverage, 2000-2006," *Health Affairs*, Web Exclusive, w135-144, February 20, 2008.
[14] L. Clemans-Cope and B. Garrett, *Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation, 2001to 2005*. (Menlo Park, CA: Kaiser Family Foundation, December 2006)
[15] McKinsey. (September 2004). "Will Health Costs Eclipse Profits?" *McKinsey Quarterly* Chart Focus Newsletter.
[16] P.R. Orszag, "Testimony: Growth in Health Care Costs," United States Senate Committee on the Budget, January 31, 2008.
[17] Congressional Budget Office, *Geographic Variation in Health Care Spending*. (Washington, DC: CBO, 2008).
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Tuesday, March 4, 2008
2:00 p.m.
Hearing: Expanding Healthcare Access

Jeanne Lambrew

Jeanne M. Lambrew joined the Lyndon B. Johnson School of Public Affairs, University of Texas, faculty in the summer of 2007 as associate professor of public affairs. She conducts policy-relevant research on Medicare, Medicaid and the uninsured, and long-term care. Dr. Lambrew worked on health policy at the White House from 1997 through 2000 as the program associate director for health at the Office of Management and Budget and as the senior health analyst at the National Economic Council. In these positions, she worked on the creation and implementation of the Children's Health Insurance Program, development of the president's Medicare reform plan and long-term care initiative, and implementation and oversight of Medicaid and disability policies. Prior to serving at the White House, Dr. Lambrew was an assistant professor of public policy at Georgetown University and a special assistant coordinating Medicaid and state studies at the Department of Health and Human Services. Dr. Lambrew has her master's and doctoral degrees from the Department of Health Policy, School of Public Health, at the University of North Carolina at Chapel Hill.

Mr. OBEY. Dr. Chollet.

Ms. CHOLLET. Mr. Obey and members of the Committee, good morning and thank you for inviting me to testify this morning. I also commend you for your sincere interest in this topic and your concern about access to care for all Americans.

The Robert Wood Johnson Foundation State Coverage Initiatives issues each year a State of the State Report, and in the last year I think aptly said that for many States that are moving forward, the status quo is no longer an option. And it is no longer an option for the reasons that Dr. Lambrew indicated: Costs are out of control, coverage is eroding, access to care is impeded, and the impediments to access to care also reflect the quality of care and ultimately the cost of care. So this tangle of problems has become intolerable in virtually every State, but some States have begun to act on it.

You asked me to address the current and the planned State comprehensive access initiatives. My written testimony addresses the initiatives in four States—New York, Maine, Vermont, and Massachusetts. The planned initiatives in other States generally are variants on these. The States that are moving forward have taken pages from the books of these States and combined them in ways that are unique and still changing as we speak, as the legislatures continue to debate these questions either in regular session or in some States, like New Mexico, in special session. So those questions and the configuration of their initiatives is changing as we speak.

But I would like to go back to these four initiatives which have become the templates for reform in many States. While they have many details and they differ from each other, they have a few elements in common that I think are key.

The first is that each serves small group workers and individuals with income above the State's Medicaid and CHIP eligibility levels, but for whom conventional insurance is clearly unaffordable. Medicaid and CHIP stop in most States around 250 percent of poverty or less, and health care in most States is unaffordable below 300 percent of poverty, leaving a large gap of adults and children without access to insurance, especially if they are not offered insurance through an employer.

The second is each of these programs offers deep subsidies to these target populations in order to make health care affordable; not only to make the premium affordable, but in some States, depending on the configuration of the product, to make the out-of-pocket spending that Dr. Lambrew referred to also affordable.

The third is that each hopes to encourage small employers to continue to offer coverage, but none relies on this strategy. Each expects to serve large numbers of individuals as group coverage erodes, especially for low-wage workers. None of them anticipate that that erosion of coverage in the group market is going to stop any time soon, and, in fact, they all expect that it will ultimately play out to a dominantly individual health insurance market in their State, especially, as I said, for this target population of low wage workers.

And, finally, each offers a defined insurance product or set of products that compete in the commercial health insurance market

and, as a result, these programs anticipate that it would be entirely possible that they would become the dominant insurer for the segment of the population that they would serve, that is, individuals and small group workers.

There are some essential differences in this strategy and my written testimony goes through some of them in great detail or in significant detail.

One, the Healthy New York program is a reinsurance program; it is not a direct insurance program. It works with HMOs and picks up a portion of the costs—generally called a corridor reinsurance strategy—picks up a portion of their costs between $5,000 and $75,000 per worker or per enrollee per year, so that when the enrollee's premiums accumulate to $5,000, Healthy New York kicks in 90 percent of the cost at that point for each dollar spent, up to $75,000. Above $75,000, the carrier is expected to privately reinsure or otherwise retain the cost of that coverage.

Healthy New York is offered through HMOs in the State. HMOs are the predominant source of style of coverage in New York State, so the Healthy New York product is available in every community.

Maine operates the Dirigo Choice program, which serves small group workers and individual residents with incomes below 300 percent of poverty. Dirigo offers three comprehensive health insurance products, each with high deductibles, each, when not subsidized, is qualified for a health savings account. The enrollees below 300 percent of poverty are subsidized in two ways: their premium is bought down by the program so that they are paying an income-scaled premium; the deductible is bought down so that the deductible, that very high deductible, is income-scaled for enrollees below 300 percent of poverty; and the out-of-pocket limit is reduced to make both the premium and the uninsured expenditures in the plan more affordable to low income families and individuals.

Vermont operates a program called Catamount Health, which is a standard PPO product with a $250 deductible, relatively low. It subsidizes premiums for employees also below 300 percent of poverty. It is a little different from the other two programs in that it relies directly on an employer assessment—and I will come back to that issue because it relates to the ERISA question that has already come up.

Vermont is also, unlike the other programs, committed to considering an individual mandate requiring all of their residents to obtain and keep health insurance coverage if in fact the combination of the Catamount Health plan, outreach efforts to enroll eligible residents in Medicaid, and Dr. Dynasaur, their CHIP program, do not achieve 96 percent coverage by 2010. So they are on a track to reconsider the success of this program in just a couple of years.

Massachusetts has enacted arguably the Nation's most comprehensive set of reforms in 2006. Effective in 2007, Massachusetts now requires every resident to be insured. It blended its small group and individual market so that the products that are available to small groups are available to individuals at the same price. It established a connector to vet and market health insurance plans to individuals and small groups. Within the connector, it established Commonwealth Care, which is a program to subsidize in-

dividuals with income below 300 percent of poverty, to help them meet the mandate to obtain coverage.

Massachusetts, at the same time, expanded its Medicaid program so that all children at 300 percent of poverty are eligible for Medicaid. That means that the Commonwealth Care program is targeted to adults below 300 percent of poverty, while their Medicaid program picks up children.

It also assesses employers, like the Vermont program, to pay for each worker who is uninsured. But it is also, like the Catamount program, a very nominal assessment so as to not basically antagonize ERISA.

In addition, Massachusetts requires all employers with at least 11 employees to offer a Section 125 plan, sometimes called a cafeteria plan, to help individuals pay for health insurance with pre-tax dollars. That means that individuals who are offered an employer plan, many of whom, surprisingly, do not have access to a Section 125 plan, can begin to pay their contributions to care with pre-tax dollars, reducing the cost of their premiums by as much as a third.

In addition, individuals who do not have an offer of an employer-based plan can use their Section 125 plan to buy individual premiums through the Connector or elsewhere.

And, finally, Massachusetts focused on preserving the Safety Net, recognizing that this is a work in progress; and they combine and rationalize their streams of funding to support Safety Net providers in an uncompensated care trust.

You asked me to comment on whether the individual State programs, such as these programs, could build toward a national system ensuring access to care for every American, and I believe that they could. But not without a Federal vision and not without Federal leadership.

Every State that seeks to ensure access to coverage for all of its residents has to navigate a maze of Federal laws and regulations related to their Medicaid and CHIP programs; related to ERISA, which governs employer-sponsored health insurance benefits, both insured and self-insured in many ways; various provisions of the Internal Revenue Code that interact with other Federal laws; HIPAA, the Health Insurance Portability and Accountability Act, which governs small group coverage at the Federal level—at least sets out basic rules for small group coverage and some basic rules for individual coverage in the States as well. And the process of navigating these kinds of Federal rules and regulations is arduous. Every State that enacts comprehensive reform sets itself up, in effect, for a challenge based on one of these laws to either have their laws preempted or sets themselves up to somehow run afoul of Medicaid and CHIP regulations and risk loss of Federal funding for those programs.

Nevertheless, I believe that there is a very strong reason to pursue State-based systems of reform within a Federal vision, and that is largely because the States are closer to the problems of access and, therefore, State policy-makers can be more accountable to problems of access on an ongoing basis. In addition, the States have a long history of insurance market oversight and consumer protection, and that history really should be maintained and

strengthened with a national guarantee of access to coverage, not overruled or offset.

So, with those comments, I again thank you for the opportunity to testify and look forward to a further conversation.

[The information follows:]

STATE COMPREHENSIVE ACCESS INITIATIVES

Statement of
Deborah Chollet, Senior Fellow[1]
Mathematica Policy Research, Inc.
Washington, DC

Before the
Appropriations Committee
Subcommittee on Labor, Health and Human Services, Education and Related Agencies
U.S. House of Representatives

March 5, 2008

INTRODUCTION

The inability of low- and middle-income families to afford health insurance is a problem that is reaching crisis proportions. The symptoms of this fundamental problem are pervasive. They include steady erosion of group coverage among low-wage workers, weak and unstable individual insurance markets, growing numbers of uninsured and under-insured families, and growing reliance on SCHIP and Medicaid.

With only further deterioration of private coverage on the horizon, a number of states have designed and implemented new programs intended to support insurance coverage and to close gaps in coverage for low- and middle-income families. In the past several years, New York, Maine, Vermont, and Massachusetts have launched major new initiatives to help low-income and/or low-wage working families obtain coverage. These states join the ranks of states such as Minnesota, Oregon, and Washington, which for many years have funded programs for low-income adults who are ineligible for Medicaid or SCHIP.[2]

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[1] The opinions expressed here are solely those of the witness, and should not be attributed to Mathematica Policy Research, Inc., its Directors, Board, employees, or clients.

[2] Minnesota's program, MinnesotaCare, offers subsidized coverage to families with children up to 275 percent FPL under Medicaid and childless adults up to 175 percent FPL. MinnesotaCare receives federal Medicaid and SCHIP matching funds for qualified enrollees. However, coverage for adults without children with incomes between 75 percent and 175 percent FPL is entirely state-funded, and benefits for these enrollees are limited.

However, the newer generation of statewide reforms differs in significant ways from the earlier state programs, which were designed as alternatives to private coverage for adults whose incomes are too high for Medicaid but much too low to purchase individual coverage. Specifically, the newer generation of programs focuses on organizing private insurance markets for small groups and individuals as a precondition for subsidies.

At present, all of these programs coexist with struggling private markets for small group and individual coverage. But the programs in Maine and Massachusetts, especially, recognize that the new state-structured program could ultimately dominate these markets. As market leaders, these programs could gain the economic leverage necessary to constrain cost and improve quality, while offering a more stable system of coverage for individual residents and workers in small firms.

STATE INITIATIVES TO ORGANIZE AND SUPPORT MARKETS

New York. Operating since 2001, Healthy New York is a state program that provides comprehensive health benefits to more than 130,000 small-group enrollees, sole proprietors, and uninsured workers. Low-wage employers may buy Healthy New York coverage for all workers, regardless of income.[3] In addition, previously uninsured individuals and sole proprietors with family incomes less than 250 percent of the federal poverty level (FPL)—in 2008, $26,000 per year for single adults and $56,000 for families of four—are eligible to enroll, if they worked at some time in the past 12 months.

Widely regarded as a model for initiatives to expand private insurance, Healthy NY provides reinsurance as the means to reduce premiums: the state pays 90 percent of claims between $5,000 and $75,000 per year. Premiums averaged $204 per month for individual

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(continued)

Oregon operates the Family Health Insurance Assistance Program (FHIAP), which was created in 1997 with state-only dollars to address the needs of families who do not qualify for Medicaid or Medicare. In 2002, the program was included in the Oregon Health Plan 2 Waiver and began to receive federal matching funds. FHIAP provides a premium subsidy on a sliding scale to individuals (families and adults without children) with income below 185 percent FPL. FHIAP will pay employee contributions to group premiums if the enrollee is offered group insurance; otherwise FHIAP enrolls members in commercial individual coverage.

Washington operates Basic Health, which provides subsidized coverage to approximately 100,000 state residents with income below 200 percent FPL. Monthly premiums are based on family size, income, age, and health plan choice; subsidies are scaled to income. BH includes several small sub-programs, including a "financial sponsors" program that allows a third party to pay the BH premium, and an employer-sponsored program that allows employers to pay the BH premium. As of Fall 2006, about 28,000 BH enrollees had financial sponsors, and 250 BH enrollees were enrolled in the employer-sponsored program. BH is also available to foster parents and homecare agency workers or individual providers employed by clients of the state's Medicaid Aging and Disability program (Robert Wood Johnson Foundation's State Coverage Initiatives Program, http://www.statecoverage.net/profiles/washington.htm#other, accessed March 3, 2008).

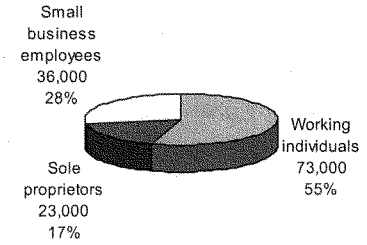
[3] Eligible small groups (with 2 to 50 employees) cannot have provided health insurance (or have contributed substantially to coverage if offered) for the last 12 months, and employers and must certify that at least 30 percent of employees are paid $36,500 or less. Qualifying employers must offer HNY coverage to all employees who make $36,500 or less per year and work 20 or more hours per week, pay at least half of single premium; at least 50 percent of employees must enroll in Healthy NY or have other coverage.

coverage in July 2006— well below market premiums.[4] All HMOs in New York State are required to offer the Healthy NY product, which includes inpatient and outpatient hospital, maternity coverage, physician services, laboratory, radiology, and preventive services—but excludes mental health, substance abuse, home health, physical therapy, and chiropractic services. Prescription drugs are covered with an optional rider.[5]

New York uses its tobacco settlement funds to finance Healthy NY. However, the cost of Healthy NY to the state has consistently been much lower than was initially anticipated. New York introduced the program in the context of its substantial regulation of the private insurance market—where both small group and individual coverage are continuously guaranteed issue and private carriers are required to use pure community rating (varying premiums only for geographic location and family size). These market rules ensure access to private coverage for residents with health problems and probably have mitigated adverse selection into Healthy NY. In 2006, 17 health plans offered 311 Healthy NY products to New York state residents.

FIGURE 1

HEALTHY NEW YORK ENROLLMENT, 2006



Source: EP&P Consulting, Report on the Healthy NY Program 2006 (January 2007).

Maine. Maine created the Dirigo Choice program to make a small group and individual insurance product more affordable by subsidizing low-income enrollees' premiums and deductibles. At the time the program was enacted in 2003, Maine had the nation's second highest employer premium costs, adjusted for the quality of benefits; the second-highest

[4] EP&P Consulting, Report on the Healthy NY Program 2006 (January 2007). Prepared for the State of New York Insurance Department (http://www.ins.state.ny.us/website2/hny/reports/hnyepp2006.pdf, accessed March 3, 2008).

[5] In 2006, the pharmacy benefit option had an annual maximum benefit of $3,000 per person, a $100 deductible, and copayments of $10 for generic drugs and $20 for brand name drugs, plus the difference in cost between generic and brand name drugs. In addition there was an inpatient hospital copayment of $500, 20 percent coinsurance (up to $200) for surgical services, and $20 copayment for physician visits and tests. EP&P Consulting, *Ibid.*

personal health care spending per capita in the country (behind Massachusetts and tied with New York); and extraordinary inflation in health insurance premiums.[6] Workers and families affiliated with small businesses and self-employed workers accounted for more than half of the state's uninsured residents.

Dirigo Choice is intended to offer a bridge between the private insurance market and MaineCare, the state's integrated Medicaid and SCHIP program. Eligibility for MaineCare was expanded to make include childless adults below the poverty level and low-income parents of children up to 200 percent FPL. Workers and dependents who enroll through a small employer may also enroll in MaineCare if they qualify; in these cases, MaineCare covers the enrollee's Dirigo Choice premium payments, deductibles, and other cost sharing, as well as MaineCare benefits that Dirigo Choice does not cover.[7]

Maine residents at any income level may enroll in Dirigo Choice, which now offers three benefit designs that differ in the level of the deductible. Those with family income below 300 percent FPL qualify for discounted premiums and deductibles, and also a lower out-of-pocket maximum. The discounts and out-of-pocket limits are based on a sliding scale relative to income. For workers and dependents enrolled through a small employer, only the employee share of the premium is discounted. Enrollees with family income at or above 300 percent FPL pay the full monthly premium (or the employee share if group-enrolled), deductible, and other cost sharing. Dirigo Choice products entail relatively high deductibles—$1,250, $1,750, and $2,500 for singles; and $2,500, $3,500, and $5,000 for families. All Dirigo Choice products are HSA-qualified when unsubsidized. Benefits are comprehensive, with no waiting period for preexisting conditions.

Currently, about 14,000 Mainers are enrolled in Dirigo Choice: 58 percent were uninsured (33 percent) or underinsured (25 percent) before enrolling.[8] About 700 small firms are enrolled in Dirigo Choice, averaging seven employees each; 43 percent had not previously offered health benefits to employees.

Unlike New York, Maine has struggled with funding for this program. The program's authorizing legislation requires it to prove that the Dirigo reform legislation has reduced medical costs—either as improved system efficiency or reduced uncompensated care—to warrant an assessment on carriers who, in turn, are expected to negotiate lower rates with providers consistent with lower medical cost. While the program has successfully made this case each year, carriers and health plan administrators continue to oppose this method of funding.

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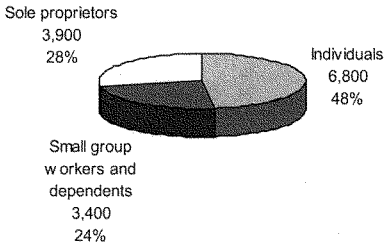
[6] Employers were acutely concerned about premium growth; average per member per year small group premiums increased 33 percent in 2001 and 29 percent in 2002. See: Debra J. Lipson, James M. Verdier, and Lynn Quincy (December 2007). Leading the Way? Maine's Initial Experience in Expanding Coverage through Dirigo Health Reforms. Mathematica Policy Research, Inc. (http://www.mathematica-mpr.com/publications/PDFs/dirigooverview.pdf, accessed March 3, 2008).

[7] Others—individuals and sole proprietors—who are eligible for MaineCare may not enroll in Dirigo Choice.

[8] Karynlee Harrington, Executive Director, Dirigo Health Agency. Personal communication, March 3, 2008.

FIGURE 2

DIRIGO CHOICE ENROLLMENT, JANUARY 2008



Source: Dirigo Health Agency.

Vermont. In May 2006, Vermont enacted Catamount Health, introducing a new health plan into the commercial market available only to residents who are uninsured. The benefit package resembles a standard Blue Cross Blue Shield PPO with a $250 deductible. Enrollment in Catamount Health began October 1, 2007.

The state subsidizes premiums and cost sharing on a sliding scale for Vermonters under 300 percent FPL. The program is financed through a combination of individual premiums, an assessment on employers, and new tobacco taxes. Assessments on employers are $1 per day for each worker not offered and eligible for group coverage and who is uninsured or has inadequate coverage. The first eight employees are exempt from the assessment in 2007 and 2008; the exemption will be reduced to six employees in 2009 and to four employees in 2010 and thereafter.

The legislation also offers premium assistance for workers and dependents who are eligible for Medicaid, SCHIP, or the Catamount Health Plan, and who have access to approved employer coverage.[9]

[9] The Catamount Health Plan is one part of a much larger piece of legislation that also sets out guiding principles for affordable access to care for all Vermont residents and guidelines for cost containment that focus on chronic disease prevention and effective management. The legislation also increased reimbursements for evaluation and management procedures (generally office visits) and for the care coordination program under Medicaid and the Vermont Health Access Plan (VHAP) for adults below 150 percent FPL. In addition, to the extent permitted, rates will be increased for Medicaid and other state program providers using the quality and performance measures developed in the Vermont Blueprint for Health. See: Robert Wood Johnson Foundation's State Coverage Initiatives Program (May 2006), Vermont Moves Toward Universal Coverage (http://www.statecoverage.net/stateside0506.htm, accessed March 3, 2008).

As in New York and Maine, insurance coverage in Vermont remains voluntary. Nevertheless, Vermont estimates that approximately 25,000 of the 60,000 uninsured persons in the state will enroll in Catamount Health. If Vermont does not reach its goal of 96 percent coverage by 2010, the state will consider enacting an individual mandate, requiring all residents to obtain coverage.

Massachusetts. In 2006, Massachusetts enacted arguably the most comprehensive set of health reforms in the nation. Implementation of the plan began in late 2006; by May 2007, more than 100,000 previously uninsured people had gained coverage. Massachusetts' plan has seven key components:[10]

- ***Individual Mandate***. All adults are required to purchase health insurance. The mandate is enforced through the state income tax.
- ***Employer Requirements***. Employers with 11 or more employees must provide health insurance coverage or pay a "fair share" contribution of $295 per full-time employee. These employers also must offer a Section 125 "cafeteria plan" permitting workers to purchase health care with pre-tax dollars. A Free Rider surcharge will be imposed on employers who do not provide health insurance and whose employees use free care.
- ***Commonwealth Health Insurance Connector***. A new Connector offers affordable, quality insurance products to small businesses and individuals. The Connector Board approved plans offered by seven of the state's health insurers that provide a range of coverage options, including a specially designed, lower-cost product for 19-26 year-olds.
- ***Commonwealth Care Health Insurance Program.*** Commonwealth Care provides sliding-scale subsidies to individuals with incomes up to 300 percent of the federal poverty level for the purchase of health insurance. Individuals with incomes less than 150 percent of the federal poverty pay no premiums. Commonwealth Care plans have no deductibles, and are offered by the managed care organizations that participate in the Medicaid program. As of January 11, 2008, 169,000 low-income adults had enrolled in Commonwealth Care plans.[11]
- ***MassHealth (Medicaid) Expansion***. Massachusetts extended Medicaid coverage to children up to 300 percent of the federal poverty level and raised Medicaid enrollment caps for adults. By February 2008, MassHealth enrollment had increased by 90,000.[12]

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[10] See: Kaiser Commission on the Medicaid and the Uninsured (June 2007), Massachusetts Health Care Reform Plan: An Update (http://www.kff.org/uninsured/upload/7494-02.pdf, accessed March 3, 2008).

[11] Doug Trapp (February 11, 2008), Massachusetts Health System Reform Feeling the Pinch, AMNews (http://www.ama-assn.org/amednews/2008/02/11/gvsb0211.htm, accessed March 3, 2008).

[12] *Ibid.*

- ***Insurance Market Reforms.*** Massachusetts merged its individual and small-group insurance markets—so that the same products and rates are available to individuals and to small groups. The cost of health insurance premiums for small employers was expected to increase by about 1.5 percent, with premiums for individuals falling 15 percent.
- ***Preservation of the Safety Net.*** The state's Uncompensated Care Pool, which reimburses providers for uncompensated care, is converted into a new Health Safety Net Trust Fund. The Health Safety Net Trust Fund combines Uncompensated Care Pool funds with other Medicaid funds, including Medicaid Disproportionate Share Hospital (DSH) funds. A new fee schedule will standardize provider reimbursements payable by the Fund. As more uninsured gain coverage and uncompensated care drops, funds will be shifted into the health insurance subsidy program.

While Massachusetts already has had signal success in enrolling previously uninsured residents in coverage, affordability remains an enormous challenge. In 2007, the state estimated that 20 percent of uninsured residents would be exempted from the individual mandate on the basis of the state's newly adopted affordability standards. Still, the Connector achieved extremely low premium increases for 2008: July 1 premiums for the lowest cost plan available through Commonwealth Choice for the average 37-year-old, uninsured Massachusetts resident are just five percent more than in 2007 ($194 per month, compared with $184 in 2007) and about half as much as premiums before the state's health care reforms (estimated at $335 for a 37-year-old individual, with much lower benefits).[13]

BUILDING TOWARD A NATIONAL SYSTEM

Coinciding with and following Massachusetts' enactment of sweeping reforms, a number of states embarked on serious discussion of similarly major efforts to improve access to coverage. With the leadership of their Governors, at least six states—California, Illinois, Minnesota, New Mexico, Pennsylvania, and Washington—debated major reform legislation, including (in New Mexico) an individual mandate. Proposals to develop a statewide program guaranteeing access to coverage for all residents were introduced and are pending in eleven states.[14]

However, the states face a number of significant obstacles in building a system of coverage for all residents—including a maze of federal laws and program rules that pose major risks for a preemptive challenge of their reforms, unintended tax consequences for residents, and/or loss of significant federal funding. States that would attempt to engineer major reforms to bolster

[13] See: Jon Kingsdale (February 15, 2008), About the Connector (http://www.mahealthconnector.org/portal/site/connector/menuitem.dc4d8f38fdd4b4535734db47e6468a0c?fiShown=default, accessed March 3, 2008.

[14] These states are: California, Delaware, Hawaii, Iowa, Maryland, Minnesota, Missouri, New Mexico, New York, Ohio, and Rhode Island. See: National Conference of State Legislatures (March 3, 2008), Health Reform Bills 2007-2008 (http://www.ncsl.org/programs/health/universalhealth2007.htm, accessed March 3, 2008).

employer-based coverage must navigate ERISA, COBRA, HIPAA and various provisions of the Internal Revenue Code (IRC) that govern the tax-qualification of employer-sponsored coverage.

States that would build a broader system of individual coverage must confront the possible loss of significant tax preferences for employer-based coverage. Massachusetts' reform—requiring employers with at least 11 employees to offer a Section 125 plan to fund individual coverage if the employer does not otherwise offer group coverage—must run a gauntlet of federal rules that if not carefully heeded could cause significant unintended tax consequences for employers and employees.

States that might wish to follow the example of New York, Maine, Vermont, and Massachusetts may not have nearly as strong a base of Medicaid and SCHIP eligibility in place. Not only do these states confront the prospect of less federal funding to support coverage expansions, they view future federal funding of even their current programs to be at serious risk.

Finally, many states fear the implications of action when neighboring states—many with major population centers spanning their borders—may do nothing. These fears variously include in-migration of people in need of affordable health insurance coverage and out-migration of employers seeking to avoid any role in sponsoring or financing coverage. Many also fear the exit of insurance carriers that view state efforts to expand coverage as competition, an unwarranted governmental intrusion, or both.

The federal government's exclusive oversight of employer-sponsored health plans as well as its role as the source of funding for the states' largest public insurance programs—Medicaid and SCHIP—already bind the states in a loose federal structure of health care financing. However, for the past forty years, the federal government has given to the states broad authority both to develop their Medicaid and SCHIP programs, and subsequently also to comply with federal HIPAA rules governing private insurance in ways that fit their unique circumstances and resources. Consequently, the states—which are closest to the day-to-day problems of failed access—have become responsible for developing a more comprehensive approach to ensure access, but in general have neither a clear scope of authority nor the resources to do so.

With few if any exceptions, building state reforms to a national system will require federal leadership—both to define the vision of a national system and to coordinate federal rules and regulations that conflict with that vision. But there are strong reasons to locate important details of major reform at the state level—including the more immediate accountability of state officials to consumers and providers, and the states' long experience with insurance market oversight and consumer protection.

To build state efforts toward a national system, at least four areas of federal law would need scrutiny and potential change to be consistent with a national system guaranteeing all Americans access to affordable coverage:

- **ERISA**. The limits of ERISA, which protects employer-sponsored plans from state regulation, should be clarified. This would include, but would not be limited to, clarification of the states' authority to develop "pay or play" rules, which assess employers that do not provide health coverage for their workers in order to fund public coverage.

- **HIPAA**. Minimum insurance rules should be established to make good on HIPAA's promise of access to coverage regardless of health status. These might include continuous guaranteed issue and community rating of individual coverage, as well as specification of permitted rating factors and potentially also limits on rate variation. Confronted with such rules, many states would need to consider designing more comprehensive management of their individual health insurance market and might also require individuals to maintain coverage—such as Massachusetts already has done and other states are considering.

- **IRC**. Federal tax provisions that disadvantage the purchase of individual coverage should be revised, particularly in the context of new federal rules that would govern insurance rating and issue of coverage. In addition, federal rules regarding use of Section 125 plans to purchase "creditable" individual coverage should be clarified to minimize the risk of inadvertent tax consequences for employers and workers.

- **Medicaid and SCHIP**. Categorical eligibility rules should be eliminated, and federal funding should be rationalized and extended to assist families that cannot reasonably afford private health insurance. Consistent with supporting continuous coverage, crowd-out rules—which presume extended gaps in coverage, requiring low-income adults and children to be uninsured in order to obtain affordable public coverage—should be modified or eliminated.

With a consistent vision of continuous access to coverage and leadership at the federal level, the states can be expected to follow through, developing real systems of coverage that would be fairer to consumers and insurers and also more stable as group coverage continues to change with the economy and the nature of employment.

MATHEMATICA
Policy Research, Inc.

DEBORAH J. CHOLLET

SENIOR FELLOW

EDUCATION

1979	Ph.D., Economics, Maxwell School of Citizenship and Public Affairs, Syracuse University
1972	B.S., Economics, University of Missouri at St. Louis

POSITIONS

2000 -	Senior Fellow, Mathematica Policy Research, Inc.
1994 - 2000	Vice President, Alpha Center, Washington, DC
1990 - 1994	Georgia State University, Atlanta, GA
1992 - 1994	Director, Center for Risk Management and Insurance Research, and Associate Professor, Risk Management and Insurance
1990 - 1992	Associate Director, Center for Risk Management and Insurance Research, and Associate Professor, Risk Management and Insurance
1989 - 1990	Executive Director, Advisory Council on Social Security, U.S. Department of Health and Human Services, Washington, DC
1982 - 1990	Senior Research Associate, Employee Benefit Research Institute, Washington, DC
1980 - 1981	Senior Research Fellow, National Center for Health Services Research, U.S. Department of Health and Human Services, Rockville, MD
1977 - 1980	Assistant Professor of Economics, Temple University, Philadelphia, PA

EXPERIENCE

MATHEMATICA POLICY RESEARCH

Project Director and Principal Investigator, Health Insurance Exchange Study (2007 -). Direct this project to assess the potential impacts of a proposed statewide health insurance exchange that would serve the individual and small group markets in Minnesota. Mathematica Policy Research, Inc. (MPR) will provide technical assistance to the Minnesota Commissioner of Health to identify alternative designs for the exchange; anticipate legal, administrative, and operational issues associated with each alternative; and identify administrative and operational issues that employers would face in establishing Section 125 plans for their workers. In addition, MPR will estimate participation and cost savings to participants, as well as other potential major impacts. Finally, MPR will estimate the cost of operating the exchange and identify options for financing those costs.

Use or disclosure of data contained on this page is subject to the restriction on the title page of this proposal.

Mr. OBEY. Thank you. Mr. Nycz.

Mr. NYCZ. Chairman Obey, Ranking Member Walsh and other members of the Subcommittee, we heard kind of an excellent national review and an overview of what is going on in the States. I want to take you down into the trenches in terms of what is happening in community health centers in delivering care directly to people.

Our community health center is located in North Central Wisconsin. We cover about 8700 square miles of territory and we provide medical, mental health, oral health, and pharmaceutical services to approximately 50,000 low-income people in our State.

On behalf of our patients, volunteers, and board members, the staff of more than 1100 community health centers nationwide, I would like to thank you for the trust you have placed in the community health center programs to help us help people and return real value to the taxpayer and the health care system.

This Subcommittee has put in place a primary health care infrastructure that each year touches the lives of over 17 million Americans, and I hope you are justly proud of that work, because it means a ton in our communities. With your help, we are capable of expanding this system of care to reach 30 million Americans by 2015.

In the coming health care debate, policy-makers and advocates must focus not only on providing everyone insurance, but on building and strengthening the critical infrastructure needed to put that insurance to use in our rural and inner city communities.

I want to share three specific examples that demonstrate the importance of the investment you make in community health centers and why strengthening that infrastructure must be a critical component of any health care reform proposal.

Those of you from rural States understand the difficulties many smaller, more isolated communities have in recruiting and retaining physicians, let alone dentists, mental health providers, and pharmacists. In partnership with their communities, community health centers are solving these problems while providing vital health care services and badly needed economic boosts for their communities.

A number of years ago there was talk of de-funding Northern Health Centers, which serves Northeastern Wisconsin. It is a predominantly very pretty part of the State. The concern was that they were a small center and they had perennial problems with provider vacancies. I volunteered to help them. At a meeting with Federal officials, a young man from the community made this point: "I have a master's degree, I have a great job with the school system, and I have great insurance, but on a snowy winter night, when my wife and I were awakened by our sick child, we realized we had lost something very special: access to health care." With slippery roads and the nearest hospital 45 miles away, they anguished over what to do. He said, in the past we could call the health center and a provider would meet them down at the health center and take care of their child. He said he wanted his health center back. And so did over 5,000 rural residents who signed a petition circulated throughout the area.

The point made was if not the health center program, then who would help their community? With a show of strong local support, the Federal representatives answered the call. They did not fund the health center. The community rallied under the leadership of that same well-insured individual. They built a new facility and today they are looking at their second expansion in the face of unprecedented demand for dental and other primary care services.

Those of you who represent urban areas may have noticed in your districts what we are experiencing in Milwaukee: health care infrastructure tends to flow, over time, out of the inner cities and into more affluent locations, leaving some neighborhoods lacking basic primary care. The result: people gravitate to hospital emergency rooms for their care.

The Milwaukee community is responding by creating the Milwaukee Health Care Partnership. The partnership has brought together the major health care systems, the community health care centers in the city, and county and State governments. They are developing a comprehensive plan to deal with the uninsured. Key among those plans are growing the inner city's primary care infrastructure with an initial focus on Milwaukee's community health centers.

Like many States, Wisconsin has increased its investment in health centers. These investments help to further leverage the continued growth in the Federal community health center program made possible by this Subcommittee, making a big difference in the lives of inner city residents and helping to improve the efficiency of our health care system.

Finally, I would like to pose a simple, but important, question. What happens when you open a new dental clinic in Wisconsin, a clinic that takes all based on need, not ability to pay, and a clinic that provides a sliding fee for those with limited financial means?

In June of last year, we opened our third dental clinic in Chippewa Falls. In the first six and a half months, we treated over 5,800 patients. Our patients came from 42 of Wisconsin's 72 counties, often driving hours to get to our clinic. We have never advertised this clinic, our marketing budget is zero, and as of today we are booked out through May.

This map over here illustrates how far poor people need to travel to get dental services. And for those of you who are not familiar with the State, you can see in the far southeastern part of the State that we have had people from Milwaukee and Kenosha come to our health center in Chippewa Falls. That is 250 to 300 miles distant. Green Bay—which many of you may know where that is—that is 190 miles distant.

Think about how far you folks have had to travel for your last dental checkup and think about the difficulties that many of these poor folks face trying to get dental services.

So why do our largely poor patients travel so far? The answer is simple, it is pain. It is unrelenting oral pain. They have no access. In Wisconsin, 20,000 people per year go to emergency rooms because of non-traumatic oral pain. We do not know how many more show up in urgent care centers or in physician offices. They get antibiotics and they get pain medicine; they do not get treatment.

This year we will provide dental services to over 25,000 patients in need. Still, over half a million low-income people in our State lack access today.

I would like to share just one example of how oral health and general health are connected, and the importance of your investments in health centers.

A diabetic patient presented as jaundiced and very ill, and this was at one of our dental centers. He had a large lesion on his leg for the past four years that would not heal. He also had severe oral health disease. Following a full mouth extraction and dentures, he reports his blood glucoses are under control, he has good skin color, his skin lesion finally healed, and he is very happy.

You are called upon to make tough choices with limited resources. Health centers return real value to people all across this great country of ours. Health centers also return real value to the taxpayers of this country. We are grateful for the investments you have made in our system of care, yet, we can and should do more. We are prepared to do with your help.

Thank you.

[The information follows:]

Testimony of Mr. Greg Nycz
Executive Director, Family Health Center of Marshfield, Inc.
Before the House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
Wednesday, March 5, from 10:00am - 12:00pm
Room 2358 of the Rayburn House Office Building

Introduction

Chairman Obey, Ranking Member Walsh, and Members of the House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies:

My name is Greg Nycz. I am the Executive Director of a federally and state funded community health center located in north central Wisconsin. Our center provides medical, mental health, oral health and pharmaceutical services to approximately 50,000 low-income residents of our State.

On behalf of the patients, volunteer board members, and staff of the more than 1,100 community health center organizations nationwide, I thank you for the trust you've placed in us to help improve people's lives and return real value to the taxpayer and the health care system. Decisions made by this Subcommittee and by many state legislatures across the nation have put in place a primary health care infrastructure that each year touches the lives of over 17 million Americans. With your help we are capable of expanding this system of care to reach 30 million Americans by 2015.

About Community Health Centers

Over more than forty years, the Health Centers program has grown from a small demonstration project providing desperately needed primary care services in two underserved communities to one of the fundamental elements of our nation's health care safety net. Funding was approved in 1965 for the first two Neighborhood Health Center demonstration projects, one in Boston, Massachusetts, and the other in Mound Bayou, Mississippi.

Today, health centers serve as the primary health care safety net in thousands of communities across the country and, thanks to the work of the Subcommittee, the federal grant program enables more low-income and uninsured patients to receive care each year. Health centers currently serve as the family doctor and health care home for one in eight uninsured individuals, and one in every five low-income children. Health centers are helping thousands of communities address a range of increasing (and increasingly costly) health problems, including prenatal and infant health development, chronic illnesses including diabetes and asthma, mental health, substance addiction, oral health, domestic violence and HIV/AIDS.

Federal law requires that every health center be governed by a community board with a patient majority—a true patient democracy. Health centers are required to be located in a federally designated Medically Underserved Area (MUA), and must provide a package of comprehensive primary care services to anyone who comes in the door, regardless of their ability to pay. Because of these characteristics, the insurance status of health center patients differs dramatically from other primary care providers. As a result, the role of public dollars is substantial. Federal grant dollars, which make up roughly twenty-two percent of health centers' operating revenues, are intended to cover the costs of serving uninsured patients; just over 40% of revenues are from reimbursement through federal insurance programs, principally Medicare and Medicaid. The balance of the revenues are from State and community partnerships, privately insured individuals, and low-income uninsured patient's sliding-fee payments.

The Health Centers program is administered by the Bureau of Primary Health Care (BPHC) at the Health Resources and Services Administration (HRSA), within the U.S. Department of Health and Human Services (HHS).

Funding Background

Health centers nationwide greatly appreciate that the Subcommittee has approved substantial funding increases for the Health Centers program over the past several years, the result of which has been a broad expansion effort enabling health centers to serve many of those that remain underserved in our country. Since 2001, this Subcommittee has nearly doubled its investment in

the Health Centers program. In that time more than 2,500 new health center sites have been created, and more than 7 million new underserved patients have gained access to care in a health center. In addition to the overall funding increase, the Subcommittee has provided specific increases in funding to stabilize existing centers through base grant adjustments. This balance between stabilization and expansion is a crucially important characteristic of Congressional support for health centers, and I urge that it continue.

The Health Centers program has succeeded in expanding access to primary and preventive care services in underserved communities across the country. The Office of Management and Budget (OMB) rated the Health Centers program as one of the top 10 federal programs, and the best competitive grant program within all of HHS. The Government Accountability Office (GAO) has credited the program with success and recommended further expansion. The Institute of Medicine (IOM) has recommended Health Centers as the model for reforming the delivery of primary health care.

Yet despite this record expansion, hundreds of communities have submitted applications since FY 2002 that received high ratings, but could not be funded due to lack of funds. There is clearly a tremendous need and a tremendous desire to expand health center services to new communities. With additional resources, health centers stand ready to provide low-cost, highly effective care to millions more uninsured and underserved individuals and families.

An investment of an additional **$248 million** in the Health Centers program in Fiscal Year 2009 could expand this system of care to 1.8 million new patients, according to a recent study by the George Washington University Department of Health Policy. Carving out one quarter of that increase - **$62 million** – for base grant adjustments for existing health centers would ensure that these centers can keep pace with rising health care costs and rising numbers of underserved patients. This level of funding in FY2009 also keeps the Health Centers program nationally on a path to our collective goal of reaching 30 million patients by 2015.

The Need for Health Care Access

Despite the success of health centers to date, there remains a tremendous need for primary care services in communities across the United States. A recent study by the National Association of Community Health Centers and the Robert Graham Center found that nationwide, 56 million people are without regular access to a primary care physician. Access to oral health and mental health services is likely even more scarce.

Health professional shortages threaten access in rural and urban settings alike. A recent study published in the *Journal of the American Medical Association* found more than 1400 clinical vacancies at health centers across the country during 2004. The report cited vacancies for more than 760 primary care physicians, 290 nurse practitioners, physician assistants, and nurse midwives, and 310 dentists – anywhere from 7% to 18% of the current workforce in those positions. Not surprisingly, the greatest shortages were found at the most rural and inner-city health centers.

One of the principal tools health centers and other safety net providers rely on to help ameliorate these recruitment and retention challenges is the National Health Service Corps program,which provides scholarship and loan repayment awards to primary care physicians, nurse practitioners, dentists, mental and behavioral health professionals, physician assistants, certified nurse-midwives, and dental hygienists in exchange for service in underserved communities. However, even as the NHSC program has increased the proportion of assignees that it places in health centers over the past 5 years – to just over 50 percent in 2005 – the simple fact is that less than 17 percent of all physicians, 22 percent of all dentists, and only 7 percent of non-physician providers working at health centers that year were NHSC assignees.

The NHSC has been an important part of the recent expansion of health centers but the ultimate success of any future growth – and indeed, the very future of health centers – will clearly require a larger NHSC, and one more closely tied to the health centers program. A funding level of **$150 million** for the NHSC in Fiscal Year 2009 would be an important first step toward that goal.

Our own experience in north central Wisconsin has benefited from the partnership we have with Marshfield Clinic. However, for many of our sites it is difficult to recruit physicians, mental health providers, and dentists.

There are a variety of programs funded by the Subcommittee that work synergistically to assist us at the local level. The National Health Service Corps is one of the most prominent resources. In addition, our State Primary Care Association and our State's Office of Rural Health, both funded through HRSA, have created a dental recruitment program that has been a great help to us in placing dentists in smaller rural communities up north. Finally, we've been able to utilize telehealth resources to extend mental health and preventive dental services out to communities who lack adequate providers. Our telemental health services reach out to 22 centers and are exploring adding 14 community-based settings to bring mental health practitioners to 36 communities through telehealth. Our teledental operation helps to link Head Start centers to our dental facilities for dental screenings, prenatal oral health and other education, and to provide triage to preschool children with urgent and emergent dental needs. While these are individual programs under your jurisdiction there is real power when they are used synergistically at the community level to expand access and redress health disparities.

Community Impact in Wisconsin and Nationwide

In the short time we have, I want to share three specific examples that demonstrate the importance of the investment you make in community health centers, and why strengthening that infrastructure must be a critical component of any health reform proposal. Those of you from rural states understand the difficulties many smaller more isolated communities have in recruiting and retaining physicians, let alone dentists, mental health professionals and pharmacists. Engaged communities with support through the health center program are solving these problems while providing vital health care services and a badly needed economic boost for these communities.

In the coming health care debate, policymakers and advocates must focus not only on providing everyone insurance, but on building and strengthening the critical infrastructure needed to put that insurance to use in our rural and inner city communities.

Some years back there was talk of defunding Northern Health Centers, which serves northeastern Wisconsin. The concern was that they were a small center and had experienced provider vacancies. I volunteered to help. I suggested they survey the community about the need for the center and that we put together a delegation to state the case for the center to the federal officials. At the meeting a young man from the community stated their case. He said "I have a Masters degree, a great job with the school system, and great insurance, but on a snowy winter night when my wife and I were awakened by our sick child we realized we had lost something special, access to health care." With slippery roads and the nearest hospital 45 miles away, they anguished over what to do. He said in the past he could call the health center and a provider would meet him down at the clinic and take care of their child. He said he wanted his health center back and so did over 5,000 residents who signed a petition circulated throughout the area.

The point made was: if not the health center program then who would help their community? With the show of strong local support, the federal representatives answered the call. They did not defund the health center. The community rallied under the leadership of that same well insured individual. They built a new facility and today they are looking to their second expansion in the face of unprecedented demand for dental and other primary care services.

Those of you who represent urban areas may have noticed in your districts what we've experienced in Milwaukee: that health care infrastructure tends to flow over time out of the inner cities and into the suburbs or other affluent locations, leaving some neighborhoods lacking basic primary care. When that happens people gravitate to hospital emergency rooms for their care.

The Milwaukee community is responding by creating the Milwaukee Health Care Partnership. The Partnership has brought together the major health systems with the community health centers and county and state governments. They are developing comprehensive plans to deal with the uninsured. Key among those plans are growing inner city primary care capacity with a

focus on Milwaukee's community health centers. Wisconsin, like many states across the country, has increased its investment in health centers. These investments help to further leverage the continued growth in the federal community health center program made possible by this Subcommittee, so that we can make a big difference in the lives of inner city residents and the efficiency of our health care system.

Finally, I'd like to visually demonstrate the overwhelming need that exists for basic primary health services – in this case oral health services – by posing a simple question. What happens when you open a new dental clinic in Wisconsin? A clinic that takes all based on need not ability to pay. A clinic that provides a sliding-fee for those with limited financial means.

[See Map, Appendix A]

We opened our third dental clinic in Chippewa Falls on June 18, 2007. In the first 6 ½ months we treated over 5,800 patients. Our patients came from 42 of Wisconsin's 72 counties, often driving hours to get to our clinic. We have never advertised this clinic - our marketing budget is zero. And yet, as of today, we are booked out into May. Why do our largely poor patients travel so far? The answer is simple – pain, unrelenting oral pain. They have no access. In Wisconsin, 20,000 people per year go to emergency rooms because of non-traumatic oral pain. We don't know how many more show up in urgent care centers and physician offices. They get antibiotics and pain medicine. They don't get treatment.

Two days ago we opened our fourth dental clinic in Park Falls, a community of 2,687 people in northern Wisconsin. Before we even opened we were booked out for two months. Park Falls, like many smaller rural communities, has had its share of difficulties experiencing negative population growth over the last five years. Our new dental clinic, in addition to meeting critical health care needs, will provide 28 new jobs in the city and bring thousands of people from across northern Wisconsin into the city for dental care. Your support of the health center program, as important as it is for meeting basic health care needs, also offers critical economic benefits critical to rural and urban inner city areas.

This year we will provide dental services to over 25,000 patients. We believe the need in our state for dental services alone is in excess of 500,000.

To understand how your support impacts individual people in our community, we are including the following stories of patients we have helped. I would stress that these are common, not rare, occurrences at our dental centers.

These stories help to illustrate how oral health and general health are connected.

Case example: A Family Health Center patient living in Clark County was referred to the Ladysmith Dental Center by his Marshfield Clinic Oncologist. His cancer treatments were negatively impacting on his oral health status, and as a result he began losing weight. The patient was initially scheduled for an emergency visit and follow-up dental care. All of his teeth needed to be extracted and he was fitted for dentures. To date, the patient has improved oral health and has gained 10 pounds.

Case example: An elderly woman on Medicare presented at our Ladysmith Dental Center with severe diabetes, which was not controlled well due to the condition of her teeth. She had driven over four hours one way to get to our clinic. She had only a few teeth, which had to be extracted. Over several visits we were able to provide her with dentures and in a subsequent visit she reported that she is now eating better and has her diabetes under better control.

Case example: Another diabetic patient presented at our Ladysmith Dental Center. The patient was jaundiced and very ill and had a large lesion on his leg for the past four years that would not heal. He also had severe oral health disease. Following a full mouth extraction and dentures, this patient has been back for routine care. He reports his blood glucoses are under control, he has good skin color, his skin lesion is healed and he is very happy.

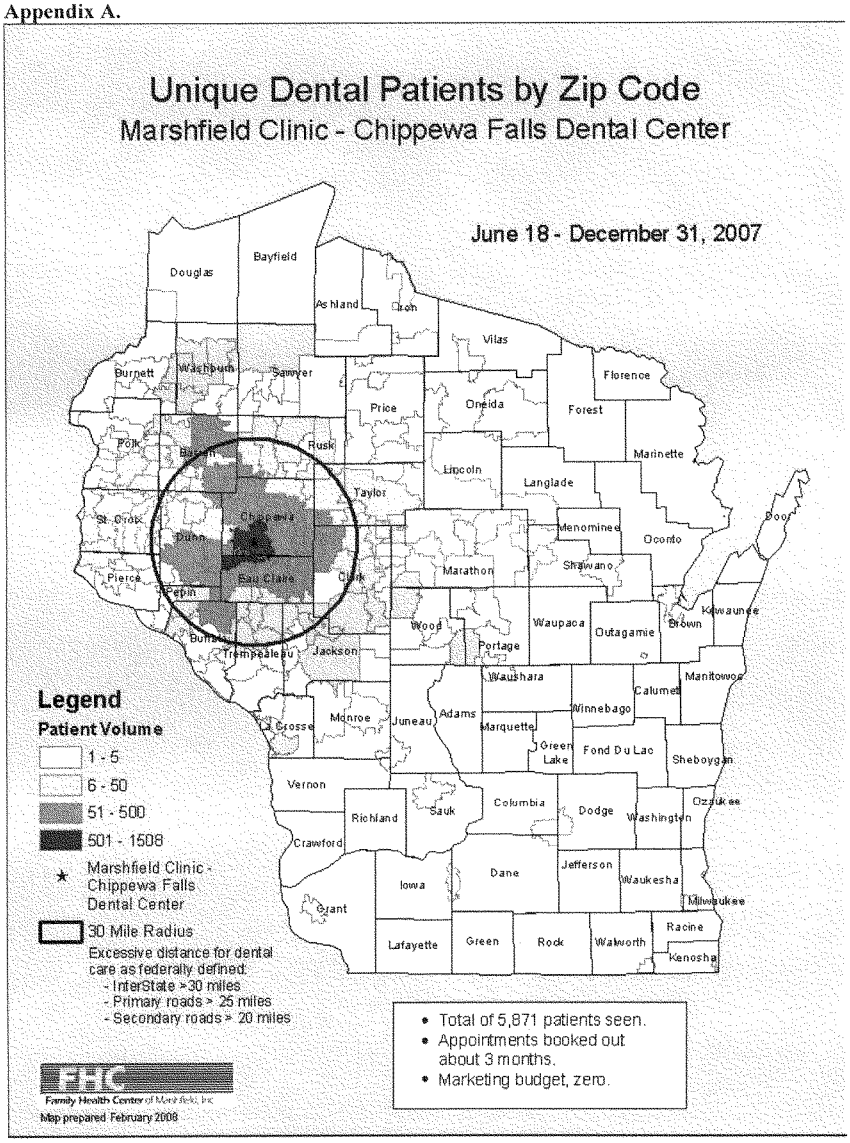
For younger people oral health care can mean better attendance at school, improved self image and even a job.

Case example: A patient presented at our Ladysmith Dental Center as an emergency. She was in high school at the time of her first visit and she qualified for a full discount under our sliding-fee program. Due to the extensive dental care needed and her family's inability to afford that care, she was not able to find a dentist that would see her. Her extensive dental care included root canals, crowns, and major fillings in the majority of her top teeth. To date, the cost of her care exceeds $5,000. She is now an established patient with the dental center and the majority of the work was completed in time for her senior picture.

Case example: A 20-year-old female with no income presented as unemployed and depressed with very poor oral health. We provided extractions and dentures. She now has an improved self image and a job.

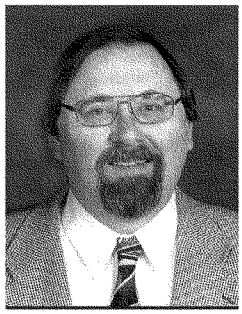
You are called upon to make tough choices with limited resources. The health center program returns real value to people all across this great country of ours. The health center program also returns real value to the taxpayers of this country. Community health centers are grateful for the investments you have made in our system of care, yet we can and should do more. We are prepared to do so with your help.

Appendix A.


Unique Dental Patients by Zip Code
Marshfield Clinic - Chippewa Falls Dental Center
June 18 - December 31, 2007
Douglas
Bayfield
Ashland
Iron
Vilas
Florence
Burnett
Washburn
Sawyer
Price
Oneida
Forest
Polk
Barron
Rusk
Marinette
Taylor
Lincoln
Langlade
Oconto
St. Croix
Dunn
Chippewa
Menominee
Door
Pierce
Pepin
Eau Claire
Clark
Marathon
Shawano
Wood
Portage
Waupaca
Outagamie
Brown
Kewaunee
Buffalo
Trempealeau
Jackson
Waushara
Manitowoc
Calumet
Winnebago
La Crosse
Monroe
Juneau
Adams
Marquette
Green Lake
Fond Du Lac
Sheboygan
Vernon
Richland
Sauk
Columbia
Dodge
Washington
Ozaukee
Crawford
Dane
Jefferson
Waukesha
Milwaukee
Iowa
Grant
Lafayette
Green
Rock
Walworth
Racine
Kenosha
Legend
Patient Volume
1 - 5
6 - 50
51 - 500
501 - 1508
Marshfield Clinic - Chippewa Falls Dental Center
30 Mile Radius
Excessive distance for dental care as federally defined:
- InterState >30 miles
- Primary roads > 25 miles
- Secondary roads > 20 miles
FHC
Family Health Center of Marshfield, Inc.
Map prepared February 2008
• Total of 5,871 patients seen.
• Appointments booked out about 3 months.
• Marketing budget, zero.

EXPERT BIOGRAPHIES

Areas of expertise: Public Policy on Health Care Access; Access to Health Care Services for Underserved Rural Areas and Economically Disadvantaged Individuals and Families



Greg Nycz
Director
Health Policy, Marshfield Clinic
Director
Family Health Center of Marshfield, Inc.

Greg Nycz, director of Health Policy for Marshfield Clinic and director of Family Health Center of Marshfield Inc., is a leader, advocate and spokesman for local, statewide and national public policies related to health care access.

He joined Marshfield Clinic as a biostatistician for Marshfield Clinic Research Foundation in 1972 after earning undergraduate degrees in mathematics, psychology and computer science at the University of Wisconsin-Stevens Point. Since then he has served as director of the Clinic's Health Systems Research Department in 1980; director of the Family Health Center of Marshfield, Inc., in 1990; and director of Health Policy in 1997.

The Family Health Center of Marshfield, Inc./Marshfield Clinic partnership has been a model of how a health care delivery system can be developed to meet needs of rural, medically underserved populations. It was formally recognized as such by the Clinton Administration in 1999.

Nycz, who completed a U.S. Public Health Service Primary Care Policy Fellowship in 1997, has been a co-investigator and/or project director for numerous research projects related to providing health care services to underserved rural areas and economically disadvantaged individuals and families.

Nycz also has been invited to attend, participate and make presentations at local, state and national conferences on such issues as the future of family health centers, mental health services in rural populations, Medicare and Medicaid services, health insurance for the uninsured, health care financing, research opportunities in rural settings and public and private efforts to improve public health.

Among many recognitions, Nycz has been honored with the American Dental Association Access Recognition Award in 1995, the National Association of Community Health Centers Advocacy Award for outstanding work to advance the legislative agenda of the health center movement in 1996; and the Wisconsin Rural Health Association's "2000 Rural Health Achievement Award" for leadership, innovation and service for rural health in Wisconsin.

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Mr. OBEY. Thank you.

Mr. Popper, I am sorry that you look like you were a suspicious character and could not get through security this morning. [Laughter.]

Mr. POPPER. That is quite all right. I could have gotten here earlier. My wife was injured last night, so I had to get a four-year-old and eight-year-old off to school this morning.

Mr. OBEY. Is she all right?

Mr. POPPER. She is okay. She just is not very mobile, so I had to get the young ones off to school. I would not have had the security problem if that had not happened.

Mr. OBEY. Well, thank you for making the effort.

Mr. POPPER. No problem. Thank you. I am really honored to be here to speak to you this morning.

My name is Richard Popper. I am Executive Director of the Maryland Health Insurance Plan.

The Maryland Health Insurance Plan is one of 34—soon to be 35—State high-risk pools available in soon to be 35 States in the United States. Although I only represent one high-risk pool, I do have a sense of some of the broader issues—which I am going to speak about today—regarding high risk pools. I used to be a member of the board of directors of the National Association of Comprehensive Health Insurance Plans, which is the high-risk pool association, and prior to that I was the Assistant Director of the California Managed Risk Medical Insurance Board, which oversees California's high-risk pool and also their S–CHIP program, Healthy Families. For that I worked in Los Angeles County government, which is ground zero, as we all know, for the uninsured. So I do have somewhat of a broad perspective beyond Maryland.

The Maryland Health Insurance Plan, as I said, is one of soon to be 35 high-risk pools across the United States. High-risk pools are nonprofit or government organizations created to offer health insurance to the uninsurable population—and that is different than the uninsured. To understand who the uninsurable population is, you need to understand sort of how the health insurance market is set up in the United States, which some of the previous speakers talked about.

Health insurance in the United States is voluntary. You can opt to purchase it if your employer offers it or you can opt not to. If you do not have employer-based coverage and your income is not low enough to be on Medicaid or M–CHIP, but you are not sick enough or old enough to be on Medicare, you have to buy an individual insurance product, similar to buying car insurance: you go to see an agent or you can buy it online. And just like with car insurance, with car insurance you can get denied car insurance if you have a poor driving record.

In the individual health insurance market in the States that have high-risk pools, you can be denied health insurance because of your health condition. It can be something as serious as you have leukemia, cancer, diabetes, or it could be you are 20 pounds over weight standards. In Maryland we have one plan that denies people for severe acne. It can be that much of a difference in health conditions that result in an individual insurance plan denying you coverage.

So when you want to buy insurance, you have the means to buy insurance, and no one will sell it to you, in the States that have high-risk pools, people are denied health insurance and they become what we call uninsurable. They want to buy insurance, no one will sell to them, so they turn to a State high-risk pool. Currently, the 34 State high-risk pools across the U.S. have 190,000 subscribers enrolled in them, and, as I said, those people's health condition can vary significantly, from something very serious to something fairly minor, but because they have added risk, carriers do not want to provide them coverage.

Risk pools provide individuals access to comprehensive health insurance coverage, but, because it is a risk pool, they pay a higher premium, generally, than what healthy people would pay if they were granted an individual policy and could pass medical underwriting. On average, risk pools surcharge their premiums for enrolled members from about 125 percent, or 25 percent above what healthy people would pay, to 200 percent, or twice the rate at what healthy people would pay for an individual insurance product.

About nine of the high-risk pools States offer a low-income subsidy. Maryland is one of those States that tries to discount the premiums for low-income individuals to try to create sort of a bridge from the Medicaid program so that the premium can be more affordable for people who are low-income but uninsurable.

The reason high-risk pools charge more premium is because we are in business to lose money; we do not make profits. Our loss ratios vary from 110 percent in one State to 390 percent, which means for every $1.00 in premium we get, we have claims costs that are $1.10 in one State all the way up to for every $1.00 in premium we get we have $4.00 in claims costs. So in order to subsidize that, we charge higher premiums, but we also do assessments or other funding mechanisms among the 34 States. Most of the States assess individual market and some States small group, small employer health plans that are regulated by the States, and they assess it equally among all the other people who have group insurance or individual insurance.

A couple of the other States use maybe tobacco funds or tobacco tax. In Maryland, we have a hospital assessment, so whenever you go into a hospital in Maryland, you pay a sales tax, almost, on top of your facility fee that helps fund the high-risk pool. It is designed to provide a broad assessment to fund these people with chronic health conditions or uninsurable health conditions to make the insurance affordable and help subsidize the high-risk pool, which otherwise could not be designed.

In understanding high-risk pools, you need to understand we are not like the Massachusetts initiative or Healthy New York. We are not designed, as I say, to save the world, to cover everyone. We are not designed to provide universal coverage in our high-risk pool. What we are designed to do is provide sort of universal potential access to everyone. Everyone in the State who wants to buy health insurance can buy health insurance; it becomes a question of affordable, which we know is the key question.

The makeup of high-risk pools is very interesting. About a third of the Maryland high-risk pool are self-employed individuals. Other populations that enroll in high-risk pools are unemployed people,

employed people who work at companies that do not offer health insurance coverage, people who are retired or disabled. About a little more than half of the enrollees are women and enrollment can vary State-to-State. Some are more dominated by the self-employed; others have high levels of employed people.

In Maryland, if you look at my testimony, page 3, I lay out some of our most popular or most top-reported occupations of employed people who enroll in the high-risk pool. This includes sales representatives, consultants, realtors, truck drivers, limo drivers, nurses, day care providers, housekeepers, waiters, teachers; people you bump into every day who do not have insurance coverage through their job but need to buy it and want to buy it, and the high-risk pool is the only place where they can get it.

It is usually a temporary stopping place. Most of our members only enroll for, on average, two years. We have some people who will be with us for ten years, but, on average, people come and then they get other coverage. Maybe they are so disabled they are in the waiting period for Medicare to kick in after two and a half years; maybe their spouse gets a job; maybe they go into Medicaid because their situation deteriorates. But we tend to be a transient health insurance plan, not a long-term one.

States have used high-risk pools to respond to recent Federal mandates to expand coverage. Some of the previous speakers talked about HIPAA, the Health Insurance Portability and Accountability Act of 1996. That required States to offer guaranteed issued coverage to individuals who had group coverage and exhausted it; either their employer dropped the health insurance plan or they left their job or were fired or decided to retire; they took up COBRA—which we know can be expensive—they maxed out the COBRA; at that point they have a two month, 63 day guaranteed issue period and States are required to offer these people guaranteed issue.

And most of the high-risk pool States, the high-risk is the guaranteed issue mechanism that allows people who have this Federal mandate that they must get health insurance, their only option to go to is the high-risk pool. Thirty percent of the Maryland health insurance plan's 13,000 members are eligible because of this Federal mandated HIPAA right that they have.

Also, in 2002, Congress passed the Federal Trade Act that required States or encouraged States to offer mechanisms for people who lost their job because of international trade or whose pension plan went insolvent and their pension was taken over by the Pension Benefit Guarantee Corporation and they no longer had their group coverage as well. Maryland and a lot of the high-risk pools are the mechanism in the States, besides COBRA, that offer coverage for these people to access the 65 percent tax credit that is used for the Federal Government to subsidize the cost of their premium either in COBRA or in the high-risk pool.

Maryland had the highest take-up of any State in terms of HCTC, the health coverage tax credit-eligible populations, largely because we were Bethlehem Steel, which went insolvent and was broken up into pieces and 20,000 former employees and retirees of Bethlehem Steel in Maryland had no place else to go if they were under age 65 to get their health insurance, and they came to the

Maryland Health Insurance Plan. So we do not have the highest HCTC enrollment; we have the highest take-up rate.

Also, we get a lot of people who have been approved for Social Security because they are obtaining Social Security early, at age 62, or because they are on Social Security disability and they have to wait two and a half years for Medicare coverage to kick in. We get a lot of referrals from congressional offices for people who finally get approved for Social Security disability, but they have to wait two and a half years for Medicare and their income is not low enough to be on Medicaid, so they often call us up to refer them over to the high-risk pool in the State of Maryland.

We also do outreach to all the Social Security field offices in Maryland so that folks who get Social Security disability know that there is something for them to hold them over until Medicare kicks in after up to two and a half years.

So because high-risk pools have formed a way to either meet recent Federal mandates or to fill in the cracks in the health insurance marketplace, Congress, in 2002, for the first time, appropriated funding authorized by the Federal Trade Act to high-risk pools. This was wonderful for the high-risk pools because, previously, we were dependent on State funding or assessment funding; and that appropriation amounted to $40,000,000 in fiscal year 2003, another $40,000,000 in fiscal year 2004. Maryland was the first State to receive this new Federal funding, which we were really grateful for, and it does help us to reduce premiums or reduce member costs or disease management programs, and also expand our capacities.

The funding, which we really appreciate this Committee having a lead role in because in fiscal year 2008, in December, this Committee was able to appropriate, through the leadership especially of Chairman Obey, $49,000,000 to keep this program going because it has not been appropriated every year. It was not appropriated in fiscal year 2005; it was not appropriated in fiscal year 2007. So we really appreciate it and we look forward to Maryland getting its share.

As you look at different options that some of the previous speakers discussed to expand coverage, please bear in mind that in a lot of these options to expand coverage high-risk pools will play an important part. If the Federal Government elects to mandate insurance, that everyone has to have health insurance coverage, like a lot of States do for to meet that mandate, will use the high-risk pool, because that is an option for people who are high-risk, as a mechanism to make sure that there is guaranteed access to health insurance in order to meet the Federal mandate.

If Congress, instead of mandating coverage, elects to provide subsidies to encourage people to buy coverage—such as a tax credit, which we already administer through the Federal Health Coverage Tax Credit Program—again, high-risk pools will be a mechanism through that tax credit for people to buy coverage if they are uninsurable.

The last thing I would ask the Committee to think about is that if this issue of expanding health coverage and reducing the uninsured continues to take up a lot of your time analyzing options, debating options, and it goes on for a number of new years and in-

volves the new administration that will come in next year, bear in mind that high-risk pools are serving the uninsured today, tomorrow, next week, next year. So as these debates go on at the macro level, please bear us in mind that we are down in the micro level actually serving these folks and providing them coverage today.

So thank you again for inviting me to come today. I hate to be the one who arrived late and leaves early, but I have a State budget hearing at 1:00, and while your allocation of risk pools gave us $3,000,000, I have $100,000,000 on the table in Annapolis at 1:00, so, with all deference to you, I will have to leave around 11:45. But thank you very much.

[The information follows:]

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TESTIMONY
of
Richard Popper, Executive Director
MARYLAND HEALTH INSURANCE PLAN
before the
APPROPRIATIONS SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES AND RELATED AGENCIES
U.S. HOUSE OF REPRESENTATIVES

March 5, 2008

Mr. Chairman, members of the Committee, my name is Richard Popper, Executive Director of the Maryland Health Insurance Plan. Thank you for the opportunity to testify today about state health insurance high risk pools.

The Maryland Health Insurance Plan is one of 34 state high-risk pools in the United States. Risk pools function as nonprofit or state-run organizations created under state law to offer comprehensive health insurance to over 190,000 individuals who are unable to secure health insurance coverage because of their health status. I am addressing you today both as the director of Maryland's high risk pool, and as a member of the National Association of State Comprehensive Health Insurance Plans, which is the non-profit national organization of state risk pools.

The role of high risk pools is best understood against the largely voluntary health insurance system in the United States, which is comprised of two major components:

- The group market provides health insurance plans to employers, whose employees can choose whether or not to enroll themselves and their families
- The individual market provides insurance to persons who wish to purchase coverage for themselves or their families directly from an insurance company. Because these individuals apply voluntarily, individual market insurers require medical screening as part of the application process. They reserve the right to reject, rate-up, or impose exclusions for individuals who have pre-existing medical conditions.

Unless a state requires insurers to provide individual coverage to individual market applicants with pre-existing medical conditions, those persons generally

remain uninsured. This segment of the uninsured population is known as "uninsurable" because they lack a health plan willing to offer them health coverage, or can only get limited coverage, or coverage at extremely high rates in the private market.

High-risk health insurance pools serve the uninsurable population, who often have pre-existing conditions such as cancer, diabetes, heart disease, AIDS or other chronic illness that causes them to be turned down for coverage. Risk pool members provide access to comprehensive health coverage for uninsurable individuals, who pay somewhat higher rates for this coverage than healthier individuals. Maximum premiums are capped, typically at 125% to 200% above the average medically underwritten individual health insurance rates. While premiums are higher than the standard market rate, risk pools still required additional subsidies to supplement plan costs, since each state's pool inherently loses money by taking in total premiums that are less then the cost of claims paid. Risk pools have loss ratios that vary state to state, from 111 to 390%, which means that for every dollar in premium the pool receives, it can incurs an average of $1.10 to $3.90 in claims costs.

Three-quarters of state risk pools are subsidized by an assessment made to insurance industry carriers, with the remaining 25% of pools funded by some other state funding mechanism, such as state tobacco or special fund taxes, or a hospital assessment which is what we use in Maryland. Risk pools are overseen by an appointed board of directors, usually including representatives from the insurance industry, consumers, medical professionals and legislators or agency directors; and are generally regulated by the state's insurance department.

Consumers who use risk pools come from a wide variety of backgrounds:

- Typically 50 to 60% of plan members are over age 50.
- Usually more women than men enroll – in Maryland women make 55% of members
- Enrollment is typically made up of the self-employed; employees of small businesses that don't offer insurance; people that formerly were in the employer group market such as retirees, the unemployed or young people coming off their family's coverage; and workers who are not a part of a large employer plan.

  In Maryland's pool, our members report the following employment status:

Self employed	30%
Not employed	29.1%
Employed	27.8%
Retired/disabled	12.1%

The following are the top reported occupations of employed Maryland pool members:

136 sales representatives
135 secretaries/receptionists/clerical staff
112 realtors/real estate agents
100 consultants
75 truck or limo drivers
73 nurses or therapists
70 daycare/childcare providers or nannies
69 barbers/beauticians
67 waiters
56 teachers, educators, or assistant teachers
30 housekeepers

The pool is a temporary stopping point for many. While some enroll for extended periods, many enroll for a limited time and leave when other coverage becomes available, with the average length of enrollment from two to three years.

States establish risk pools not just to serve the uninsurable, but also to keep the state's individual insurance market competitive and individual market premiums affordable. This is because the pool allows individual market health plans to spread the cost of higher risks relatively evenly. In addition, risk pools are often the mechanism by which states complied with recent federal mandates to expand health coverage. Risk pools also fill in the cracks that federal heath programs do not cover. For example:

- Risk pools are the most frequently used mechanism that states have chosen to comply with the Federal guarantee-issue requirements for individuals who exhaust their group health coverage, as required in the 1996 Health Insurance Portability and Accountability Act or HIPAA. For Maryland, 30% of our members, 3,800 individuals are HIPAA eligible.

- Pools are also a frequent option states use to provide guaranteed-issue coverage for individuals who have lost their health coverage due to international trade agreements entered into by the U.S., and/or because their employer's pension system has failed and been taken over by the U.S. Pension Benefit Guarantee Corporation. Such individuals are eligible for the federal Health Coverage Tax Credit or HCTC, created by Congress in the Trade Adjustment Assistance Act of 2002. Maryland has had the highest take-up rate for HCTC eligible individuals, with up to 10% of our members receiving the HCTC credit largely due to the break-up of Bethlehem Steel.

- Disabled or retired risk pool members are often on Social Security and are either too young to be eligible for Medicare, or are disabled and in the initial 2 ½ year waiting period before Medicare coverage begins.

Because pools are a proven method of providing everyone the right to purchase health insurance protection, and given that risk pools have stepped up to provide coverage under recent federal mandates, Congress authorized federal grant funding in 2002 to subsidize losses for qualified risk pools.

Federal funding of a portion risk pool losses is benefits consumers, providers and the insurance industry, yet it has not been consistently provided. The 2002 Trade Act provided $40 million a year in both FY2003 and FY2004 for risk pool operating losses, however no funding was appropriated in FY 2005. In early 2006, Congress and President Bush agreed to enact the State High-Risk Pool Funding Extension Act of 2006 (H.R. 4519), which authorized $75 million in annual risk pool funding for 2003 through 2010. Funding under the new authorization was appropriated in FY2006, but not in FY2007. In FY2008 $49 million was appropriated, out of the $75 million authorized, largely due to the leadership of Chairman Obey and a number of members of this Committee.

Although risk pools greatly appreciate the recent $49 million federal appropriation for FY2008, it should be noted that this funding covers only a fraction of risk pool losses, which totaled $722 million in 2006. For example, Maryland received a $2.9 million grant in 2006, yet incurred a $50 million loss that same year.

As Congress and the current and future Administrations consider the numerous options to reduce the rate of uninsured and keep health insurance affordable during difficult economic times, risk pools are and will continue to be a proven method of providing the right to purchase health insurance protection:

- If Congress adopts an individual mandate requiring everyone to purchase insurance, either through their employer or an individual policy, risk pools will be a vital solution in many states to make sure that a comprehensive coverage is available for purchase, regardless of one's health condition.

- If Congress adopts tax credits or other financial incentives to assist individuals to purchase health insurance coverage, risk pools will be necessary to assure that a health insurance coverage option is available for those who otherwise could not obtain insurance due to their health status.

- If the national debate continues, with further analysis and evaluation of complicated and challenging options to assist the uninsured, risk pools remain available today, tomorrow, next month and next year for otherwise uninsurable individuals needing health coverage. Your continued support of ongoing appropriations to the federal high risk grant program will help assure that this proven method of purchasing coverage continues.

Thank you again for the opportunity to address you this morning.

Bio: Richard Popper

Richard Popper is the Executive Director of the Maryland Health Insurance Plan (MHIP), Maryland's high risk pool for uninsurable individuals and their families. MHIP provides 13,000 uninsurable individuals comprehensive health insurance, and also offers a separate State Pharmaceutical Assistance Program for 30,000 moderate income Medicare recipients enrolled in the new Medicare Part D drug program. Richard's previous positions include Assistant Director of the California Managed Risk Medical Insurance Board, which operates California's high risk pool and children's health insurance program, Deputy for Budget and Finance for Los Angeles County, a Consultant for KPMG Peat Marwick, a Budget Analyst at the Office of Management and Budget, and as an insurance underwriter.

Richard graduated from Saint Joseph's University in Philadelphia, and holds a master of science degree from the Heinz School of Public Policy at Carnegie Mellon University in Pittsburgh.

Mr. OBEY. All right.

Mr. Walsh.

Mr. WALSH. Thank you, Mr. Chairman.

That was fascinating. Thank you all very much. I would like to ask three questions. I have five minutes, so I will try to make my questions brief, if you could make your answers brief.

Dr. Lambrew, you gave us this great package of charts and in it you say that 47 million Americans are uninsured, and on the next chart you say at some point 82 million are uninsured, 26 million are always uninsured and 36 million are temporarily uninsured. Can you sort of explain that a little bit, those disparities in numbers?

Ms. LAMBREW. Thank you. What happens is that you basically have the 47 million is a mix of the two, it is a mix of people——

Mr. WALSH. Always and sometimes?

Ms. LAMBREW. Exactly. And that is why you cannot see the 47 million on the chart. They are also different data sources, just so you know, so that often comes out. But when we try to figure out how to target the uninsured, it is tough, because we have some people who are just the chronically uninsured—these are people who generally have high health costs or have some preexisting condition, have trouble getting insurance, but more often they are people who are unemployed or coming in and out of jobs and they just cannot afford it. They do not have the access to it, nor can they afford it.

Mr. WALSH. Thanks.

Dr. Chollet, you talked about the different State plans and I think what you said was it would not be a bad idea for every State to have their own plan as long as the plan was to get everybody under the umbrella, but have the Federal Government basically get out of the way. Is that what you said?

Ms. CHOLLET. Not quite. I think the vision for State level plans has to come from the Federal Government. I think there has to be a national vision. I personally——

Mr. WALSH. So create a template for these State plans?

Ms. CHOLLET. Yes, sir.

Mr. WALSH. And then change the rules federally so that would enable those?

Ms. CHOLLET. That is right. And HIPAA in many ways is a good example of that, which laid out a national vision for how small group health insurance should be marketed, guaranteed issue; it established minimal rules for individual coverage—it should be guaranteed renewable. HIPAA stepped back in some very key areas and, therefore, to my mind, it does not meet its stated objective of making coverage available to everybody regardless of health status, but it made some very important contributions and it amended Federal laws as necessary to make that vision implementable by the States.

So I think the vision does have to come from the Federal Government. I do not think, though, there should be 50 unique State programs that are totally unique in all respects. I think citizens should be able to expect some continuity moving from State to State, but the minimal continuity is that they should have access to affordable health care somewhere.

Mr. WALSH. Great. Thank you.

And Mr. Nycz, the community health centers provide a remarkable service, I agree. Our community health center in Syracuse, New York is headed by a dentist, so that is something he cares, obviously, very deeply about. But the question I had—and you got at this a little bit—regarding health coverage or access to health care in those communities, whether it is Chippewa Falls or it is downtown Syracuse, can you tell me how much cheaper it is to treat a patient in a community health center setting as opposed to going to a hospital emergency room?

Mr. NYCZ. There are a lot of national figures on how much community health centers save, which we can get that information to you, but the cost of not taking care of people—I think which is also the Chairman's point—is huge, and these folks that are going to dental emergency rooms, they are getting 250—the Medicaid agency has to pay about $250, on average, for those folks, who leave the emergency room after $250 of expense with the same problem they entered, and they still need care.

So they come to us. We are trying to redirect them to save that $250 on the dental side. And as I said, in Wisconsin we know that there are at least 20,000 a year of those visits, and the vast majority of those are Medicaid. So we are paying, taxpayers are paying for those visits. They do help people with pain and give them something for the infection, but the underlying disease process continues.

Mr. WALSH. Whatever you can garner to provide us, just unit cost, you know, community health center visit, triage sort of visit versus emergency room.

Mr. NYCZ. The other thing I will say is they are struggling with this in Milwaukee and I think they got an excellent plan. It is going to take more because people have now oriented themselves to emergency rooms; they just show up. So they are trying to work in information technology in that to link the community health centers with the emergency rooms and then address the health literacy issues and redirect them. So even if you have community health centers and you open up access, we still have to think smart about this in terms of redirecting those patients out of the expensive emergency rooms.

And the last thing I will say is a lot of people who go to emergency rooms end up in the hospital.

Mr. WALSH. That is true. Thank you very much.

Mr. Chairman, I yield back.

Mr. OBEY. Ms. Roybal-Allard.

Ms. ROYBAL-ALLARD. Dr. Lambrew, first of all, thank you for sharing your snapshot of our broken health care system. What you did not include in your testimony today, but have included in your past writings, is your analysis of the under-use of preventive health services in this country and our inability to realign incentives from sickness to wellness.

This under-use of prevention services is highlighted by the fact that CDC's budget has been losing ground over the past few years and this year the President wants to further cut CDC's budget by $433,000,000. In your opinion, what has been the consequences of

these cuts to prevention and what percentage of our national budget do you think should be devoted to prevention?

Ms. LAMBREW. That is an excellent question, and I think that when we think through what we spend now, they are not very good estimates, but of our roughly $2,000,000,000,000 health system, we estimated that about 1 percent to 3 percent is dedicated to prevention; and that is not just through CDC, it is also through health insurance companies paying for mammographies and screening, etc. That is very, very little in the face of what our new challenges are.

This century, our challenges are chronic illness. It really has eclipsed all the kind of historical sources of diseases, to the point where, when you look just at obesity, we know that the next generation of children may have shorter life expectancies than their parents because of the obesity crisis. We have not seen that ever since we have been recording these statistics.

Can we solve this only through health insurance? Absolutely not. It has to be a partnership with communities, schools, workplaces, as well as ensuring that the high value preventive services that we do know get delivered in the health care system are affordable and available. It really does require a comprehensive approach.

And going back to the previous question about can we actually save money, the statistics are pretty overwhelming. I mean, we know if we fully immunize all children, we could save about $40,000,000,000. I cannot remember over what time period, but we can save from immunization. If we could tackle this obesity crisis, the statistic is startling. Returning seniors' obesity levels back to what it was in the 1980s could save Medicare $1,000,000,000,000 over 25 years according to a bunch of very smart economists.

So there is clearly a need to invest in prevention. We do not do a good job. It needs to be done in partnership with CDC and the public health system as well as the integrated system. I have definitely been proposing ideas, something like a wellness trust, as a way to consolidate and redeploy our prevention dollars to really get at that.

Ms. ROYBAL-ALLARD. What specific impact does the under-use of prevention have on our under-insured population and do you think that it is possible to build a realignment of incentives from sickness to wellness into the current healthcare system?

Ms. LAMBREW. Sure, and the under-insured issue for people with insurance not using it, I might get this not exactly right, but there was a study recently that looked at Medicare co-pays that said even just adding a $10 co-pay for mammography for seniors resulted in a significantly big drop in utilization. So we know it is a problem because we do not have financial incentives out there for people to use the type of preventive services that they need.

I will say we also every week we see new studies from the American Cancer Society and other folks that say that because of our lack of comprehensive prevention, we get diagnosed later when it is harder to deal with our cancers than any other nation.

Ms. ROYBAL-ALLARD. If we are going to successfully realign our priorities, should we also be focusing on educating the right mix of providers within the healthcare system and what do you think that mix should be?

Ms. LAMBREW. Absolutely. When we think through our challenges, when I talked about the primary care shortage, we do not have enough providers in the primary care community to deal with our acute and chronic illness, let alone the kind of prevention workforce that we need.

There was one study that said if we had every doctor provide the recommended clinical preventive services, it would take that doctor, for a typical patient load, seven hours out of a day to do so. We need to find new ways of delivering prevention, given how critical it is.

Some of the ideas I have been working on: look at broadening the prevention workforce, creating new certification programs, making sure that the pharmacists, the people in schools and workplaces can do this because a lot of it can be done in those settings.

But I would say, going back to Chairman Obey's earlier comment about what do you all do to get ready for health reform, the workforce issue is enormous, just enormous. We need the software as well as the hardware, software being the people who can really dig in and get these systems aligned, as well as the hardware of clinics and hospitals and information technology to make it all work.

Ms. ROYBAL-ALLARD. Dr. Chollet, in your testimony, you speak about the importance of giving the States broad authority to develop their Medicaid and S–CHIP programs. In the last two years, CMS has issued a series of seven regulatory packages designed to decrease the Federal outlay of Medicaid services. Many of these were originally rejected by Congress because they eliminate payments for legitimate healthcare expenses and because they pass the unfunded cost on to the States.

Now, California has approximately 6.7 million individuals on its Medi-Cal program and the fiscal impact of these rules on the State will be several billion dollars annually. The result will almost certainly be to destabilize an already fragile healthcare safety net system, causing closure of hospitals and the reduction of services.

Do you have any thoughts on how the Federal Government can reduce Medicaid expenditures without passing legitimate healthcare costs on to the States and without compromising access for our most vulnerable citizens?

Ms. CHOLLET. Ms. Roybal-Allard, it is an excellent question.

This is a huge issue for every State and certainly for a State like California. The complexity of the Medicaid and CHIP rules, the capriciousness from the States' perspective of funding for these programs, the lack of reliability with respect to how the budget will change from year to year has had a huge chilling effect.

These programs are the baseline. They are essential to the fabric of how the States finance healthcare and increasingly so as group coverage has eroded and as individual health insurance coverage has moved out of the reach of populations below 300 percent of poverty in every State and in some States, arguably, below 400 percent of poverty.

The problem has reached into the middle class, but the States find that they are not able to rely on funding at the very base any longer, and therefore many States just sit and wait and wonder what is going to happen to their Medicaid and CHIP budgets.

I think what I would suggest and what I introduced in my written testimony is that these rules be rationalized so that the Federal Government and the State governments can reliably predict what the expense is going to be and that there be a Federal Government commitment to making these programs a stable foundation for every State. It is what they need and, in the absence of it, the States cannot move forward in guaranteeing access to coverage for their middle income populations which are increasingly at risk.

Mr. OBEY. Mr. Honda.

Mr. HONDA. Thank you, Mr. Chairman.

I think, Mr. Nycz, you had a comment to her question. I thought I would give you an opportunity to respond.

Mr. NYCZ. Yes, actually I do have an idea on how you can reduce Medicaid expenditures and improve quality, and that is expand the community health center program. There is research that demonstrates that health centers can provide cost to Medicaid patients at a lower rate by championing things like prevention and early detection.

The other point that I guess I would make is that there was a brand new article just came out this month in Lancet Oncology, and they took a look at all the people with cancers in the country and found that uninsured and publicly insured through Medicaid have way more late stage cancers, and they did not find that for Medicare which was interesting.

In one of the commentaries on that in that same journal, they mention that Canada, the U.K., places where they do have universal health coverage, there is still it is much less common for individuals who are lower income, lower educational level to access screening services.

So having insurance alone is not enough. You need an army on the ground that can help work with people in the communities, and that is why I support and I have been working for community health centers for the last 35 years.

Mr. HONDA. Thank you.

Let me just add my appreciation to the Chairman for putting this together. This is a helpful discussion for me.

One of the areas that is of interest to me is the ability for our community health centers to have adequate resources to find culturally and linguistically competent providers and implement best practices in our communities. What kind of activities exist right now and what are some of the gaps that we should be looking at?

Mr. NYCZ. Well, first of all, you provide support for an amazing array of programs that come together synergistically to help in communities, and the workforce issue is really key. The National Health Service Corps is critical to growing community health centers. That is absolutely critical.

But you also fund State primary care associations, rural State association. Those folks come together, and they help us recruit dentists, for example. They have dental recruitment programs.

We use Telehealth, for example, which your Committee also funds to extend mental health services to remote areas.

Finally, I think we try to get bilingual-bicultural staff, but in the end we are increasingly looking to growing our own. The National

Association of Community Health Centers work with A.T. Still University. They have stood up a dental school. They have stood up a medical school.

Ultimately, I think we are going to have to address the workforce issue by finding those people who are uniquely qualified to serve the patients in the areas where we are trying to help.

Mr. HONDA. I have visited a lot of reservations, and what I think I saw was pretty devastating. It was appalling. Where does that fit in the context of the things under discussion since we are talking about sovereignty and also delivering healthcare.

Mr. NYCZ. In Wisconsin, most of the tribes after that Indian Health Self-Determination Act, I think 1984, most of the tribes chose to have their own healthcare facilities. They are also plagued, however, with difficulties in recruiting and retaining.

They do have federally-qualified health center status in Wisconsin. The State in that program helps them a lot, but workforce issues continue to plague, I think, tribal clinics.

Part of what A.T. Still is doing in dentists and physicians is they are growing people with the specific thought that they would go to work in community health centers and in tribal clinics and in VA facilities across the Nation.

Mr. HONDA. Very quickly, before my time is up, Mr. Conyers has a bill, H.R. 676. Do you have any reaction to that bill, or do you know anything about that bill?

Mr. NYCZ. I guess I do not. I do not know, but I kind of side with what the Chairman said. As a health center director, I do not care what is done. If it can help people get healthcare, I am for it.

Whether it is incremental or universal, the fact remains it is not going to be just providing coverage and money. It is going to be in the trenches with the right people, bicultural, bilingual folks who can take care of people on their level and who can champion prevention.

So I am sorry I cannot comment on that particular.

Mr. HONDA. Thank you, Mr. Chairman.

Mr. OBEY. Mr. Ryan.

Mr. RYAN. Thank you, Mr. Chairman. I appreciate this hearing too. This has been great. So thank you for all your time.

I have a couple of questions and then a question for the whole group.

Mr. Popper, one of the questions I have is you get these folks into the high risk pool. Have you done any analysis as to what the savings has been even though their premiums are high and they pay more? Have you done anything to study, even though the costs are high, what savings there are to the system?

Mr. POPPER. I cannot speak about all 34 States, but the Maryland Health Insurance Plan was designed to reduce uncompensated care. That is our statutory mission and that is why the hospitals agree to this surcharge on hospital facility fees to fund the program because they realize that if our population does not get insurance, these folks will end up in the emergency room and getting all their services through the emergency room. So we have a proven method of reducing uncompensated care by keeping people out of the emergency room.

Only about a third of our costs go to hospitals. The rest goes for prescription drugs, specialty outpatient, primary care physicians, durable medical equipment, what have you. So we are designed to reduce uncompensated care, and we do do that because really these folks would have no other place to go.

Mr. RYAN. What has been the reduction?

I mean I know that the hospital assessment does not pay for everything. You are piecing this whole thing together.

Mr. POPPER. Right.

Mr. RYAN. But has there been a reduction in these folks going to the emergency room that you could somehow quantify?

Mr. POPPER. Oh, yes, clearly. What is interesting in the Maryland Health Insurance Plan is that our losses for the first two months that people are enrolled are twice as high as they are after someone has been in the plan for twelve months.

So people come in. They are uninsured. Seventy percent of our new members are coming freshly in uninsured, and they access services because they have a lot pent up demand in things, and then the costs drop within a year, our per month costs. So that drops.

In terms of a dollar for dollar of every dollar in the Maryland Health Insurance Plan reduced three dollars in uncompensated care, I do not have that number for you today. I could work to get it for you.

Mr. RYAN. Yes, if you could, that would be great.

Mr. NYCZ. Because we see their medical costs drop after being in the plan.

Mr. RYAN. If the national association has that information for the 34 States, that would be great too.

Mr. NYCZ. I will work on getting that for you, Congressman.

Mr. RYAN. I appreciate it. Thank you.

Dr. Lambrew, you mentioned 1 to 3 percent of healthcare money is spent on prevention. Do you have any recent numbers on every dollar of prevention that is spent, how much that saves us in the system?

If you said it, I missed it and I apologize.

Ms. LAMBREW. I did not say it partly because it depends on what the prevention is. Prevention is a term that covers lots of different services, anywhere from a mammography which is quite clinical down to smoking cessation which is more about how do we prevent people or encourage people to quit.

There have been some studies of workforce-workplace wellness programs that try to say that the range of activities that businesses usually conduct, which is trying to get people or encourage people who have chronic illness to adhere to services, making a good cafeteria, all that kind of good stuff.

The studies generally say for every dollar you invest, you save three dollars within several years, and that is the closest I have seen to anything as kind of a generalized study on this, but it is on the workplace wellness system for kind of an average set of workers.

Again, we can see it service by service. We have some cumulative sense, but I know there is a whole effort going on. I think the Urban Institute has a big project. CBO is considering this right

now because if we do not get better at figuring this out, how can we expect you to make the investments?

Mr. RYAN. One final question and I guess I will throw it to you, Dr. Lambrew since I love the Center for American Progress, and I will let you hit this out of the park.

I think we have made some mistakes as far as how we present this, and Mr. Honda mentioned Mr. Conyers' bill of which I am a cosponsor. The fact that in the U.K. and in France, their life expectancy is a couple years longer than ours here. We make this healthcare argument. Our argument should be you will live longer if we put this system in place.

So I want to ask you why is it in the U.K. and France that they live longer than we do here in the U.S.?

I have been to France a couple times. A lot of smoking going on over there. I wonder how that fits in. [Laughter.]

Ms. LAMBREW. Yes. Actually, I should check the statistics. I still think we might smoke more.

We are similar in many respects especially if you look at some of the European nations and Australia in terms of our demographics. It is not significantly different.

Income statistics are generally similar. McKinsey Global Institute has been doing some studies, looking at controlling for wealth, how do our costs compare?

We stand out because we allow this uninsured problem to persist. There is no doubt that is why we are singularly different than these other nations. Every other industrialized nation does find a way to provide basic access to their citizens. As a result, it is not just infant mortality and life expectancy. It is outcomes from surgery.

The study that we just heard about is a landmark study. There was another one in Health Affairs a month ago that talked about deaths amenable to healthcare, that found that everybody is declining but here we decline slower. Every other country has kind of dropped in their deaths amenable to healthcare at a much more rapid rate than we have.

To throw in another one, a study that looked at people who join Medicare and followed them five years out and found that people with chronic illness who join Medicare have a significant improvement in their health status after five years being on Medicare. I mean the statistics are overwhelming.

Health insurance matters. We do not provide it to most people. It is not everything, and we do need to have complementary systems. It is solvable. It is important, and I do hope that this becomes the election issue that it promises to be.

Mr. OBEY. Let me ask a few questions. We are told that we are probably going to have votes around 11:30 on the floor, so that will pretty much crunch this hearing.

Mr. Popper, whenever you feel that you have to leave, please feel free to. We understand the situation.

Dr. Lambrew, let me ask a basic question first. You indicated in your statement that access needs to be addressed in order to address skyrocketing healthcare costs. Some people would say that is counter-intuitive, that the more access you have, the more cost, the more you are going to drive up cost.

Tell me why you say what you said.

Ms. LAMBREW. I think there are multiple different reasons, but the two I would bring to the fore because we have some data on it are, first of all, when we have again the 82 million people who have gaps in coverage at some point in time, to the extent that they incur costs through the emergency room, because there are other uncompensated care costs in the system, most of those costs get passed along to other people in the form of what is called the hidden tax where we basically are paying for that uncompensated care because providers have to charge people who have insurance more.

One study suggests that every family pays $922 more per year in premiums because of this cost shift of what can be claimed on the uninsured being shifted to people who already have health insurance.

It is a vicious cycle: more uncompensated care, more of a cost shift to people with insurance, the more expensive it is, the more people drop coverage. So, number one is this idea of cost shifting that exists in the system.

The second, and there was a study done by the Commonwealth Fund back in December that really tried to illustrate this, is we know there are some things we could do to change our cost trajectory: prevention, chronic disease management, information technology, making our system more rational and less complicated. All that is harder to do if we have gaps in the system.

So we are limiting and inhibiting our system-wide cost containment tools by having people coming in and out of coverage arrangements and not being able to implement the types of changes we know.

I mean when you look at what the Congressional Budget Office has been doing, the director keeps testifying and saying, our budget problem is a healthcare problem, and we cannot solve the Medicare and Medicaid problem until we solve the system-wide problem.

It is a huge problem. We have to solve the system-wide problem. As one economist said, covering all the uninsured is a prerequisite to doing so.

Mr. OBEY. Anybody else want to comment on that?

Ms. CHOLLET. I would like to add one comment that relates to the earlier discussion about health status and investment in health. Part of the problem of people rotating in and out of coverage when they rotate in and out of jobs, when their income falls, when their circumstances change, is that it gives the system a very short-term perspective.

The carriers, in particular, focus on the next year. If you ask them to try to project a premium, for example, that they would offer over three years, they have a hard time doing that because they think that population, their covered population is going to change year by year.

That means when you have an investment of a dollar that will yield a three dollars rate of return over three years, every carrier sees it, at best, as a wash because I only expect to have that person in my plan for one year.

So the process of rotating people in and out of coverage generates this very short-term perspective and subverts any investment in

health status, and I think that is a problem that is unique to this country. One of the reasons that other countries do have better health statistics is because there is, in fact, a rate of return to investment in health status.

Mr. OBEY. Well, it seems obvious to me that we have the most perverse disincentives in the world for people to focus on prevention because, very frankly, for many of these diseases the consequences show up later in life.

That means that if people transfer insurance companies two or three times, the insurance company cares about the people they are covering today, and they know that it is very likely in the end that it is going to be Medicare that will wind up getting stuck with the long-term ills. So why should they focus on it?

Dr. Lambrew, you said that 22,000 people die because of the lack of insurance. I am always suspicious of numbers and statistics, with all due respect to the mathematics part in your title. Where do you get that number? How hard is it and how can you back it up?

Ms. LAMBREW. The number comes from the Institute of Medicine which, back in years 2001 through 2004, conducted a series of reports, comprehensive reports, looking at the literature and trying to document everything from does insurance matter kind of on an access basis all the way through the economic cost to society.

They, back then, estimated that about 18,000 adults would have conditions. I think that they looked at the condition at death, looked at their insurance status prior to death and estimated that of all the deaths in a year 18,000 were due to, again, what is called amenable to healthcare sorts of diseases.

But the numbers have been updated since then because that number was for 2003, I think, to 2007 which is what the Urban Institute did just this fall through the spring.

Actually, I would say as a note, it is controversial. I do not want to discount that, but at the same time when we do know, again, we can do the accumulation of evidence. I think there have been some very good reviews of the evidence that say if we take it as a whole, because we cannot necessarily pick one thing or one reason why people die, it does have a difference.

Mr. OBEY. All right.

Dr. Chollet, well, I think virtually all of you talked about the fact that we are losing employer-based coverage and seem to be evolving to individual coverage. To me, that again is exactly going in the wrong direction because the whole idea of insurance to spread risk as widely as possible so that you do not wind up encouraging all kinds of cherry-picking.

What are the best things that Congress can do to try to reverse that trend, short of passing universal healthcare which I hope we do yesterday?

Ms. CHOLLET. Mr. Obey, I do not think I have a clear answer for that question because there are so many forces that contribute to the loss of employer-based coverage. The biggest one, of course, is healthcare costs generally and, therefore, the cost of health insurance. If health care costs generally did not outpace earnings growth by order of magnitude, probably we would not see the erosion of employer-based coverage.

There are no more tricks, if you will, in the Federal pocket around tax exemption. So that is not any longer on the table.

And, there is no way to offset the fact that an employment-based system puts American companies at a disadvantage in international competition.

I think the States have become more or less resigned to a lot of movement between especially small group coverage and individual coverage and are looking for ways to accommodate that movement rather than try to counteract it.

So, in answer to your question, I think the best thing the Federal Government can do is to pay attention to the fact that there is going to be movement in and out of employer-based coverage, that small employers that now offer coverage are not likely to continue to offer coverage, and that low wage workers cannot take a discount on their wages to pay for health insurance.

So support of those kinds of systems that enable people to move between individual coverage and group coverage, if it is offered, and retain access to healthcare and their providers, I think would be the most important service that the Federal Government could offer.

Mr. POPPER. Just some color commentary from the back yard, the third or fourth largest segment of employed individuals who apply to the Maryland Health Insurance Plan are consultants. The Federal Government and—I will probably get in trouble with the governor—the State Government are using more and more contractual workers and consultants to do their work. We have people applying to the Maryland Health Insurance Plan who work for Voice of America, and you would be amazed the Federal agencies they work for and they do not get health insurance. So they have to turn to the individual market to get coverage.

You can talk about tax incentives to buy, health credit tax incentives, this and that, but you have the sort of overall market trend in employment that Fortune 500 companies, small business, governments are moving more and more away from employing people and instead contracting with them.

With Maryland State employees, you get access to buy the employee health benefits, but the State does not put any money towards it. So you have to buy the full loaded group cost to buy it, and a lot of those people do not do it. Then when they get sick, they come over to the Maryland Health Insurance Plan.

With the Federal Government, if you are a contractor, I do not think you get an option to buy into the Federal health system. So just some news from the back yard in terms of the type of people we see coming into the risk pool.

Mr. NYCZ. The other thing that I have observed over the last 35 years is insurance is not what it once was when we started the Greater Marshfield Community Health Plan comprehensive first dollar coverage.

When you think about what is insurance and why do we have it, if you are a person of means and you have assets that you want to take care of, then insurance helps you spread the risks so that you do not have to tap your assets in the case that you get really sick.

If you are a low income person without any assets, with very little revenue, insurance in that sense does them no good. So then you look at to what extent does that insurance used in a different fashion as a tool to allow them to access health services.

And so, you would evaluate insurance differently if you were looking at a low income, uninsured population compared to, in the State risk pools, people who generally have more means but because of their work environment and their preexisting health conditions cannot get insurance in the individual market.

Ms. LAMBREW. A very quick comment which is I do some work with a coalition called the Better Healthcare Together which is famous for Wal-Mart and SEIU being the key members. They basically say that they do not think that they can solve this on their own, so they are trying to advocate for national change.

But, in the interim, there is one thing you all are responsible for and people are grateful for which is funding the research on what works and what does not. At the end of the day, we are going to have to figure out who gets what.

I do not want to use the word, rationing, because that is an ugly word, but until we can prioritize what is high value and what is low value and figure out how to do that, we are not going to be able to get at this trend.

Comparative effectiveness research, which you funded through AHRQ, is critical. We see the business coalitions coming behind it. Our CBO director has said this could save. It actually could self-fund itself over 10 years according to what their estimate of the CHAMP Act.

I thank you all because that is an important, critical investment that you have been making over time.

Mr. OBEY. We will hear more of this, this afternoon, in our panel. But it certainly seems to me that if we are moving, and I profoundly believe that we are, to universal healthcare being dealt with at the Federal level, you have tremendous incentives to actually figure out what does work and what does not work because the Federal Government is going to be spending a hell of a lot more money. It would be nice if we spent it on something that was useful.

Mr. Nycz, you know how much this subject bugs me, but it really bugs me that dental care seems to be looked at as one of those fancy extras that is not basic to real healthcare. I wonder if you would just take a couple minutes to comment on why that is not true and also tell me, give me some examples of how dental care has led to catastrophic health situations for individuals.

Mr. NYCZ. Well, I think maybe part of the reason dental care is viewed that way is because as a profession you hear a lot and you see on billboards, people are talking about cosmetic dentistry, not dental health related stuff but cosmetic. So people get the impression that is teeth whitening. That is everything else.

Most of the people are deeply affected by this problem pretty much live in the shadows of our society. Folks with means, I still believe, do not fully understand this problem, but we have a raging epidemic of early childhood carries.

I mean it breaks your heart to see kids coming in where you say we have to pull six teeth. We have to do crowns, and this is a little six year old child.

How does it affect the family when you have a child with chronic pain, up all night? You have to go into work. You cannot go into work. I mean I think it affects productivity. When children are affected that way, the parents are affected that way. If you cannot get help for your child, that is a horrible feeling as a parent.

You can go from children. You go through the life cycle. You can up to people who are thinking about having children. The research that we are getting out the National Institute or Oral and Cranial Facial Research says there may be an impact of periodontal disease in pregnant women on the birth of their child.

The Journal of Obstetrics and Gynecology, I think back in January of 2006 or 2007, had an article telling ob-gyns to take a look in the mouth and, if you have a woman with progressive periodontal disease, it may lead to a very low birth weight baby.

The researchers are still working on that, but my view on that is if you have a pregnant mom and she has periodontal disease, a lot of these folks are on Medicaid. They cannot get care. So even if you tell the ob-gyns you have to refer them, unless you have a place for them to go, then they just load up guilt on them.

We do not wait, so we prioritize pregnant women with periodontal disease. Even though we have waiting lists, we will put them at the head of the list and get them because it may mean.

I mean think about how many thousands of births we have in Milwaukee. We have this huge disparity in low birth weight babies and infant mortality between the black community and the rest of the community. How much of that is driven or could be driven by the fact that they are not getting access to basic services including dental?

So you go up the ladder. You go to the elderly. There is no dental benefit for the elderly. How does it affect the nutrition of someone who cannot chew because they have few teeth and the teeth they do have are painful and they do not have money to get dentures? So it affects their nutrition.

Studies out of England and here, if you are institutionalized and you are an elderly person, you can aspirate or inhale bad oral bacteria that can cause pneumonias. In England, they found one of the largest reasons for people going from nursing homes into hospitals is because they are aspirating these bad oral bacteria into their lungs and because of their fragility, they are contracting pneumonias. That is a great expense.

I know that is happening in our Country too. We are going into the nursing homes. We are training the nursing professionals on how to brush the teeth of the nursing home residents so they get daily oral hygiene to prevent that from happening rather than waiting for them to hit the hospital where we just fill them with antibiotics and hope that they are okay.

We have had vets, a lot of people. There is a lot of talk about honoring our vets and that. When we built the Chippewa Center, we talked to the Veterans Affairs person there, and he said he gets 10 calls a week from veterans of all wars who cannot get dental care because, of course, it is not service-related.

And job services agencies, we spend a lot of money trying to help low income people get better, pick themselves up by their bootstraps, get better education and get into a job. Yet, in Clark County, a county of 33,000, they tell me there is 100 adults a year that they cannot place in jobs because of rotten, broken and missing teeth.

Why do we tolerate that? I mean we can fix that. Community health centers can fix that if we get enough capacity.

I do not care where you go on the life scale, sometimes it is jobs. In my written testimony, we talked about a 20 year old who came in depressed, with horrible oral health. She did not have a job. She was going nowhere.

It turned her life around. She has a job now. She is feeling better about herself.

I could go and on. There are so many examples. If anybody talks to you like that, I would invite you to invite them to our centers and have them sit down and talk to some of the people.

When I was in Ladysmith, we had a fellow from Chippewa Falls, 55 miles south, before we built the Chippewa Falls clinic. He saw somebody with a suit walking around, and he asked the dentist who was working on him, who is that? Oh, that is the director, Well, have him come in here. I want to show him my mouth.

Soda drinker since age six, this person is going to be a denturist at the age of 20, but he had to get from Chippewa Falls to Ladysmith. It was a great burden for him to get there, and we could not do this all at once. So he was saying, can you please get care closer to home which is one of the reasons we built.

I told him, I do not need to embarrass you by looking in your mouth. We are already working on it.

The disability community has two or three strikes against them. Dentistry is largely a small for profit, solo enterprise. If you want to entertain and take care of intellectually and neural developmentally disabled people, you cannot do it in a standard office. You got to have a larger space. You got to have wheelchair lifts and special equipment, and it takes three times as long to take care of standard work.

So it is expensive to take care of them. It takes longer for all those reasons. You need special facilities. They do not get care. Some of the people who are traveling the furthest to get to us are the people for whom travel is the most difficult, people with severe disabilities.

Mr. OBEY. Thank you.

One last question, then I will pass the witness until the bells ring. If you were to pick out the top three or four things that this Committee ought to do or the top three or four places where we ought to put additional resources to deal with the issue of access, just very quickly, where would you put it?

Mr. NYCZ. I have great ideas on this: increasing community health centers. We are asking for funds that are not in excess of what we can achieve. It is a planned growth strategy.

There is plenty of research that shows health centers save money, and there is plenty of research that shows where you build primary care infrastructure, the costs—Winberg's work and so forth—even for the Medicare program where you have an over-

supply of specialists relative to primary care, less quality, higher costs.

So you guys are actually building primary care infrastructure and building that infrastructure is, in a sense, a core healthcare reform that may allow us, when we get to universal health insurance, to afford it better. So I would say absolutely that, and then the National Health Service Corps has to come hand in hand because we have to be able to staff those facilities.

And, if I get another one, I would say Telehealth is something that does help in the remote, rural areas, and definitely we are finding it very helpful.

Mr. OBEY. How about the rest of you?

Mr. POPPER. I would just say in terms of what this Committee could do is the high risk pool funding that has been provided, which we really appreciate, has not been provided consistently.

There has been some move on the part of Congress in authorizing it to try to target it and put in incentives, so the money is used to expand access or reduce member cost which Maryland has no problem with. That is the way we use it. But if it is not provided consistently, it is hard.

We talked earlier about insurance plans not being able to predict. Dr. Chollet talked about not being able to plan next year. If we do not get the funding consistently, it is hard to insure, as we did in Maryland, 300 more people in our low income program, offering really low premiums. Then the money is not appropriated next year, and then the premiums go up or we cannot sustain it.

So in insurance, for us, and I know you have a lot of people asking for funding, but if it could just be consistently provided, that would be very helpful to the pools to make sure we sustain the affordability and access goals that this Committee wants us to sustain by providing us the funding.

Ms. CHOLLET. I would second both of those statements. I think there would be three places that I would focus on, and the first would be community health centers. I think they are essential, and they have been under-funded. There is no replacement for them.

Second is an issue we talked about before, which is effectiveness research and not just any effectiveness research but effectiveness research that is really targeted to helping health plans and health programs prioritize delivery of services.

Oregon did this decades ago or 15 years ago and still stands out as a unique model of a State that actually examined the relationship between illnesses and services and decided on what was effective and what was not and actually prioritized what would be funded by their Medicaid program and were able to remove categorical eligibility rules so that everybody under poverty is eligible for the program and eligible for services that are deemed effective across the provider community.

And, finally, in the area that Mr. Popper referred to, assistance to the States and helping them maintain and build new programs. It is not only the administrative cost assistance that was given to the high risk pools but the State Health Planning Grants that you sponsored, Mr. Obey, to help States plan for a better system and to maintain capacity for that level of planning and public discussion in lean economic times.

I think in the absence of those State Health Planning Grants, we would not have seen the leader States that I mentioned in my written testimony. They relied on those funds to have a public discussion and to build and maintain the capacity that was needed in the State to enact those pieces of legislation.

Mr. OBEY. Thank you, Mr. Popper.

Ms. LAMBREW. Going last is hard because they said everything I want to say as well, but I will say in addition to the workforce and comparative effectiveness research, two different things on prevention and on the State planning grants.

On prevention, I think we should look hard at how we spend our money, how it is divided up within CDC programs, within the block grants because I think if we did a rackup and then tried to figure out how would we think through potentially pooling, redeploying and then increasing the amount of public health spending on it, it is a little bit more dramatic.

It is not just increasing the spending. It is thinking about the spending. I think it might be a good time to do it if we are on the verge of a national debate.

The second thing I would say is with the State planning grants, it did certainly help people. Hands down, States did things they would not have otherwise done without it.

But it also created a set of really engaged people who are advocates now, who have moved through different levels of government. Some of them have come to Washington, and others have gone everywhere else.

That is a human workforce capital investment that is not in the provider community but in the policy community. I do not know if there is anything else we could do with that, but I cannot begin to tell you how many times I have spoken with a group and worked with different States. Some real smart people have come into this field as a result of those grants.

How we can think about workforce investment and policy is something I think you ought to pursue.

Mr. NYCZ. I would like to say something about NIH because that is obviously a big part of what you fund every year. I think the NIH roadmap and the push to try to move knowledge into communities and to get things flowing is really a good trend.

Again, I will come back to community health centers. As a community health center director, I view myself as a consumer of research results, to try to translate those results and put them into practice.

I think societal investments that we make as a society in research. The outcomes of those investments should be available to everyone in that society, and health centers are helping to do that.

The CTSA programs now and their roadmap where they are trying to build translational research support in 60 major health science institutions—Madison, U.W.-Madison School of Medicine and Public Health has received one of those grants. They are reaching out to community health centers and trying to establish what I call kind of knowledge pipelines that will help us translate data.

The work that is coming out sooner and the people who bear the disproportionate burden of disease are the folks we serve, are the

poor. We have to find a way for them to capitalize on the research. I think the roadmap and some of the move to translational research should be applauded.

Mr. OBEY. Thank you.

Mr. WALSH. Thank you, Mr. Chairman. Mr. Nycz, the Federal budget provides about $2,000,000,000 for community health centers, but the actual budgets—costs to maintain, to run, to provide services at those clinics—is roughly about $9,000,000,000. Where does the rest of that money come from?

Mr. NYCZ. A big part of it is medical assistance. Because of where we are located, we serve a lot of medical assistance patients.

Mr. WALSH. Can you be more specific on medical assistance?

Mr. NYCZ. When we serve Medicaid patients, we bill for those services and we receive payment. So that is a huge chunk.

Mr. WALSH. So, Medicaid payments.

Mr. NYCZ. Medicaid payments. A smaller chunk but more active in the rural areas is we also serve low income Medicare patients, and we get money for that.

Plus, in the community health center program, pretty much everybody, unless you are in abject poverty, pays something on a sliding fee. For example, in our center, we get over a million dollars a year in sliding fee payments. That helps us with our programming.

Mr. WALSH. Thanks.

The two ladies who spoke more on the macro level, the idea that the western democracies in Europe are basically government-run healthcare systems. I am told that creates two tiers of healthcare, the healthcare for everybody and then the healthcare that individuals who have means go outside of that system.

Is that, in fact, true? If so, what does that do the overall quality of healthcare in those countries, first. Second, does that create a more positive healthcare system for those countries?

Ms. LAMBREW. I will let Dr. Chollet talk in a second, but in terms of, I will just take on three issues.

One is this idea of waiting lists and queues and what are the data showing on that. I think what happens here is that we do have our own type of queues. If you are low income, uninsured, you have a different system and often find yourself waiting, not getting access to care that you need for delays and money reasons.

We also, interestingly enough, for our insured population, our delivery system is stressed enough that same day access to healthcare is worse here than in European nations. So if you are insured and you need to see your doctor today for an urgent need, you are more likely to wait here than most, not all, other nations.

So we see that their triage system is more for discretionary service, kind of oriented things. We have here a socioeconomic kind of triage system as well as one that because of our delivery system stress and lack of a system, we have people waiting for urgent care.

On tiering and two tier systems, I do not know that there is any country that is so government-run that there is no such thing as an outside system. Canada has been debating whether or not they allow for private insurance on top of their provincial insurance. But, for the most part, every system allows it because they want

to be able to have a system where people have the basics and then people who have means get more.

Mr. WALSH. What percent of the people take advantage of those second tiers, third tiers?

Ms. LAMBREW. I am just going to say offhand that we looked at this two years ago. At the low end of the scale, it is a couple percentage points, I think, in Britain and in—I am trying to think what other nation.

Australia has been trying to promote it because Australia kind of has a basic Medicare program. They want to be able to have more in a second tier than they have now, but they have not had very much success with it. So it depends.

Mr. WALSH. What is the overall impact on healthcare because of that second tier or third tier?

Ms. LAMBREW. You know it is hard to find. As Senator Daschle, whom I work with, says often, we have islands of excellence in a sea of mediocrity.

We have some excellent healthcare. We have some outcomes that cannot be beat.

But there are very few studies that say systematically when you look at across not just our statistics on our health but our outcomes, survival from different types of treatment. When you have cancer, what are your odds of survival? These are the sorts of statistics that for people in the system, are they getting the kind of quality care, and we just do not rank at the top.

Part of it access. It cannot all be access, but it is the area that distinguishes us.

Ms. CHOLLET. Just in answer to your question, what is the impact of the private sector tier, if you will, on the public program, there is not enough of the private sector tier to wag that dog, if you will. The public program really defines the quality of care and access to care in the nation, and the rest of it sort of sits on top and does not do significantly other than what the public system does.

What it does is allow a different system of triaging, but it does not allow a different quality of care per se.

Mr. WALSH. Thank you both very much.

Mr. OBEY. Mr. Honda and Mr. Ryan, we have five minutes.

Mr. HONDA. Listening to you, it sounds like some of the opportunities that are out there could be taken up by school districts too, where they use their school facilities like the district office and colocate social services, health services and things like that.

I was reminded of when we put our new district office together for the Franklin-McKinley School District, we put a doctor's office in to make sure that all the kids were up to date on their shots, and then a dental office to make sure that the youngsters were getting good dental care.

10 years ago, I first heard that we saved a kid from dying of dental infection. I had never thought about that before; hearing what you are saying now just brings it even up to a higher level of urgency. So I appreciate all of your work and your input.

Mr. RYAN. Yes, I have one question that I would be surprised if you had the answer to. One of the issues, the core issues in our Country is the level of stress that we live under in the United States as opposed to some of the European countries.

I know I jokingly mentioned smoking, but to watch, as you all do and as we do from our levels and at the local level, the amount of stress that the families go under that are dealing with these healthcare situations.

I was just having a conversation with a friend of mine the other day whose wife had a premature delivery, one pound, two ounces, a year or two ago. Now she is in the second pregnancy, has had surgery and obviously had one premature birth and is going through all these surgeries and everything. The insurance company says to the family, this is not pregnancy-related, so we will not cover it.

Whether it is the dental or any situation that you guys are dealing with in the trenches, have we been able to measure the effects of stress in our society and how this just exacerbates a lot of these health issues that are being dealt with?

Mr. NYCZ. I am not familiar with that research, but I will tell you in kind of linking back to the schools, that we have programs that work in after school time. One of the observations we have had where we have 300 some kids in high need. We work on homework. We do all kinds of things with them.

One of the observations that came out of that is it lowers the stress in the families because their children have a place to go. Frequently, mom and dad are both at work. Then when they come home and they are tired from the end of the day, the kids' homework is done. They are doing better in school.

I was surprised myself to learn about this when we were looking at the impacts of our after school programs. The schools love it. They refer to these programs, and they are now working on trying. They would like us and the United Way may help us at some point to put in a dental facility right there where these kids are coming in.

I mean we have had actual examples in terms of there are some simple things you can do. You know where your kids are. They are in a good program. They are eating right. There is recreation. There is a gym there. They are learning homework. Many of them come back to volunteer.

The surprise was in the family surveys that it alleviated family stress.

Mr. RYAN. This is almost directly related to a lot of the mental health promotion that we talk about here.

Ms. LAMBREW. I will just add quickly. Last year, there was the Child Health Summit or Child Summit that you had here at the House, and there was a scientist who is beginning to look at some of the clinical research on prenatal stress and how that could affect the child.

We had some clinical linkages, but I think also there is a growing body of research that says in addition to our kind of obvious mental health problems, behavioral problems like alcohol use, drug use, and even obesity. Obesity may be self-medication for families under stress.

If we cannot figure out the role of stress in some of behavioral as well as our clinical settings, we are going to continue to have, I think, this chronic disease epidemic. [Laughter.]

Mr. HONDA. I think that when we talk about being more efficient and saving time, we do not use the time that we save.

Mr. WALSH. You need to add an iPod to that, and it will calm it right back down.

Ms. LAMBREW. We will have NIH fund the study of getting rid of BlackBerrys, iPods and cell phones in how to reduce stress.

Mr. RYAN. I want to volunteer for that study if I can. Thank you very much.

Mr. OBEY. Thank you all. We appreciate your time.

The Committee will resume at 2:00 in the full Committee hearing room.

U.S. Rep. Tom Udall (NM-3)
Labor/HHS/Education Subcommittee
Access to Healthcare
Ms. Jeanne Lambrew
3/5/08

1. **Dr Lambrew, please give us your suggestions on how health care spending can be reigned in.**

   Addressing the high and rising cost of health care must be a top policy priority – not just because it limits access to health care, but because it hurts our economy. It limits businesses' competitiveness and contributes to our fiscal deficit.

   There are three major drivers of health costs in the U.S. system. The first is that we assume that more or expensive care is better care. This is not always, or even often, true. Decisions are usually made without knowing the additional benefit or cost of a service or drug. People with multiple or chronic illnesses, who account for over 70 percent of the cost in the system, usually have numerous doctors offering competing and sometimes conflicting therapies. Duplicative tests are common in the absence of an electronic medical record. And the best outcomes are not concentrated in areas that offer the most services or with the highest costs. Focusing on providing the right care at the right time would both improve health and reduce costs if done well. Policies to promote this include:

   - Investing in comparative effectiveness research that will help patients, providers, policy makers and the public make better health care decisions;
   - Coordinating care across the system through models like medical homes, chronic disease management, and team-based care;
   - Sharing patient information and best practices and reducing duplication and errors through a national system of privacy-protected electronic health records;
   - Limiting self-referrals and other incentives for inappropriate overuse of care;
   - Simultaneously reforming medical malpractice and improving patient safety as a means of limiting "defensive medicine;"

   Second, we don't pay for what works to keep people healthy. The system pays more for an amputation for a diabetic than it does to prevent that complication in the first place. It pays the same for a high- and low-quality care. The United States could get more quality for its health care dollar by:

   - Prioritizing proven prevention practices through coordination and greater financial incentives for 100 percent use of them;

- Rewarding successful health care practices and providers though payment and other health system policies;

- Using information on what works in designing coverage to incentivize high-value care.

Third, the complexity and fragmentation of the health system makes it both hard to negotiate for fair prices and easy to shift costs to the payer with the deepest pocket – or least ability to negotiate, like the uninsured. This not only leads to higher prices but adds to administrative costs. This could be reduced by:

- Increasing pooled purchasing, enabling strength in numbers and economies of scale to get the best quality for the premium dollar;

- Providing a choice of plans, public and private, to encourage competition on price and quality in a system that guarantees access to fairly priced policies;

- Lifting the secrecy around prices and quality and harnessing information to improve system performance;

- Insuring all Americans, which would limit cost shifting and promote timely and appropriate use of health care.

2. **Dr. Lambrew, you note the shortage in family practice residencies. To what do you attribute this? How do we address this shortage?**

This is a complicated problem with no simple solution. Some of the family practice gap has to do with demand. Our health care system pays less for family practice than specialty care. Some of this reflects a bias toward an instant treatment to a problem rather than a "wait and see" approach or the hard work to prevent the problem in the first place. Aligning payment incentives for patients and providers toward keeping people well rather than treating them aggressively when sick would strengthen the demand-side pressure for family practice residencies. In addition, models like the medical home that pay physicians for coordinating care over time and across illnesses could increase the financial support and demand for family practice physicians.

In addition, there are challenges in increasing the supply. Attracting and retaining family doctors is hampered by factors such as the cost of medical education; the bias in the system for specialty and hospital-based residencies, and the punishing work environment for family physicians (e.g., long, unpredictable hours; complexity of multiple insurers; threats of malpractice suites). The Committee has a long history of supporting programs to lower the cost of medical education for targeted providers, and to train minorities and people from rural or underserved areas. Other more systemic proposals include reviewing the scope-of-practice laws to fill some of the prevention and primary care gap with different types of providers (e.g., physician assistants); creating a national, fair

system for medical error reduction to limit the toll that medical malpractice takes on physician supply; and contemplating an overhaul of the medical education system to limit the financial barriers to entry.

3. **Dr. Lambrew, you cite the disparity in coverage amongst whites, African Americans, and Hispanics, but claim that is not the only explanation for why racial and ethnic minorities have lower use of prevention, delayed use of needed care, and worse outcomes. Can you elaborate on what some of the other reasons might be, in your estimation?**

Across many illnesses and diseases, racial and ethnic minorities experience some degree of worse access to care, quality of care, and outcomes, according to *National Healthcare Disparities Report* for 2007. Since 2000, there has been no overall progress in reducing racial disparities. Some of these disparities relate to socioeconomic differences: the inequality in income, education, and similar factors spills over into the health system. However, according to an Institute of Medicine report, *Unequal Treatment,* even controlling for socioeconomic factors, health disparities exist. The report attributes some of this disparity to racial attitudes and discrimination that persists in the United States. This occurs at several levels: patients may not trust providers or the system; providers may make inaccurate assumptions about patients based on their race or ethnicity; and the utilization managers in the system may create barriers to those of different races or ethnicities. It recommends, among other policies, increasing minority representation among health care providers, strengthening the stability of the doctor-patient relationship, promoting the consistency and equality of care through evidence-based guidelines, and enhancing consumer and civil rights protections.

But it is important to note, as do most major studies on the topic, that lack of a health insurance for all Americans is a major impediment to reducing radical disparities. Simply stated, insuring all Americans is a necessary, if not sufficient, step to reducing racial and ethnic disparities in health.

May 8, 2008

U.S. Representative Tom Udall
1410 Longworth House Office Building
Washington, DC 20515

Dear Representative Udall:

I had the privilege of testifying before the House Labor-HHS Subcommittee in March, and wanted to take this opportunity to answer the questions you submitted for the record during that hearing.

To begin, the National Health Service Corps is a critically needed program that assists health centers to recruit and retain health professionals. Currently more than 4,000 NHSC clinicians, provide health care services to millions of Americans in need.

About half of all NHSC providers are at health center sites. In order to successfully recruit and retain clinicians in underserved areas for extended
periods of time, the statutory authority of the NHSC must be extended and funding for this crucial program must expand.

Our request for funding in Fiscal Year 2009 is $150 million for the National Health Service Corps program.

In my testimony I spoke particularly about the challenges involved in meeting the dental access needs in underserved communities across the United States, particularly in rural communities. The National Health Service Corps plays a crucial role in addressing that need as well: a 2006 study published in the *Journal of the American Medical Association* found that 32.6% of rural CHC dentists are either past scholarship awardees or are currently receiving loan repayment from the NHSC.

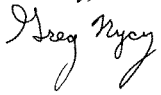
While we support the President's call for funding of additional dentists in the NHSC in Fiscal Year 2009, we are concerned that, under the President's proposal, this increase in funding would be offset by reductions in the administrative account (the "field" line) necessary to administer the NHSC program. This account funds vital programs, including the SEARCH (Student/Resident Experiences and Rotations in Community Health) program, the NHSC Ambassadors program, and the Ready Responders program for meeting emergency preparedness needs.

While the Health Centers program has seen historic growth as the result of your Subcommittee's hard work, in recent years the National Health Service Corps program has been flat-funded. At the local level and at the national level, it is critical that these two programs work together and grow together. Investments in the growth of the Health Centers program will only be further leveraged by commensurate investments in the NHSC, as health centers will be able to serve more patients in need in a more rapid fashion.

On a local level our community health center has supplemented its federal grant support with state grant funds designed to provide us with resources to expand access to dental care. We established our first dental clinic in Ladysmith, Wisconsin back in 2002. At the time, our State Primary Care Association was fond of reporting on the growth of dental chairs in Wisconsin's community health centers. I sat down with our State Medicaid dental analyst to discuss our need for Medicaid data to help guide our operations. I asked what type of information could we provide them as part of our accountabilities for the use of state tax dollars. His insightful response was "report on the number of FTE providers not dental chairs." This response drove home the point that if our health centers were going to be accountable to state and federal authorities for the investment of tax dollars we must demonstrate that we can deliver more than just infrastructure. To do so, we must be able to recruit and retain staff to always keep those "chairs" busy. Given Ladysmith's rural and relatively remote location, how would we recruit the five dentists, five hygienists and the other support staff needed to keep our chairs busy? In the early years of our dental expansion activity the National Health Service Corps played a key role in helping us obtain the personnel we needed to produce precisely what the state wanted to buy – increased access to dental services for its Medicaid recipients and its uninsured, low-income population. Our success in this area with the important assistance from the National Health Service Corps helped us to garner additional state investments, which has now lead to four dental centers in four separate communities.

As a nation, I hope we are committed to standing up the infrastructure necessary to care for all or our residents. Growing in the National Health Service Corps must be part of our workforce strategy if the investment in infrastructure in rural and inner-city areas is to realize its full potential to positively impact the lives of the citizens who live in these less affluent or more remote regions of our country.

Sincerely,



Greg Nycz, Director
Family Health Center of Marshfield, Inc.

U.S. Rep. Tom Udall (NM-3)
Labor/Education/Education Subcommittee
Access to Healthcare
Ms. Deborah Chollet
3/5/08

Q: Ms. Chollet, you touch on the key components of the Massachusetts plan in your written testimony. You also mention the debate in my home state of New Mexico going on around this issue. Can you tell us what Massachusetts did right, and how they were able to get to the point that they enacted major reforms? What lessons can we take from their efforts?

A: Thank you for your question, Mr. Udall. A number of factors contributed to Massachusetts' success in enacting major reforms.

Certainly, Massachusetts had a relatively low uninsured rate to begin with and a higher rate of employer offer, particularly among small employers. Consequently, the problem was not so big as in some other states. However, while this consideration arguably made reform somewhat less daunting, it also potentially made the case for major reform less compelling.

So what compelled reform in Massachusetts? Policymakers in Massachusetts generally point to a number of factors that I summarize in four categories: momentum, leadership, crisis, and opportunity.

- Massachusetts had a history of incremental health care reforms that built momentum for more comprehensive reform. Policymakers were knowledgeable about issues and potential solutions. Moreover, a strong advocacy community was pushing for something to be done: a ballot question requiring universal coverage almost passed and posed an ongoing threat to policymakers.
- Massachusetts had excellent bi-partisan leadership on health care issues from its Republican governor and Democratic House leader.
- Massachusetts was presented with a crisis: it had tapped into federal dollars to fund the safety net, and CMS would not renew the state's waiver as it existed. Therefore, Massachusetts stood to lose $385 million in federal funding if a new plan was not developed. In addition, Massachusetts' individual health insurance market was widely viewed as unstable and unaffordable.
- Massachusetts looked for opportunities within its current circumstances to support major reform and found several. It already had a generous Medicaid program with successful outreach and enrollment, providing a strong base of coverage for low-income residents. It was able to take some of the federal dollars that it had used to support its safety net and reallocate them to finance subsidies in a new CommonwealthCare program for residents with modest incomes, but not eligible for Medicaid. Finally, it had already made some individual health insurance market reforms to improve access (requiring all carriers to use adjusted community rating), bringing access and rating rules very nearly equal in the small group and individual markets and making it much easier merge the markets.

The principal lessons to be taken from Massachusetts' experience can be grouped into the same categories. Specifically:

- The process of reform is important and often protracted. The value of the process is in educating policymakers and developing strong public-interest advocacy for change. Other states that have enacted major reforms also have had long histories of public discussion about the need and options for change.

- Bipartisan leadership and a determination to work together are essential. Reform of the magnitude enacted in Massachusetts cannot occur without leadership and cooperation across party lines.

- Policymakers must see a clear, compelling, and near-term need for change. Massachusetts faced an immediate crisis in funding its safety net and a general sense of imminent melt-down in its individual health insurance market. But other states objectively are in circumstances that are not much different: in all states, low-income, uninsured residents have difficulty accessing the care that they need, and safety net hospitals and other providers struggle to survive. Also, in virtually every state, the individual health insurance market is inadequate to meet the need for coverage: residents without access to employer or public coverage are much more likely to be uninsured than to find affordable private coverage as individuals. Episodic coverage and impeded access to care compromise the quality of care and health outcomes, add system-wide cost, and increasingly present serious public health risks.

- Once determined to enact major reforms, it is essential to look for opportunities to re-craft current funding, programs, and markets. For example:

  - In all states, Medicaid and SCHIP are essential building blocks for coverage. States that have enacted major reforms generally have extensive Medicaid and SCHIP eligibility under federal waivers and plan amendments.

  - States can build on current systems and tax preferences for employer-based coverage and financing. Small employers generally want to maintain coverage if they now offer it, but need more stable premiums and simpler administration. Small employers that do not want to offer coverage will offer premium-only cafeteria plans, but need assistance in setting them up in order to avoid inadvertent tax consequences. Employees value choice among plans—but not a proliferation of confusing choices. Government can play an essential organizing role to facilitate coverage for employers and workers in small firms. Massachusetts embraced that role by forming a Connector and developing CommonwealthChoice.

  - Finally, states can confront problems in their individual health insurance markets, regulating how coverage is issued and rated. States that have high risk pools can ensure that high-risk pool coverage is as accessible and affordable as coverage in the general market—but none yet do so. As in Massachusetts, enactment and enforcement of an individual mandate is likely to be essential in making the individual market both stable and accessible.

TUESDAY, MARCH 11, 2008.

IMPLICATIONS OF A WEAKENING ECONOMY FOR TRAINING AND EMPLOYMENT SERVICES

WITNESSES

SANDI VITO, ACTING SECRETARY, PENNSYLVANIA DEPARTMENT OF LABOR AND INDUSTRY

BRUCE WYNGAARD, VICE CHAIR, OHIO WORKFORCE POLICY ADVISORY BOARD

ANDREW SUM, DIRECTOR, CENTER FOR LABOR MARKET STUDIES, NORTHEASTERN UNIVERSITY

LARRY E. TEMPLE, PRESIDENT, NATIONAL ASSOCIATION OF STATE

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