Testimony of Steffie Woolhandler, M.D., M.P.H.
Before the Health Subcommittee of the Committee on Energy and Commerce
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Mr. Chairman, members of the Committee. I'm Steffie Woolhandler. I am a primary care doctor in Cambridge, Massachusetts, and associate professor of medicine at Harvard. I also co-founded Physicians for a National Health Program. Our 16,000 physician members support nonprofit, single-payer national health insurance because of overwhelming evidence that lesser reforms – even with a robust public plan option - will fail.

Private insurance is a defective product. Unfortunately, the Tri-Committee health reform plan would keep private insurers in the driver's seat, and, indeed, require Americans to buy their shoddy goods. Once failure to buy health insurance is a federal offense, what's next? A Ford Pinto in every garage? Lead-painted toys for every child? Melamine-laced chow for every puppy?

Even middle-class families with supposedly good coverage are just one serious illness away from financial ruin. My colleagues and I recently found that medical bills and illness contribute to 62 percent of all personal bankruptcies – a 50 percent increase since 2001. Strikingly, three-quarters of the medically bankrupt had insurance – at least when they first got sick.

In case after case, the insurance families bought in good faith failed them when they needed it most. Some were bankrupted by co-payments and deductibles, and loopholes that allowed their insurer to deny coverage. Others got too sick to work, leaving them unemployed and uninsured. And insurance regulations like those proposed in the tri-committee bill cannot fix these problems.

We in Massachusetts have seen in action a plan like the one you're considering. In my state, beating your wife, communicating a terrorist threat and being uninsured all carry $1,000 fines. Yet despite these steep fines, most of the new coverage in our state has come from expanding Medicaid-like programs at great public expense. According to the state's disclosure to its bondholders, our health reform has cost about $5,000 annually for each newly insured adult. That's equivalent to over $200 billion annually to cover all of America's uninsured.

But even such vast expenditures haven't made care affordable for middle-class families in Massachusetts. If I were to lose my Harvard coverage I'd be forced to lay out $4,800 for a policy with a $2,000 deductible before it pays for any care, and 20 percent co-payments after that. Skimpy, overpriced coverage like this left 1 in 6 Massachusetts residents unable to pay their medical bills last year.

Meanwhile, rising costs have forced the Legislature to rob Peter in order to pay Paul. Funding cuts have decimated safety-net hospitals and clinics, and the current budget drops coverage for 28,000 people.

As research I published in the New England Journal of Medicine showed, a single-payer reform could save about $400 billion annually by shrinking health care bureaucracy – enough to cover the uninsured and to provide first dollar coverage for all Americans. A single-payer system would also include effective cost-containment mechanisms like bulk purchasing and global budgeting. As a result, everyone would be covered with no net increase in U.S. health spending. But these savings aren't available unless we go all the way to single payer.

Adding a public insurance plan option can't fix the flaws in Massachusetts-style reform. A public plan might cut private insurers' profits, which is why they hate it. But their profits account for only about 3 percent of the money squandered on bureaucracy. Far more goes for marketing (to attract healthy, profitable members) and demarketing (to avoid the sick). And tens of billions are spent on the armies of insurance administrators who fight over payment and their counterparts at hospitals and doctors offices. All of these would be retained with a public plan option.

And overhead for even the most efficient competitive public plan would be far higher than Medicare's, which automatically enrolls seniors when they turn 65 and disenrolls them only at death, deducts premiums directly from Social Security checks, and does no marketing.

Unfortunately, competition in health insurance involves a race to the bottom, not the top. Insurers compete by NOT paying for care: by denying payment and shifting costs onto patients or other payers. These bad behaviors confer a decisive competitive advantage. A public plan option would either emulate them – becoming a clone of private insurance – or go under. A kinder, gentler public plan option would quickly fail in the marketplace, saddled with the sickest, most expensive patients, whose high costs would drive premiums to uncompetitive levels.

In contrast, a single-payer reform would radically simplify the payment system and redirect the vast savings to care. Hospitals could be paid like a fire department, receiving a single monthly check for their entire budget, eliminating most billing. Physicians' billing could be similarly simplified.

Eight decades of experience teach that private insurers cannot control costs or provide families with the coverage they need. A government-run clone of private insurers cannot fix these flaws. Only single payer national health insurance can assure all Americans the care they need at a price they can afford.

Thank you.