S. HRG. 111–25

ROUNDTABLE DISCUSSIONS ON COMPREHENSIVE HEALTH CARE REFORM

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

ON

IMPROVING QUALITY AND REDUCING COSTS, EXPANDING COVERAGE, AND FINANCING OF COMPREHENSIVE HEALTH CARE REFORM

APRIL 21, MAY 5, AND MAY 12, 2009

Printed for the use of the Committee on Finance

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ROUNDTABLE ON IMPROVING QUALITY AND REDUCING COSTS IN THE HEALTH CARE DELIVERY SYSTEM

TUESDAY, APRIL 21, 2009

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The roundtable was convened, pursuant to notice, at 10:12 a.m., in room SH–215, Hart Senate Office Building, Mr. John Iglehart (moderating).

Present: Senators Baucus, Conrad, Bingaman, Kerry, Lincoln, Wyden, Schumer, Stabenow, Cantwell, Nelson, Menendez, Carper, Grassley, Hatch, Snowe, Kyl, Bunning, Crapo, Ensign, Enzi, and Cornyn.

Also present: Democratic Staff: Bill Dauster, Deputy Staff Director and General Counsel; Liz Fowler, Senior Counsel to the Chairman and Chief Health Counsel; Tony Clapsis, Associate; Shawn Bishop, Professional Staff Member; Kelly Whitener, Fellow; Toni Miles, Fellow; Catherine Dratz, Health Policy Advisor; Chris Dawe, Professional Staff; and David Schwartz, Health Counsel. Republican Staff: Kolan Davis, Staff Director and Chief Counsel; Mark Hayes, Republican Health Policy Director and Chief Health Counsel; Nick Wyatt, Tax Staff Assistant; Michael Park, Health Policy Counsel; Terri Postman, Detailee; Susan Walden, Health Policy Advisor; and Jill Kozeny, Communications Director.

Panelists:

John Iglehart, Founding Editor, Health Affairs;
Paul J. Diaz, J.D., President and CEO, Kindred Healthcare Inc., Louisville, KY;
Glenn M. Hackbarth, J.D., Chairman, Medicare Payment Advisory Commission, Washington, DC;
Allan M. Korn, M.D., Senior Vice President, Chief Medical Officer, Office of Clinical Affairs, Blue Cross Blue Shield Association, Washington, DC;
Peter V. Lee, J.D., Executive Director, National Health Policy, Pacific Business Group on Health, San Francisco, CA;
Mark B. McClellan, M.D., Ph.D., Director, Engelberg Center for Health Care Reform, Brookings Institution, Washington, DC;
Lewis Morris, J.D., Chief Counsel to the Inspector General, Office of Counsel to the Inspector General, Washington, DC;

Mary D. Naylor, Ph.D., FAAN, RN, Marian S. Ware Professor in Gerontology, University of Pennsylvania School of Nursing, Philadelphia, PA;
Debra Ness, President, National Partnership for Women and Families, Washington, DC;
Frank G. Opelka, M.D., FACS, Vice Chancellor for Clinical Affairs, Professor of Surgery, Office of the Chancellor, Louisiana State University, Health Science Center, New Orleans, LA;
Glenn Steele, Jr., M.D., Ph.D., President and CEO, Geisinger Health System, Danville, PA;
John Tooker, M.D., MBA, FACP, Executive Vice President/CEO, American College of Physicians, Philadelphia, PA;
Richard J. Umbdenstock, FACHE, President and CEO, American Hospital Association, Washington, DC; and
Ronald A. Williams, Chairman and CEO, Aetna Inc., Hartford, CT.

[The prepared statements of panelists can be found in the appendix.]

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The Committee will come to order.

Hubert Humphrey said, and I quote him, "Freedom is hammered out on the anvil of discussion, dissent, and debate."

Today, the Finance Committee holds the first of three roundtable discussions. We hope that these discussions might be the anvil on which we hammer out health care reform.

The Committee has spent a significant amount of time laying the groundwork for comprehensive health reform. In the past year, we held a dozen hearings, held a day-long health reform summit just across the street at the Library of Congress.

Now, the time for action approaches. These roundtable discussions will preview many of the policies that the Committee will consider in its June markup.

We will follow up today's roundtable on delivery system reform with another on expanding health coverage to all Americans on May 5, and then we will have our third roundtable on financing health reform on May 14.

Why is delivery system reform such a critical part of comprehensive health reform? Because our current system falls short. It falls short in terms of the value that we get for the dollars that we spend. We spend more than any other country in the world, yet the U.S. health system scores 65 out of 100 on indicators of health outcomes, quality, access, equity, and efficiency. And we know from previous research that adults receive recommended care only about half of the time in our country.

We have the opportunity to modernize our outdated payment systems, and today's payment systems encourage delivery of more care rather than better care.

We have the opportunity to improve quality. We can encourage care coordination. We can promote integrated, patient-centered delivery of health care.

Each of our participants brings an important voice to the discussion. They are experts, or stakeholders, or both. Among our guests are folks from the hospital and physician communities; we have

consumer and business representatives; we have voices for chronic care management, current and former government officials, and experts in health care fraud and abuse.

Forgive me for not taking the time to introduce each person. We have distributed a biographical sketch and a brief statement for each part icipant.

Before today's session, we gave each participant some questions that will help start our dialogue, and beyond that, I anticipate a fruitful discussion.

So let's get started with our discussion. Let's start hammering out health care reform.

I personally believe that this is a terrific, wonderful opportunity that we have, not only in the health care community but also in America. Not many times like this pass by. I think it is very important, it is exciting, in fact, that we have the opportunity here to come together and to come up with health care delivery that makes sense for Americans so more Americans have higher quality health care at an affordable cost and access to our health care system in a way we all know that it should be.

We also must remind ourselves that if we do not act now—that is, this year—the consequences will be dire. The alternative to not passing significant health care reform is dramatically increased costs in health care for consumers, for business, for governments, and it will be very difficult later on to pass the kind of health care reform that we know is needed. It will be harder to do that later on, so we have a terrific opportunity now. It is going to take a little work, but anything worthwhile takes a little bit of work. And I just feel very, very good and very excited that the time has now come, the stars aligned, where we are going to do meaningful health care reform in America. And today is going to mark the beginning of that effort, and you are all part of it, and thank you so much for being here today to help us move along that path.

Now I would like to turn to my partner here, Senator Grassley.

OPENING STATEMENT OF HON. CHUCK GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. Thank you, Mr. Chairman, and thanks to all of you who are going to participate today, as well as the members who are going to have to spend so much time on this issue over the next 2 or 3 months as we work to put this bill together.

This is the toughest issue and most needed issue that Senator Baucus and I have ever been involved in, and it is not just talking about health care. It is talking about things that affect 16 percent or 17 percent of our gross national product.

Most everybody agrees that our health care system is not performing as efficiently as it should. We have escalating costs, an inefficient delivery system, and 47 million people lacking health insurance. We need to make significant improvements in our delivery system, and we must make these reforms in a fiscally responsible way.

A job this big and this important requires everybody to be working together. During the last year, the Finance Committee has held a series of hearings on health care reform. We have heard many witnesses tell us what is wrong with the system and how they be-

lieve health care delivery can be improved. Indeed, some health care providers deliver high-quality care at lower cost. We want to learn from people who are doing things well, take the best ideas, and apply them where we can.

Each and every one of you plays an important role in the health care system. If we are to succeed in making real changes that benefit millions of Americans, all of us are going to have to listen and consider many ideas. Now is the time for innovation and for reform.

I urge all of us to roll up our sleeves and help us figure out how to make these proposals work. Everyone will have to be willing to recognize strengths, improve upon weaknesses, and find common ground.

I am very appreciative that all of you have come here today to help with this process. Working together, we can make a difference and we can improve our health care system.

Thank you.

The CHAIRMAN. Thank you, Senator.

In an effort to ensure the most productive conversation, I urge all my colleagues, all of us, and panelists to be quite brief. There are many of us here, and there is not a lot of time. So I urge each of us to get straight to the point, get straight to the heart of the matter in your comments, and that will be most productive.

Mr. John Iglehart will moderate. We discussed this in advance, John and I. The thought is that John might give a few ground rules. Then he will begin asking questions of panelists. You all have questions in advance anyway. Our thought is that Senators could then jump in any time they want, but I would ask Senators and panelists who wish to speak to just raise your hand, and John will then recognize you.

Again, let's be brief in our comments, and if I personally think that someone is speaking a little bit too much, you will hear this little sound. [Gavels.] That means it is time to cut it off. Okay. Thanks a lot.

We are very honored to have John here. John moderated an earlier discussion over at the Library of Congress and did such a great job that we thought we would invite him back. John, thank you very much.

Mr. IGLEHART. Thank you, Senator Baucus.

The panelists, too, given my position at the table here, if you do have a comment or a question you would like to make or ask, if you would put your ID cards in a vertical position, I would be able to see that a little better than if not. And, of course, I will entertain questions from Senators, or comments, any time their raise their hand.

We will begin questions with Dr. Glenn Steele, who is the CEO of the Geisinger Health System in Pennsylvania. And the question I would ask him or the comment I would start with, anyway, is that Geisinger Health System nationally has been recognized as an innovative system that has tried a number of things to focus on improving quality, increasing the efficiency of its plan, and the like. And given that, Dr. Steele, the first question I would ask you is: As the Congress works on health care reform, what are the key les-

sons that the Congress should take away from the Geisinger experience?

Dr. STEELE. Thanks. First of all, it is an honor to be here. I am privileged to be a part of this august group.

I think the Geisinger experience is a remarkable way of framing the issue. We are able to take our insurance leadership and we are able to take our clinical leadership, the docs and the nurses, and focus on the patient groups that we think get the least good care. There would be the chronic disease patients. This would be the patients with the greatest variation for hospital-based therapy. It would be the end-of-life patients.

What we start with in the discussion, since we are in this integrated health system, insurance and provider, is: What is the end result we would like to get with that group of patients? How would we like to go from where we are now to where we want to be? And then we back out from the correct incentives.

So we do not start with a negotiation that is based on getting more units of pay for a particular piece of work. What we start with is: Where do we want the patients ideally to be in 3 or 5 years? And then how do we get the reimbursement aligned throughout our doctor group, throughout our doctors and the hospitals, to get there?

I think what we have shown—and, again, the question is: Is it scalable, is it generalizable to other markets and other non-integrated systems? But what we have shown, John, is that when you increase quality for these groups of high-utilizing patients, you are also decreasing cost. So increased quality and decreased cost actually will cohabitate.

That would be my answer.

Mr. IGLEHART. Let me follow up and ask you, many of your patients in some of your system are located in rural areas in Pennsylvania. What are the challenges presented in terms of care coordination, more efficient delivery, when it comes to serving patients in rural settings?

Dr. STEELE. Well, the obvious issue is access to primary care, access to a series of small hospitals that, you know, are very challenged in terms of their operating costs and access to capital. And one of the things that we have done is to try to take responsibility for that. We have established a huge number of primary care physicians out in 43 counties. We attempt to take care of as many of our Geisinger patients as possible in non-Geisinger hospitals, many of which account for half of their admissions—those very small rural hospitals. And we have found ways actually to extend our capital access to these hospitals in order for them to get up to snuff in very expensive technology.

So I think the other advantage in rural areas—everybody always bemoans rural areas, but actually we have a very stable population, and that gives us an advantage because we can see the effects of what we do not just over 30 days or 6 months, but over many years. We have stable families, sometimes multigenerational, and we can use that asset to help take care of a lot of these chronic disease patients without having to have them, schlep into the emergency room.

So the rural issue actually cuts both ways, and there are some real advantages we have found. We couldn't do it without electronics. We couldn't do it without Health Information Technology (HIT) throughout our entire geography. It would be impossible because of the physical distances.

Mr. IGLEHART. Now, you describe the Geisinger system as an integrated system, which it certainly is. But the patients come from the channels of payment derived from several different channels. And in a recent paper that Health Affairs published that you coauthored, you talked about the sweet spot of one-third of Geisinger patients for whom you are financially and clinically responsible, and then the other 70 percent or so of Geisinger patients come through, as I understand it, a fee-for-service payment channel.

Can you describe either differences in costs or differences in efficiency between this sweet spot cohort of one-third of the patients and the other 70 percent?

Dr. STEELE. You know, I am going to be a little circuitous on this one. Seventy percent of our payer is Capital Blue Cross, Highmark, Northeast Blue Cross, and Coventry, and governmental payors and 30 percent, as you say, is our own insurance company. So for that 30 percent where we are both giving care for patients and we are insuring them, that is where we have committed our major innovation, because as I said, we can have our insurance leaders and our docs and nurses in a different conversation than we have with Capital Blue Cross, Highmark, Coventry, and Northeast. That conversation is the old-fashioned "we are trying to get the best rates we possibly can per unit of work we do," and that is high yield for us.

Now, when we create an innovation, whether it is our ProvenHealth Nagivator—an advanced medical home program—or whether it is the "warranty" we have developed that takes cost out, it is obvious that we do that for all the patients, regardless of who the payer is. So it benefits all the patients. And because our insurance company is relatively small and is competing with big, big insurance companies, the way that insurance company sells its commercial product is to take some of that value and give it back through lowered premiums to the small commercial buyers.

Mr. IGLEHART. And then one last question. Do you have a problem hiring or retaining under contract primary care doctors in your plan, Doctor?

Dr. STEELE. We do not, John, because we pay them better than market, and we pay them better than market because we cross-subsidize from our specialists. That is part of our social contract. Our specialists basically understand how important it is to have the entire continuum of care, and our commitment is to having primary, secondary, specialty, non-hospital, and hospital based. So it is a cultural and very important social contract that allows us to get those folks.

It is a tough market, obviously, and one of the other things that is very important is the re-engineering of our primary care. We have a lot of physician assistants (PAs) and nurse practitioners now doing things that used to be assigned only to primary care physicians. So we can recruit them, but we are also re-engineering.

The CHAIRMAN. John, if I might ask both Glenn and also Mr. Hackbarth, your recommendation of how we can transfer, transport what you do to nationwide—that is, through Medicare or however? You know, to be honest, all these concepts, I think, are pretty much all agreed upon as good delivery system reform. And some sectors of the economy are doing it. Some hospitals, some docs, some specialties are doing this. Certainly Geisinger is. So the real question, for me anyways, is your advice on how we transfer it, how we transport it to the country as a whole, maybe using Medicare or whatnot. Just what advice do you have and what problems do you see going along the way, and how would you iron out those kinks?

Dr. STEELE. Well, the first thing I would do is to redesign CMS. I think CMS needs to be an engine of innovation, not a stultifying bureaucracy. I think that part of the redesign should be based on a patient focus, and I would start with the patients that are probably the highest cost and probably have some of the poorest continuity of care. And then I would back out—after you decided where you wanted to go with that group of patients, I would back out how you paid for that care.

Now, going from where we are in our structure to where we would want to be in medical home or bundled payments or what have you is not going to be easy to get perfect straightaway. So I think there is going to have to be some sort of a learning network or some sort of an ability where you take the demonstration projects and you really make a much more rapid cycle time so that you are not waiting 5 to 8 years for each demonstration project to give you some innovative approach.

Mr. IGLEHART. Senator Stabenow?

Senator STABENOW. Thank you very much. Thank you, Mr. Chairman, and thank you to each of you. I guess my question——

The CHAIRMAN. If I might, I am just curious. Glenn did not get a chance to answer that question. I asked the same question of Glenn. If he could just answer that question, because MedPAC has a lot of thoughts on that, too, I would guess. I am sorry, Senator.

Mr. HACKBARTH. Thank you, Senator Baucus.

Geisinger is a terrific organization. My own professional experience in health care management is in Geisinger-like organizations, but as you say, most of American health care is not currently organized that way, and so we will need to start with building blocks and move in measured steps towards better coordination, better integration of care.

I would like to identify two opportunities in Medicare. One is to change how we pay physicians, with particular emphasis on both increasing the level of payment for primary care and changing the method of payment for primary care, not just paying fee-for-service but also paying a lump sum per patient, as is embodied in the medical home idea.

We have abundant research that shows that strong primary care is essential for a well-functioning, high-performing health care system. As you know all too well, primary care in the United States is weak and, unfortunately, getting weaker. So that is a key priority.

A second major opportunity that we see both for improving care and reducing cost as well as starting to build some organization in

the health care system is a focus on readmissions. As you know, Senator, Medicare has a very high readmission rate. About 18 percent of Medicare patients are readmitted within 30 days of a hospital discharge at a substantial cost financially and some cost in terms of pain and suffering and risk for the patients involved as well.

What is striking about those numbers is there is a very large variation in readmission rates across hospitals, and so we see in that an opportunity for the high readmission rate hospitals to improve by learning lessons from their peer hospitals.

We think that there are two types of changes that Medicare ought to make in order to encourage a focus on readmissions. One would be to feed back data to hospitals and their medical staffs on how their readmission rates compare to their peers' and then follow that with a penalty on excessive readmission rates.

Concurrent with that, we think that Medicare ought to invest in pilots of what we refer to as bundling, whereby Medicare would make a single payment covering all of the cost of the admission and perhaps post-acute care as well, so it would cover the hospital inpatient care, physician services provided inpatient, plus potentially post-acute providers. And so if there is a single payment, there will be a strong incentive for all of the participants—the physicians, hospitals, and post-acute providers—to focus on how we can reduce the readmission rate.

A secondary advantage of that is that providers that heretofore have acted in silos independently of one another will need to come around the same table and say, "How do we solve this problem?"

The CHAIRMAN. Good. Thank you.

Mr. IGLEHART. Senator?

Senator STABENOW. Thank you.

Dr. Steele, I wondered if you could speak a little bit more about your ability to focus on chronic diseases and be patient focused as an integrated system? Because as I understand it, you own your own hospitals; you have home care; you have nursing homes. And that is a different delivery model than we have in other areas. You have your own insurance company that is covering a third of your patients. To what extent does that—if you could speak more to how that affects your success in doing what we all want, which is to be creating a system that is more patient focused?

Dr. STEELE. Senator, I think it is critical, and, you know, we could talk about the blocking and tackling, but the main reason that folks with congestive heart failure end up being admitted and readmitted and/or readmitted—in our experience—is they do not take their medicines at the right time or correctly. I mean, it is just that simple.

Now, solving that problem is an immense and complex series of blocking and tackling issues that we have accomplished in different ways. We put nurses in our community practice sites, and the nurses take care of 125 of the sickest patients on a 24/7 basis, so it is kind of like concierge care for the sickest, not the richest. And it basically helps to redesign the practice, so the primary care physicians are able to do something else if the nurses are really triaging those sickest patients.

The real question is: What are the lessons for scaling and generalizing to the rest of the country? And I do not have simple answers for that. But I think if in Medicare you are able to focus on that as a 3- to 5-year goal: number one, I bet you would cost it out through CBO and it would be a huge savings; and, number two, you know, if you could create some sort of an innovation engine that would allow other systems that were like ours or virtual systems to try to solve for us, because we are not going to be able to come up with the perfect generalized solution.

Now, if you don't get there, then maybe there should be a Plan B, and the Plan B would be something that would be a lot more onerous, you know, than 3 to 5 years of innovation and trying to get there. So that would be my response.

Senator STABENOW. Thank you.

Mr. IGLEHART. Senator Conrad?

Senator CONRAD. Just following up on Dr. Steele, and I pose this to the panel because I do not know—perhaps, Mr. Iglehart, you can direct the question. The statistic that jumps out at me is 5 percent, roughly 5 percent of Medicare beneficiaries—Dr. McClellan would know this—use half of the budget. Five percent use 50 percent of the money, and they are the chronically ill. And we do a very poor job of coordinating their care. The result is we get weaker health care outcomes than we should, and it costs far more than is necessary.

Have you, Dr. Steele, in your organization found that coordinating the care for those chronically ill does get better health care outcomes, does save money? And what is the empirical evidence that tells us that?

Dr. STEELE. We are going to turn a paper in with an experience of about 35,000 Medicare patients and about 3,000 to 5,000 commercial patients—with chronic disease, and hopefully it will get accepted in a nice peer-reviewed journal and we can talk about it. But I can tell you that from our original experiment, which started about 4 or 5 years ago, where our insurance company put these nurses into the community practice sites to help re-engineer the practice and focused on that group of patients you are talking about, the return on that for the patients was incredible. It was in a number of our sites over a 50-percent decrease in rehospitalizations, you know, in a year, and that has been durable.

Now, most of the financial benefit of that in our system comes back to our insurance company. But because we are an integrated system, we can do internal transfer pricing and get a lot of those rewards, financial rewards, back to the folks that actually deliver the improved care. And, you know, we would have to innovate as to how to do that in non-integrated health systems. But we have got pretty hard data that, when you redesign, you really do benefit the patient, and quality goes up while cost goes down. They are not inversely related.

Mr. IGLEHART. Dr. McClellan, do you want to respond?

Dr. MCCLELLAN. Yes, Senator, just to pick up on your question, there is no double that for many of these Medicare beneficiaries, most of whom have a chronic condition, they are experiencing complications and higher costs, worse health because we are not doing nearly all we could to help them get better outcomes. And Dr.

Steele has talked a lot about the activities that the Geisinger clinic has undertaken, and, by the way, some of those were supported by payment reforms in Medicare to support those kinds of coordination of care activities. But the problem for most of the physicians in your States—and I am sure you hear about this from all of them all the time—is that they know steps that they could take that could help patients comply with their medicines better, that could help them manage their diseases better. They just do not get any support for that in most of our current payment systems. They get paid on a fee-for-service basis, and what Medicare typically does when costs go up is you squeeze down the payment rate so it gets harder and harder to spend time with patients. Things like having a nurse practitioner help care for the most complex patients; things like actually taking the time and effort to put information into an electronic system so that it can be shared; things like spending extra time educating a patient about why certain drugs or certain dietary or activity changes are needed—none of that gets reimbursed. So it is very hard for providers today, outside of integrated systems like Geisinger's where they are actually now supported in doing this, to provide the kinds of care that would really help improve the outcomes.

The problem on the other side, of course, is that if you talk to some of the budget experts at CBO and the Medicare actuaries and so forth about just simply taking steps like starting to pay for all these things that we do not pay for now, there is a real concern that that could add to health care costs if it does not really result in changes in care that get those better outcomes and that reduce health care spending.

So that is why I think some of the movement in this direction that your staffs are supporting—and I really commend the bipartisan effort here—is to move away from just relying on fee-for-service payments, but instead of simply paying more for more or other kinds of stuff, move towards having some accountability around better results, reducing these complications, as Dr. Hackbarth mentioned, reducing the readmissions, getting costs down, improving patient outcomes in measurable ways. That is the general direction that we are trying to move in, and the big challenge, of course, is how can we do it in a way that is not too disruptive for care today, most of which is not integrated at all, yet still is going to give us some assurance that we are getting real meaningful change quickly. And I think there are a number of proposals that your staffs are working on that people on this panel have suggested that can be put together to create a vision to get there.

The CHAIRMAN. John, I must interrupt here. We have a little business to conduct which will help health care reform, and that is to confirm Kathleen Sebelius as Secretary of HHS.

[Recess.]

The CHAIRMAN. We will turn back to our business. John?

Mr. IGLEHART. Mr. Hackbarth, I would like to get back to your days as an executive at the Harvard Community Health Plan and the Harvard Vanguard Plan, because you administered a plan that had capitation payments and fee-for-service payments, as does Geisinger. And the question I have is really the relative efficiency that you recognized during that period of time. Fee-for-service

seems to be, if not universally recognized as kind of the problem or the major problem, or one of them, certainly, of the current system, and I would like to get your thoughts on the relative value and efficiency of those two kinds of payment channels.

Mr. HACKBARTH. Well, at Harvard Vanguard, which is a 500-physician, multi-specialty group practice in Boston, we were about two-thirds prepaid global capitation covering all services from the most basic to the most complex, so we would get a lump sum per patient payment per month, and then about one-third was fee-for-service. And to be blunt, fee-for-service was a pain in the neck to deal with, and we were able to provide the sort of care that we thought patients needed by using the global capitation payments.

The key is that we—and I say "we" meaning the clinicians of the group—have the flexibility to allocate resources where they see the most benefit for the patient; whereas, under fee-for-service you only get paid if you check certain boxes and you do certain activities, and some of the most critical activities in health care are not paid for by fee-for-service.

So from our perspective, the global capitation was a much more effective system, and we used those payments to improve care for our fee-for-service patients. It is not just an issue of the payment level in fee-for-service. It is what is not paid for is the crux of the problem.

Mr. IGLEHART. Taking the experience of the last 9 years as chairing MedPAC, and recognizing that earlier experience, and also recognizing Senator Baucus' earlier question about how you take experiences and scale them up to some national level, what thoughts or recommendations might you have based on MedPAC's work about moving to a more efficient payment system?

Mr. HACKBARTH. You know, I think we need to look at both ends of the provider continuum. We do have some organizations that have the potential to be Geisingers of the future, and I think if Medicare combined with private payers offer payment methods that reward the effective integration of care, we will get more of those organizations. And so I am sure that Mark McClellan will talk later on about an idea that he and colleagues have developed called accountable care organizations, and basically it is a way, within the context of fee-for-service Medicare, of rewarding organized, integrated delivery of care. We think that concept has potential, although it is quite tricky to figure out the precise payment method within Medicare to make it work.

So we need to work that end of the continuum, foster more organized, integrated delivery organizations. But having said that, as I said in response to Senator Baucus, there are going to be large parts of the American health care system that are not ready for that, and so we need to start smaller with them, build up our primary care base through higher payments for primary care, different methods of payment, and then we think around hospital admissions there is another opportunity to begin bringing providers together—physicians, hospitals, and post-acute providers—to better organize and integrate care. So work both ends of the provider organization continuum.

Senator WYDEN. John?

Mr. IGLEHART. Yes, go ahead, Senator.

Senator WYDEN. A question on this point. We have been at it maybe 20, 25 minutes, and this panel has already done a very good job, it seems to me, of showing we are spending a lot of money on health care. It is $2.5 trillion this year, but we are not spending it in the right places. And, clearly, that started with Glenn's comments and has been echoed.

So I wanted to ask and maybe direct this to you, Dr. McClellan: It is clear that of that $2.5 trillion, well over $700 billion of it is spent in areas that are of modest or no value. That is what Peter Orszag said at CBO. Lew Morris at the Inspector General said $60 billion is out the door on fraud. The Center for Medicare & Medicaid Services says $10 billion goes for inaccurate payments.

Why don't you start by saying how we could better spend that $700 billion in a way that we might actually show the American people would wring some savings out of that $2.5 trillion sometime in the next few years? Because that is what I think they are waiting to hear. They have got bailout fatigue. They are not going to support spending trillions of dollars in new money. But if you and your colleagues can show us how we can wring out some savings—and I, for example, am very attracted to Glenn Steele's idea. I am pretty much ready to say we ought to go to a warranty approach—a warranty approach that involves the doctors and good quality. That is a way to generate some savings. But, Mark, how do we start with that $700 billion plus and show the American people we are squeezing some savings there before we ask them for more money?

Dr. MCCLELLAN. Senator, this is a core question. I am sure the other panelists have some views on it that will, I think, reinforce some of the things that I am saying. But as you pointed out, our health care system is doing a pretty good job of showing us the money, and we know where the money is going. But we are not getting what we should in terms of the results. We are not showing the results.

A lot of the comments that you have heard so far have all been focusing in the direction of emphasizing getting better results for patients. And as you heard just a minute ago from Dr. Hackbarth, giving providers more flexibility in how they get there rather than just micromanaging them by paying for certain services, not paying at all for others, is very important for doing that, but that needs to go along with some accountability for what we really want our health care system to produce.

That is what the American public wants to see. They want to be healthier. They want to see these gaps in preventable complications close. But also, if you look at surveys—and I know you have since you have spent so much time and effort on finding a way forward on health care reform—they are also very concerned about disrupting the kind of care that they get now. The very important relationship they have with their doctors and their other health care professionals is really important to them.

So as we make these changes, we need to make sure to do it in a way that is not too radical and too disruptive, especially for the vast majority of Americans whose doctors cannot even get, if they wanted to, timely information on whether the prescriptions are

being refilled or what other specialists are being seen or whether their patient has been admitted with a complication.

In the short term, there are a number of proposals, like medical home payments, like health IT payments, like moving towards bundled payments for admissions, that could move us in the direction of showing that we are getting better results and we are doing a better job of supporting doctors and patients in doing good care, and over time we need to put more emphasis on the fact that we are actually getting better outcomes and lower costs.

So that is how I think this can fit together, and I think it is very important for this Committee on a bipartisan basis to, as you did, point out the problems that we have in our health care system today, but also a path that is not too radical and disruptive but that can over time get us to some fundamentally better outcomes at a lower cost. And I do not see another way to get there besides measuring the outcomes that we really care about and starting to build that into our payment systems and benefit designs and all aspects of our health care system, much as Geisinger has already started to do.

Mr. IGLEHART. Senator Cornyn?

Senator CORNYM. Thank you. It has been widely observed that we do not really have a health care system, we have a sick care system. And I want to ask, perhaps playing off of Senator Wyden's questions, how we can save some money, but also by encouraging or providing incentives for individuals to take some personal responsibility to do some of the things that will keep them healthier and well longer, thus avoiding costly and perhaps painful, health care conditions.

I am aware—and no doubt the panel is, too—of some instances where various companies are trying to control their own health care costs. Safeway, which—Mr. Steve Burd, who has, I know, consulted with a number of us on a bipartisan basis, has really kind of a fascinating program at his company, which perhaps is duplicated elsewhere, which provides a financial incentive to the employees to do things like quit smoking, lose weight, get exercise, control their blood pressure, control their cholesterol, get a colonoscopy on a periodic basis—the kinds of things that will keep them healthy longer or perhaps diagnose conditions early on when they are less costly and less dangerous to treat.

What kind of delivery system are we going to design for Medicare or other public tax dollar-supported programs to provide some incentive for individuals to take some responsibility for their own health care and to stay well and healthy longer?

Mr. IGLEHART. Mr. Lee?

Mr. LEE. Senator, Peter Lee with the Pacific Business Group on Health, and I just want to affirm the question in that many large employers are investing a lot of money, time, and effort in engaging their employees in staying well. And we talked about, Mark, the spectrum on the provider side. We need to look at the spectrum on consumer side of engaging folks that are well to stay well. And I think that the lessons from the private sector should be brought over to Medicare, which is to encourage people that are well to engage in healthy habits, but also for people with chronic disease to have incentives to be engaged in disease management programs.

The issues on the treatment side need to be married with the consumer side.

I think also, though, we have a challenge with Medicare. Medicare is often seen as one size fits all as opposed to being tailored. And I think we need to really look at how Medicare can implement consumer-facing programs such as do we have networks within Medicare for centers of excellence that you encourage people with information and incentives to say this center is doing a better job. This is a challenge, but we need to look at lessons from the private sector that can be brought in, consumer facing on the public sector as well.

Mr. IGLEHART. Senator Bingaman?

Senator BINGAMAN. Thank you. I was just struck by Dr. Steele's point when he was asked what could be done to take the practices that you have got at Geisinger and expand them. I thought his answer was redesign CMS to be an engine of innovation.

I would just be interested in Dr. McClellan's view as to what the obstacles are to us getting that done. It seems to me, you know, Congress is way into the weeds on health care reform and writing these laws and trying to understand the intricacies of this business. Why can't CMS be given a broader mandate—or maybe they have a broader mandate—to implement many of these practices that I think everybody around here says make a lot of sense and save us a lot of money and improve care?

Dr. MCCLELLAN. Let me start by saying a word of praise for the staff at CMS that have an enormously, impossibly complex job, very limited resources to do it. They are overseeing the largest health care programs in the world for the most difficult populations and the most vulnerable populations in terms of coverage. So with their limited budget, they frankly need a lot more resources, would be the number one thing, and I think would help get more done.

But as you pointed out, the way that Medicare is managed now does not leave a whole lot of room for discretion in implementing the kinds of reforms that we have been talking about today—moving away from payment on a fee-for-service basis, promoting wellness, and new steps to help patients with chronic disease manage their disease at a lower cost.

Congress, in due respect to this Committee, you all set the payment rates for each and every Medicare service in each and every county around the country.

Now, you have also given CMS a lot of demonstration authority, and Dr. Steele mentioned this. In fact, while I was at CMS, we implemented a demonstration program with Geisinger to pay them more when they demonstrated that they were getting better outcomes at a lower overall cost for their patients. I think that program has helped motivate and implement the kinds of steps that Dr. Steele talked about over the last couple of years.

It would be very helpful to enable CMS to engage and support more pilot programs like that. You heard a minute ago about the cycle time for trying out new approaches in payment or in benefit design being much slower than it should be if we want to see timely and effective impacts on health care costs and the health of Americans. That is going to take more resources, and it is going to

take at least a clear authority for CMS to pilot and test out these new approaches.

In the Medicare Modernization Act, there was a pilot program for Medicare Health Support, a kind of disease management program. It ended up not in most cases delivering the savings that had been hoped, but at least it could be tried out on a large scale, and at least successful programs could be expanded quickly. That might be a model to look at more widely as you are considering these reforms.

The CHAIRMAN. I might ask, though, Dr. Steele, what did you have in mind when you say reform of CMS? Three minutes. [Laughter.]

Dr. STEELE. I have the ability to speak without any knowledge at all.

The CHAIRMAN. You are not alone. [Laughter.]

Dr. STEELE. Again, I do not think we are going to get it right for all of these changes straightaway, and yet I think we have huge leverage through Medicare, and also through Medicaid. We have not talked about Medicaid either. That is another incredible lever. And I think if we are interested in getting closer to an integrated system, whether it is a real one or a virtual one, if Congress could set the big rules—here is where we want to go in 3 years or 4 years; you folks figure out how to get there. And by the way, if you do not get there in improving this quality of care and decreasing this cost, then we will have a Plan B—I have a feeling that ramping up from our small experiments to maybe, I do not know, three, four, five million out of the 40 million would be the next step in looking at scalability, with much more feedback, much more ability to change on the fly.

A lot of what we did was accomplished because we were able to change on the fly. There were a lot of unanticipated consequences for things that we did that we could respond to. That is at a 35,000-foot level, it is without working specifically with CMS, you know, so it is easy to make these pronouncements.

The CHAIRMAN. Thank you.

Mr. IGLEHART. Senator Snowe?

Senator SNOWE. Thank you. I held some listening sessions in Maine over the recess, and many of the issues that you raise here today with respect to primary care being instrumental and improving the quality of care and lowering costs is exactly what I heard at home. And one of the issues that was raised, however, was the crisis that exists with physician shortages, particularly in primary care. And if you look at the number of studies that have been released on this question, I think it is all the more evident that we have a dearth of physicians with respect to primary care. Americans lack access, almost a third of Americans of working age lack access to primary care providers. Seventy percent, I was told, of health care needs can be met in primary care. And yet we have a lack of primary care providers across the spectrum. And, in fact, we will have a serious crisis by the year 2025, and even more so if changes are made to the system.

So I would like to ask you, Dr. Tooker and Mr. Hackbarth, and anybody else who cares to comment on this question, how do we reverse that? And what is the timetable for reversing it? Because,

obviously, it is going to take some time to, you know, turn this ship around with respect to primary care physicians and nurse practitioners and physician assistants across the spectrum, which is a critical problem, even more so when only 2 percent indicated an interest in even going into the primary care field, which I think is all the more troubling given the fact that I think the emphasis on prevention and early diagnosis is going to be key in transcending from a system that responds to a crisis and rather trying to design a system that is to prevent the illness in the first place.

So, Dr. Tooker, would you care to comment?

Dr. TOOKER. I would be delighted. Thank you, Senator Snowe, and thank you, Chairman Baucus and Ranking Member, for this opportunity.

As Senator Snowe has said, I think on the one hand the value of primary care is highly recognized as a critical part of a high-performing health system. But that value is not translated into valuing primary care providers, including physicians, in this country. The disparity in payment across specialties of primary care compared to other specialties is wide, and the first recommendation would be to restore those primary care physicians who are providing care right now, quickly, immediately, with improvements in reimbursement for primary care physicians now.

Related to that, though, and I think a critical part of this notion of the funding for primary care, including new models of care, such as the patient-centered medical home, is funding the infrastructure to provide the care that these patients need. As Glenn Steele has said, Geisinger helped to reform primary care at Geisinger, both by improving the compensation for primary care physicians so that they do not have difficulty recruiting primary care physicians to those practices, but also in providing the infrastructure for those physicians and the team-based care that they provide to be able to provide the care—for example, care coordination. Thinking about our Medicare population in particular, about a quarter of Medicare patients have five or more chronic conditions. They will see lots of physicians over the course of a year, 40 or more outpatient visits in a year, hospitalizations, et cetera.

There is an enormous amount of information that has to be managed for each individual patient, and that does require infrastructure. It requires the people with the skills, such as advanced practice nursing, which in team-based care is invaluable, but also requires—and Glenn mentioned you cannot do this without the electronics—the need for practices to be able to acquire health information technology, and obviously that has been a big part of the stimulus package as well.

I think we also at the same time need to recognize that the demand for these services is only going to increase with an aging population, and to your point about prevention, I think Senator Cornyn made the same point, that at the present time primary care, population health, and preventive services are not reimbursed, so there is not time for the physician and the team to provide those services now. In a medical home model with team-based care, with adequate compensation for the care coordination, those services can be provided. I am not, though, saying that if you were to score this 1 year from now that you would be able to document

savings—funding primary care would have to be a long-term proposition.

The last point I want to make in response to your question, Senator, is that while I am a huge admirer—I am from Pennsylvania now, formerly from Maine. I am a huge admirer of Geisinger, but we have to recognize that the vast amount of this care in this country is provided in practices of five or less now, 80 percent or so. And we are talking about in the range, in the 2006 National Inventory Care Study, of 900 million ambulatory visits in the course of a year. So the vast amount of this is taking place in small settings, and there is this big divide between the electronics that Geisinger has and what a two- or three-person practice has. And while we might want it some other way, that is the reality which we are dealing with right now.

So I think there has to be frank recognition of the fragmentation of health care in this country, and Maine is a good example of that right now.

On the other hand, Maine is also leading in the sense of innovation of developing a primary care medical school with Tufts to try to solve some of these problems that you were talking about.

Thank you.

Mr. IGLEHART. Mr. Hackbarth?

Mr. HACKBARTH. Two quick additional points, Senator Snowe. In addition to the medical home, MedPAC has recommended that Congress provide for a bonus payment basically for clinicians that are focused on primary care practice. So this is an additional payment on top of the standard fee-for-service payment that would go to clinicians that are in certain specialties and through their pattern of practice demonstrate a commitment to primary care.

In addition to that, we have made several recommendations about the process by which Medicare sets the fees for different types of services, the relative values, and we think that that process is skewed in a way that is detrimental to primary care.

The last point that I would make is that, you know, even if we do all of these things—medical home, primary care bonus, change the RVU-setting process—the unfortunate reality is that we are going to face a shortage of primary care clinicians in the future. We are going to have too many older people with complex illnesses and not enough people coming through the pipeline. And so I think another part of, if not a solution, another part of addressing the problem is increased use of advanced practice nurses. In Harvard Vanguard Medical Associates, my old group, we made extensive use of advanced practice nurses to complement the efforts of physicians, and I think the health care system needs to do that more broadly.

Mr. IGLEHART. Dr. Korn, do you have a quick comment?

Dr. KORN. Yes. I am with the Blue Cross and Blue Shield Association, and I think I can weave together some of the suggestions made by Senators into a recommendation. What can CMS do?

You know, the Blues are somewhat unique. We are national, but we are also very, very local. And so as CMS thinks through any number of innovations and/or pilots, you might consider partnering locally with successes that have been achieved. And we are beginning to emulate the Geisinger model in a fee-for-service environment. I am sure you know in Iowa that we have a model where

nurse case managers work for the individual physicians' offices rather than the plan, and care management is directed to those patients whom the physicians suggest are most ill.

Montana a number of years ago innovated with a remarkable program to control the use of unnecessary radiologic procedures.

Massachusetts has now put together a program where, in a fee-for-service sector, using a very unique contracting strategy, they are beginning to emulate the incentives and loyalties that a Geisinger system has.

The reason I am somewhat passionate about this is because age 65 is an artificial designator. The payer changes, but the delivery system does not. And so if there is some way for those of us who care about these things and finance this care to learn from one another and benefit from one another's experience and even use one another's capabilities in reasonable relationships, I think there is a real opportunity. And the Blues are prepared to collaborate and share with all of you in any way we can.

Thank you.

The CHAIRMAN. I see that Senators Cantwell and Carper have been trying to seek recognition for a while. I do not want to get in your way here, John, but I just know they have been——

Senator CANTWELL. Well, I wanted to jump in there on the primary care shortage issue and just ask or emphasize more about the education system, about incentives for getting those to go into primary care with more loan forgiveness, more focus on medical residency support, and more on the structure—I mean, obviously, we have to quit disincenting from a structural perspective primary care service, but we also, as you said, have to deal with the shortage, and I think we need to be much more aggressive.

I am hearing from my hospitals in Spokane—and I know, Umbdenstock, you just came from there, running the association—patients are now coming back to the emergency room for their primary care. It is not just the cost of going to the emergency room. People are using the emergency room as their primary care physician, and it is costing us. And so we have to deal with this demand wave that is coming in for the population and match it up with education programs. So I wondered if you supported those kinds of incentives.

Mr. HACKBARTH. MedPAC has just recently begun looking at medical education and Medicare's role in financing medical education to see if there are ways that we can use the leverage of that financing to influence the output. We have not yet made specific recommendations. We may well this coming fall. But among the issues that we have identified are, of course, the mix of people being trained is not what we would want from the perspective of a high performance health system, and conceivably—and this is not a MedPAC recommendation, but conceivably, you could imagine Medicare saying, you know, we are going to skew our payments to reward more primary care training than others.

You could imagine Medicare or the Federal Government more broadly establishing special programs of expanded loan forgiveness for clinicians who commit to primary care activities.

There are also some more technical issues in how Medicare pays for residents that actually get in the way of proper ambulatory

training. The training is skewed towards inpatient hospital and away from ambulatory settings.

So there are a number of levers that we think Medicare might be able to influence that could change the output in constructive ways.

Mr. IGLEHART. Senator Hatch?

Senator HATCH. Well, thank you. Now, in my opinion, just along the same lines, we have access to the finest facilities and technology in health care, but their effectiveness will always be limited if we do not have well-trained professionals. The workforce shortage in our health care system is reaching crisis proportions, in my opinion, and is a multifaceted and complex problem that ranges across the entire cross-section of the medical profession, from nurses to primary care physicians to emergency room doctors.

Now, to truly understand this problem—and I have been very impressed with some of the things you have said, Mr. Hackbarth, and MedPAC. But to truly understand this problem across this broad spectrum of issues, I would like to suggest maybe the formation of a medical or health care workforce shortage commission to not only study the several efforts already underway, but to provide Congress with a blueprint of recommendations to better coordinate these efforts and suggest new strategies to drastically reduce, if not completely eliminate health care workforce shortages.

So I am very interested in hearing your various perspectives on that suggestion and see if that is a worthwhile thing to do. Dr. Tooker, we will start with you.

Dr. TOOKER. Yes, thank you very much. I think that builds on the comments from you, from Senator Snowe, and also the testimony that we had originally provided.

To me, there is, unless the market is going to fix itself first in the sense that primary care is competitive in the market, it will not be enough just to try to fix medical school and graduate medical education, and by the market, I mean that we need to value primary care as highly as we value every other critical service that is provided to our patients now.

I think it is important—and that is why I mentioned the primary care medical school in Maine—to have innovation where medical students are specifically encouraged to practice a certain kind of medicine in a certain geographic area. Maine is unique, or northern New England is unique, and I think that there, that is a potential benefit. For example, loan forgiveness, because the debt of medical students now is in the range of $160,000. They are making rational decisions to pursue careers that are going to reimburse them higher.

But I think sometimes we are not talking enough about how and where they are trained, and we, of course, have very impressive academic medical centers in this country, and in GME we have hundreds of other community programs that are developing our trainees now. But I would say—and I am certainly a part of it, coming from a major academic medical center in Philadelphia—that primary care is not valued in academic medical centers the same way that other tertiary and quaternary services are. Academic medical centers are ranked by the number of NIH grants

that they get, how specialized their services are, not for primary care.

So I would tend to agree with Senator Hatch that we need independently to look at workforce from the point of view of what is the best workforce to provide care for the patients in this country as opposed to other models which are disincenting our young people to go into primary care.

Now, to their credit, the AAMC, the Association of American Medical Colleges, has been out front in the sense of a patient-centered medical home model in which they have committed as a matter of policy to providing the appropriate training for the patient-centered medical home. But a lot of that training is difficult to provide in typical academic medical centers, and as Glenn Hackbarth has said, we need to expand funding to making payment available for community-based training for these types of physicians.

Senator HATCH. Well, I appreciate those comments. Can I ask a follow-on question, Mr. Iglehart?

Dr. Brent James of Intermountain Health Care in Salt Lake, one of the top quality experts in the country, often says that the United States is number one in providing "rescue care." Rescue are is saving accident victims, premature babies, heart attack victims, transplant patients, and dialysis patients, just to name a few. The good news perhaps is that no other country comes close to the United States in providing rescue care.

Unfortunately, rescue care has little or no impact on the general population and on more effective approaches to place a stronger emphasis on primary care and preventive medicine.

Now, how do we as a country go from providing the best rescue care in the world to providing our citizens with better primary care and preventive medicine? Anybody who cares to answer.

Mr. IGLEHART. Dr. Opelka from the surgical community, thoughts on that? And also your workforce perspective, if you would, please.

Dr. OPELKA. Thank you very much, and Chairman Baucus and Senator Grassley and the rest of the Committee members, we appreciate the opportunity to be here on behalf of the American College of Surgeons.

If I could, Senator Hatch, first to the workforce issues, they are complex and we are starting now to see some actual shortages in surgery areas. We have got about a 16-percent reduction in general surgeons over the last 10 years. We are now reaching the point where we are losing general surgeons in aggregate, and in other areas of surgery, like urology and ophthalmology and orthopedics, the number per 100,000 is dropping year after year.

Now, perhaps some of that is right-sizing in surgery, but perhaps some of it is not. And certainly in general surgery, and particularly in the rural areas, if we think about the medical home—and we are highly supportive of the concept of the medical home—the general surgeon actually is the first responder for the entire medical home community. And with a shrinkage of that general surgery support, it supports all the rest of the acute care in a hospital. When you start to lose your general surgeons in a hospital, you start to lose your hospitals. It is very difficult for rural communities to actually support other activities in a hospital if they do not have the gen-

eral surgeon. And we will actually see an erosion of some of the trauma support that we currently have and established at a very high level.

In other specialty areas, you can leave Boston and Worcester, Massachusetts, and start heading to the west and you will not find another neurosurgeon until you get to New York. So when you have major trauma injuries, head injuries, transporting those patients, if you do not have the general surgeon to stabilize them in those communities and they cannot get them to a neurosurgeon in a timely fashion, we are going to have other major issues.

Now, the real problem with the workforce and the reason I think your idea is such a great idea is that it takes a long time to develop these surgeons in their specialty areas. It is 6 or 7 years before they complete their training after medical school, and then to truly flourish and develop that expertise is another 3 to 5 years as they mature as a surgeon.

So the queue is very long. The pipeline is a long push. When we are behind in general surgery, it is going to take us years to catch up. So we need programs to address these workforce shortages and to incentivize people to go into those areas.

Lastly, then, to address your issue, I think switching our focus is probably not to switch our focus on the excellence that we have, but to truly hit into these chronic care diseases where even the surgical specialties are on board that we need better primary care, we need better coordination of care with our primary care colleagues to take care of not an isolated silo of care, but to take care of a continuum of care. How do we deliver the best care not for this moment for this patient but over this life for this patient for that disease condition?

Senator HATCH. Thank you.

Mr. Chairman, I presume we are able to submit questions to the panel, because this is an excellent panel.

The CHAIRMAN. Absolutely.

Senator HATCH. I just want to compliment them for taking the time to be here.

The CHAIRMAN. I might just put a little bug in Senators' ears, and even the panelists, that we may want to, because this is so important, come back this afternoon, too, and just keep going here, because there are not many opportunities like this, and this might be the appropriate thing to do. But yes, questions——

Senator HATCH. Mr. Chairman, I have a lot of questions, but I have to, like all of us——

The CHAIRMAN. We all do.

Go ahead, John.

Mr. IGLEHART. Senator Nelson?

Senator NELSON. Thank you. I want to throw out a couple ideas and get you all to respond.

Number one, the advantage of Medicare Advantage, a Medicare HMO having a 14-percent differential, should we put that on a competitive basis? Because it was originally set up to save costs, and, of course, it did not save costs.

And the other one, dealing with the workforce, Medicare supports residency slots. Well, that was all frozen in 1998 with the re-

sult that your growth areas are way underfunded now in the growth States for residency slots.

So maybe if we could start with Mr. Williams, that you could address the Medicare HMO.

Mr. WILLIAMS. Thank you, Senator, and it is a pleasure to be here and have an opportunity to share our point of view.

I think it is fair to say that there are opportunities for meaningful cost savings from the Medicare Advantage program. I would, however, ask us to recognize that the base Medicaid Advantage benefit that is exactly comparable to Medicare is well delivered with innovative programs that really do improve quality and improve the quality of care that patients do, in fact, receive. And I think Aetna as well as the industry are open to a variety of approaches to understanding that with a couple of suggestions.

One is we need to recognize and avoid sudden shocks to the 10 million Medicare beneficiaries who entered this particular program. And as we figure out how to get from where we are to where we go, we need an appropriate slope so that the health care delivery system can collaborate in right-sizing and readjusting its whole mechanism to be certain that we maintain the right value for the beneficiary and avoid those sudden shocks—with the understanding that there is an opportunity to make some meaningful changes there.

I think also we need to keep a focus on providing incentives to the providers for improving quality both in Medicare Advantage and base Medicare.

And, finally, whatever we do, I would encourage us to keep it simple but, most importantly, keep it predictable.

Senator NELSON. Would you be in favor of competitive bidding?

Mr. WILLIAMS. Well, I think like most ideas, I think we are open to all ideas. We do not really understand exactly what specifically competitive bidding means.

Senator NELSON. So that the plans would be based on their cost instead of a government-set rate.

Mr. WILLIAMS. Well, I think we are open to any change in the system that results in a predictable slope, minimal impact to beneficiaries, and a way to create value for Medicare beneficiaries and for the Government.

Senator NELSON. And the graduate medical education?

Mr. UMBDENSTOCK. I want to thank you, Mr. Chairman, and the members of the Committee for the chance to be here today. I am Rich Umbdenstock from the American Hospital Association. And we would be very supportive of increasing the number of residency slots, Senator Nelson. We have heard the estimates, and we know the shortages on the front lines. So looking forward, you know, something of at least a substantial number of new residency slots in the 15,000 range or something, because some of the estimates and requests have gone as high as 25,000 and 30,000, but a huge new opportunity is necessary.

As my colleagues have said, being sure that we focus those new slots or the residency program in general toward what we need in the primary care area is very important, but also to Senator Hatch's concerns, looking beyond residencies to the workforce and the shortages we face overall equally important. We struggle with

the nursing shortage and the continuing projections there in the hundreds of thousands of nurses that we are going to need, that we just are not able to accommodate today. So we would be very supportive on both counts.

Mr. IGLEHART. Mr. Umbdenstock, a question. If the number of GME positions that Medicare funds was increased, what guarantee would the Federal Government have that those increased positions would go into primary care specialties?

Mr. UMBDENSTOCK. Well, John, I think it is all in how you design both the program and the rewards so that both the incentives for medical students to look toward primary care and the way in which, again, as Dr. Tooker said, we make that an attractive career path, not just in the residency realm but also in the market realm, coming out the other end, that, in fact, there is a viable—not just profession but a viable business model. So it has really got to be thought of in connection between both the educational sphere and the real world that those physicians will enter upon completion of those residencies.

Mr. IGLEHART. Okay. Senator?

Senator MENENDEZ. Well, thank you very much. Very informative, and I appreciate your willingness to come and your service, and, Mr. Chairman, for putting an excellent panel together.

I have two questions that I would like to pursue. One is I want to echo my colleagues who have talked about the primary care issue. We are 48th in New Jersey relative to the number of primary care physicians to families, and so that is an issue. And for those of us in the minority communities, we are concerned about the disparity that further is enhanced by that reality.

Mr. Hackbarth, you mentioned the 10 percent that MedPAC has talked about as a bonus. While that is certainly worthy, is that sufficient to draw what we need in terms of the primary care community? You might be looking at keeping a universe but, obviously, it seems to me that may not be enough, and what else you would be doing. And, secondly, a different question—and I would like to hear your answers—to Ms. Ness, this whole issue of the medical home concept is one that has a lot of promise to it. I would be interested in your thoughts on how that model works for women's health care in this context. As we all know, many women consider their ob/gyn as their primary health care physician, and when you look at the array of services from pregnancy to specific cancer care, it is a pretty wide range of services.

Do the current medical home demonstration projects adequately address these women's unique health needs? If they do, fine. Tell me how they do that. If they do not fully, is it something that we should be considering looking at a women's health medical home? Those are the two things I would like to hear some responses to.

Mr. HACKBARTH. Senator, we do not think that a 10-percent bonus by itself is sufficient. We have recommended that as part of a broader package. So, in addition to the bonus, we have talked about ways that the process by which relative values are set, the fees for individual services are set, can be changed in ways that we believe will increase payment for primary care. We also, as I said earlier, believe that the medical home idea is an important part of that package.

I would mention that there have been some steps already taken in the Medicare payment system that have increased payment for evaluation and management services, many of which are provided by primary care clinicians. I will not get too far down into the weeds, but in combination, steps taken in the last couple years have increased payment for those services by 10 or 11 percent. So it would be that 10 or 11 percent, a 10-percent bonus on top of that, some changes in the price-setting mechanism, medical home—that is the sort of package that we think may be sufficient in scale to have a meaningful effect. It is not just one piece.

Mr. IGLEHART. Ms. Ness?

Ms. NESS. Thank you, and I really appreciate the opportunity to be here, Senators. I am really encouraged by the conversation that I have been listening to because as an organization that has been representing the interests of women and families for more than 35 years, I can say that the urgency is very great. People want us to transform this delivery system. They get that it is broken. They get that it is not working as well as it should. They want better quality care. They want it to be more affordable. And they also get that we need to get better value for our health care dollars. They know we need to make changes to make this all sustainable over time so we can ultimately get to coverage for everyone.

And one of the most exciting things, I think, about this conversation today has been the amount of focus on what is needed for the patient. And Dr. Steele said something very profound when he started us off. He said at Geisinger they started first by looking at what the patient's needs were, and then they designed delivery and the way they were going to pay for it around those patient needs. And if there is one message I would like to deliver, it is that I think we need to think about delivery system reform, payment reform, from the perspective of: is it going to get us to making a more patient-centered system? Will it meet the needs of patients? And will it meet the needs of the highest-risk, most vulnerable patients, the ones who are falling through the cracks the most, but the ones who are also costing us the most money?

We know that the folks with multiple chronic conditions are costing us at least 75 percent of our health care dollars, and that is only going to get worse. The population is aging. The number of chronic conditions people have is escalating. And from a women's perspective especially, women who are reaching those middle years, the baby-boomer generation of women who are now just beginning to deal with their own chronic conditions, also facing the caregiving responsibilities of dealing with aging relatives who are living longer with more complex conditions than ever. Their struggle with the shortcomings in this fragmented, uncoordinated delivery system is just going to be off the charts.

So the conversation today about shifting to primary care, shifting our payment system so it incentivizes us to move toward better integrated, more coordinated, shared accountability, that all makes sense. I would like to just put a spin on that, if we look at that from the patient perspective, some of the same things, what it takes us to.

For example, we talked about needing to really move from acute care focus to focus on managing chronic conditions and more focus

on primary care. Well, we have to value primary care more and differently than we do today, but we also probably need to think differently about how we go about that valuation process. Right now, we look at resource costs, and we assign values. Well, we do not look at the values to patients. And what would happen if you included a patient voice in how we establish the payment decisions around what is valued and revaluing primary care?

The medical home model moves us in the right direction. It is the right idea. But as it stands now, it will not meet the needs of the most vulnerable patients, those folks with the multiple chronic conditions, those folks with geriatric syndrome.

Senator Lincoln, you have legislation that gets at the importance of geriatric assessment, for example. Senator Wyden, you have legislation that looks at the importance of making sure we can deliver care to people at home.

Right now, the medical home is not there. We need to evolve it. So we need to think about this as getting to primary care payment that pays for the right services based on patient needs, which probably means some kind of a risk-adjusted model that is matched to patient complexity and covers those things like geriatric assessment and care at home and making sure we have the link to community-based services. So putting the patient lens on some of these things I think helps steer us in the right direction.

With respect to your question, Senator Menendez, about women having particular needs, that is another example of us needing to ensure that we are matching what we pay for to the actual patient needs. And I think the important thing here is that we want patients to be able to choose where they get their care, and for many women an ob/gyn is their provider of choice. But we then need to make sure that those ob/gyns are providing the full range of primary care services or linking to those services so women get the full range of services that they need.

So I think there are ways we can move in the direction of ensuring that women in their peak reproductive health years that have a range of needs have those needs met in the context of getting comprehensive primary care.

I want to reinforce what folks——

Mr. IGLEHART. Yes, we better move on.

Ms. NESS. Sure.

Mr. IGLEHART. I want to ask Dr. Naylor to follow up. Her team at the University of Pennsylvania has done a lot of work targeting the chronically ill elderly population. What lessons can we learn from the research that you and your team have done, Dr. Naylor?

The CHAIRMAN. Dr. Naylor, you might remind us who you represent.

Dr. NAYLOR. I represent the University of Pennsylvania School of Nursing.

The CHAIRMAN. Okay. Thank you.

Dr. NAYLOR. And I have had the great fortune to work with a terrific multidisciplinary team based at Penn from the schools of nursing and medical school and Wharton, et cetera, on testing a model designed explicitly to look at the challenges and issues around the 20-percent of older adults who are waking up each day with multiple chronic conditions, often complicated by cognitive im-

pairment, depression, and for whom we have not yet figured out how to well serve them. So we have been testing and refining an approach. It is called transition care, and it targets this high-risk group as they are at their most vulnerable, as they have acute episodes of illness, explicitly designed to interrupt this chronic illness trajectory that constantly brings these elders in and out of the hospital. And across multiple multi-site studies, we have demonstrated consistently the capacity of this approach to care to improve their outcomes, to improve their function, quality of life, to improve, obviously, their satisfaction with the care experience, as well as their family caregiver's satisfaction, to significantly reduce hospital readmissions and to save health care dollars. In our last clinical trial, we were able to improve outcomes and reduce readmissions through 52 weeks post after the index hospital discharge at a means savings per Medicare beneficiary of $5,000.

So what are the lessons learned and how can some of what we have learned contribute to this conversation today?

Well, the first is that I think we have a great opportunity here to target this 20 percent who are not well served by our current care system. I think we have a great opportunity to apply evidence built over many years to apply to this population. Across our work and across many other studies, we have learned that delivering services to this population is a team sport. It requires the input of nurses, physicians, mental health specialists, therapists, social workers, pharmacists, and it requires continuity of care.

Consistently across clinical trials, we have demonstrated that nurses have been most successful in directing this approach in patients' homes, in the emergency department, in the hospitals, wherever it is that their needs are, and making sure that all the physicians, all the other team players are on board with a rational, streamlined plan of care.

We think that in terms of lessons learned it would be very appropriate for us to focus on the development of new measures, process and outcome measures, that are much more closely aligned with the needs of these people. Quite frankly, most elders do not what their hemoglobin A1c is. They want to know that people have prepared them for their next site of care. They want to know that they have a person that they can point to when they have questions or concerns, et cetera, so we know what the process measures are that are important to these individuals.

In terms of outcomes, they are concerned about function. They are concerned about quality of life. And we need to be thinking about the development of measures that, therefore, support the development of team approaches to get at these.

Finally, let me say that we do need a different payment system. In order to accomplish the goals that we have outlined on top of our fee-for-service system, we really need to target a transition care benefit that would enable this approach to care to be available to Medicare beneficiaries who are at high risk, who require much more than we currently provide, again, in order to interrupt this cycle that we are clearly able to do, our evidence has shown us.

Mr. IGLEHART. Senator Grassley, please.

Senator GRASSLEY. Only if you are done discussing what you wanted to discuss. Right after that I——

Mr. IGLEHART. Well, I would just ask Senator Baucus' question about is this scalable, your model.

Dr. NAYLOR. First of all, I think this model is highly complementary to great primary care, to great chronic care, to the independence at home initiative, to the chronic geriatric assessment and chronic efforts approach, et cetera. We have worked in collaboration with Aetna and with Kaiser Permanente to translate this model into the real world of clinical practice and have demonstrated its capacity to replicate both clinical and economic outcomes.

We have developed tools of translation, web-based training modules to prepare nurses and other providers throughout the country to deliver this, clinical information systems that house the evidence that make it available to colleagues in Maine and Iowa and every other State across the country. We have created quality improvement tools and strategies to make sure that we continue to invest in building the team's capacity to do this.

We place a high premium, though, on providing and preparing family caregivers to do this because, in fact, they are the primary deliverers of care in this country, and we have not paid enough attention to their needs. So we have provided tools also for these family caregivers in order to make sure. So it is absolutely scalable.

Mr. IGLEHART. Senator Grassley?

Senator GRASSLEY. Yes, I want to bring up an issue that I have to get some comfort with over the next 2 or 3 months as we try to put together a bipartisan package, and it is the irony of, on the one hand, people saying we have to spend more on health care and the other one, as has been evidenced here, that we are wasting a lot of money, like Senator Wyden said, $700 billion; like was just said by Ms. Ness, better value for health care; like Dr. Steele said, we can increase quality, reduce costs. You have heard Senator Baucus and this Senator say on so many occasions that if they practiced medicine in the rest of the country like they do for Michigan over to the Pacific Northwest, from Kansas north to Canada, we would save one-third of all the money we are spending on Medicare as an example.

So this is what I would like to point out and get any two or three of you to respond. And I do not call on anyone to respond. I would like to point out the irony that we are talking about all the unnecessary and inefficient spending that we have while also looking at increases in spending even more on health care reform during this debate as we try to put together a bill.

How long will it take to set a course to improve delivery? And are we being bold enough and particularly on delivery reform? In other words, how do we make sure that we are really tackling delivery reform? Because if we do not, we are really setting ourselves up to make the costs worse, not better. And I do not call on anyone. Whoever feels that they can address it. But it is something I have got to get some comfort with.

Mr. IGLEHART. Mr. Williams?

Mr. WILLIAMS. Yes, I would start out by saying that it all starts with the notion of starting where we are and working with what we have, and I think we have an enormous amount of capability in the system to improve quality and reduce cost. By that, what I

mean specifically is that the employer-based system has been a huge source of innovation, and many of the things we have talked about this morning about Medicare and disease management have proven models that the employer community has embraced which have significantly slowed down the rate of increase for certain employers, and at the same time improved quality, and let me give you just a few examples.

One is if we can find ways to apply the irrefutable science based as published in peer-reviewed journals by tapping into the information that we have in the system already—claim data, which actually is much richer than many people think, the pharmacy data, the lab values. At an individual patient level at Aetna, we have sent out to physicians 480,000 care considerations based on data we know about the patient, with the patient's consent, and checking that against the irrefutable science base. In the large percentage of those cases, those considerations have resulted in identifying gaps in care, identifying procedures that should be—screenings that should be conducted.

And so I think what we have done—and we are not the only ones who are doing some of these things. Others are. There is a huge opportunity to apply the strengths of the employer-based system to really help improve and slow down the rate of increase both in Medicare as well as in the current system.

So I think those would be some of the things that I would suggest.

Mr. IGLEHART. Dr. Steele?

Dr. STEELE. Senator, I think the leverage is in Medicare, and I believe that if you instruct some sort of patient-focused goals on the highest utilization areas, which, as I have mentioned before, are generally the areas where we do least well in carrying, and you give discretionary capability, much more discretionary capability to some aspect of CMS to innovate for an evolution—and it has got to be done carefully, but you set a time limit, and that time limit is obviously your discretion. And if you do not get where you want to go, which is patient focused, in that time limit, then there is a Plan B. And I think that Plan B would be—you know, that is for you, but it should be pretty motivating.

The CHAIRMAN. And what would some of the components be of Plan B?

Dr. STEELE. I am not willing to say right now. [Laughter.]

The CHAIRMAN. That is why we are meeting.

Dr. STEELE. I am interested in pushing Plan A. Plan A is innovation. It is taking advantage of the market-based approaches. But it is insisting that for those four or five major utilization cohorts, we actually achieve some obvious metrics of significant improvement on both quality and value, and then we could talk about Plan B later.

The CHAIRMAN. Well, sometimes a very sobering Plan B will encourage a Plan A.

Senator GRASSLEY. Can I just follow up? And this is more of a comment, but it is also in the form of a question. Can this Senator just for himself assume, since I have not heard anybody on the panel suggest we need to spend more money, that maybe that is

your conclusion, that we do not need to spend more money? Can I conclude that?

The CHAIRMAN. No. [Laughter.]

Senator GRASSLEY. Well, then, I think somebody ought to tell me, yes, we have got to spend a lot more money.

Senator BINGAMAN. I thought Dr. McClellan said we do need to spend a lot more money in Medicare and Medicaid. Wasn't that your testimony?

Dr. MCCLELLAN. Well, let me clarify this in two ways.

One is if you are going to ask CMS to do more and more quickly to drive the kinds of reforms in health care that Dr. Steele has talked about, let's face it, they are going to need more support. They already have a very, very big job to do for a very sensitive and vulnerable set of 90 million-plus Americans, and that is going to take some more support for the agency.

I do not think that is really the kind of big dollars that you are talking about, though. You are talking about numbers like $700 billion.

And just to be frank, Senator Grassley, I think some of the proposals that you have heard about today do mean more spending, at least in the short term, like you did with health IT in the stimulus bill, like some of the additional payments for primary care, medical home that you have talked about today. I do not see any way to do that, to take those steps meaningfully, without spending more at least in the short term.

That said, as Senator Wyden said, we have got to show some results to the American public around closing these huge gaps in quality of care and reducing these unnecessary and potentially excessive costs.

So if you were to link some of these reforms that might have some costs in the short term will real steps towards accountability for getting the results, sort of like you did for health IT, you are going to have this additional spending, but it is tied to meaningful use, which still needs to be worked out. But I would argue that that ought to be an actual impact, demonstrated impact on improving outcomes, patient-level outcomes, like Debra Ness talked about, and reducing overall costs. You have that same kind of model applied elsewhere, I think you could get to the point, with good measures, with accountability, get to the point where you are saving significant amounts of money over time and demonstrating to the American public that they are getting better health care as a result of these reforms.

Mr. IGLEHART. Senator Baucus, there are a number of Senators who have questions. I might ask these folks if they could write in their responses—is that all right?—so we can get to the Senators' questions.

The CHAIRMAN. Yes. I do think it is more important at this point that Senators ask their questions, frankly. We will play it by ear and see how this moves along.

Mr. IGLEHART. Senator Lincoln?

Senator LINCOLN. Great. Thank you. Well, thanks to all of you for being here.

There has been an awful lot of talk about medical home and talk about how much we are going to spend and how much we are going to save——

The CHAIRMAN. I wonder, Senator, because Mr. Hackbarth, while we are on this subject of investment in returns, if he just might spend a second to—MedPAC has got some thoughts, I am quite certain, on how you spend a little bit to save more down the road.

Mr. HACKBARTH. Yes. Well, I largely agree with what Mark McClellan said. I do think that you are going to need to make some targeted investments, and health IT being the classic example.

The CHAIRMAN. What else besides health IT?

Mr. HACKBARTH. Well, we have also been strong advocates of comparative effectiveness and to provide better information.

The CHAIRMAN. Right. What else?

Mr. HACKBARTH. Those are the two big investments, in addition, of course, to universal coverage, which is beyond Medicare's purview.

You know, we very much agree with the premise of what Senator Grassley said, that the task here is to level down. We have got huge variation in health care spending, low spending per Medicare beneficiary in Iowa and Montana and my home State of Oregon, and dramatically higher spending in other parts of the country.

The task before us is not to figure out ways to bring up spending in Iowa and Montana and Oregon so it is closer to Florida in the name of equity. What we need to do is bring Florida down closer to the other States. No offense intended to Florida or any other State, but I think that is the fiscal challenge we face.

One other lesson I think is important to note. The way health care is delivered varies a lot in the Western quadrant of the United States that Senator Grassley referred to. There is not one single right way to deliver efficient health care. It can be done a lot of different ways. And so we need to respect that.

One other finding is that the resources we put into the health care system, the mix of specialists and the like, and where they locate has a huge impact on spending patterns in locales.

So to go back to Senator Cantwell's point, the training process and the sort of people we are putting out into the health care system and where they locate will have a huge influence on local spending levels.

Mr. IGLEHART. Senator Kerry?

Senator LINCOLN. Well, I did not get to ask my question.

The CHAIRMAN. Senator Lincoln gets to go next.

Senator LINCOLN. Thank you. We have just talked about the medical home, and when we talk about it, we have got a medical—I do not know. I never came in here thinking we were not going to have to make an investment of spending in order to realize the savings that we want down the road. We are moving from an acute-care system to a chronic management system, and it is going to take resources.

When we talk about the medical home, one of the problems is that about 85 percent of Medicare beneficiaries would qualify. To me, it seems like what Dr. Steele is saying, that we may not get everything right off the bat, but let us focus on the group that will

bring us the greatest savings and the greatest example of the savings that we can have.

If you think about it, you know, we could do a much better job if we could capture the real complex and expensive patients with multiple chronics if we also deal with the cognitive impairments as well.

So if you think that roughly about 20 percent of Medicare beneficiaries have five or more multiple chronic conditions, but they account for 85 percent of our spending. So if we do some—and we are working with the Committee, Dr. Naylor, in those transitions like you are talking about in a model that would, I think, encompass a lot of what I have talked, what Ron has talked about, and others, where we would use all of those models to reach that 20 percent that are 85 percent of the costs through a plan like we are talking about.

I just think that we have to be realistic about the steps that we take in order to get everyone covered. When you talk about cost, I mean, we have got to make an investment. There are other countries out there that are covering a lot more people with a lot less percentage of their GDP than what we are.

So I hope that we will look incrementally at how we take the steps to get to where we need to be, but without a doubt, I appreciate Ms. Ness and Dr. Naylor bringing up the issue in terms of how we deal with these chronic care management schemes as well as the fact that when you are looking at cognitive impairment, that is a huge part. Those patients are 3 times more costly in the Medicare system, and that is going to be important.

The thing is I did a tour much like Senator Snowe in taking a pulse on rural America and their health care, and to the issue that Senator Nelson brought up in terms of the need for more primary care physicians, there is a critical need out there, but it is not going to just come by paying them more. I got to tell you, when you go into these small communities—and I am full of them in Arkansas—it is quality of life, it is education for their kids, it is jobs for their spouses. It is not just a reimbursement system. We have got to look at that, and the best way to look at it is to grow your own.

If we get residents into a residency program at the University of Arkansas Medical School, they are much more likely to stay in Arkansas than they are to ship in doctors from New York or Chicago or anywhere else to come practice in these small communities. Growing your own is the best way you can do it.

So I do not know if any of you all have comments on that, but I appreciate the chronic care issue, because I think for States like ours that are disproportionately elderly, disproportionately low-income, and disproportionately in rural areas where they are difficult to serve, it is going to be critical.

Dr. NAYLOR. Let me also add that the level of satisfaction of health care workers, providers that work in teams and complement each other is tremendously important, too. So physicians love the capacity to work in partnership with advanced practice nurses and others to complement the skills that they bring to serve these people. It is not going to happen by any one provider doing it alone. So we have to really foster a primary care system that is based on

capitalizing on the expertise of health professionals as well as community workers and the family caregivers.

The CHAIRMAN. I might say, if I might, that Senator Carper and Senator Kerry have been seeking recognition for quite some time, and they both have time constraints. So I do not know who wants to go first between the two of you, but I know they have both been seeking recognition for some time. I know Senator Carper was a long time ago. I think you were ahead of Senator Kerry, actually. Senator Carper?

Senator CARPER. I will be brief. Thank you so much for being here, and it is good to see some of you again and others to have a chance to hear from you for the first time.

Senator Cornyn mentioned Safeway, supermarket people out in California. I was there last Thursday, and I had a chance to talk with them about what they are doing in order to be able to basically provide health care costs for 200,000 employees in 2008 at the same level as they provided in 2004. And a lot of it is what they figured out how to do was to harness market forces to incentivize their employees to do certain things to ultimately maintain or level off their health care costs but provide better outcomes.

I studied a little economics—not enough, probably—as an undergraduate and in graduate school, but I have always been intrigued by the notion of how do we harness market forces, how do we change behavior by harnessing market forces and incentivizing folks.

Like several of my colleagues, over the recess period that we just concluded, I held a series of listening sessions around the State of Delaware—all three counties, mind you. [Laughter.]

Senator CARPER. It did not take all that long, but they were good sessions.

One of the things I will share is that the folks at the sessions were talking about market forces, and I used a different example than medical care, and I just want to share it with you. We have been trying to figure out how to mitigate against home foreclosures. A lot of people, millions of people are facing home foreclosures. How do we do that? How do we get the mortgages to be modified in order that folks can stay in their homes, lower interest rates, whatever, stretch out their mortgage payments?

We found that one of the keys in all this is a person called a "servicer," the people that we send our mortgage payments to, and they then take that money and they send it out to investors, the people buying these mortgage-backed securities around the world. And we are trying to push for foreclosure mitigation, and we found out that the mortgage servicers did not want to help modify mortgages to help folks out. Why not?

Number one, they did not get paid for it. Number two, if they did it, they get sued by the investors.

Now, if you are thinking about how to harness market forces to get things done and the key person is a servicer and they know if they are going to help you modify a mortgage they will get sued and they are not going to get paid for it, why should they get involved?

At one of our listening sessions, we started talking about fee-for-service. If you are physician, you get paid for doing more proce-

dures. You get paid for maybe ordering more tests, especially if you own a facility. You get paid for maybe having more lab work done, more MRIs, more, x-rays. But the other thing that kind of drives that behavior, aside from fee-for-service, if you do not do those things and there is a problem, somebody gets hurt, somebody dies, you get sued. You get sued.

What we did with the servicers in the mortgage foreclosure deal is we provided them a safe harbor. We provided them a safe harbor in order to try to take care of that. We also gave them money up front out of the TARP fund, as I recall, to actually pay them for doing the work, and then we said if you do this work and you help work out mortgages, we will make sure that you are in a safe harbor situation.

Some people who screw up and kill people in hospitals and who do serious harm, they ought to be sued. They ought to be sued, no question. A lot of people die. We know all that. But in terms of a safe harbor and the idea of trying to work on this market force deal where we incentivize people to do more services, more procedures and so forth, and by doing that to protect themselves from being sued, how do we balance that out? And this safe harbor idea, is it something that might be extended to health care?

Mr. IGLEHART. Any comments? Yes, Peter.

Mr. LEE. One, 160 million Americans are covered through their employers. Employers believe in the market. And I think you have heard a lot of examples about payment changes that move to get the market to work. So it is not fee-for-service. We are bundling. We are sort of bringing payments together. Doing that, though, I think we need to have a market that actually brings together the public and the private sectors. We do not have enough of a market signal for many providers when they are dealing with many different health plans, CMS, and so how do we align payments so the market is working because we have aligned signals? So that is one.

The second thing I would note—and I really cannot agree enough with Senator Grassley's note about needing to be bold, because employers and Americans are being crushed by health care costs. So we do need to be bold. We need to take some rapid steps. But part of the challenge is we do not in many areas have enough of the right measures to say who is really doing the right job. Which doctor is using resources most effectively? Which one is doing a better job for patients in terms of getting outcomes? And so we need investments in having better measures so we know what we are rewarding.

And, last, if I could, Senator, I think that your idea with regard to medical malpractice is a very important one. We should look at if you are a doctor that is following the guidelines, do you get a safe harbor. Again, we should be looking and encouraging doctors to follow the evidence, to have the tools to do a better job with market forces. I think there are tools we can use.

Mr. IGLEHART. Senator Cantwell?

Senator CANTWELL. Yes, on this question of efficiencies and savings, isn't there a big opportunity in cost savings in the area of long-term care and shifting our focus to community-based care, particularly when this dual-eligible Medicaid/Medicare population is something like 44 percent of the Medicaid spending and 25 per-

cent of the Medicare budget? Mr. Diaz or somebody. I mean, it is something like States that have implemented community-based care programs have saved like 7.9 percent or seen a decrease, and those States that do not have those programs have actually seen an increase in cost?

Mr. DIAZ. There is no question that there are still significant opportunities to take advantage of home and community-based services. At the same time, I want to echo some of the comments we heard earlier. I think that in order to better navigate the transitions in health care—and we see in our own experience almost 47 percent of the patients going through our long-term acute-care hospitals and our nursing and rehab centers accessing home care. It is about navigating the transitions, and the investments that have been talked about, particularly in physician-directed nurse managers, that is where we see the greatest opportunity, to bring an interdisciplinary team together to manage these transitions, prevent avoidable hospital readmissions.

I do think that it is not a zero-sum game, though, I mean, that the different sites of service, properly managed, with the right—you know, improved regulation and certification, can help us reduce costs and move patients through the system and keep patients from re-entering the system whenever possible.

But at the heart of it I think is a physician and a care manager, and there is plenty of evidence out there from Hopkins and others that there is a great opportunity to do that.

Dr. MCCLELLAN. Let me just add to this. Washington State has some experience with putting more emphasis on home and community-based care leading to measurably better outcomes for patients. They are more satisfied, their caregivers are more satisfied, and lower cost per person. And this is an area where Medicaid programs around the country, including in Washington, have led the way in making these reforms. What they generally do, though, is not just focus on community care but focus on the person, give the individual person with the long-term care needs and their caregivers more control over how resources are spent on their behalf, and then they choose the best way to get their care. Maybe it is at home, maybe it is a group home arrangement or something like that.

This is harder to do when the Medicare program is involved because, for people who are on both Medicare and Medicaid, it is separate funding streams. It is one stream that comes through Medicare with all the Medicare services, and another one that is managed primarily by the States through Medicaid.

There are some good examples there of programs that have put it all together, including a program called Evercare that was actually started by some nurses because they were so frustrated with all of the preventable hospitalizations and complications and medication overuse and misuse that was happening for this very vulnerable population. They put it all together. They demonstrated that they are delivering better care.

So the experience from long-term care services and supports is that if you give people more control and have good measures and accountability around the outcomes that you want—reducing com-

plications, avoiding hospitalizations, getting overall costs down—you can get much better results.

Senator CANTWELL. Well, if the savings for Washington State have been in the hundreds of millions, wouldn't it be in the billions nationwide if we implemented the same system?

Dr. MCCLELLAN. Absolutely could be.

The CHAIRMAN. Senator Ensign, you have been seeking recognition for a long time here.

Senator ENSIGN. Yes, thank you. Thanks, Mr. Chairman.

I want to go back a little bit, because it really has not been emphasized. A couple of Senator did, but the panel really has not addressed it that much. Ms. Ness, when you talked about patient-centered care, one of the things that really has not been talked a lot about is patient accountability; in other words, the patient having skin in the game financially. A couple of people have kind of touched on it; but that is really, I think, what Safeway and other private, basically self-insured companies have discovered. And you have mentioned some up-front costs that later get return on you. Well, Safeway's experience was they actually saved almost 12 percent the first year. It was not a long-term savings because they actually had the patient put something in the game. And I actually believe that we can model even some of our Medicare reforms along the lines of putting the patient in the accountability loop, especially because of the idea of information technology and putting transparency in the system, both on costs as well as outcomes.

We understand there are huge differences between what one colonoscopy costs 3 miles away from what another colonoscopy costs, and an MRI versus an MRI, or a whatever. But there are a few diseases that take up most of the health care costs, and we can focus on them—you do not have to focus on 500 diseases. You can focus on a few of them, and that is what Safeway did. They focused on basically four areas: obesity, smoking, heart disease—especially hypertension—and diabetes. Even if you have something like that, if you manage it properly, you can save huge costs. If you are a hypertension person and you are taking all the proper drugs on the hypertension case, you can, if the patient has the incentives, the financial incentives—the skin in the game, so to speak—they can manage that, and not only is it better for them, but it is also better for the system. So I actually would argue that we do not need more money in the system. We need to spend our money more properly and have the incentives.

A couple other points to make on this, and then anybody who wants to comment on this can. Obviously, obesity is one of the biggest problems we can have in our children. The massive obesity rates that we see in our children are going to hugely explode medical costs as these folks get older if we do not get control of it. But in all of the adult population, I think the statistics are something like 40 percent of Americans are considered obese—not just overweight but actually obese. You know, those numbers are startling, and it contributes to all of the other factors.

We only allow 20 percent of the current premium cost to be incentivized through—or the total of the premiums to be incentivized as positive incentives. We need to raise that so that we can truly reflect what it costs to insure a smoker. Incentivize them

to quit smoking. What it costs to actually insure somebody who is overweight. Not to penalize somebody who is genetically predisposed to that, but incentivize them to get on weight loss programs and exercise programs. All of these preventative things, it was always told to us these are long-term benefits. Safeway has proven, and other companies have proven actually the short-term costs are there, and we need to talk to CBO and some of the other people about scoring this thing properly so that we can put these incentives in our private health care system as well as Medicare and Medicaid too. Long term and short term, save total costs for the system so we actually will have the money to be able to take care of the uninsured.

I believe that that is what Safeway has discovered, is harnessing those market forces through incentives, once again, for the patient—this is patient directed, but it is also patient responsibility, and I think that both of those things need to be in our health care system, along with a lot of the other reforms that you folks have been talking about today.

Ms. NESS. Senator, I could not agree more that a key component here is getting to real patient engagement in managing their health and making better decisions about their health care. And you identified the three operative things that we have to have in place. We have to have the right information and tools for consumers, and that gets directly to transparency. It gets to what Peter Lee was saying about having measures that are meaningful to consumers and that help them be able to make judgments about which providers they should see. It also gets to the importance of comparative effectiveness research so we know what works and what does not. We need to be able to give patients the information that would enable them to make better decisions, to see the differences. That is part of engaging them.

A second thing is we need to make sure that we give them the right benefit design so the incentives are there, and incentives to engage in healthy behaviors is one type of incentive. Incentives to be able to better manage your chronic condition is another set of incentives. And we know there is experience out there of plans that have designed benefits that, for example, reduce co-pays for the kinds of medications that help people with chronic conditions manage their condition. Compliance goes up; people stay out of the hospital. So the right benefit design is critical here as well.

One other thing I want to say is that we are now learning how valuable shared decision making tools can be. These are tools, informational tools, which tell people for their condition what are the range of options, what are the pros and cons, and allows them with their health care clinician to make a decision that weighs those and is consistent with their values and preferences. And guess what? When people use those kinds of tools, they tend to make decisions that are more conservative. They tend to get better outcomes, have higher satisfaction and lower costs.

So patient engagement is a great thing. We need to make sure we give people the right information and tools.

Mr. IGLEHART. Senator Cornyn?

Senator CORNYM. I have a question for Mr. Morris and responding or reacting to a question by the Ranking Member, which some

have addressed, whether the United States is spending enough money to deliver health care.

As I think the Chairman pointed out, we spend more as a percentage of our gross domestic product than any other country in the world. My hope would be that before we spend more money, we look at the money we do spend and see whether it gets spent on the target, whether it is effectively spent delivering health care, as opposed to, for example, the $60 billion that the Washington Post has reported is lost to Medicare fraud each year. That is just Medicare. According to the Centers for Medicare & Medicaid Services last fall, 10.7 percent additional is lost through Medicaid fraud, waste, and abuse.

So, in light of the fact that Medicare and Medicaid are the mainstays on the Government Accountability Office's list of high-risk programs, would you be concerned that any new public plan option or perhaps Medicare for All, so to speak, would be vulnerable to waste, fraud, and abuse? And what do you think you need and what kind of tools does the Department of Justice need in order to root out this kind of waste that does not go into the delivery of quality health care for the American taxpayer?

Mr. MORRIS. Senator, first let me say that we in the law enforcement community very much appreciate being part of this discussion. I do not pretend to be a health care policy wonk, but I do know from the perspective of law enforcement that building and reforming this program has to recognize that waste, fraud, and abuse not only takes money out of needed health care, but promotes cynicism on the part of the taxpayer who believes we are wasting their dollars.

We begin with the premise that how you build a system will define how the unethical will cheat it. So, for example, if you operate on a pay-for-service basis, the incentive is to *overutilize.* If you operate on a *capitated* system, the incentive is to underutilize.

So to address the current system as well as to think about how to effectively protect an expansion of the health care benefit to make Medicare a system for all, to use your suggestion, we believe there are five principles that should be brought to the analysis, and there are a series of recommendations that stem from each of those. Let me hit those five very briefly.

First, we think that we need to scrutinize the individuals and entities that want to participate as providers and suppliers before we allow them to enroll in the program. We need to move from thinking about participating these programs as a right to considering it a privilege. This means scrutinizing who they are, looking at their backgrounds, making sure they are accredited and can perform the services that we are allowing them in to treat our beneficiaries and have access to our trust fund dollars.

Second, we think we have to establish payment methodologies which are reasonable and reflect changes in the marketplace. In my written testimony, I give just one example of the many audits and inspections we have discovered that we pay way too much for services. Oxygen concentrators—we pay $7,200 for the rental of an oxygen concentrator that you can buy for $600. Not only is that a waste of taxpayer dollars, but beneficiaries are paying excessive co-

payments. So this is impacting not only the program, but the very beneficiaries we are trying to help.

In addition to saving dollars, we think having methodologies that are responsive to changes in marketplace reduce abuse. It has been our experience that many of those who come into Medicare and Medicaid to commit fraud see these enormous dollars and actually use some of those excess profits to generate kickbacks to produce more referrals. Perversely, they are using our money to generate further schemes.

Third, we need to assist health care providers and suppliers in complying with our program requirements. It is a complicated set of programs. The vast majority of providers and suppliers are honest. They want to comply with the program, and they need all the help we can give them. Part of that, we believe, means requiring that as a condition of participation, providers, suppliers, and practitioners have compliance programs in place. These should be tailored to the particular type of practitioner or supplier and should be tailored to the sort of risk that they present. But we think it is incumbent on those who are going to participate in our program to have internal controls to ensure they are doing it right.

Fourth, we think it is critical that we do a better job of vigilantly monitoring the programs for evidence of waste, fraud, and abuse. This requires better data systems. This requires us to be able to better sense how claim patterns and trends are occurring. It requires that we have a better sense of who the problematic providers are and the we build large adverse-provider databases so we know who is coming into our system and where they have been before.

Finally, we think we need to do a better job of responding swiftly to detected frauds, imposing sufficient punishment, and promptly remedying program vulnerabilities. We have in place, with our partners in the Department of Justice and U.S. Attorneys' Offices, strike forces throughout the country which are going in and targeting target-rich environments, like Miami, Los Angeles, Houston and Detroit, where criminal elements and organized crime have come in and prey on our program. Through effective use of prosecution and investigation, we are putting a stop to it.

Now, a question has been raised throughout this panel is: Will it take resources? I think it will. I think in order to build effective databases, in order to more effectively monitor the system and respond promptly to these vulnerabilities will require resources. But I will also tell you that I believe that there will be a tremendous return on that investment.

By way of example, over the last 3 years, for every dollar spent on the Inspector General's office to combat waste, fraud, and abuse, we brought back $17 to the Medicare trust fund. So I would submit to you that it is a good investment.

The CHAIRMAN. I might follow up on that, if you do not mind. I would say the question that Senator Cornyn asked is: Where is the waste? Jack Wennberg says there is a lot of waste. CBO says there is a lot of waste, and that 700 figure is a CBO number. Senator Cornyn asked the question about waste, fraud, and abuse, and the question is: How much of the waste is fraud, waste, and abuse and how much of the waste is other inefficiencies in the system?

My sense is that there is waste, and partly because practice patterns vary significantly all across the country. I remember when Uwe Reinhardt testified before this Committee, from Princeton, oh, maybe a few months ago, he said he checked with three different hospitals in New Jersey to see how much each spent in the last 6 months at the end of life in three different hospitals. I have forgotten the ratio, but it was wildly different between the most expensive and the least expensive. And he called them all up and asked them why: "Why do you spend three times"—or whatever it was—"what the other hospitals spend?" The answer is, "That is just the way we do it."

My sense is that there is a lot of waste, therefore, in addition to fraud, waste, and abuse, which we have now discussed. And Mr. Morris did a terrific job in outlining some ways to address that.

My sense is that there are also other areas with a lot of waste in the system, and I wonder if anybody else wants to comment on that. Dr. Steele?

Dr. STEELE. All of the publicity on this single price that we have gotten called a "warranty" is not the real substance of what we have done. The substance is re-engineering our care, and the way we did that was to get rid of all unjustified variation. And the way we got rid of unjustified variation was to have our professionals either take consensus- or evidence-based best practice off the shelf or by forcing them into arriving at an evidence- or consensus-based themselves. And that is the method for increasing the quality and decreasing the cost. You know, everything was publicized as the warranty, but it was really going after that unjustified variation.

And so I could not agree with you more, and if you can find best practice in many, many parts of the country, in many markets, in different systems, and somehow get an engine to disseminate that best practice, that would be a real way of making significant advances in these high-cost cohorts that we have been talking about all day.

The other thing, Senator, is that the docs and the nurses get tremendous pride of purpose in leading these changes. It is not as if you are forcing them to do it. They think it is cool, and there is nothing like having a professional lead this if you want to get something done.

The CHAIRMAN. Senator Stabenow?

Senator STABENOW. Well, thank you, Mr. Chairman.

Just to follow up on that point, I guess one of the questions—I have had a couple of different questions in terms of how we get to where we want to go in terms of quality, the comparative effectiveness and so on. How do we get from the lab bench to the patient's bedside on this information? And I know that last year we heard from the RAND Corporation that we only receive necessary preventative care services and recommended care for acute health problems a little more than half the time.

Now, in Michigan, we have had a wonderful program through the Michigan Hospital Association, the Keystone Center, which is now being expanded out through pilots. But I guess the first question I would have is: How do we get from the lab bench to the bedside? And, secondly, as we talk about pilots, I think several people mentioned the slowness of turning these things around. I know that in

talking to one of the demonstration projects that the University of Michigan health care system was involved in, it was a Medicare physician group practice demo, pay-for-performance project, authorized in the year 2000, did not start until 2005.

So, you know, how do we move these things? How do we make these things happen?

Dr. OPELKA. Senator, thank you very much. Frank Opelka with the American College of Surgeons.

I think that, you know, the way we look at this is—in the past has been, at least for me, over almost 30 years practicing surgery, I never knew what my results were. And it is only now that we are actually starting to see some of the tools that are coming out showing me what those results are.

I think we need—we have a lot of data, but it is claims data alone, and we do not have a robust clinical data system that actually starts to drive this. And Glenn has piloted some of that in his own programs by taking his data and looking at what he does. In surgery, we have several tools that we do not have well disseminated across the country, and we need to get them disseminated. Beginning in the VA in the mid-1980's, they developed the National Surgery Quality Improvement Program. That shows an enormous improvement in the quality of care, decreased length of stay, better overall outcomes for the patients. And it has a return on the investment, but it takes an initial investment to get out there for a hospital to deploy that resource.

We have got a trauma system that actually is successful, but it varies State by State, so we have our own variation in trying to implement a national trauma system. We need to put those systems together, and we need to join a lot of these efforts with our chronic disease management and how we actually create the coordination of care across those disease management systems, taking something like the STS thoracic surgery/cardiac database and combining that with the cardiology database, combining that with the claims data so we have clinically enriched data sets. Our data systems are all in silos, and we are not unified on looking at a problem together and designing a solution.

That is an opportunity, I think, that the Senate can help pull all that together to put things like the National Surgery Quality Improvement Program in every major hospital that is performing every major type of surgery, to bring that together, to link the trauma systems that we have and bring all that together, to combine our chronic disease issues and outline those together where we need them.

It starts with the data, and I think physicians respond to data, and then when they get the data, we have an opportunity to change the culture. Right now our culture is "More is better," and whether we practice defensive medicine, whatever it is, we practice a culture of "More is better," and it is not. In fact, more may be harmful to patients. It is the right care at the right time for the right reason. It has to be data driven. Whether or not we have true, bona fide, absolute evidence or whether we just have observational data, we have got to make these decisions in a more unified manner.

Mr. IGLEHART. Mr. Umbdenstock?

Mr. UMBDENSTOCK. Could I piggyback on what Dr. Opelka has just said? We have got two very specific examples, and, Senator, you raise one of them, which is the Keystone Project around central line infection prevention. And based on the success of that, starting with knowing what works and having the results to prove it, we have now leveraged that through a grant to our Health Research and Education Trust to take out to ten States, and we have had to turn States away, because they are so anxious for this information and this support in order to take care of that kind of problem. So I think with the results and with the knowledge comes the speed and the flywheel effect.

We have also seen it with the Hospital Quality Alliance where hospitals now for 5 years have been publicly reporting against consistently defined and agreed-upon measures, and we are starting to see that, in fact, the frequency with which patients receive the agreed-upon process steps and care steps is increasing significantly.

So, again, with the information and with the knowledge that, in fact, we are going to invest in something that is going to, in fact, make it better for patients and providers alike, we see the flywheel spinning much faster.

Mr. IGLEHART. Senator Wyden?

Senator WYDEN. On this point, because I think the Chairman is right, I think we are getting close to wrapping up the morning session, to keep coming back to squeezing out the inefficiency and squeezing out the areas where there are additional savings. I want to put one other element into this discussion of efficiency.

If you watched the entire morning session, I think you probably walk out of here and say, "What Glenn Steele has come up with sounds like the greatest things since night baseball, and I want to sign up for that Geisinger Steele program."

So then you unpack it through to today's system. If you are lucky enough to have employer-based coverage in this country, more than half of you do not even get a choice about what your coverage is. So more than half of the people would not even get a chance to go to Geisinger. Then in that system, you do not get any financial reward under today's system for choosing the Geisinger kind of approach, and I wanted to just wrap up with a question on this point for Dr. McClellan and Peter Lee.

How important is it, in your view, to make sure that people have more choices—by the way, everybody up on this panel has plenty of choices. We have got plenty of choices of good-quality packages, and I think the American people would like to have the kind of choices the Members of Congress have and not just have one. But how important is it to have more choices and then to get a financial reward for making the careful selection of a Geisinger-like good-quality package? Dr. McClellan and Mr. Lee.

Dr. MCCLELLAN. Senator, I do think it is important, and Senator Ensign highlighted the value of these kinds of choices as well. You pointed out some critical elements. One is that you can save money if you choose less expensive care, if you take steps in your own life to bring costs down. And we have heard from the panel about the importance going along with that, is good information and support in comparing across these choices, making informed decisions about

your health. We do not do as good of a job as we should in supporting those kinds of decisions to promote this sort of effective competition.

I think you really do need to take this holistic approach in the end if these reforms are really going to work. Chairman Baucus emphasized that, look, you know, even if we find ways to improve specific aspects of care, the fact of the matter remains that there are still these huge variations in overall costs and utilization. You know, we can do a great job, and we should, of improving the efficiency of a hospitalization, reducing the complications during a hospitalization. But as you point out, hospitalization rates and hospitalization days vary two-, three-, four-fold around the country. So there needs to be a further step that focuses at the level of the person around choices to enable them to find better care at a lower cost, information to support those decisions, and then ways for health care providers and insurers and new Internet companies—you name it. Who knows where health care is exactly going to be in 10 years from now? But supporting those kinds of reforms that get people better care at a lower overall cost has got to be the bottom-line goal here, and choices, done right, are a very important part of that.

Mr. LEE. Absolutely, choice is critical, and we have heard a lot on this panel about the importance of choosing treatments, choosing lifestyles. But you have taken it up the level of choosing a health plan. And some large employers actually have incentives to pick that better plan. If you do not have a choice, though, you have got nothing there.

And so I think what we have heard across this panel of needing information to say which is better in terms of quality of care and in terms of the cost-effectiveness, linked to incentives, linked to tools to use it. And I think when we look at a delivery system, that needs to also include choice of plans so people can make the choice between which plan is the right one for them as well.

The CHAIRMAN. I think Dr. Hackbarth——

Mr. HACKBARTH. Yes, I just wanted to chime in on Senator Wyden's point. I absolutely agree with you, Senator. In fact, I think that was one of the cardinal lessons of the managed care backlash of the 1990's. Employers, at least many of them, restricted choice, and they grabbed the savings for themselves as opposed to giving their employees a choice, a cost-conscious choice of alternatives. And I think it is very important as we try to change the health care delivery system that the patients, the enrollees in health plans, feel invested in the process, that they are making choices and they are benefiting from the choice of more efficient alternatives. Otherwise, we will have another backlash, and things will unravel on us.

The CHAIRMAN. I would like to focus a little more on CMS. What investments, what changes are needed? Presumably we in the Congress cannot dot all these i's and cross all these t's in how all this is implemented. I sense there is a lot of agreement in what the general approach should be. But the question is how do we execute, how do we implement, and CMS is a major player here. I think Dr. Steele had at least an idea, you know, empower CMS to be more

flexible, empower them to come up with the solutions that we are all talking about here.

So what changes and what investments are needed in CMS?

Mr. IGLEHART. Back down to the other end. Mr. Diaz?

Mr. DIAZ. Yes, thank you. I want to comment from the perspective of a multi-State provider. We operate in 40 States. We live in a public and private world. We are in partnerships with private plans and Medicare and Medicaid for some of the very chronic patients that we talked about today. And we talked earlier about the potential for a broader mandate, and it seems to me that is part of the opportunity here, that there are immediate savings and immediate benefits to patients by a broader mandate to—you know, MedPAC's authority. When we look at some of the dislocation and managing the transitions of payments, we see that in the dislocation between the Medicare and the Medicaid program. And we see that CMS, all the well-intentioned folks there typically regulate and develop policy based on silos—long-term acute-care hospitals, skilled nursing facilities—with very little study of the interrelationships and the opportunity to better coordinate care.

So I think there is an opportunity, consistent with many of the comments we heard today, for a broader mandate of looking at how we move past the silos, again, having physicians and care coordinators as the real drivers of the engine, and that there are immediate opportunities to bring down those silos and give MedPAC and give CMS a broader charter to look at those opportunities along with looking at the opportunities with the private plans as well.

Mr. IGLEHART. Mr. Hackbarth?

Mr. HACKBARTH. I would say three things, Senator, and these have been mentioned by other people. They need more money, more resources, more people to do the tasks that they've been assigned. They need less detailed, less prescriptive legislation, more latitude to make decisions—subject, of course, to proper oversight. And, third, I think we need a different model of how we innovate in the Medicare program.

Right now it takes 6 to 10 years for a new idea to sort of work its way through the process. If it is a large-scale test, it needs Congressional authorization for the money, and it takes a couple years to design, recruit participants, then you have 3 years of the project, a couple years of evaluation. It goes back through the legislative process. That way of developing new payment models for the Medicare program is way too slow for our needs. And so we need to look at each step of that process and see if we can cut out steps in time. And one idea that Glenn Steele has mentioned is the possibility of sort of a standing network of providers that can pilot ideas on a fast-turnaround basis. That would be one idea. There are others as well.

The CHAIRMAN. Thank you.

Mr. IGLEHART. Dr. Korn?

Dr. KORN. Very briefly, Senator, agility. If Aetna and Independence Blue Cross were able to come together to support a medical home model in Philadelphia, why isn't Medicare at the table? Of all the innovations that the insurers are rapidly using across the United States, the combined market share and the impact of the

physician's practice to rapidly share in these pilots and innovations on a local basis would, I think, advance knowledge very rapidly.

Mr. IGLEHART. Mr. Lee?

Mr. LEE. Alignment of the CMS partnering with private plans is incredibly important, but I would build on everything that Dr. Hackbarth said in terms of the decision process to change who is at the table. And Debra Ness noted this, but in terms of having more agility, ability to rapid cycle authority that Congress needs to grant in an appropriate ways that CMS can act, but then who should be at the table? I come back to patient-centered, and we have too many decision processes that has, with all due respect, only those who are actually getting paid at the table, not having those that are actually getting care, patients, consumers, as well as those, employers and others, that are paying the bills.

Mr. IGLEHART. Ms. Ness?

Ms. NESS. And just very briefly, building on what Peter just said, I think we need to make sure that the innovation, the demos, the pilots, whatever it is we are doing, we do begin to integrate the private sector and the public sector components. We cannot have the innovation going on in silos.

Mr. IGLEHART. Dr. Opelka?

Dr. OPELKA. One of the things that we learned with our other insurers is we sit down and partner over issues and try and come up with innovative solutions together. We don't do enough of that with CMS, and I think there is a real opportunity to actually sit down, put a problem on the table, and try and solve it more collegially together and have the ability to move more nimbly than we currently move.

Total system redesign, because of the cost and the need to redesign chronic care, as Mary has said and as John has said, we totally support that within the college.

I think that we need to enhance how we do the value assessments on the outcomes-based care initiatives, like surgery, cardiology, other areas other than primary care. How are we looking at what we are doing to know that we need to do those procedures that are absolutely necessary, where the overuse is. We need to actually cut back on where we've got defensive medicine that is really just running up a cost. And so the safe harbor concept, I fully support that.

And, lastly, preserving the key elements of the surgical workforce is important. Trying to pull monies out of the surgical workforce to start up and fund other initiatives could actually have a real deleterious effect on how we maintain the surgical workforce.

Mr. IGLEHART. Dr. Steele?

Dr. STEELE. You know, again, I think the narrative is important, and if we focus on where we are now with some of these incredibly poorly cared for, high-cost groups of patients, and you give direction that you want to get to another place over a period of time, and you hold CMS responsible for creating the innovation to do that as opposed to the much more specific granular kinds of instructions, then the only thing I would add is if you actually do this health care reform——

The CHAIRMAN. We are going to do it.

Dr. STEELE. CMS——

Senator SCHUMER. He means it, too. He means it.

Dr. STEELE. Your goal should be to have CMS as the workplace that everybody wants to be a part of, because you are going to be dependent upon the human resource over there. And it should be the place where people want to work if they want to work in government.

The CHAIRMAN. That is a good point. How do we accomplish that?

Dr. STEELE. We can talk later.

The CHAIRMAN. Okay.

Senator SCHUMER. Mr. Chairman?

The CHAIRMAN. Anyone else want to address this one subject——

Mr. WILLIAMS. Yes, Mr. Chairman, I want to get a point in here, if I may. Just a couple of points on CMS.

One, I think this notion of public-private partnerships is extremely important, and one of the things I would continue to encourage is the ability to share claim and clinical data between Medicare and the private sector so that we enrich both the claim database as well as the quality database, building on National Quality Forum-approved data.

Innovation is fundamentally important. Two years ago, we had zero members with the personal health record. We now have ten million members who have their own personal health record that they own, that they can take with them, that captures all of their data.

The other point I would make is network-based products. You take an area like bariatric care, bariatric surgery for weight loss. We built networks and determined that by looking at those networks, the quality of care and cost was 15 percent lower a year later for those physicians and institutions that were in the network, and they were selected on the basis of quality, good thorough assessment, good counseling for the members. And it was 4 percent higher than the average outside. The use of network-based products is a fundamentally important missing component and tool, and I think that brings us back to public-private partnerships.

The other point I would make is just flexibility, the ability to innovate with things like value-based insurance design so that the insurance products, whether it is a pharmacy or other benefit, really has the ability to adjust the co-pay based on that individual member's health circumstances. Prevention for you may be different than prevention for someone else, and we need the ability to have variable definitions of prevention based on the clinical circumstances.

And, finally, there is a whole set of missing decision support tools that give a member alerts on health screenings that they should be having, an ability to give an alert to the member and an alert to their physician, that there seems to be a gap in care based on the evidence-based standards. All of those things represent standards that have been innovated in the commercial health care sector that are readily available and that are unavailable in base Medicare today—all of which contribute to improving quality and reducing cost.

Dr. TOOKER. I just want to make a follow-up point—this is John Tooker from American College of Physicians—about CMS. It looks

to us—to me, at least—that we are going to be trying to test multiple models of payment as well as multiple models of health care delivery. And CMS is going to be crucial to the testing of those models.

And it seems to me that there may be opportunities to improve the relationship of Congress, the White House, and CMS so that there are common expectations at the time that legislation is developed all the way to the implementation of programs through CMS. Just looking at the Medicare patient-centered medical home demonstration project that was authorized in 2006, it is not yet started; whereas, in the private sector at the State levels, both Medicaid and the private insurers are well down the road of testing models of the patient-centered medical home. And there are lessons to be learned from partnerships of CMS with those State and private entities that in our opinion would help improve the ability of CMS to implement.

Second is distinguishing between pilots and demonstration projects and, where possible, to take the lessons learned from pilots and implement them as soon as possible as opposed to having to go back through an authorization after a demonstration project, which takes an additional period of time.

Mr. UMBDENSTOCK. And, Mr. Chairman, just briefly, I would be remiss if I did not suggest we look at the regulatory side as well and the burden that that causes. The amount of regulation that hospitals live under today really has to be examined and rethought and redesigned.

In the case of CMS, it is additive, and I think we have to figure out how to replace the old with the new. I will give one example and be brief: the Hospital Quality Alliance. Terrific move to publicly report on nationally agreed upon measures. As I said earlier, hospitals have signed on and are very anxious to get their data back.

The agency has to be able to process that data in a realistic time frame and get it back, so it needs the resources in order to do that. It needs the resources in order to display that data if the public is going to use it to make decisions.

At the same time, though, getting that data out of the hospital and off to the data processors and to CMS has taken significant resources, especially nurses to comb through records where we need that done. And we have not seen any relief on regulation on the payment side or anyplace else. There is never a substitution of one priority for another or one regulatory burden or cost for another. Those substitutions we are trying to make every day at home on the front lines. I think we need to think about how we can help CMS think that way as well.

The CHAIRMAN. Okay. Senator Schumer?

Senator SCHUMER. Well, thank you, Mr. Chairman. First I want to thank you. This has been a great morning. I have watched a little of it on the TV from my office and I have been here. I am sorry I cannot be here the whole time.

I would like to focus on the public plan option, which has had some discussion but nothing direct, and some of the witnesses here today who have offered criticisms of the public plan option also strongly support the new payment and quality initiatives—medical

home, accountable care organizations, bundled payments. And I do not see—I think there is, at least in some places, almost a knee-jerk saying you cannot do this, you cannot have a public option, where it seems to me we should take the best of these ideas and use them in a public plan option. A public plan option could be formed in many different ways. There is a whole lot of rhetoric, you know, on the public plan option, but we have not even defined what the insurance product will look like, how it pays doctors, how it pays hospitals, what part of the Federal Government will be running it. It could be in CMS. It might not be.

So I would first ask everybody to keep an open mind. We all agree that reform must occur. We need higher quality. We need better care. And I think a public plan option could help make that happen.

To Dr. Korn, here is what I would ask you and then ask others to comment. You criticized the concept of a public health plan in the association's recent advocacy, and I wonder if there is not a way to work together on this important component of health care—that is what my question is—or if the opposition that your association has is simply about protecting a monopoly over a small group and individual market? If the field was level, the playing field was level in rules and requirements that private plans and the new public option plan had to live under in the new health exchange, why would you oppose it? Competition is healthy, right?

Dr. KORN. Competition is healthy. We are always open to discussion, and I think that no door is ever slammed shut on increasing competition among private insurers. However, some of the fundamental concerns with a governmental programs, though, that I think we have to deal with realistically are that a federally sponsored program would not have to have reserves, would not pay taxes. It is very hard to imagine what a level playing field would look like when the ultimate competition is an economic proposal to a potential purchaser. So there are many issues to be thought through here before we can determine how that might work.

Certainly we do want everyone to be covered, and certainly there are those who under no circumstance could afford any option, and we think there is a role for the Federal Government in filling that gap through existing programs, if possible, if they were not willing to subsidize premiums to those of us who are in the commercial sector.

So the level playing field is somewhat difficult to envision given the requirements of private insurers, and I wonder if maybe Mr. Williams would have any further reflections on that.

The CHAIRMAN. I might say, too, that the next session is going to deal with coverage, which is a more appropriate forum for this particular subject. It is fine to bring it up now, but this session is designed more for delivery system reform. The next session is going to be coverage in all various ways we cover Americans. But I am glad you raised the point. We do not have the panel yet——

Senator SCHUMER. I know. But even——

The CHAIRMAN. And I might also say, as you are saying, Senator, that my judgment is the public plan option should be on the table along with everything else. Nothing is off the table, because we have such a terrific opportunity here to move forward together.

One of the beauties of all this—it is tremendous when you think about it—we are being strategic here. We are coming up with a plan which will take several years to implement and to take effect and help reduce cost and help improve quality of health care and help improve coverage. Instead of Congress going down the usual road of every year a little bit here, a little bit there, pushing the balloon here and it bubbles up someplace else, this is exciting. This is strategic. This is a whole new approach in health care reform that we have taken in Congress for a long, long time. That is why I want to keep everything on the table, everybody keep an open mind. There is always a way to skin a cat. There is always a way to work out something here. It is give and take everywhere. Then the public option is clearly in that same category.

Senator SCHUMER. I appreciate that, Mr. Chairman. The point I was making to Dr. Korn is it might be that for a private nonprofit insurer or private for-profit insurer, a public plan might work to your advantage. You know, I know everyone thinks, "Well, I am going to get this segment of the market and this is the segment I want." But part of our job is to make sure you cover other—and it is true, it is related to coverage. But it also is related to innovation and cost savings and things like that. And to me, at least, I would never—there may be some people who say only have a public plan. That makes no sense. But it equally makes no sense to sort of push off the table, as the Chairman said, to have a public plan even in your own self-interest. And, admittedly, our interests and your interests are not always the same.

Do you want to say something to that, Mr. Williams?

Mr. WILLIAMS. At this point I would just say the Chairman has spoken and we understand it is all on the table.

Senator SCHUMER. Everyone agree with that? [Laughter.]

The CHAIRMAN. Everything is on the table. Everything is on the table with the single exception of single pay. I do not think single pay is on the table. This country is not going to adopt single pay—at least not this time. I do not think. But everything else is clearly on the table.

I have a question on behalf of Senator Kerry. He was unable to stay for the hearing. I would like to ask it on his behalf. He asks: Medicare Part A and Part B have different payment structures that often result in silos and discourage care coordination. Some of you on the pane have discussed the need for bundled payments. Can you elaborate on this concept? What else besides bundling can be done to better coordinate care between services covered under A and B?

We discussed that a little bit, but why doesn't somebody just sum up an answer to that? Anybody who wants to take a crack at that on behalf of Senator Kerry.

Mr. IGLEHART. Mark?

Dr. MCCLELLAN. We have talked about a number of different approaches to try to payments aligned, better support, results, and care at the patient level, this patient-centered care notion. The medical home can help with that by giving primary care providers more of an opportunity to bring together different pieces of health care delivery, the bundled payments by bringing more alignment between physicians and hospitals and post-acute providers. All of

these kinds of things move in the same—have the intent of moving in the same direction.

I would add to that the notion of accountable care organizations, which we have talked about. That is at a bit higher level, trying to get some recognition of the importance of better results truly at the person level, at the population level, and trying to get costs down at that level as well.

As you heard from many of the providers here today, with hospitals, physicians all working in a very fragmented way today, you have got to be careful about how you move in this direction, and it may require some extra support in the short term to get there. But it seemed like from this panel there is a lot of support for recognizing that if we can do a better job of having payments that support coordination of care and person-level results, that will help us get the kinds of delivery system changes that we want.

Mr. IGLEHART. Mr. Morris?

Mr. MORRIS. I also think we will need to look at the current fraud and abuse laws to ensure that the effort to align the interests of hospitals and physicians is not blocked by current laws, which in many cases inhibit those sorts of changes. There are civil penalties, the Stark law, and the kickback statute all in play here, and we will need to look at those to ensure that they are not inhibiting positive innovation.

The CHAIRMAN. Right. I hear that.

Mr. UMBDENSTOCK. Three things, Mr. Chairman, quickly.

First of all, conceptually we understand where this is trying to go and why it has not been tried broadly, demos just starting. I think we need to learn a lot and bring it back to the Congress and decide what needs to go forward, what is the best way to move.

Secondly, to underscore what Lew Morris just said, we need some legal review, if not legal relief, so that hospitals and physicians can work together more closely, clinically integrate so that we deliver on a higher-quality product, but understand that the legal barriers have been lowered.

Thirdly, as we talk about bundling as it is presently being discussed around acute and post-acute, there is no common assessment tool to figure out where to put the patient in different post-acute facilities. Work has begun on that. We need to know more about that and how to do that properly for the patient's point of view but also the provider's.

And, lastly, we have in that same realm in the post-acute numerous regulations that restrain or constrain where a patient can go or how many patients can go to what type of facility from what type of facility. We have got to think about lowering all of those barriers if we are going to truly pay as one and operate as one, and that is going to take—I think that has got to be considered as well.

The CHAIRMAN. Thank you.

Mr. IGLEHART. Dr. Naylor?

Dr. NAYLOR. On the idea that everything should be on the table, I hope that we will consider in the payment options an opportunity for accountable entities defined by local communities that are strategically targeted and designated to provide services to this 20 percent of Medicare beneficiaries who need more than the medical home or the primary care services will provide and who will not

necessarily be well served by a bundled payment delivered to hospitals.

So I hope that we can think about what our evidence suggests is an appropriate approach to improve the care, reduce the readmissions, and achieve health care savings.

Mr. IGLEHART. Mr. Hackbarth?

Mr. HACKBARTH. I want to take a little bit different tack. The silos in health care delivery that we have talked about are not so much a function of the separation between Part A and B but, rather, a function of the payment systems that we use within them. I think the relevance of the A-B distinction is more at the financing level, how the revenues raised to finance the program. And so, you know, I think we need to bundle payment across A and B, but I do not think the current A-B distinction is a barrier to doing that.

So I would urge you to think about A-B issues as matters of equity in financing. Is this the way we want to raise the revenues to finance a Medicare program?

Mr. WILLIAMS. I think the one other point—a couple of points I would make. One is as we think about the process of bundling, we need to make certain that we do not lost sight of patient preference as they go through a course of treatment, because as you bundle the payment, the patient may at some point in that process choose to have different ideas about where to get care or how to get care. And so I think all that needs to be contemplated as this process evolves. I think it is a very good process, but we need to not lose sight of that.

I think the other thing I would say is to have flexibility in the model. I think there is a question about is it a hospital model, a physician model, or even a health plan model. And all of this is going to require health information technology, software, data. For example, biometrics could be a huge component of providing better care outside of the hospital in collaboration with nurses and others in the home, along with telemedicine and other capabilities.

And so I think if we want to explore this, we should have broad, general ideas to give us an ability to figure out what works experientially.

Mr. UMBDENSTOCK. Mr. Chairman, as you know, how this plays out in a rural community with differing arrays of service capabilities is something for us to think through as well.

The CHAIRMAN. That is right. When we talk about rural, I am reminded there is rural and there is rural in this country. [Laughter.]

Anyway, rural in the East is an interesting concept. Rural in the West is really rural.

Mr. IGLEHART. A number of the panelists have brought up the subject of hospital readmissions, mostly in the context of expressing concerns about them. But I would like to ask Mr. Umbdenstock, representing hospitals, to give us the AHA view of that in terms of an issue and how to address it.

Mr. UMBDENSTOCK. I am sorry. We were finishing up on the last topic. Can you——

Mr. IGLEHART. Readmissions, and what the AHA view is in terms of how to address it.

Mr. UMBDENSTOCK. Well, first of all, a readmission is not a readmission is not a readmission. The way the term is being used today, some apply as a readmission, a second admission off of a common diagnosis or episode. Others are just talking about new admissions within a specific period of time. And so our concern is not over eliminating unnecessary or preventable readmissions. We want to do that. But when everything gets lumped into the same bucket, it becomes problematic.

We think that on the readmissions we really need to focus on those that are related to the original admission and that were unplanned as part of the patient's course of treatment. If we can focus in on those and, like other subjects here today, focus in on those that are most common for different types of patient conditions, we think we can make some significant progress on that. But lumping them all together as readmissions is a problem.

Secondly, the current proposal says that the bottom quartile or top quartile, whichever direction you want to come from, but some sort of quartile cut-off, there is always going to be a final quartile. And so we have got to look at a better way, because even as we improve on readmission rates, the notion that there is some continuing penalty hanging out there does not make a lot of sense to us.

The CHAIRMAN. Mr. Diaz?

Mr. DIAZ. Yes, just one further point. I appreciate and I think it is very important that post-acute care has been incorporated in the discussion of potential bundling opportunities. I think that there are great opportunities there. And I think it is the right goal to talk about better care coordination and improving efficiencies—or inefficiencies within the system.

I think, as has been suggested, that an incremental approach is best. There is a lot yet we have to learn in terms of the comparative effectiveness, in terms of different post-acute sites. And I would also say that part of what needs to be considered are which entities, in addition to acute-care hospitals, are best vested with that responsibility.

And, lastly, I think that, as has also been talked about, we need to make sure that incentives are aligned to build that infrastructure that is necessary to operate in a bundled payment environment to assure quality, to assure care coordination, and that that happens all across the country in rural communities as well as metropolitan communities.

The CHAIRMAN. Dr. Steele?

Dr. STEELE. Yes, I think that the readmission is a metric that you could easily apply to your goals for chronic disease management improvement. And I think that what would be a terrific engine for getting there is to go to systems that might not be the usual delivery system and see what the best outcome is. And then you essentially say how do we generalize into a much more fragmented system and work with the AHA and other community-based organizations to figure out how to bridge the gaps that are going to be there for quite a while, since everything does not look like our integrated system. But I think that there are ways of getting there in a short period of time doing dissemination from best practice.

The CHAIRMAN. This is very interesting. You know the game whack-a-mole? Every once in a while, I see another card go up here. [Laughter.]

Dr. NAYLOR. I just want to say from that patient and family caregiver's perspective, a hospital readmission is a hospital readmission. It is an extraordinarily tremendous human burden to them. And we have the capacity to reduce readmissions for Medicare beneficiaries between a quarter and a third, avoidable readmissions. And I think we are only going to succeed when we realize that the care needs of these people are much more complex. It is not just about medical management. It is about managing the community services. It is about managing the inadequate social support—all of the factors that contribute to poor outcomes. We need a comprehensive, holistic approach. We need a team model to get there. And we have evidence to guide us.

The CHAIRMAN. I experienced a little of this. My mother was in the hospital a few years ago—it was a colon matter—and we put her in a post-acute facility, and she had to go back in the hospital again because it got worse. And I know that a lot of it was because she was not cared for when she left, with her meds and everything under the sun. I could just feel the disconnect there when I was visiting her. And so when people talk about all this—my mother is real—it happens. She is fine now. She is great. But it was a bit——

Mr. IGLEHART. I have a final question, if you have any——

The CHAIRMAN. Sure.

Mr. IGLEHART. I think back a generation to the Republican administration of Richard Nixon and the proposal that he put forward that really proved to be transformational: government support for the creation of what was called "prepaid health plans" at the time and then became known as "health maintenance organizations." And, of course, it went on to evolve into managed care, and we all know what happened to that.

But my question is really, based on the concerns of the Committee and the Congress about the unsustainability of Medicare and Medicaid in the current cost trends, whether the proposals that we have discussed today are broad enough, are fundamental enough, to really address the magnitude of the problem. And I would be interested in comments, or even written comments to the Committee if time has elapsed.

The CHAIRMAN. Well, thank you, John. I think it is an excellent question, and I would like panelists to think about that, frankly. Before we get to that point, I want to give panelists an opportunity to say anything that has not yet been said. Maybe somebody has said something outrageous that needs to be addressed. Or maybe there is a nagging little something in the back of your head that you would kind of like to get out. Here is the opportunity now.

We are going to be going through something we call a "walk-through" a week from tomorrow. It will not be a markup of legislation on this subject of delivery system reform. Again, we divided this into three areas: delivery system is one, coverage second, and payment is the third, how we pay for it is the third.

But on Wednesday, we are going to do something called a walk-through; that is, the Committee will walk through tentative, sug-

gested, potential legislation with respect to delivery reform. Then we put all these three together in June, have a markup in June.

So during this next week, we will be talking to you, calling you up for some follow-up, because you have given a lot of solutions and a lot of suggestions here which I think make a lot of sense. But you have also raised a lot of questions, at least in my mind. I made notes on how to do this and how to do that and so forth. But I just want to thank you very, very, very much. This has been one of the most productive sessions I have ever participated in since I have been in the Senate. Everybody was right on target, no grandstanding; nobody is playing to the crowd.

This is why we came here. We came here to do good, public good, public service. I know I can speak for all the members of the Committee in saying so, and I know I can speak for all of you because you are in a field providing service to people. And I just want to compliment you very much.

As I said at the outset, I am very excited about this. We are going to go somewhere. Something is going to happen here. And if we are here at the take-off and just keep working, we are going to be also all together on the landing, which will be hopefully a soft landing, and one which will provide a lot of care at lower case, give access to the American people, and make us all very, very proud.

So thank you very much. Unless somebody wants to finish some comment, some statement, something that he or she thinks should be addressed.

[No response.]

Mr. IGLEHART. Thank you, Mr. Chairman.

The CHAIRMAN. The Committee is adjourned. Thank you very much.

[Whereupon, at 1:12 p.m., the roundtable was adjourned.]

ROUNDTABLE ON EXPANDING HEALTH CARE COVERAGE

TUESDAY, MAY 5, 2009

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The roundtable was convened, pursuant to notice, at 10:07 a.m., in room SD–106, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Conrad, Bingaman, Kerry, Lincoln, Wyden, Schumer, Stabenow, Cantwell, Nelson, Menendez, Carper, Grassley, Hatch, Snowe, Kyl, Bunning, Crapo, Roberts, Ensign, Enzi, and Cornyn.

Also present: Democratic Staff: Bill Dauster, Deputy Staff Director and General Counsel; Liz Fowler, Senior Counsel to the Chairman and Chief Health Counsel; Cathy Koch, Chief Tax Counsel; Tiffany Smith, Tax Counsel; and Bridget Mallon, Detailee. Republican Staff: Kolan Davis, Staff Director and Chief Counsel; Mark Hayes, Republican Health Policy Director and Chief Health Counsel; Susan Walden, Health Policy Advisor; and Kevin Courtois, Health Staff Assistant.

Panelists:

Stuart M. Butler, Ph.D., Vice President, Domestic and Economic Policy Studies, The Heritage Foundation, Washington, DC;

John J. Castellani, President, Business Roundtable, Washington, DC;

Gary Claxton, Vice President and Director, Health Care Marketplace Project, Henry J. Kaiser Family Foundation; Washington, DC;

Donald A. Danner, President and CEO, National Federation of Independent Business, Washington, DC;

Jennie Chin Hansen, R.N., M.S., FAAN, President, AARP, Washington, DC;

Karen Ignagni, President and CEO, America's Health Insurance Plan, Washington, DC;

R. Bruce Josten, Executive Vice President, Government Affairs, U.S. Chamber of Commerce, Washington, DC;

Len M. Nichols, Ph.D., Director, Health Policy Program, New America Foundation, Washington, DC;

Ron Pollack, J.D., Executive Director, Families USA, Washington, DC;

Sandy Praeger, Commissioner of Insurance, State of Kansas, and Chair, Health Insurance and Managed Care Committee, National Association of Insurance Commissioners, Washington, DC;
Sara Rosenbaum, J.D., Chair, Department of Health Policy, George Washington School of Public Health and Health Services, Washington, DC;
Diane Rowland, Sc.D., Executive Vice President, Henry J. Kaiser Family Foundation, and Executive Director, Kaiser Commission on Medicaid and the Uninsured, Washington, DC;
Raymond C. Scheppach, Ph.D., Executive Director, National Governors Association, Washington, DC;
Scott Serota, President and Chief Executive Officer, Blue Cross and Blue Shield Association, Washington, DC; and
Andrew L. Stern, International President, Service Employees International Union, Washington, DC.

[The prepared statements of the panelists can be found in the appendix.]

The CHAIRMAN. The committee will come to order.

[Interruption from the audience.]

The CHAIRMAN. The comments from the audience are inappropriate and out of order. Any further disturbance will cause the committee to recess until the police can restore order.

[Interruption from the audience.]

The CHAIRMAN. The committee will be in order. The committee will stand in recess until the police can restore order.

[Whereupon, at 10:07 a.m., the roundtable was recessed and resumed back on the record at 10:08 a.m.]

The CHAIRMAN. Today the Finance Committee hosts the second of three roundtable discussions on health care in America.

[Interruption from the audience.]

The CHAIRMAN. The committee will be in order.

[Interruption from the audience.]

The CHAIRMAN. The committee will stand in recess until the police can restore order.

[Interruption from the audience.]

The CHAIRMAN. The committee will stand in recess until the committee can restore order.

[Whereupon, at 10:08 a.m. the roundtable was recessed and resumed back on the record at 10:10 a.m.]

The CHAIRMAN. The committee will come back to order. Let me try something else here.

[Interruption from the audience.]

The CHAIRMAN. For all those who are listening, and especially for those in the audience here——

[Interruption from the audience.]

The CHAIRMAN. And especially those—sir? Sir? Sir? Sir, if you would let me just say something. Sir?

[Interruption from the audience.]

The CHAIRMAN. The committee will come to order.

[Interruption from the audience.]

[Whereupon, at 10:10 a.m. the roundtable was recessed and resumed back on the record at 10:12 a.m.]

Senator KERRY. Is there anybody in the audience who did not come to——

[Laughter.]

The CHAIRMAN. Let me say this. I think I speak for everybody on the committee and everybody in the Congress, that we deeply, deeply respect the views of all members of the audience and all Americans who feel deeply about health care reform, especially those who are worried about the single-payer system or a public option, who really do fervently believe that that is the proper result. That is a view that many people have. It is a view which I respect. There are other approaches to health care reform, which I also respect.

The whole point of this hearing, and other hearings, is to try to determine the best route, the best option in determining how to best reform our country's health care system. So for those of you who remain in the audience who may be inclined to stand up and, out of order, state your views, I encourage you not to do so because I want you to know that I personally care deeply about your views. I deeply respect your views. I hear what you say. I talk to a lot of people in my home State of Montana who have the exact same views. I represent 900,000 of the world's best bosses, Montanans, and many of them have the very same view.

But we are going to get the best result here the more we can have an orderly discussion as to how we should best reform our health care system. So I want to say to everyone, and especially those of you who might be inclined to stand up, that I urge you not to so that we can proceed with the hearing—holding your views also deeply in mind as we proceed. Thank you.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Today the Finance Committee hosts the second of three roundtable discussions on health care in America. The committee has spent a significant amount of time laying the groundwork for comprehensive health care reform, and now the time for action approaches. This roundtable discussion will preview many of the policies that the committee will consider in a walk-through session next week, and depending upon comments from Senators on the committee, in a markup in June.

The week before last, we had a roundtable on delivery system reform. Today we are here to discuss how to provide health coverage to all Americans. Next week, we will hold our third, and final, roundtable on financing health care reform.

As we discuss policy options for coverage, it is important to keep several facts in mind. First, the United States is the only developed country without health coverage for all of its citizens. Approximately 87 million people, 1 in 3 Americans, went without health insurance for some period during 2007 and 2008, and the situation is only getting worse.

Second, the economic climate has caused even more people to become uninsured. According to the Kaiser Family Foundation, for every 1 percent increase in the unemployment rate, Medicaid and CHIP enrollment increases by 1 million, and the number of uninsured Americans increases by 1.1 million.

In today's economy, that means a lot of folks are affected. In March, 2009, the unemployment rate rose to 8.1 percent, and according to the Center for American Progress, 14,000 more people lose their health insurance coverage every day.

Third, why is covering all Americans so critical? It is because people without health insurance generally experience poorer health and worse health outcomes than those who are insured. The Urban Institute reports that 22,000 uninsured adults die prematurely every year because they lack access to care. In addition to the uninsured, another 25 million Americans are under-insured. They do not have enough coverage to keep their medical bills manageable.

Despite their insurance coverage, medical debt keeps these Americans from feeding their families, paying their rent, or heating their homes. Finally, the uninsured affect those who have insurance. When the uinsured who cannot pay health care providers shift those costs to those who can, those who have insurance. This cost shift accounts for roughly 8 percent of the average health insurance premium. That is $1,100 per family, or $410 per individual in 2009.

We have an opportunity to make sure that all Americans have a fair chance at good health, make sure that no family goes bankrupt due to medical costs, to make sure that the insured no longer have to bear the costs of the uninsured. The cost of inaction is too high. It is too high for individuals, for families, businesses, and State and Federal Governments.

Each of our participants today brings an important voice to the discussion. They are experts, stakeholders, or both. Among our guests are folks from the insurance and business communities, we have labor and consumer representatives, we have experts in insurance markets and public programs.

As we proceed with today's discussion, I urge everyone to keep in mind that coverage is one part of health reform. We must also address rising health care costs and must find responsible and sustainable ways to finance reform.

Forgive me for not taking the time to introduce each person here today. We have distributed a biographical sketch and a brief statement for each participant. Before today's session we gave each participant and Senator on the committee some questions to help start our dialogue, and beyond that, I anticipate a fruitful discussion. So, let us get started.

Before I introduce Senator Grassley, though, a couple of points here. Number one, I will recognize Senators as they seek recognition. I ask Senators just to raise their hand. I would also encourage all participants who wish to speak spontaneously or in reaction to some outrageous statement that was made, raise your hand so I will recognize you as well.

I am going to try to keep the discussion flowing, subject per subject. That is, if we are on the individual market and some of the problems in the individual market, I just encourage Senators to stay on that subject. But of course, we never constrain Senators. Senators may want to speak on any subject that they might. But we will do our very best to try to make this as significantly on point as we can.

Unfortunately, I think we are going to have a vote around 11:00, so we might have to break and come back. But I will do my very best just to keep things flowing.

I would now like to introduce my colleague, Senator Grassley.

OPENING STATEMENT OF HON. CHUCK GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. Yes. Thank you, Mr. Chairman. And thanks, all of you, who are on our panel, for participating in this roundtable. The first roundtable was very, very successful. I think this one will be, too. The subject that we are dealing with today is a little more difficult than the previous subject and they probably get more difficult as time goes along. So, you are participating in one of the more difficult decisions that this committee has to make.

Most everyone agrees that our health care system is in need of fixing. The American health care system, if you can even call it a system—and I would rather not use the word "system"—is in desperate need of reforms. We spent twice as much on health care as other developed countries, but even with all of this spending our health care outcomes are not as good as in other countries.

We have escalating costs, inefficient delivery systems, 47 million people lacking health insurance, millions more live in fear of losing coverage. Our responsibility is how to get affordable coverage to everyone, and we must make these reforms in a fiscally responsible way. We need to bring costs under control.

In March, Senator Baucus and I joined other members of Congress and other stakeholders at a White House Conference on Health Care. In bringing everyone together, it was clear that we agree on many issues and still have a long ways to go on others. But overall, I left the White House knowing that Republicans and Democrats share a commitment to expanding health insurance coverage and improving the way that care is paid for and delivered.

Last week we had our first roundtable on delivery system reforms. It went very well. Now we are moving on to tougher issues. There are more controversial issues when it comes to coverage. I will not name them all, but individual mandates, government-run public plan, and Federal health boards are just some of those issues that will come up. There are no easy issues when it comes to coverage.

We are here today to share ideas and to weigh in on all the coverage issues that we need to tackle. If we are to succeed in making real changes that benefit millions of Americans, all of us are going to have to listen and consider many ideas.

On all of these tough issues, we need to find solutions that work. Everyone needs to work together to find common ground. I am very appreciative of all of you who have come together to help with this process.

Mr. Chairman, I yield.

The CHAIRMAN. We have a quorum here. I apologize to the experts here, the panelists, but we now have to conduct a little bit of business and will make it as expeditious as possible.

[Whereupon, at 10:21 a.m., the roundtable was recessed to enter into Executive Session.]

[After recess—10:22 a.m.]

The CHAIRMAN. All right. Let us get to business. I want to start out by talking about the individual market. I want to ask Gary Claxton, Karen Ignagni, and Sandy Praeger, can you tell me a little bit about the current factors used in determining premiums in the current individual market and a bit about the current state of the market as on open for obtaining health insurance? Just focus a bit on the individual market, its strengths, its weaknesses, the problems, and how we begin to reform the individual market.

I will start with you, first, Gary Claxton.

Mr. CLAXTON. Thank you, Senator. Thank you very much. Rates are currently set in the individual market based on health status, age, gender, geography, whether or not someone smokes, and, of course, benefits. There are also some other practices in the market that are a little bit less apparent.

Some insurers will vary the rates that people are charged based by their duration in the policy, for instance, how long they have actually had it. This allows insurers to offer the lowest possible prices when the policy is first issued, but then people get higher increases each year than they would normally get. Unfortunately, it is the kind of practice that is not disclosed.

Another factor that can affect rating at renewal is whether or not the insurer is still accepting new business into the policy. Closed blocks of business tend to have much higher rates of increase from year to year than policies that are still being offered.

If you look at the market and want to characterize it in terms of its ability to offer people good coverage options, the market is basically characterized by policies with low actuarial value and high administrative costs, so the policies tend to have high cost sharing, a lot of coverage limits, and the sort of administrative cost of selling these policies is pretty high, in part because of the turnover in the market and also because of the commissions that are paid to people.

The lack of tax subsidies for this market make it much less attractive than group insurance, so people do not tend to choose nongroup coverage unless they do not have a group option. Because they are paying the entire cost and because they do not get any help through the Tax Code like group insurance does, people tend to buy policies which are much less valuable.

The CHAIRMAN. Cutting to the quick here a little bit, is there anybody on the panel who agrees with the statement that the individual market needs significant reform? Is there anyone who disagrees with that statement, that the individual market needs significant reform?

[No response.]

The CHAIRMAN. Seeing no objections, we will establish that as a predicate here. All right.

Now, I want to ask somebody, how are we going to form the individual market? Ms. Ignagni, I will ask you, and also ask Sandy Praeger, a former NAIC president and current Kansas Insurance Commissioner.

Ms. IGNAGNI. Thank you, Senator. First of all, thank you for convening this forum. We very much appreciate the opportunity to participate. I think Gary has made important observations which

caused us in the health insurance arena to step back and consider what was not working.

In our proposals, we have recommended a full-scale reform and a complete overhaul of the rules associated with the individual market. In fairness, just for a little context, it is important to note that, with the exception of Massachusetts, there never was a law passed that requirede everyone to participate in the market, so health insurance rose and developed practices similar to life insurance, property and casualty, et cetera. The problem is, people in the individual market generally wait until they need insurance to purchase, so we stepped back and said, how do we solve this problem and how do we provide health security to people, which is the fundamental question you are asking?

Our proposals are as follows, simply: guarantee issue, that everyone gets insurance; two, nobody falls through the cracks because of preexisting conditions; three, no health status rating so that no one would be discriminated against or penalized because of their prior health care status, requiring them to pay more. This would level the playing field.

We are proposing Federal guidelines that could be implemented and executed at the State level, so there is no inherent benefit of living in State A, B or C. This would be a whole-scale reform, would solve the underlying problems that Gary articulated very well, and that you implied in your opening statement. We are fully supportive of this whole-scale reformation.

We also are fully supportive of Federal regulations. We are not proposing voluntary efforts, we are talking about uniform guidelines that would be specified in legislation so that everyone could understand there is transparency, there is effectiveness, and there would be regulatory accountability.

The CHAIRMAN. Jim? Senator Bunning?

Senator BUNNING. Yes. I do not disagree with you, I just would like to find out who is going to pay for that from the present setup that we have, the many different, various payors, whether you are in a group policy or whether you are in a single coverage policy, or whether your employer furnishes you benefits. That does not cover about 47 percent of the American people. How do we get enough money in the system to take care of that?

Ms. IGNAGNI. Senator, would you like me to respond?

The CHAIRMAN. Go ahead.

Ms. IGNAGNI. There are three answers, very quickly, Senator, to your question: one, there is no question that health reform will require additional resources; two, there are efficiencies that can be applied if you bring everyone into a system versus having people fall through the cracks because they have high health care costs or previous health care status, as you know.

Senator BUNNING. I understand that.

Ms. IGNAGNI. Three, we strongly believe, as part of health care reform, and this committee has done considerable talking about the third point, which is, as part of reform, we have to bend the cost curve so that we can free up resources that can be applied, either through changes in reimbursements, through other kinds of emphasis on prevention and wellness. There are many strategies that can help you bend the cost curve.

Senator BUNNING. Or does that mean that those of us who are presently covered and paying are going to have to ante up more to make sure that everybody is covered?

Ms. IGNAGNI. Well, you are now, frankly. There is a surcharge that is being paid on health insurance because people are not——

Senator BUNNING. I understand that. But I am talking about a significant amount. When I look at Sweden and I look at Canada and I look at the United Kingdom, where we have single payor and government single payor, we have a tax rate of 60 percent or higher in those countries. So can you give me a ballpark figure?

The CHAIRMAN. If I might, Senator, we are going to take up financing, how we pay for all this, in the next session. That is an excellent question you are asking. It is a question on everybody's mind. The past session, as you know, was on delivery system reform.

Senator BUNNING. All right. I will wait.

The CHAIRMAN. Today's is on coverage, various ways of coverage. The third, is how we are going to pay for all this.

Senator Kerry?

Senator KERRY. Thank you, Mr. Chairman.

Ms. Ignagni, you said that you agree that there ought to be reform of the individual market, and particularly that you are not rating on health status.

Ms. IGNAGNI. Yes, sir.

Senator KERRY. But I have introduced legislation today, which I hope will actually become part of this ultimately, but if it is not we should pursue it, I think, and that is that you do rate gender. Gender rating is a pretty common insurance practice, and women are charged higher premiums than men for identical coverage.

The National Women's Law Center says that a 25-year-old woman can pay up to 45 percent more than a 25-year-old man for the same coverage; a 40-year-old woman pays 48 percent more than the 40-year-old man for the same coverage; and a 55-year-old woman pays 37 percent more than a 55-year-old man. So it seems to me that is insurance discrimination and I would like you to address whether that should also be eliminated.

Ms. IGNAGNI. Yes, sir. We do not believe that gender should be a subject of rating.

Senator KERRY. But it is, correct, in many places?

Ms. IGNAGNI. It is, sir. And in our reforms we have not recommended that that be continued. We recommend that it be discontinued.

Senator KERRY. So do you recommend that we actually create a prohibition?

Ms. IGNAGNI. Yes, sir. And to add credence to your point in terms of the data, what it says is the following: women tend to incur higher costs in their childbearing ages versus men, and then that flips around 50 to 55 and men incur higher costs later in life. So our thought was that it does not make sense, as we are thinking aboute a reform system with everyone participating, and subsidies to help people make sure that the care is affordable. So, we agree with you.

Senator KERRY. Well, I am glad to hear that.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman.

I think Senator Bunning touches on the key question and the relationship of coverage to finance. I think you are absolutely right, Mr. Chairman, in saying that finance is a topic for another time. I think there is a way to get at this issue that keeps it primarily on coverage.

If you go out on the streets of this country and you talk about coverage, it is almost a no-brainer issue. People want coverage like their members of Congress have. That is what you hear again and again and again. I think we know that there are some ways to do that, a variety of different ways, including ways that are budget-neutral.

The key is individual choice. I think that is central to the reform issue. In fact, 85 percent of the firms that offer health benefits in this country offer only one health plan type, so you have got most Americans not having the kinds of choices that members of Congress have.

My question is for you, Mr. Nichols, and for Stuart Butler. I think Stuart is down at the end. Is not the key in terms of health care reform containing costs and satisfying the public to make sure that our people have these choices like members of Congress have? They are part of a big group so that they can have the benefits of cost containment when you spread the cost and the risk, they do not get discriminated against, they do not get cherry-picked. Is that not the key to reform, is having those kinds of individual choices as part of a big group, Mr. Nichols?

Dr. NICHOLS. Well, Senator Wyden, it is certainly true that—it is kind of interesting. There is almost a parallel. If you think about your last roundtable where a lot of discussion was on patient-centeredness, insurance really ought to be about individual-centeredness. That is, how do we give all people in the United States the same kind of choices that people in very large groups get? Certainly members of Congress and the people who work for the Federal Government are one group. A lot of large firms also offer a very large set of choices. What we really want to do, it seems to me, is bring the efficiencies of very large-group purchasing to everyone.

When you do that, it turns out you can then afford fairness because then you can have the rules that Karen just talked about, that fundamentally if you have a big pool, then the overall pool is the population that is healthy so you do not have to worry about all the things that the individual insurers had to worry about when the purchase was voluntary, et cetera.

But the key to making competition work—and I think that is really what this committee is most focused on here—is making sure that the insurers have to satisfy the individual preferences. Now, you know there are 300 million Americans who have a couple of different preferences about how you want to have your arrangement set up.

If you just have a situation where they have to sell to one owner or to one HRVP or somebody who is picking a plan for a bunch of other people, then that is not as good as allowing individuals their own choice. It forces the insurers to reflect those different choices,

and I think, in fact, they are quite willing to do that because the last thing they want is a straightjacket on exactly one type of plan.

What they want is to have those preferences meet in the marketplace. But the key is changing their business model. Fundamentally, in the past, before they have been willing to do away with the kinds of procedures that Gary described and that Karen is now skewed, basically they made money by selecting risk, by making sure that they prevented some from being insured with the others.

What we want is a system where everybody is covered, and where they make money by helping us find value in the health care system. Again, that is how it is linked to what you did last week, that it is about finding value in the health care system. Individual choice will drive you there.

The CHAIRMAN. I have a question for Mr. Castellani, the employer's perspective in all this. We are talking about the individual market. What is businesses' view on its role here, from your perspective?

Mr. CASTELLANI. Thank you, Senator. Clearly, from business' standpoint, and particularly the larger businesses that the Business Roundtable represents, having everybody in the market is very important. We think the insurance reforms that Karen Ignagni laid out are absolutely essential, if we can bring everybody into the market because that is one of the key starting points.

For large employers, we tailor our benefit programs to match the needs of our employee bases and their families. One of the most important things that helps us do that and do it in an affordable way, is ERISA, so one of the biggest concerns we have is, while we open the market and while we have everyone covered, that large employers still have the protection of ERISA so that they do not—while they can provide choice, which the Senator is pointing to, and they do indeed provide choice—have to have 50 different programs to provide those choices.

They can have a single-employer program that covers all of their employees and their retirees, if they cover retirees. That is how we gete the kinds of cost efficiencies that will allow, in our case, 35 million lives to be covered from just the 160 companies of the Business Roundtable, and then overall, the 177 million Americans that currently get their health insurance from their employer.

The multi-state employers both support the kind of health insurance market reforms that are necessary to get everybody in, but also would urge that you keep in mind the efficiencies that ERISA gives us as multi-State employers to be able to have an affordable product that is tailored to our employees.

The CHAIRMAN. I see Senator Stabenow is seeking recognition. Before I do that, Senator, might I just ask the small business perspective? Mr. Danner, your view?

Mr. DANNER. Sure. We certainly agree very strongly in the need for, as Mr. Nichols said, large-group efficiencies. We have supported for a long time creating larger marketplaces, like an exchange. We think that is important for both individuals and small businesses. We certainly agree that both individuals and small businesses need more choices in the marketplace. Of the small businesses that do provide health care, it was mentioned earlier,

about 80 percent of them only provide one plan. So their employees would need, and would like to have, more choices.

We also agree that there needs to be, in both the small group and individual market, added additional competition. The small businesses want a competitive marketplace that gives them added options for choices to quality plans.

The CHAIRMAN. I know there are lots of Senators seeking recognition. Let me ask, do you favor the basic provisions in the white paper, that is, the exchange concept, and also the requirement that everyone have health insurance? Does that help small business, those two points?

Mr. DANNER. We do very much favor an exchange system, some kind of added marketplace in an individual mandate. I think we are open to the idea. Our members support some kind of individual responsibility.

The CHAIRMAN. All right.

Senator Stabenow?

Senator STABENOW. Thanks, Mr. Chairman.

To follow up on Mr. Danner's point in terms of whether or not there is enough competition in the marketplace, the American Medical Association has published reports on the current insurance marketplace, indicating that they believe it is very anti-competitive at this point. Results of mergers and acquisitions since 2000 have resulted in insurance companies controlling over one-third of the national market for commercial health insurance and they found anti-competitive markets in 94 percent of their metropolitan statistical areas. I would take my question a little different way, and I would like Dr. Nichols to comment, and then others as well. Ron Pollack, if you want to comment as well.

When we look at the current situation, let us argue for a moment that there is a consumer plan option. Some folks have called it a public option, but the idea of a consumer-driven public option that would negotiate rates, and, Dr. Nichols, as you indicated, across the board, no special treatment, no connections to Medicare, just straight across-the-board competition. Would that not help us improve access, coverage, and cost in the current marketplace that we have today?

Dr. NICHOLS. Well, I think it would, Senator Stabenow. I think it really speaks to Mr. Danner's point, that a lot of what—and we have all been workong on these issues for quite some time, trying to find a way to solve the small business problem. They often do find that they do not have much competition in their local markets. I would say, all health care markets are local and so the national market share, while I respect the AMA and their work, is not really relevant to what the real businesses in real life see.

It sort of varies quite a bit across the country. But it is unambiguously true. I have been in hearings where Senator Snowe was the chairwoman, and Senator Kerry too, where the businesses talked about how little competition there was in their spot. So, there is no question that that is a major issue. I think a well-designed plan, as you put it, is consumer-driven public plan. We will go with that name for the day. That is a great one, maybe better than the one I came up with.

That is about two things. It is about restoring the trust that, with all respect, the insurance industry has lost from a lot of people, some of whom were screaming when we began today. But people have lost the faith that their insurer is going to be on their side. A lot of what public policy is about is making rules so that the self-interest is channeled into public interest. That is what reform is all about. Karen has now accepted those principles, and I think we can move on, but there are still people that do not trust. So, that is number one.

Number two, it is about a benchmark. Because we do not trust, we want to see, is it indeed sort of fair, what we are being told? That lack of trust feeds into the need for the benchmark, so the benchmark can provide, in essence, an actuarily fair price. I agree completely with everything you have said. It has got to be a level playing field. If it is not, it will not earn the trust of everybody else. It, too, has to be essentially allowed to compete. It has got to be allowed to fail. It has got to compete for business. It has got to earn the trust of the people. But if it does that, I could not agree more, it will be a very useful benchmark as long as the field is, indeed, level. So, I would agree.

The CHAIRMAN. Mr. Pollack? I think she asked you to respond as well.

Senator STABENOW. Yes. Thank you.

Mr. POLLACK. I like your term, and I support that direction. There seem to be two arguments that are made in opposition to such a plan. One, is that it is not good enough, it is going to provide lousy service, it is going to ration care. The other argument is, consumers are going to perceive it is too good, and as a result more and more people are going to join this consumer-driven plan and leave their current private insurance plan.

It seems to me it is the latter concern that needs to be addressed. I think Len Nichols described, I think, the key component of this accurately, namely, we have got to have a level playing field in terms of the rules that are created. If you have a plan that in effect competes with others, it is hard to say that at the same point it should be the referee as well. So if we can separate those two functions, then I think the greatest concern that has been expressed can be dealt with.

The CHAIRMAN. Thank you, Senator.

Senator STABENOW. Thank you.

The CHAIRMAN. Senator Roberts, I think you were next.

Senator ROBERTS. Yes. Thank you, Mr. Chairman. Thank you for your perseverence in regards to the outbursts earlier. Those folks were undoubtedly from the House. That is just the way they are. [Laughter.]

I just mark them down as "undecided." [Laughter.]

This is a very unusual way of doing it. We have 18 people and a Senator. Not that the Senator is not a "people." Sorry. An awful lot of talk gets into what I call health care policy gobbeldy-gook. I do not mean to make that a pejorative in regards to what anybody has said.

I have a question for Scott Serota from the Blue Cross people, one of those dreaded health insurance folks. I like your beard, Scott.

There was an article in the Wall Street Journal April 17 that I think made a heck of a lot of sense, and I think it dovetails into what we are talking about. But it raises another point. It says, health insurance does not automatically lead to health care. With more and more doctors dropping out of one insurance plan or another, especially government plans, there is no guarantee that you will be able to see a physician, no matter what coverage you have.

Thirty-eight percent of primary care doctors in Texas took new Medicare patients last year. The statistics in New York State are about 25 percent. The problem is even worse in Medicaid, 50 percent. The same thing with HMOs. Now, Scott, I am going to get to my question here pretty quick, but I just have a few comments first.

This so-called public plan option has been described as simply offering a consumer another choice or increased competition. Everybody is for that. I think the Chairman mentioned that, boom, right off the bat. But I am concerned that it could, in fact, eliminate most private insurance and leave us with a government-rationed health care system. I am going to underline the "rationed" part.

Basically, the worry is that the public plan, to some, is only one step in the larger strategy of simply eliminating private health insurance. If this is the case, the one thing that we talk about, patient choice, patient access, it is patient access to health insurance that will really suffer. Medicare pays hospitals 30 percent less and physicians 20 percent less than private insurers in Kansas. Sandy, you know this. Our hospitals have lost over $1 billion in the past several years due to Medicare under-payments.

Scott, my question to you is: what are your views on the potential for reduced access to care under the proposed government plan? And before you answer that, I want to give you an example. Two weeks ago today I had a knee operation. Should have had it a long time ago. I consulted with I do not know how many doctors, finally found the time to do it and got it done. I am in recovery. I awoke to six doctors looking over me. This was my doctor, the head of surgery, four other doctors, the anesthesiologist—who was hoping I would recover—and there were six doctors. I thought, my God, they have operated on the wrong leg or something.

They wanted to know about the single-payor plan, Mr. Chairman, and they wanted to know about bundling, and they wanted to know about all of the things that we talk about here. I think the basic conclusion was that if this happens, they are gone. Now, they were a little long in the tooth in regards to their experience; most of them have been practicing doctors for 25 years.

What I want to know is, especially in a rural area, who is going to do that knee operation and how long are they going to have to wait? I do not see anybody here that can do it. I trust Sandy to do it, and you, too, Scott. I really worry about the availabilty of health care providers, as we have seen today that we are rationing health care. Here we are talking about superimposing this big plan over the current plan. Not that I do not want reform. You always have to have a "while I" in there.

So I guess my question to you is: what are your views on the potential for reduced access to care under the proposed government plan, and especially in our rural areas?

The CHAIRMAN. Sounds like all those doctors liked all of that bundling, though.

Senator ROBERTS. That is right.

The CHAIRMAN. Mr. Serota?

Mr. SEROTA. Thank you, Senator. First, you would not want me to operate on your knee, trust me. I am not equipped, nor have the appropriate credentials for that. If the government plan pays providers the way it does under Medicare and Medicaid at the same time that we try to expand coverage for an additional 47 million, I think there will be negative consequences on access, clearly, in the delivery system.

According to the Lewin report, hospital and physician net income could decline by as much as approximately $70 billion under a government plan. Over time, a government-controlled system, if we take the assumption that was put forth, that eventually it would move toward a single-payor outcome, I think you would find delays for major surgeries, delays for MRIs, lack of access.

The number of primary care physicians—we are already at a crisis stage with the number of primary care physicians and primary care access points—diminished even further. I think you could expect longer wait times, which could lead to lower quality of care and reduced access, a lack of capital in the system which would allow institutions to reinvest in their physical plants and other things, some of which are in need in a number of areas.

So a government-run plan that is based on reimbursement levels which exist today, I think, would have a tremendously potentially devastating effect on access and the existing delivery system, causing terrific problems and a reduction in quality.

Senator ROBERTS. Well, thank you for your answer. That gets back to Senator Bunning's question on, how on earth do we pay to make sure that that does not happen? Does anybody have a contrary view, or a similar view, or any view? Yes, sir? Dr. Nichols?

Dr. NICHOLS. Well, Senator, I would certainly agree with Mr. Serota, that if we paid Medicare rates nationwide tomorrow it would be a bad idea. But I do not think that is necessarily what a public plan has to do. If you will remember how Senator Stabenow phrased it——

Senator ROBERTS. Yes.

Dr. NICHOLS. We envision a world in which they would pay market rates. They would have to negotiate precisely in those rural areas where, if they do not pay what those clinicians—I grew up in rural Arkansas, by the way. I know something about having to drive 80 miles for surgery. I think fundamentally it is about paying what the market will bear, and that means paying what the market demands, so they have got to negotiate like everybody else. So I think, in fact, you could design a public plan that would be competitive. That is what a lot of States have done, and that is basically, in my view, the proof of concept that you could do it.

The CHAIRMAN. All right. I would like to just keep on this subject if I could for a second.

Mr. Stern, you might have a view on the public plan and what its consequences might be, I suppose, depending upon how it is formulated.

Mr. STERN. I mean, first of all, if we start with certain assumptions we obviously get certain results. If we start with the assumption we are going to pay Medicare rates we are going to get to one set of results. If we start where Senator Stabenow started, we will get to a different set of results where there is more of a level playing field. I think it is important just to repeat: 94 percent of markets, according to the AMA, are not competitive.

People, as Senator Wyden said, do not have choices when they work for their employer, necessarily. They may get one choice. If you are a worker in Maine or New Hampshire, where if you are a State worker particularly where your rates are disproportionately higher for the same benefits that other State workers get in other States because there is a lack of competition, I think the question is, are we going to have excessive regulation to try to make all the insurance companies comply with the laws—and I am not for excessive regulation—or are we going to enhance competition?

I think enhancing competition along the lines as Senator Stabenow said is a much better way than trying to figure out all the different regulations we can create to try to make sure there is a level playing field and fair competition.

So if you look at costs today, where there is a lack of competition, if you look at the fact that there is not enough competition—I am a big fan of increasing competition on a fair set of rules and letting the consumers choose which is the plan that they want and not having necessarily anyone else choose but the individual.

The CHAIRMAN. I see Senator Bunning. Senator Cornyn, I think you are next. I would like to stay on this subject for a minute or two more, if we could.

Senator Cornyn, is your question on this topic?

Senator CORNYN. Yes.

The CHAIRMAN. All right. Senator Cornyn?

Senator CORNYN. Thank you, Mr. Chairman.

My question is for Ms. Ignagni regarding the so-called "public plan." It is interesting how this public plan is now called a consumer-oriented health plan. I think it is more descriptive to say it is a Washington-directed unfair competition plan, because the government is not a fair competitor. The government price fixes. It tells how much it is going to pay and you take it or leave it. That is the problem now with Medicare and Medicaid because there is a promise of coverage, but no access, because you cannot find doctors who will accept that price that the government is willing to pay.

So I agree with you, Mr. Stern, about the importance of competition. I think the best evidence that competition works is Medicare Part D, the prescription drug plan, which has come in under cost and actually has a lot of people engaged in offering plans. But I do not know how you can have competition unless you have transparency as to price and outcomes to let consumers get the information they need in order to make the right choices, because otherwise I am unaware of any other way to try to contain costs, other than the Federal Government saying, this is how much we are going to pay, take it or leave it. So how do we increase transparency as to price and as to outcomes in a way that will allow for competetion to take place?

Ms. IGNAGNI. Senator, I think you have framed this very importantly, in the sense that I believe that Len Nichols has done a very valuable piece of research here. What it demonstrates is how hard it is to actually achieve these objectives that Len thoughtfully lays out. Government does not have the infrastructure to negotiate rates right now.

Imbedded in Len's paper, very importantly, they talk about how it would take a while to set up this particular structure. It also would take a significant amount of resources on the eve of a Medicare trustees' report that we know the trust fund is going to look at lot worse today than it did this time last year. So what you would ultimately be doing is replicating what the private plans do, so you are either going to be negotiating global budgets—bundling is essentially global budgets—episodes.

What you drop back to, is to solve the Medicare reimbursement problem you would have to drop back to some administered pricing system that might be 10 percent over Medicare or 20 percent over Medicare, leaving still the private sector to absorb the cost shifting from the under-funding of the current Medicare and Medicaid programs. That would lead to a declining number of employers who would want to stay in that system moving over. Therein is our concern.

For us, we think that notwithstanding Dr. Nichols' very important research, that I think when the public program was developed and the concept of public program was developed, I think nobody expected that the private sector would step up and say, yes, there is a problem here and it needs to be solved. So we are not asking individuals—the people who spoke this morning, Mr. Chairman, I think made an important point, and you did, too, imbedded in your remarks.

We are not asking any individual to trust us, we are asking them to trust the government, because we are proposing very aggressive, comprehensive government regulations where we would be accountable, where it would be transparent and the rules would be fundamentally changed. That is the type of competition we are talking about, which is imbedded in the Federal Employees Health Benefit Program and imbedded in many of the countries in Europe, and it works very well, very satisfactorily. But this is a whole-scale change in the rules.

The CHAIRMAN. I see Senators Bunning, Menendez, Hatch, and Snowe seeking recognition. Do any of you want to stay on this subject here?

Senator BUNNING. Yes. This is to the subject.

The CHAIRMAN. To the subject? All right. Then you are next.

Senator BUNNING. Mr. Josten, you made a point in your written testimony about the creation of a public plan, and I hope that you would expand on. You said that costs to employer plans are increased due to the cost shifting from Medicare and Medicaid, and that assurances that a new public plan would not cost shift ring hollow, particularly in light of unfunded liabilities under these two programs currently. Can you elaborate on that? Would you like to expand on that?

Mr. JOSTEN. Senator, cost shifting seems to be indemic to the current delivery system. Our memberse, for years, have felt that

the under-reimbursement of both Medicare and Medicaid is shifted back at the hospital level to the one place that they can really shift it to, which are to the premium payers on the employer side of the ledger. The employers then end up shifting some of that cost downstream to their employees. We need to fix that part of the system and that gets to our concern about a public plan.

We think once you have the government, basically, as the team owner and the referee, and recognizing, as Karen just pointed out, that both of these plans are already severely underfunded and are going to be more seriously underfunded going forward, the government itself has a huge interest here in reducing costs, which is the central issue, I think, for everybody sitting at this side of the table, where we do need to bend the cost curve to address getting more people into the system. But we think a public plan, in addition, will inherently destabilize the employer-based system, which today is covering roughly half of all Americans with health insurance coverage at a cost of $500 billion a year.

Senator BUNNING. Thank you.

The CHAIRMAN. Senator Menendez?

Senator MENENDEZ. Thank you, Mr. Chairman.

Mr. Serota, let me ask you, in your written statement to the committee and in advocacy that the association has been promoting recently, you have criticized this concept of a public health insurance plan. I am wondering exactly what is the principal position in the opposition that the association has.

I have heard that it is because you have a lot of individual and group market and you are concerned that the public plan could overtake the business. But if the playing field was level in the rules and requirements that private plans and this new plan had to live under in the health exchange, why would you oppose it?

Is competition not healthy if the playing field is level, all the rules and requirements that you have to live under, a private plan would have to be lived under by this consumer-driven public plan, would that not be something that would be good? Would it not be competitive? Do your plans really think that if the rules for all were the same, that you would not be able to continue to be competitive in the marketplace?

Mr. SEROTA. Thank you, Senator. I think that I would make a couple of points. First, I think it is a mischaracterization to indicate that the markets are not competitive today. According to the Government Accountability Office, the median number of small group insurers competing in State markets today is 27, so there are sufficient competitors today in the marketplace to create a competitive market.

Further, with the regulations that we have advocated, I think that the marketplace, as indicated by Karen, will become an extremely vibrant and competitive marketplace. So my concern with regard to the public program is similar to the comments that the previous speaker made, and that is that inevitably, regardless of the intentions, I think, what has happened, at least historically, is a movement toward government rate setting by fiat as opposed to competition. If you look back at history, in 1965 the Medicare program was supposed to pay market rates. That is how it was introduced, that is what was passed.

Senator MENENDEZ. But I think we are not talking apples and apples here. I am saying, if the rules and requirements were all the same for this consumer-driven public entity as your companies, why would you be at a competitive disadvantage?

Mr. SEROTA. Well, we would have to see. I would have to see what the program looked like. The idea of the government competing on a level playing field is one that is hard for me to conceive, so I guess I would have to see the particulars and——

The CHAIRMAN. I am going to have to interrupt you. We have about three minutes left on this vote. Senator Carper, do you wish to proceed? We have three minutes left on this vote. Or you can come back.

Senator CARPER. Yes. If we could just pick it up when we come back.

The CHAIRMAN. We will recess and come back. As soon as Senator Grassley comes back, though—he has already voted—then he will reconvene. We will stand in recess until Senator Grassley returns. Thank you.

[Whereupon, at 11:03 a.m., the roundtable was recessed.]

[After Recess—11:05 a.m.]

Senator GRASSLEY. The meeting will come to order on the authority that I get from Senator Baucus. [Laughter.]

Thank you all very much for putting up with these votes and the confusion that always goes on in the Congress at voting time.

I want to continue the discussion and ask a question of Karen and Stuart Butler on this point. I do not want just those people to answer. I would like to have reaction, because some of you on the panel might obviously have a difference of opinion.

Some have said that a government-run plan is needed to keep private insurers honest. In the absence of a—Karen is not here. Stuart, in the absence of a public plan, do you think aggressive rating reforms and requiring insurers to take all applicants would go a long ways towards "keeping insurers honest?"

Dr. BUTLER. Well, I think it would, Senator. There is complete agreement that we have got to have more effective competition and choice, and we have got to hold plans accountable. That is not really a point of disagreement. The issue is whether you can, in fact, set up a level playing field with a public plan as the instrument to make sure there is that situation.

I think the very fact is that you as a member of Congress, and Congress itself, will be held responsible, both for setting the rules and the public plan will be your plan. Everybody will see it that way. So I think it is impossible to imagine a true level playing field in that circumstance.

As far as how you can actually achieve the objective that is put forward for a public plan, I would point out that in the Federal employees' system, which does cover over 10 million people, the same issues arise: how do you get effective competition; how do you hold plans accountable; how do you make sure people have true available plans wherever they are in the country, and you achieve that through an exchange, through setting broad rules, and also through negotiating with particular private plans on a national basis to make sure they are available everywhere.

You do not need, in the FEHBP, a public plan. I do not believe you need it generally. I think you should look at the way you structured the FEHBP system to achieve the very objectives that have been purported as being only achievable through a public plan. I think it is a combination of appropriate rules and requirements, and expectations and objectives. I think it is also recognizing that you do not have to lay down very specific benefits. You set categories of benefits, as you do in the FEHBP, so I think you can, in fact, achieve those objectives.

Senator GRASSLEY. Ms. Ignangi, would you respond, please?

Ms. IGNAGNI. Yes, sir. I apologize for not being here. I took a facility break.

Senator GRASSLEY. Did you hear the question?

Ms. IGNAGNI. Yes, I did.

Senator GRASSLEY. All right.

Ms. IGNAGNI. The answer to your question depends on whether or not individuals believe in government regulation, because what we are proposing is a whole-scale change and a complete overhaul of existing regulation, so it would be set out at the Federal level, clearly, transparently, hitting the mark with respect to, no one falls through the cracks, no one is discriminated against because of preexisting conditions, and no one has to pay according to health status.

There would not be gender differentiation. That essentially is the thrust of what folks have quite correctly talked about as something that needs to be done. We squarely support it, we have proposed it, and we stand behind it. We are ready to be accountable to those rules.

In fairness, it is important contextually to remember that, with the exception of Massachusetts, no one passed a rule, ever, saying that everyone should be participating in the system, so the health insurance arena grew up similar to life, property and casualty, and other insurance products in our system today.

Now, as we think about health reform, there are new opportunities. So, no, I do not accept the premise that to keep the plans honest you need a public program. Moreover, I think the discussion this morning thus far has demonstrated how difficult it is to actually achieve that elusive goal of leveling the playing field. Government does not have the infrastructure to negotiate rates with providers.

To set that up it would completely replicate what the health plans do today. Governmenet has been unable to do disease management, or care coordination, or real pay-for-performance, or the kinds of other strategies that we have implemented within private health plans that are getting results. So we accept the premise that the system is not working today. It needs to be reformed and, in fact, we need very clear, specific, and effective government regulations.

Senator GRASSLEY. Yes. Go ahead, please.

Ms. PRAEGER. Yes, Senator. Sandy Praeger, and I am represeting both my State—Kansas—as the Insurance Commissioner, but also the National Association of Insurnace Commissioners.

I would like to make a couple of points. One, on the issue of the public plan competing with the private plans, many State employ-

ees have, in fact, a choice between a public plan, self-insured by the State, and a private plan. So I think as long as the rules are the same—and that point has been made, I think, by several folks—I think you can make that kind of a system work. I think what you do not want is the ability to segment the market and have, with different rules, the ability to choose one over another because the rules encourage, in a sense, an adverse selection.

Let me, if I could, make another point, too, because it is about the way the current markets in our States function. We have seven States that do not allow rating based on health status. Also, let me just comment, we have a great opportunity here to, I think, get rid of one of the most onerus aspects of the current system, and that is rating based on health.

The people who need health insurance are sometimes absolutely just priced out, especially in the individual market. But you cannot do that without requiring that everybody have coverage, otherwise you will just wait until you are sick and then buy the coverage. That is where we do need rules set at the national level so that all of the States are functioning under the same system.

Now, as we move towards phasing in a new system with Federal national rules, I think we have to be careful to recognize that those States that do currently allow rating based on health have a very wide variance between the young/healthy and what they pay and the older/sicker and what they pay. So phasing in a plan, gradually phasing in some age rating factors, for example, and narrowing the rating bands, I think will make this more doable, leaving the oversight of that phase-in to the States who currently provide that kind of oversight. So those are just a couple of points that I wanted to make.

Senator GRASSLEY. Ms. Hansen?

Ms. HANSEN. Thank you, Senator. I would also want to concur with Ms. Praeger on that issue because one of the populations I think that I will probably have a chance to speak to a little bit later are the people who are between 50 and 64, so this age rating component is highly significant just because it is one thing to include people under the tent, but if that becomes a barrier, having them under the tent but not being able to afford it, becomes no access. So I just want to make sure that we keep that clearly in mind and understand that there is a gradual rating process in order to make this affordable at the same time. Thank you.

Senator GRASSLEY. Mr. Claxton?

Mr. CLAXTON. Just to add on to your point about market reform, while guaranteeing issue and making sure that health status rating is eliminated is important, I have been doing insurance regulation and insurance stuff a long time and worked on many Medigap and other guaranteed issue rules. You do have to do more to make sure that coverage is truly available. Insurers can selectively market still in these kinds of arrangements by where the producers are, where they choose to set up their—what parts of the country or what parts of an area they choose to serve.

So you really need to make sure the coverage is available to everyone, maybe through an exchange or something, but you need something where you can go and get coverage without having to work too hard at it, something like the website for Part D, for in-

stance. Everyone could go there and get coverage, and that is one way to eliminate some of the risk selection behaviors that can still exist.

Senator GRASSLEY. I know a couple of other people want to chime in here, but Senator Hatch has to leave right away. Let him ask his questions and then we will go back to you two.

Senator HATCH. Thank you. Thank you, Mr. Ranking Member. I appreciate it very much, Mr. Vice Chairman.

I want to go back to the public plan option. So I ask this question of Mr. Serota, and also Ray Scheppach, if I can, to get your ideas on this. A lot of our discussion has been rightly focused on the concerns related to creating a new public plan option. However, at the same time I am concerned about the extensive Medicare and Medicaid expansions that some people are talking about.

Let me put it in perspective. My State is currently at approximately 74 percent of the Federal poverty level, and nationally expanding Medicaid to 133 percent, which PhRMA and Families USA endorsed recently, will almost double the size of the program and thus cause significant market crowd-out.

Another big concern is cost. Simply expanding it to even 100 percent—which New York is at 100 percent. If you just go to 100 percent in Utah, that will cost the Federal Government, and all the other States, would cost them somewhere between $500 and $700 billion over 10 years, and the State government, $24 billion in 2009 alone, as we view it.

In the same vein, expanding Medicare to the early retiree population—that is 55 years or older—will also cause significant strain on the program that is already under tremendous financial stress, and that is Part A.It would probably go bankrupt by 2015. To me, a combination of Medicaid, Medicare, and SCHIP expansion, which we have already done, has much the same intended effect as a public plan.

Now, let me ask the two of you, I would like your thoughts on my concerns here, because I am very concerned about this.

Dr. SCHEPPACH. In terms of back-of-the-envelope estimates, Senator, our sense is that the Medicaid expansion, up to about 100 percent of poverty, would cost in the neighborhood of $65 to $75 billion. Now, some of that, about $24 billion, is actually for the new population, but our assumption is that the current reimbursement rates, where States average about 72 percent, would probably have to go up close to the Medicare rates to do that and that would drive the cost of the existing population up. So you are probably in the ballpark of $65 to $75 billion. You would pick up an extra, I think, $11 million people taking Medicaid, from probably $54 million to $65 million.

Senator HATCH. Over 10 years, I am estimating $500 to $700 billion.

Dr. SCHEPPACH. Well, States clearly cannot finance that. Governors would oppose it as unfunded mandates. Just to give you an order of magnitude, States are already struggling with sustaining the current Medicaid and that is over 10 percent of the general fund revenues of the States currently. So, it is a huge increase.

Senator HATCH. Thank you.

Scott, do you agree with that?

Mr. SEROTA. Yes. Senator, I agree with the previous comments.

Senator HATCH. How about my comments?

Mr. SEROTA. Oh, absolutely. I think the Medicaid program and the current Medicare program cover significant numbers of Americans already, and expanding those programs have created a de facto public program in place today.

Senator HATCH. That is great.

I have a question for Mr. Castellani, and also Bruce Josten. Did you want to make a comment, Mr. Pollack?

Mr. POLLACK. Thank you, Senator. As the Baucus white paper makes clear, 37 percent of the uninsured have incomes below 100 percent of the Federal poverty level. Now, for a family of three, that is precious little income, $18,310. If we are going to do something for the low income, we have got to do something, frankly, to upgrade the Medicaid program. The Medicaid program today is presumed by a lot of people to cover anybody who is poor. In fact, of course, that is not true.

Let me just take two populations. For parents, the median income eligibility standard among the 50 States is only 67 percent of the Federal poverty level. Only 16 States reached the Federal poverty level. For adults who have no dependent children, literally, in 43 States you can be penniless and you are ineligible for Medicaid coverage.

So if we are going to be serious, I think, about covering people who need care the most and who are least able to get it, we are going to have to upgrade Medicaid and create a national floor. My hope is that the national floor, as we in PhRMA had suggested, would go to 133 percent of the Federal poverty level. But there needs to be a national floor so that nobody can fall through. Medicaid provides some very important services.

Senator HATCH. Well, let me just interrupt you there. I understand about helping low-income Americans. I want to do that. But I would personally use more innovative processes or approaches, like low-income subsidies for private coverage instead of simply expanding Medicaid, which, once it is expanded, you cannot change that or turn that around. We could have a lot of flexibility to do this coverage another way.

So, I understand the problem and we have got to solve that problem. I do not want to ignore what you are saying, but I would prefer doing something like that which gives us more flexibility, and maybe even more ability to do it, and to do it within certain constraints.

Mr. POLLACK. Senator, there are some things that Medicaid provides that you just do not get in the private sector, and very important for low-income populations. For example, for children, there are very important protections so that they get early screening and treatment for virtually any condition that they have; if they have got a hearing problem, a vision problem, a dental problem, that is going to be taken care of.

There are other services which are important in a State like Utah, particularly for those people who live in rural communities who may not be able to get to a health facility. The Medicaid program provides them with transportation services which they are going to need in order to see a physician. They will get home- and

community-based care, which they do not get today in the private sector. So I would urge that you give serious consideration about expanding Medicaid, at least for those people at the lowest income levels.

And one other thing, Senator. The Medicaid program provides certain kinds of cost protections that simply do not exist in the private sector. For those, for example, below the poverty level, no premium is charged. For those people who seek services, either prescription drug services or other kinds of services, there is only nominal cost sharing. As numerous studies have showed, if you charge any significant amount of cost to those people at these very low-income levels, they are not going to get the care that they very much need.

Senator HATCH. I understand.

I just had one other question to Mr. Castellani and Mr. Josten.

The CHAIRMAN. Did you want Ms. Rosenbaum and Ms. Rowland's response, too?

Senator HATCH. If you would like to, sure. Go ahead.

The CHAIRMAN. You want them to?

Senator HATCH. Yes, if you do not mind me asking the other questions later.

The CHAIRMAN. Fine. Go ahead.

Senator HATCH. Ms. Rosenbaum had a comment.

The CHAIRMAN. Ms. Rosenbaum, and also Ms. Rowland.

Senator HATCH. And Ms. Rowland, yes.

Ms. ROSENBAUM. Thank you, Senator. I would just like to add to Mr. Pollack's statement. The other thing that I think is notable about the low-income population is that their underlying health conditions are so serious. Interestingly, the severity of health conditions, whether it is children or adults, does not abate at the Federal poverty level. There is a tremendous burden of illness well into, actually, moderate income levels.

If we are focused on health reform, I think as we should be, not only about the act of covering but also about bringing down disparities in health care and health status, the Medicaid program as the sponsor of the coverage probably has a lot more experience in designing the internal workings of coverage to deal with children and adults with severe health burdens. Issues such as childhood asthma or adult mental illness, conditions that, even if they are not so fully disabling so that you are not on Social Security Disability benefits, create a burden of health problems that private insurers, even when they are very good and very thorough, simply do not have the experience managing.

Now, this is not to say that greater efficiencies cannot be brought to how Medicaid affectuates the coverage or arranges delivery systems. But, in terms of having to weigh this very important issue that you put your finger right on, which is which people will get their subsidies through Medicaid versus which people will get their subsidies in a more commercial or traditional insurance-oriented exchange system, my own recommendation would be that, in order to advance the equally important goals related to the reduction of health disparities, you actually rely more on Medicaid for the direct sponsorship of the coverage, while looking to align Medicaid and the exchange in how delivery of care actually takes place. That is

where you can get efficiencies that each sponsor, buying alone, may not be able to.

Senator HATCH. All right. Ms. Rowland?

The CHAIRMAN. Ms. Rowland?

Ms. ROWLAND. Senator, I just wanted to add that when we look at the uninsured population, unfortunately a substantial share of them are below the poverty level. What we have seen in the Medicaid program is the ability for the program to provide a broad range of benefits, and we have heard today a lot about provider participation issues.

But when we look at how the population on Medicaid compares to those with private insurance who are low-income, the Medicaid population actually does better on many access measures. So I think building on an operational program and minimizing the need for transitions may help bring some of the lowest income uninsured into a system and not overburden the exchange, which a subsidy program might do.

Senator HATCH. Well, thank you. I think I am quite a bit of time——

The CHAIRMAN. Well, let me get to Senator Ensign. Do you have one more question?

Senator HATCH. I have one more.

The CHAIRMAN. All right. Go ahead, Senator Hatch.

Senator HATCH. For Mr. Castellani and Mr. Josten. As much as I am worried about the employer penalty under a play-or-pay mandate, I am more worried about what employers will be required to offer to avoid this penalty. All signs are pointing to the fact that some want the more expensive—very expensive—Blue Cross Federal coverage for anyone. According to the National Bureau of Economic Research, even asking employers to provide a $9,000-per-year package will cause per-hour wages to decline by more than $3 and cost us more than 220,000 jobs.

Now, that is not all. The administration is also taking a look at eliminating corporate deferral as a potential pay-for. We already have the second highest corporate tax rate in the world, second only to Japan. Now, this will ensure that every multinational company will relocate abroad—at least that is what the leaders have told me—causing irreversible harm to our economy.

Now, all these policies, as the sum of their whole, look to me like they are going to have a devastating impact on our economy. So what I am asking the two of you is, is my assessment wrong on this or is my assessment of these policies accurate?

Mr. CASTELLANI. Senator, you make a very good point. It is the cost issue that brings employers to this table. Again, all of our members provide health insurance. They want to continue to provide health coverage for their employees because, quite frankly, it both enhances productivity, as well as provides a good way to recruit and retain key skilled employees, good-quality employees. We want to be in this game, but it is the single biggest cost pressure that we face day in and day out. It took oil at $150 a barrel to even tie it.

In an increasingly international marketplace where we are competing against companies who reside in countries that have a different model, a different tax model, a different health care cost

model, or where we are competing against companies that do not provide health care, this cost burden for U.S. corporations, particularly ones who participate in the global marketplace, is really unsustainable.

So if the answer here is not to improve the delivery of the system, to improve the coverage of the system so that we bring the cost trajectory down, but rather increase the costs either through what is happening with health care costs well above GDP or what is happening with our tax system, then U.S. companies cannot compete.

So our premise here: we want to continue to provide health care coverage but we have to be able to do so in a way that allows us to compete in the international marketplace. And that is why we need the kind of efficiencies that this committee has talked about, that you have all talked about, and a level playing field so that we can compete and we can create jobs.

Senator HATCH. Mr. Josten?

Senator GRASSLEY. We have talked a lot today about medicaid expansion. There are a few points I want to make sure are made today about that idea: (1) Expanding Medicaid will be a tremendous financial challenge for States. We should not ignore that, no matter how easily some folks say "let's just expand Medicaid" or "yes we can"; (2) access is a serious problem in Medicaid. Ray Scheppach of NGA argued that States will need to increase reimbursement rates to Medicare levels to truly provide *access to care.* That will *not* be cheap; and (3) Sara Rosenbaum testified that Medicaid can be the sponsor of overage while private insurers deliver coverage. I think it is very important we don't build a high wall between Medicaid and private insurance. People should be able to move seemlessly without changes in their coverage or providers—particularly children.

The CHAIRMAN. Senator Enzi? I am sorry. Senator Ensign. Thank you. Senator Ensign?

Senator ENSIGN. People get us confused all the time. They call us twins. [Laughter.]

The CHAIRMAN. I apologize. I apologize.

Senator ENSIGN. I would make a quick comment. It was an interesting discussion we had earlier when we were talking about the public plan, and Mr. Stern talked about more choices. I think a lot of folks talked about more choices. I cannot remember the Senator that pointed out about Medicare Part D, and that there are a lot of different choices offered under that plan.

One observation to think about is, why do the individuals have the choices? Well, one of the reasons is because the benefit goes to the individual. In our Tax Code, the benefit goes to a company. It does not go necessarily—indirectly it goes to the individual, but it does not go directly to the individual. In other words, you get your tax deduction for your health insurance only through an employer.

The individual, if you are self-employed or if you are out there without insurance and you want to buy it in the individual market, you do not get the tax deduction yourself. So if we want to have all of those various choices and we truly want to have a bunch of different market forces coming into play, I think there are two really critical aspects that we have to have.

One, is that the individual needs to get the benefit, the tax benefit, whether it is a deduction, whether it is a credit, depending on your income level. You could do probably even a hybrid system between those two. If we want to have the universal coverage you could do it through a combination of those two things. Then if you wanted to set up the delivery system where you had the competition between the plans, those people could be able to then choose between those various plans that are out there.

The question, though, that I want to bring up has to do with—and I have talked a lot about this. I think Wal-Mart has done a lot on that, I know Safeway, Steve Byrd, has been up here and talkd to a bunch of us—basically encouraging healthy choices. A lot of the plans out there today do not encourage healthy choices, they just do not. There are not the proper incentives for people to have healthy choices. There are not the financial incentives. Most of the plans are really not set up for that, to be able to do that. You may give incentives here and there, but it is not the same way as, like, an employer could be able to do that.

Safeway has figured out, with four different conditions, that certain conditions cost more money to insure various people. They basically focused on smoking, obesity, controlling hypertension, and controlling their cholesterol, and had pretty good results with it, being able to lower their health care costs by about 40 percent compared to the rest of the country over the last 4 years. I would say that is a faily significant result.

My question has to do with that. Right now, they are only allowed to incentivize up to 20 percent of the premium. Maybe Ms. Ignagni and Mr. Castellani, if you could comment on this. Should that be raised? Safeway has been saying that they could do a lot more if you could raise the amount of that premium, the percentage of that premium, say up to 50 percent. If anybody else on the panel wants to comment on that, if that would encourage more people to do more healthy choices, which would then in effect lower the cost of health care in the United States.

Ms. IGNAGNI. I think, Senator, you are probing an important area and I would answer it in two ways, make two points. One, the Safeway example is very interesting because they have done this in cooperation with the UFCW, the union, and I think that that speaks to the breadth and depth of the proposals that have been on the table. You are quite right, that if you participate in disease management you get an incentive for doing that, you pay less, if you stay with it and hit certain markers.

We do believe, in our laundry list of proposed reforms that we talked with the Chairman about just a little while ago, one of the issues that we have flagged is to have a discussion with all of you in the Congress at large about a permissible set of circumstances in which we could encourage this type of behavior more broadly, number one. So we agree with you very strongly.

On the other hand, we would want to have a very important, transparent conversation so that everyone is clear about the incentives, where they might be applied, where they should not be applied, et cetera, so that we have the rules of the road very clearly established, number one.

In the Safeway-UFCW situation that you are probing, I think there is reason to think about giving them more room. There are employee benefits managers that can actually work on both sides, on the labor and the management side, and I think they could teach us quite a lot about what is possible. There is a safety valve there for workers so that people are protected, and employers and the union are working together very well. So I think that is a good example.

There are other companies where there is not a collective bargaining situation who are also doing very provocative and productive things. So I do think where you have benefits managers that can take responsibility for coordinating that, there is a reason to really think about, in the corporate setting, giving more room. I think we could do that quickly, find out some real experience that could be applied broadly. But we would very much like, across the board, to be able to do this. The reason I am hesitating a little in saying yes broadly to your question about, why not expand it for everyone, in a small business situation, which Don Danner talked about, for example, one of the most important things we have to do is set up the infrastructure where they can have more choices.

Senator ENSIGN. Right. If you did it through small business health plans you could get to the size where you could make these incentives work.

Ms. IGNAGNI. Yes. Well, that is right. You have more choices if you set up portals the way they have done in Massachusetts, where small business knows what is offered. Now it is very hard to find out, et cetera, et cetera. So, we are strongly supportive of that. I think in those arenas, where there was interest, there might be some real opportunities there as well. But we would offer them, from an insurance perspective, a fully developed package that would not depend on a small business having to have an employee benefits manager.

The CHAIRMAN. The following Senators have sought recognition—I will read the list—in this order: Senators Menendez, Cantwell, Snowe, Stabenow, and Kerry.

Senator Menendez?

Senator ENSIGN. Senator Baucus, I had asked Mr. Castellani to comment on that.

The CHAIRMAN. Fine. Go ahead.

Mr. CASTELLANI. Senator, you are getting at one of the key things that we hope that is part of this debate, and that is that we provide as much incentive for wellness and prevention as we provide for disease management. That is very, very critical to avoiding the kinds of costs that do cripple the entire system. When we look at our membership, about 82 percent of our members already offer disease management programs; 74 percent offer tobacco cessation programs; 85 percent have weight management programs.

All of these, and others, are key to avoiding the kinds of costs that burden the system. We believe it will make an important difference and we want to have the kinds of incentives that we are providing for our employees to engage in those programs so that they have ownership for their own success.

Senator ENSIGN. Thank you.

Thank you, Mr. Chairman. You know, one of the things we should look at as the committee as well, because some of these incentives are in the private sector, is can we provide some of these incentives in Medicare or Medicaid? For instance, we know with 40 percent of our country being obese, and it contributes to every single disease, can we provide incentives for people who are on these public plans to be able to choose healthier behaviors as well?

The CHAIRMAN. That is a very good question, one I have been pondering for some time. Larger companies who are self-insured, I think, can more easily manage in negotiations with their insurance companies and providers and so forth. It is a little more difficult on the public side. But that is an excellent point, and clearly we should work very hard to try to find ways to build in those same incentives because that clearly is going to bring down health care costs. I appreciate your line of inquiry.

Senator Menendez, you are next.

Senator MENENDEZ. Thank you, Mr. Chairman.

I want to return to Mr. Serota, and then Dr. Nichols for comparison here just so I can see if I am not missing something. We were sort of cut off by the vote. My sense of it is that you were saying—correct me if I am wrong—that you cannot envision a public plan that somehow would be on a level playing field and competitive, and therefore you reject it out of hand. Then you were making the case that there is plenty of competition in the marketplace.

So, I look at the AMA's study and they found anti-competitive markets in 94 percent of metropolitan statistical areas. I look at six States that they list in which the top two insurers have anywhere between 62 and 87 percent of the market. I look at the Commonwealth Fund's information in which they have, by way of example, 16 States in which there is anywhere between 70 and 100 percent of the market by a limited number of insurers. I am trying to figure out why, out of hand, there is a rejection without knowing the specifics of what that public plan would be, especially if the proposition is that it can be on a level playing field with the same set of circumstances.

Dr. Nichols, I think in your testimony you have a different view as to the possibility of that. As a matter of fact, one of the things I heard in New Jersey when I conducted listening sessions was not the universe who has no insurance, although that is 1.2 million people in New Jersey, it is the universe that has insurance that talks about the endless time on the phone, the run-around, the denials, the whole process of the appeals. I heard horror story after horror story. I think you referred to that, Dr. Nichols.

So am I right, Mr. Serota, about my understanding of what your answer to me was? If I am wrong, tell me where I am wrong. Dr. Nichols, tell me why it seems like you have a somewhat different view.

Mr. SEROTA. Well, Senator, I think you accurately characterized part of my concern, and that is that I cannot conceive of a government program competing on a level playing field. I think you mischaracterized that where you said I have dismissed it out of hand. What I think I said is, I have not seen it.

But it is very difficult for me to conceive of a government program that is overseen by Congress, developed by Congress, and

regulated by Congress, competing on a level playing field in the private market. I mean, you become a competitor and a regulator in the same environment, and a financer. I think that that creates an unlevel playing field. It is hard for me to conceive of how, in fact, that could work and that could be a level playing field.

The CHAIRMAN. Dr. Nichols, do you seek recognition?

Dr. NICHOLS. Sure. I would just hasten to add that I understand Mr. Serota's concern. It does not happen very often, but I will show two examples and then get to specifically, sir, your specific question, Senator Menendez.

The two examples—let us just take a step away from health for a moment and remember the post office. The post office, last time I looked, is a government entity. The post office came under some competition pressure.

The CHAIRMAN. Yes. A lot. FedEx, UPS.

Dr. NICHOLS. Exactly. What I remember, sir, because I grew up in rural Arkansas, there was this concern that we would not be able to keep mail going to the small towns because they "needed a subsidy" of the money they were earning in the cities. But we figured out a way—and I think there is a complicated story there, but it actually makes a lot of sense, and believe it or not, Senator, I think it is relevant to health care. I will come back to that later—to allow competition to eventually flourish, and in fact, now, we have very robust competetion between UPS, DHL, FedEx, Pitney-Bowes, all that stuff, and the post office is still doing some. So, that is one example.

But back to health care. Let us go back to these 34 States that, in their own wisdom of organizing how they want to buy for their employees, 34 States have created a plan that is self-funded—that is, the State bears the insurance risk, the State picks the managers, the State has, frankly, no interest in driving the other insurers out of business, the State has an interest in preserving competition, enhancing competition for their own workers, and for many of these States they have been doing this kind of competition for over 15 years.

So I just think we have got to look in a couple of places. I would offer to meet with Scott's able staff and talk about the post office, but also about these State plans because I do think, indeed.

The question, it seems to me, is why do we need it if we have the rules? I think that is a fair question. I think, for the people in this room, it probably is kind of hard to imagine. But for people who do not trust private insurance, the ones that Senator Menendez talked to in New Jersey, they wonder why we do not see the obvious, and that is that they have been, in some sense, treated badly in the past and they have a hard time accepting that it would work in the future. I certainly would agree in the long run we may not need it, but let us let it try and let us preserve that trust and let the competition flourish, which I think we could do.

Senator MENENDEZ. Mr. Chairman, could we let Mr. Pollack——

The CHAIRMAN. We are going to come back to this subject a little later, but Senator Cantwell is next in line.

Senator CANTWELL. Thank you, Mr. Chairman.

The CHAIRMAN. I do not want to keep Senators waiting.

Senator CANTWELL. Thank you, Mr. Chairman.

To go back to the question or the discussion about efficiencies, particularly as it relates to Medicaid—and I wonder whether Ms. Hansen or Mr. Stern could address this—but it is back to this question where we are looking at a public plan. To me, the question is, what are we going to do to improve the efficiency of the system and focus it more on community- and home-based care?

If you are talking about 57 percent of overall Medicaid spending being on long-term care and chronic care, why should we not be incenting States with our Federal program to move more towards community- and home-based care as a way to drive down these incredible costs that we are going to see at the Federal level? So I do not know whether Ms. Hansen or Mr. Stern wants to address that.

Mr. STERN. I would just say, Senator, that seems like such an obvious way we need to go here. I mean, Dorothy, I think it was, said in The Wizard of Oz, "There's no place like home." I think for most Americans, being in their home and supporting them staying in their home is not only a way to control costs, it is also a way to provide people the real choice they want at different times of their life when they are unable to do other things. So I think all the incentives should be to keep people where they want to be, which is in their home, to provide them the community-based support that they need.

I appreciate that you, Senator Kerry, and Senator Grassley have been all working on these issues and I think it would be a real missed opportunity if we did not use this moment of history to really push people to where they want to be—not push people, allow people to be where they want to be and give them the support they need to be there.

Senator ROBERTS. Mr. Chairman, could I ask a question on top of that?

The CHAIRMAN. Briefly, because I have Senators lined up here.

Senator ROBERTS. I am sorry. I am sorry.

The CHAIRMAN. All right.

Senator Snowe, you are next. Do you want to be added to the list, Senator?

Senator ROBERTS. Sure.

Senator SNOWE. Thank you, Mr. Chairman. I want to thank all of you for being here today. I want to follow up on some of the issues concerning the small business health insurance reform, which I think is essential. I cannot believe that it would not be included in the broader reform that we anticipate to address in June here in the committee, and also in the Help Committee.

As former Chair, and right now Ranking, of the Small Business Committee, I know this is a huge crisis for the small business community across the country, particularly now where insurance premiums have now risen more than 89 percent since 2000. Market consolidation clearly has occurred. In fact, the GAO issued a report at my request, and Senator Lincoln and Senator Bond's, talking about further consolidation of the market that virtually leaves very little competition in small markets.

The five largest carriers in the small group market, according to GAO, when combined, represent three-quarters more of the market in 34 of 39 States, which has actually increased in terms of consoli-

dation, and they represented 90 percent or more in 23 of these States, including my State of Maine. So I think it underscores the fact that there is very little competition, which of course means either people are left out of the market or have insurance policies for virtually catastrophic coverage, which is certainly what has happened in my State. So I hope that small business health insurance reform will be included in the broader reform.

Senator Durbin, Senator Lincoln, and I have introduced legislation today called the Small Business Health Insurance Option Program, which we think think goes a long way. I know that Mr. Stern and Mr. Danner have supported this legislation; Mr. Pollack has as well. We have had help from the National Association of Insurance Commissioners on the rating questions, which we think are really critical to addressing some of these issues.

We addressed the health status, basically phasing it out over 5 years. We allow pooling on a national basis, and also have State-based plans as long as they have conformed to certain criteria. We also allow the self-employed to be part of this group market that otherwise is left out. If we exclude the small business markets, then clearly we are going to leave out 52 percent of the uninsured because they are the ones that work for small businesses or depend on someone who does.

Now, one of the issues is not only including in the broader reform, but then, secondly, the number of employees it should apply to in terms of defining a small business. Now, I have heard it range from 10 employees—I think, Ms. Ignagni, you referred to as just having micro-businesses, 10 employees. Our SHOP Act includes 100 because basically the 52 percnet of the uninsured working for small businesses are those working in businesses of 100 or fewer. Ms. Rosenbaum, I think you mentioned 200 in your testimony.

So I would like to address that issue in terms of, what should be the definition of small business? Two, should we include small business health insurance reform in the broader reform, not just the individual market? What benefit would there be to leaving out a group like small businesses that clearly are going to be critical in this process?

I mean, there is a big difference between 26 million people being part of this process, or if you have 10 employees, Ms. Ignagni, then you are talking far fewer. I do not know how many are in that uninsured pool, but we know that 26 million are represented for working firms of 100 or fewer.

So Mr. Danner, would you begin on this question? Yes.

Mr. DANNER. Obviously we are very supportive of the SHOP bill. We appreciate your efforts and the efforts of Senator Bond and Senator Durbin to get there. We strongly believe that the principles embodied in the SHOP bill need to be included in broader legislation. Small businesses are half the economy, but they are also half of the uninsured. Small business members and their employees are half the uninsured. So we certainly hope that the principles of broad pools, of tax equity, the things in the SHOP bill, need to be included in broader legislation.

We also support the 100 and below employee level in the SHOP bill. We think it is very important that many businesses above 100

are able to self-insure and most businesses under 100 do not. So we think that is a good cut-off point.

Senator SNOWE. Anyone else to comment on that? Yes, Ms. Ignagni?

The CHAIRMAN. We have got a lot of Senators here. Maybe one more comment. Frankly, we have too many people here.

[Laughter.]

The CHAIRMAN. So we are just going to have to do the best we can with what we have got here. This is becoming a difficult problem logistically to manage. But if you could ask one more panelist, Senator, then we will go on.

Senator SNOWE. Just one other comment.

The CHAIRMAN. I would ask everybody, get straight to the point.

Senator SNOWE. Dr. Nichols? And thank you for your help in drafting this. You have been a great resource in this as well.

Dr. NICHOLS. Well, Senator Snowe, I would just offer this definition of, "how small is small?" If you think about the one market, in my view——

The CHAIRMAN. Briefly.

Dr. NICHOLS. One area that is working well today is the very large self-insured employers. So the small should be defined as the size at which you can self-insure safely. I think we can argue about what that number might be, but I think it is more like 300. I will just stop there.

Senator SNOWE. Thank you.

The CHAIRMAN. Senator Stabenow?

Senator STABENOW. Thank you, Mr. Chairman.

To follow up on that, I want to talk for a moment and ask some input regarding those large employers. The majority of people recieve their insurance through their employer, and frankly some of our best cost efficiencies, our cost savings have come from large employers, many of them in my State who have focused on using generic drugs, using preventative measures, other kinds of efforts.

A couple of different questions. Well, first, an observation. The reality is today that while most people get their insurance through their employer, as people are losing their jobs—and more and more of them are—they are losing, therefore, their insurance or they are paying more premiums, more co-pays because of just the nature of the cost and what is happening for employers. I could spend a lot of time on the competitiveness issues around the globe and how poorly we have designed this for employers.

A couple of questions. One, is that more and more we are seeing people who are 55 or older who are being asked to take that early out or are retiring, whatever, finding themselves losing that employer-based coverage and not qualifying for Medicare. There are creative financing options. We have now seen things like Voluntary Employee Benefit Associations, VEBAs, and so on, to try and make up the difference.

I would ask panelists what you would suggest, because this is certainly the highest cost for employers as well as people who are older. What about those who are early retirees? The Chairman's white paper suggests something possibly to look at like Medicare buy-in or something that would transition. So one thing is, what about older people?

Then, second, whatever we do in reform is going to take time to implement and I am wondering about a bridge to transition for employers right now to help employers in terms of insurance, and any kind of good-guy credit for the folks that have been doing the right thing for a long time. So, early retirees, and then what about helping employers right now?

The CHAIRMAN. You have to pick a panelist, Senator. Pick who you want.

Senator STABENOW. Well, first, I would ask Ms. Hansen, from the retiree standpoint, and then Ms. Ignagni, would you respond?

Ms. HANSEN. Right. Thank you, Senator. This is a major concern and initiative for AARP and the concern of not only these 55 and older, but we are finding people who are perhaps losing their jobs at 50. So I think the whole aspect of affordability is there and some creative ways to look at subsidies to make it possible, because I think one of the things we were talking about earlier is the concern that as you do get more health care issues as you get older, the insurability aspect—even if people, again, are all included, the cost side is going to be extremely high.

We are finding in certainly the stories that we are hearing from people who are either let go from work or, by health, have to leave work or find that they are in a situation that they just do not have the ability to get a job. The affordability component and access is just absolutely critical for some people who are not even retiring, at that age.

Senator STABENOW. Do you support some kind of Medicare buy-in?

Ms. HANSEN. I think that has been one of the discussions here. I think we are looking at your leadership collectively to take a look at what the implications are for coverage, and that there are probably many ways to get there. We would want to make sure that we have an opportunity to discuss that.

The CHAIRMAN. Senator Kerry?

Senator STABENOW. I am sorry. Ms. Ignagni had raised her hand.

The CHAIRMAN. All right, but very briefly because we have lots of Senators who wish to speak here.

Ms. IGNAGNI. I will be very quick, Mr. Chairman.

Senator, I think you have asked an important strategic question. Quickly, the answer is the following: you have a strategic choice to make in terms of designing the rules. If we design rules where the insured are subsidizing each other, even with bands and so on, there will be higher costs, as Ms. Hansen observed, for older workers.

One of the things I think was learned in the California experience most recently. They did not pass their legislation, but they had a provision that people over 55 would not have to pay more than 10 percent of income for health insurance coverage. I think you could marry the two. So think about rating and subsidization in tandem, and there are many different choices. Thank you.

The CHAIRMAN. Senator Kerry?

Senator KERRY. Thank you, Mr. Chairman.

Let me try to be quick on this. I want to get more precise with respect to the answer on part of the question that was asked by Senator Cantwell, and I direct this to Andy Stern and/or Ms. Han-

sen and Ms. Rowland if you want to contribute to this, if you would.

Senator Grassley and I have introduced the Empowerment at Home Act, which seeks to create greater flexibility for the delivery of home care, which is what we were talking about. We have got about 9 million people today who need home care. It is going to go up to about 21-plus million over the course of the next 25, 30 years as the aging population grows and as more people need it. Currently, we spend about $100 billion in Medicaid on that. Medicaid pays for about 49 percent, Medicare pays for 21 percent, private insurance pays for only about 7 percent.

My question to you is, in our Act, Senator Grassley and I use sort of an extended waiver process, et cetera, to try to expand the opportunity for care. Should we be more specific here? Should we change the percentage? Do we need to be more arbitrary? I mean, currently, 75 percent of the weight of Medicaid reimbursement goes to institutional care and only 25 percent goes to home care. Does that need to change? Can you adequately get at this and get the cost reduction in home care increase you want through the waiver process? What is the best way to structure this, bottom line?

Mr. STERN. Senator, that is a good question. What I would say is, what we cannot do is structure a payment system that rewards institutional care and have no compensation for people who want, and are able, to live in their home. I think that is what we do too much now, which is, we provide money to do certain things and do not provide money to do other things, and lo and behold we get the result you might expect.

So I think whether it is a waiver process, whether it is redoing the payment system to have the least restrictive care that people are able to operate in, whether it is having Medicare provide more support or the private insurance being required to provide more support for home care, something has to be done if we want to drive down costs.

The CHAIRMAN. All right.

Senator KERRY. Ms. Hansen?

Ms. HANSEN. Yes. I do think there is a great opportunity right now to redistribute that mix. In fact, we are finding that——

Senator KERRY. With specificity, in other words?

Ms. HANSEN. With specificity.

Senator KERRY. We should target the percentage differnetly?

Ms. HANSEN. It can be much more focused. Some States have already done that. There is also an alternative that actually, in Senator Grassley's own State, has the ability to build it into the State plan. I think that is the only State right now that has been able to achieve that. Once you build it in, then the shift will occur. Some of the States in the past have taken this lead earlier. Senator Cantwell's State and Oregon have done this and we do find a much better mix. It meets Mr. Stern's comment about people wanting to stay at home.

Senator KERRY. Great. Thank you, Mr. Chairman.

The CHAIRMAN. I am sorry I am going to have to limit it right now. We can come back. There will be a wrap-up here.

Actually, Senator Grassley has a statement to make.

Senator GRASSLEY. I am not going to ask questions. I would like to discuss this for 10 minutes, but I just want to take a minute and say two things, kind of in the form of a question, but as something for people to think about. If some of you want to respond, please do it for the record later on, do not do it now.

In the first place, in regard to lack of competition in some States, I think it is true that the lack of competition in some markets is due to the fact that some States have, through the community rating rules and through the limits on preconditions and all those sorts of things, have kind of messed up their insurance markets and a lot of the competition has just pulled out. They were not going to do it, so what is left is very, very expensive and very limited competition. So I accept some of that, but I believe that government has created a situation in some States for that to be the case.

The second point I would make would be in regard to people that want to expand Medicaid. Now, in my State, the State pays 62 percent, so doctors are not taking Medicaid people. So you want to load Medicaid down with more, with less people willing to take it. So you get back to, how do we get in this condition that Medicaid pays 62 percent, in my State as an example, and in other States it would obviously vary? This gets back a little bit to the government-run option. It has been mentioned, the fact that when Medicare was created it was designed to pay private rates, but over time the government realized that they could save money by just setting lower payment rates.

Some would create a government-run plan, with the best of intentions, but how do you know that the government will not, in the future, do like they did in Medicare, or more frequently with Medicaid, and just lower rates and give the public plan an unfaire advantage when we need a little extra money?

I yield the floor.

The CHAIRMAN. Thank you, Senator.

Actually, I am going to change the order a bit because Senator Carper, who has left, wanted to be recognized. That is why he was not recognized earlier.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman.

A question for you, Mr. Castellani. Health costs are hitting all of our businesses like a wrecking ball. I want to ask you a question about how we might unify your position and Don Danner's position for the small business folks. Here is what Don Danner said in his testimony: "Our research suggests that employees are better off choosing their own insurance plans rather than leaving the decision to their employers. No matter how smart and well-intentioned the employer, the employee has a better grasp of his or her family's needs and desires. The best approach is to give individuals the option to use employer contribution dollars to pick the plans of their choice."

Now, here is my question for unity between you and the small business folks. Supposing we said that we would do what Mr. Danner is talking about, but the worker could, in effect, use their dollars with your plan, one; you tread softly on ERISA, which I think you made a good point to the Chairman on; and second, you would

continue all the incentives for prevention that you and your members have wanted.

If that was done, clearly there are going to be some challenges, like risk adjustment in terms of how to do it. But would that not be one way to unify the big businesses and the small businesses so that all employers can come to Chairman Baucus and Senator Grassley and say, we can be on the same page in terms of holding costs down?

Mr. CASTELLANI. Well, Senator, you make a very good point. As you know well, we have really enjoyed and benefitted from the discussions and your focus on the issue. The answer is, in part yes, but in part no, because here is the concern we have. We need small business and people employed by small business to be covered. If this system is going to work, everybody has to be covered.

What we have to be concerned about is that we do not lose a large segmente of our population that we currently have in our insurance programs. As large employers that might be—for example, one of the issues that was just lightly touched on with an optional public plan—the young and healthy. And then you get stuck with old people like me. We have to have a broad enough pool so we make sure that it is affordable and we can be competitive.

So the concern I would have is, yes, you are right, we want the small business people to be covered because we are subsidizing those who are not covered now, but we cannot have it at the expense of the affordability of large employers because we need the broad spectrum of the risk pool to make it affordable.

Senator WYDEN. Can I follow that up, Mr. Chairman?

The CHAIRMAN. Yes.

Senator WYDEN. I understand that and I think everybody understands that risk adjustment is going to be a challenge under any proposal. But it seems to me you can have those big pools that you want and still have the consumer preference that Don Danner is talking about. If we do that, then the business community comes out unified and, in particular, the country walks away with the prospect that all Americans can have choices like their members of Congress, and then you eliminate some of the police fight over the public option.

Mr. CASTELLANI. Well, we certainly want everybody in the system.

Senator WYDEN. Thank you for your thoughtfulness, Mr. Chairman.

The CHAIRMAN. Senator Bingaman?

Senator BINGAMAN. Thank you all for being here.

Let me ask about oral health care. In my State, one of the big health care problems when you look at quality of health care, is lack of adequate oral health care for a lot of citizens. I am just wondering, what do you believe should be included in a health care reform proposal that might come out of this committee to deal with that problem? Is this just a question of expanding Medicaid or is this a question of doing something else? Is there any way that we can accomplish a solution to this problem as part of a more comprehensive health care reform effort?

Ms. Rosenbaum, you have written about this subject. What are your thoughts?

Ms. ROSENBAUM. Thank you very much, Mr. Senator.

First of all, I think that there is probably not a more important health condition than oral health. It is universal. It can be deadly, as we have seen now in this part of the country. I think back to my early years as a legal services lawyer and the first thing that I noticed about my clients was the state of their teeth. It was not just the cosmetic dimension of it—t was a crippling condition.

I think that oral health also poses a real challenge to Congress because it does not lend itself in some ways to insurance theory. It is the kind of care you want to finance for people. You want to help them buy the dental care they need. Dental care is expensive. So the models that have developed over time are in a program like Medicaid where we simply pay for necessary health care for people. We do not worry about the kinds of insurance principles that you have heard a great deal about today, and it makes Medicaid actually a very strong source of coverage for oral health. I would note, in relation to Senator Grassley's earlier question, that one of the reasons why Medicaid payments are so low is because its coverage is broad, which causes tension.

I think that for people who derive their coverage through pathways other than Medicaid, having an oral health component will be critical. This is particularly true and certainly for women of childbearing age because of the relationship between oral health and pregnancy outcomes. It is also an area where, going back to your last hearing, you are going to have to think about health system reform, and about encouraging the expansion of programs like health centers in the core to build up capacity in underserved areas.

Senator BINGAMAN. Mr. Chairman, Ms. Hansen wanted to comment. Is there time for that?

The CHAIRMAN. Go ahead.

Senator BINGAMAN. Please.

The CHAIRMAN. Go ahead, Senator. Yes, go ahead.

Ms. HANSEN. Thank you, Senator. I would just offer, on the other end of the spectrum, my previous work before becoming a volunteer for AARP was starting the original program of all-inclusive care to the elderly. That is a program now in 30 States. Within that model, oral health is included; dental care, eyeglasses, things that would help individuals stay more independent.

So, clearly the evidence of physical health being affected by, say, poor oral health, with cardiology problems does require a different framing of looking at health well-being. So that is something where I know there are some programs that are integrating Medicare and Medicaid and do then include oral health.

Senator BINGAMAN. Thank you, Mr. Chairman.

The CHAIRMAN. All right. Senator Carper has returned. Do you want to speak, Senator? You have been with us for some time now.

Senator CARPER. I appreciate it. Do I have to sit back in my own seat or can I sit here for a minute?

The CHAIRMAN. You may sit wherever you wish to sit.

Senator CARPER. Thank you. I am used to sitting with the press over there. This is nice to sit here closer to Chuck Grassley.

[Laughter.]

The CHAIRMAN. Yes. Right.

Senator CARPER. Thanks very much.

The point I wanted to make earlier—and I have been drawn into other discussions. We just had a tidal wave of folks from Delaware here today, just one right after the other. People, when they come from Delaware, they expect to see us, so I try to oblige them.

This goes back to some earlier conversations we were having about the public plan, whether we should have a public plan or not. I have not, frankly, focused a lot of time on that. But I have thought a lot about the role of government in issues like the one that we are discussing here today, and we thank you all for being here.

I like the thought that the role of government—thank you. I might get comfortable here.

The CHAIRMAN. Do not get too comfortable.

Senator CARPER. I will not. I will not. I will not. [Laughter.]

I will not. The role of government is to steer the boat, not to row the boat. If you look at the Federal Employees Health Benefit Program, the role of government is really kind of to steer the boat, not to row the boat.

We use the private sector, we use private insurers. Folks get to choose their doctors, and that kind of thing. But the government helps to steer the boat. I think when you look at the Medicare Part D program, it is similar. We do not have necessarily a public plan. We have a lot of private insurers. They have the opportunity to participate and we let the market decide.

There was a lot of concern early on whether we already have a Medicare Part D, especially the way it was structured. It is not the way I would have structured it, but it has got an 85 percent approval rating from the people who use Medicare Part D. As I understand it, we have been doing this for about 4 years or so under Part D, and I think each year the price comes in at budget or below budget, which in my business, that is pretty good. I have a pretty decent approval rating; I can assure you, it is not 85 percent.

But to what extent, in terms of thinking about a public plan, could we use the philosophy that the role of government is to steer, not to row? Look at FEHBP as maybe a model. Look at Medicare Part D maybe as a model. I would just welcome your comments, anybody who wants to speak up on that.

Dr. BUTLER. Well, I would like to maybe make a comment on that, Senator. I think you are exactly right, that the idea of the government steering or acting as the umpire is very different from doing that and also trying to run one of the plans. I think the FEHBP is absolutely instructive on that. It is precisely what the government does, and that is why you do not have the concerns about the role of government in that area that you do with the idea of a public plan.

That is why I do think that you could certainly pick up on what Ms. Ignagni said, and others, that you can envision the government steering and also leaning on, or negotiating with, some of the private plans to provide the kind of safe harbor that the large national plans do in the FEHBP. I mean, it does work. If you have a system that does work, it seems to me that trying to create something else, with all the issues associated with joint custody of running the plan itself and trying to set the rules, you can avoid that

with an example that clearly works well. It is what members of Congress have. It is what President Obama says he wants to have for the rest of the country. I think it is the perfect model.

Senator CARPER. All right. Good. Thank you.

Ms. Ignagni?

Ms. IGNAGNI. Senator, thank you for the opportunity. I think, metaphorically, you need a bigger oar in terms of what the government needs to do, take more control, create uniformity, and do more by way of regulating. So, that is very clear.

I think Ms. Praeger said something very important.

Senator CARPER. We need a bigger oar or a bigger rudder?

Ms. IGNAGNI. Actually, I was thinking more the oar because you have got to do a little more up front, and then the rudder as well. But we did not want to go too far.

Senator CARPER. Who should be manning the oar? [Laughter.]

Ms. IGNAGNI. I wanted to say something that I suspect may be somewhat unpopular, but I think it needs to be put out there in terms of the architectural discussion. The Federal Government setting up the rules of the road here is extremely important. We believe State enforcement—Ms. Praeger made a very good point. They have the infrastructure to do the consumer protection. Where we have gone wrong, there are two models of HIPPA: one is where the Federal Government sets minimums and the States do more, the other is where the Federal Government sets the rules of the road, without getting into the details of which is which.

The point is, if you get to the situation where the States are going to do more, you do run into the problem, the number-one problem that small businesses are facing today, where they have mandates that are developed at the State level that block out small businesses from actually purchasing insurance and designing packages that are appropriate for their workforce?

Similarly, we can go on and on, but that is just one example. I know the Chairman wants to move, so I think, as you think architecturally about this, it is very, veyr important to create no inherent disadvantage of living in State A versus State B. If we move to a system where it is HIPPA 1, where it is minimum and then the States move on and do additional things, then I do think you risk tremendous inequities.

Senator CARPER. All right. Thanks. Thanks so much.

The CHAIRMAN. Senator Roberts? Thank you. Senator Roberts?

Senator ROBERTS. Excuse me, Mr. Chairman. I grew a beard since the last time you recognized me. Rather amazing. [Laughter.]

Mr. Stern and everybody on the panel who has expressed great support for something called a community-based incentive, more especially for people who have chronic disease, and I am interested also in Senator Ensign's comments. So obviously this kind of a plan or this kind of a concept would include wellness things for blood pressure, for obesity, for smoking, and cholesterol, everything that your grandmother said that you should not do and should do. Everything in moderation.

I want to know, who is going to do all this? Because if I go out to Syracuse, Kansas, or Tribune, or St. Francis, or Matter, Kansas, the border out there next to Colorado—Sandy has been there and she knows what I am talking about. It is not the end of the earth,

but you can see it from there—I do not know who does this. In other words, I do not know how you get a community incentive program implemented with the personnel that is going to be involved, with a provider that is going to be involved.

I would just like some help here because I just jotted down who would be doing this. Obviously there would be a member of AARP who would do the best that he or she could. There is the Area Home Health Care Agency, which is a 1-800 number that is always busy, and good luck on that. These people work very hard at it, but the number of people out there just is very scarce. You have got the Meals on Wheels people, and sometimes they are the only people that visit somebody that is a senior with a chronic condition.

You have got, obviously, the home health care provider who not only provides it and the durable medical equipment, but many times they are the only person that goes out there to visit Fred, who is 6 miles out of town and 4 miles to the east. Then you have got the preacher in the church, and you have got the pharmacist. Do not forget him, because he is the guy who really operates the Medicare Part D. We ought to make him a GS–15. I do not know.

What are the incentives for a doctor? Number one, we do not have a doctor. But number two, we have doctors and nurse clinicians, and they try very hard. What would be the incentive to take that doctor and actually make them have house calls out there in our rural population?

I am all for this, you understand. But I am just having trouble seeing what the infrastructure is all about. Sandy will tell you that basically States have about 2,000 mandates with Medicare and Medicaid and State mandates. Some States have got their mandates so high that they have priced their program, or their plan, out of any kind of possibility here. So, that is a problem.

Who is going to do this?

Mr. STERN. Well, I think we just had a discussion about, what is the role of government. I think what we are seeing is the market and the payment system not working very well, for all of the reasons you have just appropriately said.

Senator ROBERTS. Right.

Mr. STERN. So I think State needs a plan. I think they need the options, the choices that allow people to stay in their home. I think every State is going to be fundamentally different. In California, there are 300,000 people that provide this service in the smallest rural areas that provide certain parts of the service.

But clearly, if we are going to build a system that deals with the aging population and deals with the growing desire of people to stay in their homes, we are going to have to have States find an integrated way to do that and the Federal Government is going to have to give them the flexibility and the resources to do those different things. Right now we incentivize people in nursing homes. I do not think that is what we want for our citizens, I do not think that citizens want for themselves.

Senator ROBERTS. No. That is a warehouse situation. If anybody else would like to help me out on this, we have got about three or four people raising their hand. Sandy, do you want to respond?

Ms. PRAEGER. Senator, thank you. One of the issues I know the committee is going to take up is the payment mechanism. I do

think we need to create incentives for good primary care—and they currently do not exist—so the primary care physician is rewarded for providing that good preventive care that right now is not a reimbursable event.

So shifting the incentives away from fee-for-service where we pay for volume of care to a value-based system where you are paying for value and create some incentives to encourage people to do primary care and to go into primary care, I think is critically important.

The CHAIRMAN. And I might say, Senator, that is the thought in delivery system reform that tends to get at your question there. I think it is a very good one.

Senator ROBERTS. I appreciate that.

The CHAIRMAN. It is not an easy one to answer.

Senator ROBERTS. I think more people want to say something.

The CHAIRMAN. But you have got your finger on the basic point.

Mr. POLLACK. I just want to say that infrastructure is probably going to follow payment incentives. RIght now, all the payment incentives are towards institutionalization, not for keeping people in homes and in their communities.

The Medicaid program is the primary payor of long-term care today. For years, we have said that institutional care is a mandatory service under Medicaid. On the other hand, home- and community-based services essentially have to go through the waiver process, which is fairly laborious. So if we created a payment system in Medicaid that treated home- and community-based care on an equal plane as we do institutional care, it will not solve the problem overnight, but as money becomes available I think you are going to see greater incentives for infrastructure being developed.

Senator ROBERTS. Well, I would remind you of the statement that I said at first: a 2005 Community Tracking Phyisicians Survey showed that only 50 percent of physicians accept Medicaid now, and this doctor says he does not take it. He realized a few years ago that it was not worth the money to file the paperwork for the 25 bucks or less that he received from an office visit. This is at the office, this is not going out to make a house call. So, something would have to change very dramatically. It is a big challenge.

Mr. POLLACK. And right now under Medicaid, actually it is the States that set these rules.

Senator ROBERTS. I understand that.

Mr. POLLACK. And so as we now have an opportunity for health care reform, the Federal Government can play a strong role to make sure that payment levels for providers are adequate so that when people have a Medicaid card, they actually can receive the service.

The CHAIRMAN. Senator Lincoln?

Senator ROBERTS. This could be an expensive proposition.

The CHAIRMAN. Senator Lincoln?

Senator LINCOLN. Thank you, Mr. Chairman. And thanks to so many of you that have worked with us in trying to come up with the solutions. I know I have worked for years with Senator Snowe on really how to focus on the small businesses and the self-employed. In our State, we know that there are well over 50 percent not only of our working families, but also in terms of those that are

uninsured, or certainly under-insured. So, I am grateful for all of the input that you all have provided us through the years on what we have been trying to do.

As much as what was mentioned here with Senator Carper, we did use FEHBP as a model, looking at how, in its infinite wisdom, the government did see that they could do a better job of providing greater coverage, more meaningful coverage to Federal employees at a lower cost when they pooled them all together and pooled that risk. So, it has been helpful.

I would just like to ask a couple of questions. I think we have got a great model in the SHOP bill to begin with. I know that there is probably places that we can always improve, but really with the input that so many of you all have made, I think we have been able to make an awful lot of improvements in terms of both availability, looking at some of the issues of making sure that States maintain their regulation of what we do, but still being able to allow State and national pools or exchanges, or within the same exchange together to be able to provide that competitive nature.

One of the things is about rural health care. I very much appreciate the fact that Dr. Nichols grew up in rural Arkansas, just as I did, in terms of that availability. I guess my first question would be, how robust is the insurance market in rural areas? I know that having traveled across the State of Arkansas during our 2-week break and listening to people, it is extremely difficult for small businesses and self-employed people out there to access anything in the private marketplace, not to mention their access to health care.

I would, on top of that, not only talking about how robust is the insurance market in rural areas and do those individuals and small businesses have affordable options for some kind of comprehensive coverage, I would also like any comments you all may have about how we balance the high cost of health care with providing a plan that is meaningful.

In most of those sessions that I had with people in Arkansas, they said that they may have had access to one or two health insurance options, but none of them were meaningful in terms of what they needed, the high premium, plus the high deductibles, the co-pays, resulting basically in their out-of-pocket costs that were just simply cost prohibitive.

So touching on a little bit about those high costs of health care, providing a plan that is meaningful, it provides things—one of the things we did in SCHIP that was so meaningful was the dental wrap-around. Senator Bingaman brought up the issue of dental and how important it is, particularly in rural America where you have less access to dental care, but more importantly people that are just not able to afford it in a plan that is going to be so costly. So, anything of those two—I know the Chairman is going to cut me off, but anything on those two that——

The CHAIRMAN. No, no, Senator. Go right ahead.

Senator LINCOLN. Yes?

Ms. IGNAGNI. Senator, I think there are three issues, and they go together. In terms of the reforms that we are recommending, having a full-scale reformation of the existing market and setting out the rules very clearly and creating portals at the State level, which would be a place where, with one click, small businesses, in-

dividuals could go on a system and clearly see whether it is—in the Massachusetts arena, it is gold, silver, bronze. You could use a different set of structures, but it should be synergistic across the States and we should figure out the best way to do it and help the States and provide the software so it can be similarly designed across the country.

Senator LINCOLN. Just like our Plan Finder with FEHBP.

Ms. IGNAGNI. Exactly. Exactly.

Senator LINCOLN. And in SHOP, we do. They just click on their State.

Ms. IGNAGNI. You do. In fact, you have done a great job of thinking about that. So, that would help considerably, number one.

Number two, the cost. We have talked to a considerable amount of small businesses around the country. I was just recently in Albuquerque and spent a great deal of time in rural New Mexico, and this is the same sort of situation you are talking about. Our plans do not have the ability—for those small employers, whether they are restaurants, whether they are service providers, they want to customize their products. We cannot do that because of the mandate barriers.

We would like to be able to do that. We can do that for large businesses, we cannot do it for small. So that is why we have to think about, what will be an essential benefit package that everybody has access to across the country, and it is offered by all providers?

Then the third issue that we have been talking about quite a lot today is the care. We were just talking about the home- and community-based care. This is a very important issue in rural America. People should have the ability to have care plans and government should not make a decision about how people seek access. So the Medicaid situation is a great case in point where it is old-fashioned. It grew up that way because institutional care was the thing that was done when Medicaid was provided. That should not be the case. We should look.

Individuals should make the decision on the places that are appropriate for them. So, we have done a lot of thinking about: (A) those care plans; (B) how to get the services to people, and there are fascinating things, as you know, going on in rural America where our health plans have been able, through a great deal of equipemnt, for example, to do off-site monitoring hooked up to computers.

Senator LINCOLN. Oh, yes.

Ms. IGNAGNI. Do the kinds of disease management that we were never able to do before. So I think the three go together and we can make some real progress.

Senator LINCOLN. Well, we have talked a lot about it in the previous panel on guided care and some of the other kind of institutional things.

The CHAIRMAN. Ms. Rowland, you wanted to respond?

Ms. ROWLAND. Senator, I think you also have to recognize, given the lower levels of income and especially the high rates of uninsurance in rural areas, that what you do in terms of subsidizing coverage and what that coverage is will be very critical.

I think you pointed out very adequately that people do not want to have a low premium for a policy they do not think is really worth the coverage. So that is why, in many rural areas, I think investing in a very substantial subsidy for a comprehensive benefit package, and for the poorest of the population, continuing to build on the kind of coverage that Medicaid can provide in terms of providing transportation and additional assistance. In fact, it is Medicaid that provides those wrap-around benefits for home- and community-based services that are generally not available in any private health insurance plan, and I doubt will be covered by many of the plans in the exchange.

Senator LINCOLN. Well, should there be something that provides an incentive to States that have large populations of, say, children or Medicaid-eligible individuals who are not enrolled?

Ms. ROWLAND. Yes. There should certainly be a way to try and reach out and get some of those individuals, and that is, in fact, a very important look at the State level too at who the workforce is for that population. Many States—Massachusetts, for example, knowing that it has a problem with dental access, has expanded the Medicaid reimbursement so that dental hygienists can bere imbursed directly without having to go through a dentist. So, I think there are a whole variety of ways in which you can really look at both improving the supply of providers and the access to coverage in rural areas.

The CHAIRMAN. Mr. Danner, do you want to speak?

Mr. DANNER. Yes, sir. Senator, certainly you have hit on what we hear daily from small businesses, particularly in rural areas, and that is that the current marketplace does not work for them. It is broken. It is difficult to navigate, it is hard to understand, and specifically it lacks competition. They pay more for less than our large counterparts do. Changes in health status can cause an individual employer with one employee to have to drop coverage, so that needs to be addressed.

That is why we appreciate all you have done on the SHOP Act. We really think there needs to be larger pools, regional or national, that small businesses can participate in to have lower cost, more choice in particular, and more options for them as they purchase for their employees.

Senator LINCOLN. And tax incentives.

Mr. DANNER. And tax incentives.

Senator GRASSLEY. If we are trying to imporve competition in the insurance market, it seems to me that one of the keys is to increase the amount of information available to consumers. This could be an important function of health insurance exchanges. If the government is setting new rules and insurers start competing more on cost and quality instead of risk selection, exchanges could be a very important tool for consumers to shop around, compare plans, and pick the one that best meets their needs. Ms. Ignagni mentioned an essential benefit package in her last answer. I just want to make a quick point. I often here people calling for a really comprehensive essential benefit package—but it has to be affordable. I want consumers to have the choice between a wide variety of plans—some less generous and others more generous. But we need to keep in mind that if the government sets an essential benefit

package that is too high, it will limit choices and be unaffordable and people who need coverage.

The CHAIRMAN. Senator Schumer?

Senator SCHUMER. Thank you, Mr. Chairman. I want to thank all of our panelists, and you, Mr. Chairman. This is extraordinary, what we are doing here, and I think it is great. But it meets an extraordinary need, so it is the right thing to do.

I would like to focus a little more on the public plan option. I guess I would sum it up. Some of you said you do not want the public plan to have an unfair advantage. I would agree. But just as bad as a public plan with an unfair advantage is a proposal with no public plan at all. I know my colleague from Kansas said people do not want the government involved.

Well, let me tell you, they have problems with the government sometimes, but they have a lot more problems with private insurance companies. The bottom line is, you need somebody who is not a private insurance company to be in the mix. There are many of us who feel very strongly about that.

We want to work with you—and I appreciated Ms. Ignagni's comments—to try and see that the playing field is level, because I do not think a public plan should have an unfair advantage. But it would be giving all of you in the insurance industry an unfair advantage not to have a public plan, particularly given the fact that in so many States we do not have real competition.

My State is one of the three that does. We have a lot of insurance companies fighting. But you look at the statistics—and no one has refuted them other than to say they do not believe them—and they are overwhelmed that you have two, three companies having the majority of the market.

Just one other point, then I want to outline something here and ask your thoughts. I met somebody years ago who was from the railroad industry. He said, one of the problems that the railroad industry had—he worked for the old New York Central—was that they did not know the cost it took to ship a car of coal from the Pennsylvania coal fields to Baltimore. So I began by asking, what is the cost of treating someone who has a particular condition, and who does it better, Medicare or private insurance? No one knows the answer. We can say, on this procedure Medicare pays less.

We might say, and I heard some of you say at our previous panel, that you folks, the private insurance industry, are more adept at figuring out who to use. But if you take two people who have, let us say, the same condition of tuberculosis, just to pick one, who are in decent health and they are both cured, who ultimately charges more for that being cured? No one knows the answer.

For anyone to say that we should not have a public plan when we cannot answer that question is just being, in my opinion, closed-minded because we do not know which one is better, at best. Some of us think private is better, some of us think—myself—public might be better. But no one knows. And to not have the competition the way the Chairman has set it up in the white paper and let them compete, I think, is closed-minded, maybe self-interested. Just as people should not say there should not be a private plan, I think it is just as unfair to say there should not be a public plan.

So I would like to focus on trying to make the public plan fair, if you will, so it is a fair competitor as opposed to having an unfair advantage. There are five or six points. I have put together a little document here that I will distribute, that talks about five or six points that might make it "fair." Even if it is not ideally what I would do, I am trying to get some kind of consensus here so we will have a public plan as competition.

We call our blueprint here Plan USA. It is a consumer-driven public health plan. I will get some details. This is just the public option. But here are some of the rules, and I would like to ask people what they think: (1) the public plan must adhere to the same rules as all other plans in the exchange. That includes actuarial reporting, community rating, and guaranteed issue; (2) the government should not serve as both the player and the umpire.

In other words, the public plan should not be administered by the same entity that runs the exchange; (3) the public plan must be self-sustaining, just as a private plan would have to be; (4) the government cannot use existing programs like Medicare as a stick to compel providers to participate in the public plan. The public plan must be required to provide the same minimum benefit design as the other insurers competing in the exchange; (5) government subsidies for low-income individuals must be uniform, whether they are public or private.

So those would be some principles to try to create a level playing field. But I have to tell you, the model that says we are not making a profit, that we are going to be automatically transparent, that we are going to provide, always, their recourse, should be in the mix.

All right. Who would like to comment? Ron Pollack.

The CHAIRMAN. Mr. Pollack, go ahead.

Senator SCHUMER. I am sorry, Max.

The CHAIRMAN. Mr. Pollack, go ahead.

Mr. POLLACK. It strikes me that there are three differences in terms of advantages and disadvantages, public plan versus private plan, one of which we talked about earlier today where I think your rules about having a level playing field make absolute sense. That is, what do we pay providers? To the extent that public plans pay less to providers, that should be changed. I think that is essentially what you are driving at when you are talking about creating a level playing field.

But there are two other ways in which there is a difference that tends to inure to the benefit of a public plan, and I do not think that is something we should try to avoid. One, is that there are certain expenses that are associated with a private plan that generally do not exist with respect to a public plan.

For example, private plans typically will do a whole lot more in marketing and advertising and paying agents' fees, and many of them are in the business for making a profit. Some are nonprofit entities. But that is an advantage. I am not sure we need to create a level playing field with respect to that.

And there is yet another difference where I also do not think we need to create a level playing field, and that is, a public plan is probably going to do somewhat better in terms of economies of scale. You are going to probably get somewhat larger enrollment in a public plan than you will in any single private plan, and that

achieves economies of scale. I do not think that is something we should discourage.

Now, it is interesting. We keep on talking about a level playing field, but we have seen something exactly the opposite with respect to the Medicare program. We do not have a level playing field. As we have learned from MedPAC, the payments to the private plans in Medicare Advantage are considerably larger than it would be for somebody who stayed in traditional Medicare.

So I think your principles make a great deal of sense. I think they address some of the kinds of concerns that we are hearing. But there are some benefits in a public plan which I think make sense to continue, and it deserves offering people that choice.

The CHAIRMAN. Who else wants to address Senator Schumer? Yes, Dr. Scheppach?

Dr. SCHEPPACH. Let me just say that unless you are willing to add a sixth point, which comes and forces the industry to publish prices and quality measures, I do not think you are going to go very far in terms of actually creating competition in these marketplaces. You may change a very little bit with respect to administrative costs, but that is it. You are not going to transform the system unless you really go to that other step.

Senator SCHUMER. Yes, we do that. I think Senator Baucus, in his exchange, involves that too and implies that as well. So, I assume there is going to be transparency.

Dr. SCHEPPACH. I am going to walk into a doctor's office, and on the wall, the prices are going to be listed?

Senator SCHUMER. Well, it is something to think about, sure. I would be happy to do that. The more transparency, the better.

Dr. SCHEPPACH. I am just saying, I think you need tehat for not only wehat you are buying in insurance, but what insurance is buying from labs, hospitals, and doctors. Until you are willing to make that step——

Senator SCHUMER. Just one of the goals of the public plan, which will have total transparency, is to see actually what is going on to begin to answer that question about the railroad car, if you will.

Dr. BUTLER. I think, Senator, you do raise exactly the kind of criteria that would have to be in place for people to be comfortable with the idea of a public plan. I think that, in itself, raises a question about, to what extent those are realistic criteria. For example, the one I particularly emphasize, you say whoever is controlling the public plan has to be a completely separate entity from those that are actually in some way setting the rules of the game.

Ultimately, of course, it is Congress who is going to be determining both. You are going to be responsible and have oversight over that public plan and over the rules. I think when you think also about, as you said at the very beginning, that it is very difficult to know exactly what the cost of something is and who is actually paying the bill for a particular procedure, it gets murkier and murkier to really imagine this level playing field, as you well know.

In this discussion of contracting out government services, for example, there are lots of questions about where the costs really are and what is actually cheaper. I think, as Mr. Pollack said, that one of the concerns with the Medicare program right now in terms of

the private Medicare plans is, are they overpaid? Did the previous Congress and the previous administration try to rig the game in favor of them? You can answer that either way, but at least that was a risk, which I think is a concern. So I think there are a lot of issues here that, in a broad sense, make it easy to say there have to be these criteria.

But then you have got to think, how does the political system actually deliver that? I think that is what the concern is and why I particularly favor the model you do have in the FEHBP, of saying let us keep everything private, let us have the government steering, negotiating, and so on, but do not mix up who has oversight over a particular plan.

Senator SCHUMER. But then you would be losing the goods and the competition that Dr. Pollack talked about.

Dr. BUTLER. Well, I think you can get at that in other ways. I think you have certainly a lot of competition in the FEHBP. I do not think you would argue that the FEHBP system that is devoid of competition or answerability or transparency, or that the government does not set reasonable rules, and so on. But it is very different from what you laid out as your plan.

The CHAIRMAN. Ms. Ignagni, you sought recognition, as have several others. This is an important question, so we will stay on it for a short while.

Ms. IGNAGNI. Thank you, Mr. Chairman.

Senator Schumer, we appreciate how thoughtful you are working to try to reconcile all these different views, so let me start there because it needs to be said. Second, there is a significant amount of capital requirments that we hvae to meet. Medicare would fail the capital test right now, so that is a very significant dollar figure that would have to be imbued into this plan, and I knowe you have thought about that.

The third issue is the payment issue, and that is where I want to spend a quick point here. Because right now, it would take a very long time for government to develop the infrastructure to negotiate with physicians. Government does not have networks, cannot put together networks. The disease management program failed in traditional Medicare, and we all know why, because there is no predictability with respect to who is coming in the doors of the physicians' offices, et cetera, et cetera.

So you would drop back, understandably, solving one problem by saying we are not going to use Medicare rates, say we are going to go to 100 percent just for purposes of discussion. So we go from Medicare paying 80 cents on the dollar on average, and will go to 100. So, it is still an administered pricing system.

Right now, and in our testimony we provided some California data, the one thing that should be done as part of health care reform, we should be able to have the same data we can get in California, and every State in the country so we know exactly what is being paid by the payor. So you see government, now, paying roughly 80 percent—a little less, on average—in California. The private sector is paying anywhere from 130 to 140.

So if you set up a new system where government is paying 80 and we are still subsidizing at the 130, 140, that immediately takes more people there, moving every employer, whether they are small

or large, using great economic sense to say, well, why do I have to pay that subsidy? It does not make sense. I am migrating to the plan. I want you to know that as we thought about our recommendations to this committee and this Congress, we did not rule out anything.

We looked at everything, which is why we have been so far-reaching in our market reforms, to try to create a situation that would solve the problems that consumers have, the trust factor. So again—you were out of the room—we are not asking people to trust us, but to trust government and to do that very transparently. You are talking about a lot of disclosure, you are talking abour rules. We are very comfortable with that. That is the way FEHBP works, it is the way Switzerland works, Germany, the Netherlands.

I think we could actually provide a great deal of help to the committee in structuring something that solves that trust issue. We accept that proposition. You are right, we need to do more, we have to have a complete overhaul of the rules, but I hope that helps give you a window into what we are very concerend about.

The CHAIRMAN. I see Dr. Nichols wants to speak and Mr. Castellani wants to speak.

Doctor?

Dr. NICHOLS. Just very briefly. First, Senator Schumer, I would like to applaud you on the principles that you outlined. I mean, if what Robert Pare wrote was half of what you have in mind, we are moving in the right direction here. I definitely agree that the key is, can we structure a truly level playing field so that competition would be fair? I think we are all in that boat. I think, in fact, what you have heard today is a lot of willingness to continue to think about this with you and others as we——

Senator SCHUMER. Which is very heartening. It is.

Dr. NICHOLS. But I would just say that I think it is unambiguously true that 34 States are doing something like this now. They manage to contract with providers, partly because they typically hire a network either that is already existing or they ask another health plan to help them go out and do that, and they basically piggy-back on the contracting that is there.

It is really kind of a daily make-or-buy decision, and 34 States have decided to keep that public option, that self-insured option alive and viable, not because States enjoy paying more for health care or because clearly States are not trying to drive competition away, they are trying to preserve that competition.

What I understand in my colleagues' comments is that they fear that government will allow the competition to be fair. I think it is kind of interesting, though, when you think about market advocates afraid of competition. The burden is on you, sir, and us to make sure that the public policy actually does create a level playing field and protect that competition, but it seems to me that commitment is very much part and parcel of where you are going. So, I applaud you.

The CHAIRMAN. All right. Mr. Castellani?

Mr. CASTELLANI. Senator, just a point or two. We share your concern in terms of what you are trying to accomplish and what this discussion is trying to accomplish. We want everybody to be covered. There is one rule that you did not include, and that is a rea-

sonable return on the capital that is employed by the taxpayers which the private sector has to provide in order to be viable and raise capital.

Our concern is, without that, which cannot be in a government system, you are going to have a public plan that is so attractive that we will lose a substantial portion of those people that we currently cover now and be left with a problem that is more expensive and unsustainable. That is the big concern. We would rather see that we can achieve the same thing through insurance market reform and then see who is not covered.

Senator SCHUMER. All right. Now, just a couple of quick points. I thank the Chairman for his indulgence. I know that you and Ms. Ignagni and others have a lot of faith in market insurance reform and that these rules can make everything work. There are many of us, both on this side of the table and that, who are not so sure it does. The present system—admittedly imperfect—has not proven that by any stretch of the imagination, although I would admit that some progress has been made.

The second point I guess I would make to you is, we do not want the public plan to be exactly the same as the private plan. There are certain advantages that the public side has. There are also certain advantages—we have heard it from many of the private side people, the gentleman from the Blues, Ms. Ignagni, and others—over the public. They do it more efficiently.

In Medicare, as I said, the cost may be less for the specific service or the specific visit, but the private sector will claim, we get you to the right person more quickly so you do not have extra things that you do not need. The private sector will still have that in this competition. It is sort of as if you are saying, well, the public advantages we should get rid of, but the private advantages we should keep. Let them compete.

I do think, Mr. Chairman, we will sort of move to have the private sector be required to do some public goods, to put some public goods into the way they operate, and the public plan required to put some private goods into the way they operate, but it is still a real competition that could show us something because, frankly, the first thing I learned when I started studying this—and I do not know close to as much as the Chairman, or Senator Wyden, or Senator Stabenow, who have studied this for so long—that we do not have all that much information.

Again, it is confounding to me that while we can measure little, discrete parts, we do not know whose coverage is more cost-efficient. The only way to find it out is transparency, which a public plan will bring about, although you probably could put in transparency, I would say to the NGA gentleman, without it. But it is much better to have it with it. But there is also competition to find out. The private sector will have some advantages, and we cannot just get up and say, well, the public advantages we should get rid of in this competition, but the private sector advantages we should not.

To Ms. Ignagni's point, yes, a good public plan, our Plan USA, would have to make some investments. They would not have profits and they would not have marketing, but they would sure have

to make some investments in paying systems and IT and things like that that you would have already done.

The CHAIRMAN. All right. We have to move on here.

Senator Wyden?

Senator WYDEN. Thank you. Thank you, Mr. Chairman. Just one last topic, and I will be quick. The most heart-wrenching health care coverage in this country for families, the most heart-wrenching issue, is end-of-life care. We saw that during the Terry Schiavo debate. I went to the floor of the Senate and said, I am objecting here. I do not want the U.S. Senate to become a medical Court of Appeals.

I think I will start with you, Ms. Hansen, on this. There are a host of issues that relate to policy. AARP has been interested in an area that a number of us care about, the idea that you would not have to give up the prospect of a cure in order to get hospice care. I think we will have support for that. But the big issue is the ethical framework for dealing with these very tough end-of-life issues.

I think what the country said during that Terry Schiavo debate is that families want to be able to make the choices themselves rather than to have government drive those decisions. As we move to the end of this discussion, can you give us your thoughts with respect to what you think the ethical framework ought to be for end-of-life so that particularly we can empower people so they will get the sense that they get to make the choices, these very difficult choices, rather than to have the government and Washington, DC dictate instructions to them?

Ms. HANSEN. Well, thank you, Senator. This is a significant, both personal individual family issue, but it is also a cost issue to society. I think one of the things that we encourage, and it is an initiative on which I know we have some support, is the ability for families to talk about this early on and have some clarity of what their wishes are and have that kind of establishment.

So having a framework that allows that kind of guided discussion at a time that is not an emergency—these emergencies occur and what happens is, there is no ethical framework, there is an action framework. The framework is to get into the care system and get many services, and oftentimes in a situation where there really is not great quality of life. The angst that family members go through is a major issue. So, I think one of the frameworks is discussing what regular people want to do.

We have research to show that the majority of people probably, if they could not achieve their level of performance or competency at a certain functional level, oftentimes want more supportive, palliative care. That actually is what would be more ethical, both for the individual and for society, so that we do not end up spending what amounts to, as shown in the study by Hogan in 2001, one-quarter of Medicare spending on end of life issues.

So if we could do it from a personal value discussion early on and have some tools for physicians and others, it would make a huge difference for individuals, for families, and for practitioners who do not get caught in a legal battle at that partiuclar time, which adds to cost, and it creates, oftentimes, services of suffering, frankly, that are not right for people if we had a better framework early.

Senator WYDEN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

I have got a question, a transition question. I think a lot of members of Congress are going to be quite concerned about the impacts of policies we are discussing today on their own States, especially their insurance commissioners in their States generally.

In my State of Montana, for example, we have no regulation of the individual market, none. There are many States in that same situation. As we implement an exchange in which we will make certain decisions, that gets into questions of design, for example, and benefits, the question is, how do we transition here?

I would just be curious as to what some of the States' reactions would be. About 14 percent of Montanans purchase coverage through the individual market and half of those are between 19 and 29 years of age. About 76 percent of the young people in Montana are below 400 percente of poverty. That is going to have certain impacts on States, too.

I also want to talk a little about rating, community rating or rating bands, because the thought is that insurance companies cannot deny coverage based on health status or preexisting conditions. I guess the next question is about rating, community rating and rating bands. Maybe the Federal Government sets some basic parameters, but then States can then implement that, those State bands, whatever the bands are. That begs the question: what should the bands be? But then there is the question of, how do you avoid redlining?

What happens if we delegate to States the authority to set geographic boundaries within States, say, how do we make sure that there is no red-lining? I know those are a lot of questions, but the basic question is, as we transition, what is the proper way to transition and what should the role of States be, and how do we deal with some of these questions that I just raised?

I am going to ask Ms. Praeger, first, to answer that question.

Ms. PRAEGER. Thank you, Mr. Chairman.

The CHAIRMAN. Both questions. Sorry.

Ms. PRAEGER. As I mentioned earlier, I think allowing the States to retain the authority to regulate and to transition from rating bands or modified community rating, whatever system they currently have. If they have no rating rules, the impact of imposing those is going to be more dramatic, especially on younger, healthier individuals, and of course it is going to benefit those older individuals who currently are paying more.

So transitioning in and eliminating those current rating systems over a period of time and perhaps allowing for, still, age rating and family status—I mean, I think those are appropriate rating methodologies to have in place, getting away from rating based on health status. But even with age, I would encourage the committee to think about beginning at a 5:1 and gradually transitioning down to a tighter rating band on age.

We do not want to negatively impact those younger, healthier individuals who currently may not be paying as much, if they are in the system at all, but if we have an individual mandate, require that they come in. These are people just getting started in their careers. They are not making the kinds of incomes that perhaps some of the older population is making.

So allowing for some transitioning in is important, especially for age factors. I think you want to keep some system of age rating in this, especially in the individual market. If we are going to bring young people in there have to be some advantages for their younger age and healthier, in general, status. So, transitioning over time I do think if we get rid of health status, which I think would be a very important step in health reform, you have to have a mandate that everybody have coverage. Otherwise there is too much opportunity for gaming.

The CHAIRMAN. Mr. Claxton, could you answer that, please?

Mr. CLAXTON. Surely. The kinds of reforms you are talking about for the non-group market are really quite transformative because you are not only changing the insurance rating rules, you are putting in substantial subsidies.

The CHAIRMAN. Correct.

Mr. CLAXTON. You are talking about changing the level of coverage.

The CHAIRMAN. Correct.

Mr. CLAXTON. There are probably more uninsured people who will come into this market than there are existing market participants, so you really have to think about, during the transition, what kind of market are you providing for all of these new people who are getting subsidies, as well as what are you doing for the people who currently have coverage?

One way you could think about it is for all the people who are coming into the market with new subsidies and for the people who are in the market now who might want to move because they will get some subsidies, they might want to find better coverage than they are able to get today, let them come into a new market that has the exchanges you have laid out, that has no health status rating.

For the people who now have insurance that they like, which might be much cheaper because they have very high deductibles or because they were underwritten and so they are healthy, and where the rate impact of the reform market would be a fairly big impact on them, let them keep their own policy in sort of a grandparenting idea for a while.

You could let the State determine how long that is appropriate. Then gradually transition them into the new benefit standards and the new rating standards. You are still probably going to have plenty of people in the market because the subsidies and the encouragement of the requirement to have insurance is going to bring a lot of new people into the market. You want to have a place where they can buy in in the competitive system you have been talking about.

Senator WYDEN. Mr. Chairman?

The CHAIRMAN. Just a second. Mr. Scheppach, I wanted you to answer first.

Dr. SCHEPPACH. Yes. I think you have got to think in terms of a 5- to 7-year period, not only for the transition in terms of the market reforms, but I think it will take time—Medicaid probably should be phased in over a period of time so that you move up to 60 percent of poverty, 75 at certain particular dates until you get up to 100 percent. I think in terms of State alliances it is probably

important to bring in the individual market and the small firm market first, then perhaps your subsidized other population. You probably ought to give States some flexibility at some point to bring in the Medicaid, or portions of the Medicaid population, State employees, and then other firms.

We are beginning to put together a plan but it would involve some up-front planning money, some certification by Governors when they believe that the systems are ready for enrollment. But as indicated, I think we are going to have to think in terms of a 5- to 7-year period to do it efficiently.

The CHAIRMAN. Senator Wyden?

Senator WYDEN. Mr. Chairman, I think you are exploring a very good area and I just wanted to see if I heard something right. Ms. Praeger, did you say that in the transition you could allow seniors to pay up to five times as much as younger people? I was not sure if I heard it right, and if I heard it right, then obviously Ms. Hansen's stomach lining is going to be bubbling here. I think the Chairman is asking a very important issue, and I want to work with the Chairman on it.

The transition area is invariably where things blow up, so if you could just kind of unpack this and make sure I even understand it. If you are talking about what I thought I heard, then I think we probably would all benefit from hearing from Ms. Hansen. So, take us through it.

Ms. PRAEGER. Currently, I would venture to say the age rating, in the individual market especially, is higher than 5:1, so this would be, even at a 5:1, an improvement. I just think it is important in the transition to recognize the winners and losers that you are going to create when you require everyone to have coverage. I think you can go to 3:1. You will be requiring, then, those younger, healthier individuals to pay more. If they are currently in the market they will be paying significantly more than they currently are.

Senator WYDEN. It does not have to be that way. I think that is what we are going to all be working for, and I think the Chairman is right to be asking this question.

The CHAIRMAN. All right. Does anybody else want to address the question I asked? Yes, Ms. Rowland?

Ms. ROWLAND. Mr. Chairman, I think it also involves who you put into that individual reform market and who you do not. So if you look at the lowest-income population, people below poverty, significantly higher amounts of chronic disease and illness, which would in fact drive up the costs in the new market.

So during a transition, I would urge that you build on the appropriate coverage that is already available through Medicaid for the lowest-income populations so that at least the population in poverty during a transition is not put in and added on to the complexity of building the new market.

The CHAIRMAN. All right.

Dr. Nichols?

Dr. NICHOLS. Mr. Chairman, I would just respectfully add that, in addition to all of the good advice you have just gotten, the most important thing in a transition is to define where you are going because it turns out, if you lay down the market and say "this is where we are going and we are going to all get there as gently and

as wisely and humanely as we can," you will be amazed at the private sector's inventiveness in getting you there faster, but you have got to specify.

The CHAIRMAN. Good point. Good point.

Ms. Ignagni?

Ms. IGNAGNI. Yes, sir. Thank you. I was going to make exactly that point. I also think, to Senator Schumer's point, if we are going to hit the mark on trust, varying this State to State is not going to leave people satisfied. So the rules of the road should be established uniformly across the country, and 30 States have nothing at all right now, as Ms. Praeger observed, and so we would want to avoid rate shock.

We have a number of ideas about how to vary subsidies, how to get people to that end point sooner rather than later, and we have begun to share them with the staff. We would be happy to talk more about that.

The CHAIRMAN. All right. It is interesting, this whole conversation. It has been assumed—I think it has been assumed—that everyone agrees that everyone should have health insurance and there should be an individual responsibility on the individual that every individual must have health insurance. If anybody disagrees, I would like him or her to speak up now.

[No response.]

The CHAIRMAN. I think that is agreed to unanimously all the way around. Most of us who think about this subject do believe that.

I have another question about benefits and benefit design. Who in the world is going to put this package together and what is going to be in the package? There are a lot of trade-offs there. One question is, who decides? There are some over the last couple, three years—more than that—who have suggested some kind of a medical board that will make some of these decisions to insulate members of Congress from the onslaught from every group under the sun that wants to be covered and design the package. Others say, no, no, no, no, that is too much big government, that is socialism, and so forth. We cannot let that happen. Which means if we go down the latter road, I guess maybe Congress is going to decide what is in the benefit package, just lay it out.

So I would like someone to give us some suggestions, some ideas on who decides and how those decisions should be made. Ms. Rosenbaum?

Ms. ROSENBAUM. Thank you, Mr. Chairman. I think that because the question of insurance benefit design is so complex, as there are 9 or 10 moving parts to just the question of how the coverage operates, I think that it is very important for Congress to set a topmost direction. If you look at Congress'——

The CHAIRMAN. What do you mean, "topmost direction?"

Ms. ROSENBAUM. In other words, there are certain, as Ms. Ignagni has talked about, rules of the road that I think Congress must address. For example, there may be certain parts of a benefit design that you allow the concept of actuarial fairness to apply to, or actuarial substitution.

There are other parts of benefit design that serve such an important public health/health care/social function that even if portions of a benefit package can vary in the implementation by what is

paid for by variable cost sharing, by the range of covered procedures that will be recognized, there are certain bottom lines that I think only Congress can set.

So, for example, whether or not, in making decisions about what is in and what is out of benefits, insurers have to use a standard of coverage for children that prohibits them from discerning between children with developmentally-based conditions and children with acute-onset conditions. It is something that only really, I think in the end, Congress can say whether or not there will be a range of coveraged benefit classes as opposed to simply medical care, hospital care, ancillary services.

The CHAIRMAN. Right. Right.

Ms. ROSENBAUM. That is what is important. So I think it is those top levels of decision-making that are very important for Congress to make, as has happened over the years with Medicare and Medicaid, then a very large delegation of powers, either to the Secretary in the case of Medicare, or to the States in the case of Medicaid, to fill in a lot of the detail.

The CHAIRMAN. Who else wants to address design package and how that decision is made? Mr. Stern?

Mr. STERN. I would just say, there is both a question of policy and politics.

The CHAIRMAN. Right.

Mr. STERN. And I think we do better on policy than politics if we keep it out of this august body's decision-making process, so I am in for subcontracting the decision to anyone other than people here, because I think it is an incredibly important decision and politics should not play a significant role in it.

The CHAIRMAN. Dr. Butler?

Dr. BUTLER. Well, I sort of agree with that, although maybe with a slightly different way of approaching it. I certainly think it would be very dangerous to get into the business of detailed benefit packages, either by the Congress or by in some way delegating that to some body, like a board, that you do not have any control over. If you did have control over that board you would be ultimately setting that anyway, but another approach might be what you do under your own system, which is to set very broad categories of benefits.

I would certainly include, obviously, pharmaceuticals in addition to what you have under the FEHBP, to say, well, we will set these broad categories. We may insist on some very minimum, very specific things that anybody can agree on, and then to use an actuarial test in terms of saying, well, is it actually insurance? Is it really protecting people in a financial way?

I think that is another way of going rather than trying to wrestle over who is going to make very detailed decisions over what I have to have, or somebody else has to have. I think as you try to do that and you try to pick somebody, you are not going to find anybody that everybody in this room would agree on.

The CHAIRMAN. Mr. Pollack?

Mr. POLLACK. There are many layers to this question. I want to pick one of them. That is, I think where Congress really needs to play a more active role is on the question of out-of-pocket costs and what the limits are. I would separate two different things, what is

in the benefit package and what kind of cost sharing are people going to have to experience with respect to the benefit. It is my hope that Congress plays a more robust role with respect to the latter so that it protects the affordability, particularly for populations that currently cannot afford health care coverage.

With respect to the former, those are decisions often left to scientific analysis, and I think that is best left outside of the hands of the Congress and left for an administrative body.

The CHAIRMAN. Dr. Nichols?

Dr. NICHOLS. Mr. Chairman, I would certainly echo what has been said, but I would also say there are two dimensions of affordability: one is for people and the other is for all of us, for the government. Your happy task in this committee is to weigh those two. So I would submit, in a sense, to agree with Sara, what you have got to do is pick a level. I would say something like the Federal employees' plan, or some percentage of that, but then leave the details to, I would say a combination of a delegated body, the industry.

Then remember, at least I think what your white paper envisions and what a lot of us are assuming will come to be, an exchange, or maybe a bunch of exchanges, maybe exchanges in different States, whatever. Those marketplaces will have at some level executive directors, board of directors. They will have people who will make decisions about what is appropriate to be sold in this place. That is where I think the industry input, the analytic input. But, your actuarial value pick will then be determinative and prevent the kind of things we are talking about. I take Ron's point, it would be smart to do both cost sharing and benefits separately.

The CHAIRMAN. You think basically, to use your words, some actuarial value pick?

Dr. NICHOLS. I think that is the right thing for you to—you have got to decide how much we can afford, sir, as a Nation, and then other people can go make it so.

The CHAIRMAN. So business today is—what, 73, 75 percent of health care costs are picked up by insurance? Is that right, Mr. Castellani?

Mr. CASTELLANI. Yes.

The CHAIRMAN. Is that in the ballpark actuarial value——

Dr. NICHOLS. Well, I think you would have to take it to a specific policy that they can write down and you have got to pick a number. You have got to say 100 percent of FEHBP, Blue Cross Standard, or 70 percent of that, or 120 percent of that, or something concrete, and then they can go make it happen.

The CHAIRMAN. Mr. Serota?

Mr. SEROTA. I guess, Senator, my comment in this regard would be that an appropriate role would be to set a minimum benefit package, and if we have effective transparent State-level insurance marts, the ability for individuals to purchase greater benefits, then that would be transparent and the benefits would be clearly articulated in the marketplace so everybody would understand what they were buying and what they were getting. But, there would be a minimum that everybody would be required to, or encouraged to, whatever words we want to use, to purchase so we had uniform, universal coverage that was meaningful in the marketplace.

But as long as we are transparent in what the benefits are, and it is clearly articulated in a State-level insurance mart, I think people can make choices about the trade-offs that they want to make with regard to their coverage.

The CHAIRMAN. Well, I am going to wrap up here, but I want to thank all of you very, very, very, very much—unless Senator Wyden has more questions—for your extraordinary contribution and for your extraordinary patience. This has been an extremely important subject. It is really complex. We are all kind of delving into the briar patch to try to figure out the answers to all this. But I want to thank you all very, very, very much.

Senator Grassley has some questions that were submitted for the record, Senator Nelson did as well.

[The questions appear in the appendix.]

The CHAIRMAN. Before we do wrap up, because of the kind of unruly nature of all this today, does anybody have something to say that he or she feels must be said? That is, did somebody say something so outrageous that it deserves a response? Is there some little nagging thought in the back of one of your minds that you would like to say at this point? I am open. I mean that.

Yes, ma'am?

Ms. HANSEN. Yes. I just wanted to pick up where Senator Wyden said I might have stomach churn.

The CHAIRMAN. Yes. I caught that, too.

Ms. HANSEN. Yes. I think the importance of—again, if we all agreed that we want health insurance coverage, we cannot be penalizing people for the fact that they happen to be at an older age or the fact that there is a natural kind of life-cycle change that you have conditions. So we are looking to your leadership as an entire leadership team to understand, again, what the benefit package is, and meaningful affordability and benefits combined together. Thank you.

The CHAIRMAN. Thank you very, very much.

I see Mr. Castellani. All right.

Mr. CASTELLANI. Senator, in the thinking, there are some of us here that have worked a long time. Everybody here has worked a long time to make it safe for the U.S. Congress and the public policy process to come back and address this issue. So on behalf of those of us, we want to thank you, this committee, and the leadership that you have provided for taking on this very important issue and driving us toward it.

The CHAIRMAN. Well, thank you very much for that statement. Clearly we are all in this together, so it is for all of us to find a solution.

Thank you all very much. The hearing is adjourned.

[Whereupon, at 1:18 p.m., the roundtable was concluded.]

ROUNDTABLE ON FINANCING COMPREHENSIVE HEALTH CARE REFORM

TUESDAY, MAY 12, 2009

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The roundtable was convened, pursuant to notice, at 10:06 a.m., in room SD–106, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Conrad, Bingaman, Lincoln, Wyden, Schumer, Stabenow, Cantwell, Nelson, Carper, Grassley, Hatch, Snowe, Kyl, Bunning, Crapo, Enzi, and Cornyn.

Also present: Democratic Staff: Russ Sullivan, Staff Director; Bill Dauster, Deputy Staff Director and General Counsel; Liz Fowler, Senior Counsel to the Chairman and Chief Health Counsel; and Cathy Koch, Chief Tax Counsel. Republican Staff: Kolan Davis, Staff Director and Chief Counsel; and Mark Hayes, Republican Health Policy Director and Chief Health Counsel.

Panelists:

Stuart H. Altman, Ph.D., Sol C. Chaikin Professor of National Health Policy, Heller School for Social Policy and Management, Brandeis University, Waltham, MA;

Joseph R. Antos, Ph.D., Wilson H. Taylor Scholar in Health Care and Retirement Policy, American Enterprise Institute, Washington, DC;

Katherine Baicker, Ph.D., Professor of Health Economics, Harvard School of Public Health, Cambridge, MA;

Leonard Burman, Ph.D., Director, Tax Policy Center, Urban Institute, Washington, DC;

Robert Greenstein, Ph.D., Executive Director, Center on Budget and Policy Priorities, Washington, DC;

Jonathan Gruber, Ph.D., Professor of Economics, Massachusetts Institute of Technology, Cambridge, MA;

Michael F. Jacobson, Ph.D., Executive Director, The Center for Science in the Public Interest, Washington, DC;

James A. Klein, President, American Benefits Council, Washington, DC;

Edward Kleinbard, Chief of Staff, Joint Committee on Taxation, Washington, DC;

Gerald M. Shea, Assistant to the President for Governmental Affairs, AFL–CIO, Washington, DC;

John Sheils, Senior Vice President, The Lewin Group, Falls Church, VA;
Gail R. Wilensky, Ph.D., Senior Fellow, Project HOPE, Bethesda, MD; and
Steven E. Wojcik, Vice President, Public Policy, National Business Group on Health, Washington, DC.

[The prepared statements of the panelists can be found in the appendix.]

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will come to order.

Before we get started, I want to say a few words about hearing each other out. The reason we are getting together here today is so that we can hear each other out. This works because we treat each other's views with respect. I respect the views of everyone here, including everyone in the audience. And that respect, in turn, means listening and not interrupting when others are speaking. I sincerely hope that everyone here today, including our guests—especially guests in the audience—will afford these proceedings with that level of respect.

The novelist Edith Wharton said, "The only way not to think about money is to have a great deal of it." Today we host the third of our three roundtable discussions on health care reform. This one thinks about money. With any luck, we will have a great deal of it.

This roundtable discussion will preview many of the revenue and savings options that the committee will consider in a walk-through session next week, heading into our mark-up next month. The committee has spent a good deal of time laying the groundwork for comprehensive health care reform. We have discussed days to reform the health care delivery system, we have talked about ways to provide health coverage to all Americans. Now it is time to think about money. It is time to talk about how to finance health care reform.

I am committed to comprehensive reform of our health care system, but I also recognize that we need to pay for it. The proposals that we have discussed in our previous roundtables and the walk-through will not come easily and the reforms we are planning will not be cheap. But Americans already spend $4.5 million on health care every minute of the day; that is $2.5 trillion a year. Without reform, over the next 10 years, America will spend more than $33 trillion on health care.

The Federal Government alone spends nearly $700 billion a year on Medicare and Medicaid, and the Federal Government forgoes almost $300 billion a year in Federal tax revenue and health care tax expenditures. The costs of health care are high for families, for businesses, and for the Federal Government and States alike. To make the system more affordable and provide coverage for all, we need to look at where we spend money on health care today. When it comes to the government, we need to look at both spending and tax expenditures.

The first place we should look for savings is within health care itself. We should reform the health care delivery system to bring

higher quality and greater efficiency to all Americans. We discussed a range of reforms during the walk-through on delivery system reform, and we will discuss additional savings options today. We should also look at the current tax treatment of health care. I know that there is some controversy about doing so. Some do not want to modify the current unlimited exclusion for employer-provided health care, and I agree that we are not going to eliminate that exclusion.

But the current tax exclusion is not perfect. It is regressive and often leads people to buy more health coverage than they need.

[Applause from the audience.]

The CHAIRMAN. We should look at ways to modify——

[Applause from the audience.]

The CHAIRMAN. We should look at ways to modify the current tax exclusion so that it provides the right incentives, and we should look to ways to make it fairer and more equitable for everyone.

We also need to look at other tax benefits for health care. Among these are tax-preferred health savings accounts and the itemized deduction for health expenses. We should try to make sure that those benefits are structured fairly and efficiently. Because of the cost of comprehensive health care reform, we will need to look at other options among those as the President's proposal to limit itemized deductions. All of these ideas deserve close and careful scrutiny and discussion.

Finding money that we can all agree on will not be easy, but few worthwhile things are. Achieving comprehensive health care reform is important enough that we must find a way to succeed. This roundtable will begin the discussion of how we can responsibly finance health care reform.

At next week's walk-through we will look at the menu of options for financing reform. We need to keep all the options on the table and everyone has to give and take to make this work, and I hope that my colleagues here will keep an open mind as we start this discussion.

Together we can find the money that we will need to finance comprehensive health care reform. It will not be easy. This roundtable is an important part of those discussions. Each of our participants today brings an important voice to the discussion; they are experts, stakeholders, or both. Once again, forgive me for not taking the time to introduce every participant. We have, however, distributed a biographical sketch and a brief statement for each participant.

As we did before, we gave each participant and Senator some questions that will help start a dialogue, and beyond that, I look forward to a very fruitful discussion. So let us get started. Let us see if we can advance the effort of comprehensive health care reform.

Senator Grassley?

[Interruption from the audience.]

The CHAIRMAN. The committee will be in order. Comments from the audience are inappropriate and out of order. Any further disruption will cause the committee to recess until the police can restore order.

[Interruption from the audience.]

The CHAIRMAN. The committee will be in order. The committee will stand in recess until the police can restore order.

[Interruption from the audience.]

[Off the record.]

Senator GRASSLEY. Mr. Chairman——

[Interruption from the audience.]

The CHAIRMAN. The committee will be in order.

[Interruption from the audience.]

The CHAIRMAN. The committee will stand in recess until the police can restore order.

[Off the record.]

The CHAIRMAN. Let me just speak a few minutes.

[Interruption from the audience.]

The CHAIRMAN. Sorry. The committee will be in order.

[Interruption from the audience.]

The CHAIRMAN. The committee will recess until order can be restored. The committee will be recessed until the police can restore order. Will the police please come more expeditiously?

[Off the record.]

[Interruption from the audience.]

The CHAIRMAN. The committee will stand in recess until the police can restore order.

I will say to everybody else out in the audience who may be similarly inclined, believe me, we hear you. We deeply respect the views of everyone here. We have got an extremely open process, and I just urge everyone to respect the views of others by not interrupting those who are speaking. There will be plenty of time to meet with everybody. This is a long, involved process.

So those of you in the audience who are not panelists and wish to be heard, I urge you just to contact my office and we will figure out a way to talk to you. I will figure out a way to listen to you. I will be there personally to listen to you. So I urge you to take that option rather than to interrupt and be rude to our panelists here, who have come a long distance and spent a long time trying to make very thoughtful presentations to the committee. But I will meet with anybody who wants to meet with me. All right.

Senator Grassley?

OPENING STATEMENT OF HON. CHUCK GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. Right or wrong, politics often is driven by polls: some follow them and some do not. I will bet if you polled every member of Congress, asking them what they think would be the hardest part of health care reform, they would probably say something like we are doing today, trying to figure out how to pay for it. If I were asked, I would say something along the same lines.

So here we are, Mr. Chairman, as the top tax writers of the Senate. It appears that we have our work cut out for us. I thank you for your leadership in trying to answer this tough question.

To start this important process, I have some questions of my own: what are the most appropriate financing tools available to us? Should we look at non-health related measures or should we stick to health-related measures? Consistent with our interests in looking at all of the options out there, I think it is appropriate to look

at both. But I will emphasize that I do not agree with all the non-health related measures that we will be examining, and some of those have been put forth recently by the President, but this does not mean that we cannot talk about them.

Yesterday, we had a White House gathering between the White House and industry folks that would lead some to believe that we do not even need this roundtable. Our money problem is somehow solved with $2 trillion of savings from better efficiencies and so forth. While I am sure that we will be waiting for some time before this fairy dust becomes real gold, the Washington Post mentioned similar promises were made in the 1970's. But look at what it got us: not much.

But the meeting yesterday does emphasize something that I wanted to emphasize. President Obama is going to be a key player in health care reform. I guess he has to be because it is this sort of leadership that is going to help us find a way to pay for health care reform.

For example, Mr. Chairman, there are maybe some financing measures that the Senate may agree on, but we have found evidence that there is a great difference between the House and Senate on how you might pay for them, so it may come down to presidential leadership.

The President's leadership is not only essential in finding ways to pay for health care reform, but the President's leadership is going to be key to health care reform generally. So, I thank you for this important meeting and I look forward to our expert panelists in helping us solve some of these problems.

The CHAIRMAN. Thank you, Senator.

I am going to just recognize Senators as they seek recognition. There is no early-bird rule here today. So when any Senator wants to speak or ask a question, just raise your hand. The same goes for panelists. Some panelists may want to jump in and say something. Maybe—perish the thought—some Senator said something that deserves a response. So, feel free to take advantage of the opportunity. Just raise your hand so I can recognize you so that you can proceed as well.

Senator GRASSLEY. I would lead off, Mr. Chairman, if you want me to.

The CHAIRMAN. Go ahead.

Senator GRASSLEY. All right. IRS has historically granted tax exemption to hospitals because they operated for the benefit of the poor. Over the last 40 years, with the creation of Federal and State insurance programs such as Medicare and Medicaid and the growth of private insurance, it has been increasingly difficult to distinguish the activities of for-profit hospitals from the activities of charitable hospitals.

It appears that tax-exempt hospitals are more likely to provide services for those with insurance than for the poor and indigent. Federal tax breaks for charitable hospitals amount to billions of dollars each year and include Federal income tax exemption, as well as the ability to raise capital through tax-exempt bonding and financing of charitable hospitals.

So, a series of questions along this line to Mr. Kleinbard, or Mr. Elmendorf, or Mr. Burman, or Gruber, or anybody that wants to

jump in. If, as a result of health care reform, everyone has health insurance, presumably hospitals should see a steep decline in, or the elimination of, uncompensated care. This trend appears to be occurring in Massachusetts. Given this trend, does it make sense to retain tax-exemption for hospitals?

The CHAIRMAN. Who are you going to address that to?

Senator GRASSLEY. Well, I suppose Mr. Kleinbard would be one to address it to.

The CHAIRMAN. Kleinbard?

Senator GRASSLEY. Kleinbard.

Mr. KLEINBARD. Senator Grassley, thank you. There is some good data that has been developed by the Congressional Budget Office and by the Internal Revenue Service. Those data are consistent with the point that you have made, that charity care within nonprofit hospitals receiving tax-exempt status is only about one-half of 1 percent greater as a percentage of revenues than is the case for for-profit hospitals, so about 4.7 as opposed to 4.2 percent.

That would suggest as well that if coverage becomes broader and broader, the number of uncompensated care cases will go down. Therefore, if you were to choose to retain tax-exempt status for hospitals, you would need, I think, to ask the question, what is the mission that makes those tax-exempt entities unique? Could that mission be repurposed?

Today, the value of the tax-exemption, all aspects of it, we outline in our pamphlet, runs in the neighborhood of $6 billion a year. So the question would be, are there other charitable purposes beyond the so-called charity care case to which the tax-exempt institutions could be directed as the condition of their tax-exempt status?

The CHAIRMAN. Dr. Gruber, you are raising your hand there.

Dr. GRUBER. Yes. I would like to speak to the experience in Massachusetts where, you are exactly right, Senator, that we have seen a large decline in our uncompensated care since our health reform law was passed. I very much agree with the spirit of the question that this raises, the question of the mission of nonprofit providers and what role they play.

I will say that there will be, under any reform, some remaining need for uncompensated care. About a third of uncompensated care today goes actually to the insured who do not pay their co-payments or deductibles, and the number of uninsured is not going to go to zero; it will not in Massachusetts, it will not in the Nation as a whole.

So I think we can definitely move to a more rationalized system, but it has to be a system that recognizes that there will still be some need for uncompensated care, even in a universal coverage world.

The CHAIRMAN. Might I ask, so how much will nonprofits make up with losing uncompensated—let us say we had universal coverage. One-third of uncompensated care, as you say, are insured, and other people get paid. Assuming we had universal coverage, how much would hospitals save? Maybe Mr. Kleinbard or somebody has a figure. Do we have a number on how much that would be, roughly? Dr. Altman?

Dr. ALTMAN. Well, there is a tremendous variation in the hospitals' use of uncompensated care. Many of our public/private hospitals can have 12, 15 percent; the average is much closer to 4 percent, 3 or 4 percent. So I think the issue here is going to be, for the average community hospital, the uncompensated care, as I said, runs between 2 and 4 percent of their revenue, but for some it could be 15 percent.

So the issue is not going to be that part, it is going to be the extra payments that we now give these institutions, disproportionate share. Those, I do agree with Senator Grassley, we need to substantially look at it. But I would argue, for what it is worth, that the benefit of the hospital deduction gives community benefits far in excess of just the issue of uncompensated care. So just like for educational institutions, I think it would be a mistake to totally wipe it out, but we can substantially reduce it.

The CHAIRMAN. Dr. Burman, are you seeking recognition?

Dr. BURMAN. Yes. One aspect of tax-exempt hospitals is that they qualify for tax-exempt bond financing, and that is a really inefficient way to subsidize anything. A large share of the benefits actually goes to the bond holders rather than to the entities that are issuing the bonds. So it would certainly make sense to rein that in or convert it into some kind of direct cash subsidy, in which case you could target it to the places that need help.

The CHAIRMAN. Dr. Wilensky?

Dr. WILENSKY. I would like to continue the targeting notion. I agree with the comment that no matter what expansions in coverage we have, there will be some people who will slip through the cracks and remain uninsured. The question is whether or not we would be better served to use the safety net hospitals, the public hospitals as the providers of last resort and otherwise use more targeted subsidies if there are specific functions we would like hospitals to take on. But the mass tax-exempt for all nonprofit hospitals seems to be reflective of an era that has long since lapsed.

The CHAIRMAN. All right. One more on this subject, Mr. Shea? Then I have a little bit of business to conduct.

Mr. Shea?

Mr. SHEA. Thank you, Mr. Chairman. I think the overall point that the difference between for-profit and nonprofit hospitals has been shrinking, as Dr. Wilensky says, it was a different era, is absolutely true. The distinctions you see today mostly, or generally, is between public hospital provision of uncompensated care and private, whether they are for-profit or nonprofit. However, as others have said, this is not all the same and there are some nonprofit hospitals that still adhere to the basic mission of providing care, regardless of whether or not people have the ability to pay.

But let me just make a point that has not been made here on this, which is, we are concerned about the destabilizing effect of this kind of tax change at the same time as we are asking enormous change from the hospital industry in terms of restraining cost. I would suggest to you, we ought to focus on that and later, perhaps, once we have universal coverage, look at this question and not try to do the two things together.

The CHAIRMAN. Why? Why not together?

Mr. SHEA. Because I am afraid it really would destabilize the basic delivery system.

The CHAIRMAN. All right. I appreciate that.

[Whereupon, at 10:25 a.m., the meeting was recessed to enter into executive session.]

[After Recess—10:27 a.m.]

The CHAIRMAN. Senator Bingaman, I think you were seeking recognition.

Senator BINGAMAN. I wanted to ask, one of the obvious issues we are going to have to make a decision on is whether or not to deal with this employer exclusion as a way to help pay for health care reform, whether to cap it, whether to deal with it at all, eliminate it. I would be interested in any of the witnesses giving us their views.

I know this is an interesting issue. The President has not endorsed this. I believe Senator McCain did strongly endorse it when he was seeking the presidency, so I am not sure where the politics of this issue are, but I would be interested in whether or not it works.

Mr. Klein?

Mr. KLEIN. Thank you, Senator. My thanks to the committee for the opportunity to be here on behalf of the American Benefits Council.

I think that, speaking on behalf of our members, we believe that the exclusion, which is really an employee exclusion, is fundamentally important in order to maintain, and hopefully expand upon, the employer-based system.

In answer to your question, I have to take issue with one point that the Chairman noted in his opening remarks, in saying that this exclusion is somehow regressive. In fact, I think we would be hard pressed to find aspects of the Tax Code that are more progressive when one considers that it is very common practice for employees at all income levels to be afforded the same employer-based coverage.

There is a very interesting report that just came out from The Commonwealth Fund, demonstrating that in fact the value of the expenditure is much greater for lower and middle income individuals than for higher income individuals and it represents a much greater percentage of their overall income. Of course, the fact that it is also exempt from Social Security tax means that it is very important for them as well, since they are fully subject to that.

Two other very quick points. The other argument that is often made for limiting the exclusion is that it will have cost savings. In fact, I think that employers and employees would agree that there are no more incentives that are needed to try to contain costs. Costs of plans are not necessarily high because the plan is excessive. In fact, a plan may be more costly than one that does not provide as comprehensive coverage because of the age of the group of people who are covered, the geographic location where they are located that may be a higher health care cost area, and so forth.

And the last point is one of enormous complexity. Congress examined this issue back during the Tax Reform Act of 1986 and it chose not, at that time—wisely chose not—to cap the exclusion.

What they did do in place was establish a provision called Section 89 of the Internal Revenue Code.

In order for any tax exclusion to work and to be equitable for workers, it would require an extraordinary amount of valuation to ensure that what would be reported on a person's W–2 form would take into account some of these regional differences, would take into account the type of coverage they have, single, single plus spouse, single plus spouse and children, et cetera. What was created in Section 89 was a very complex proposal that ultimately had to be repealed because it was unmanageable.

Senator BINGAMAN. Dr. Gruber, did you have a perspective on that?

Dr. GRUBER. Yes. Thank you, Senator. My perspective differs in some fundamental ways from the one that was just presented. Let me just point out the three reasons why I think this is a problem in our Tax Code and a natural place to look to finance the kind of health reforms we are talking about.

The first, is this is a large amount of dollars we are talking about. It is about $250 billion as of a year or two ago, making it the second largest Federal health care program in America. It is regressive. The statement that was made is incorrect. It is a benefit which, the higher your tax rate the more benefit you get from this exclusion, so by definition it is regressive. And it is inefficient, because people are buying health care with tax-subsidized dollars. When they have a decision between, should I get paid in wages or should I get health insurance that does that mean that much to me, I will get the health insurance because it is tax-free, where the wages are taxed.

In terms of the comments that were made just now about regressivity, that is just wrong. It is a highly regressive benefit. And in terms of complexity, we have to remember the world is very different now than it was. The Section 89 experience was a bit of a fiasco in many ways. We have to remember a fundamental difference with the world today, which is now every employer who is self-insured has to have a COBRA benefit that they report. What that means is that for an employer to report their benefit for tax purposes, if they are insured they get a bill that they can report. If they are self-insured, they have a COBRA premium that they already by law have to calculate that they can report.

So the fundamental problem that bogged us down in 1986, which was calculating premiums for self-insured employers, is not a problem anymore. So administratively there is not a major problem here. This is very doable. It is exactly the right place to go to finance health care reform. It is really the win-win solution. We both make our health care system work better and we raise the money we need to cover the uninsured.

The CHAIRMAN. This is a big subject. I have Senators seeking recognition. I would like to stay on this subject, frankly, and explore it. I see you all raising your hands; we will get to you. But I see Senators seeking recognition, too. Senator Stabenow, I think you were first.

Senator STABENOW. Thank you, Mr. Chairman.

The CHAIRMAN. But let us stay on this subject.

Senator STABENOW. Yes. Absolutely. I think this is one of the major questions for us. Dr. Gruber, to follow up on your testimony, and I know a number of you mentioned—Mr. Sheils, you have spoken about this, and many of you have spoken about this. But in your testimony you said that the right reason to worry about the erosion of the employer subsidy is that sick and older individuals are treated much more fairly in employer groups today. So I wondered if you might just talk about that a bit, and then if Mr. Shea, from an employee standpoint.

I know there are issues or concerns that have been raised as well about that. I would just say as a comment ahead of time, it seems to me that there are two very different approaches. One is to look at the value of the benefit, in which case it may very well be—I mean, these are negotiated benefits where people have given up wage increases to take health care packages that are important to them based on regional differences, or the age of the employees and so on. That is one thing versus capping based on income for higher individuals. So, I would welcome, Dr. Gruber, your thoughts in relationship to your comments about the right reason to worry about doing this.

Dr. GRUBER. Thank you very much, Senator. I think the context in which the tax exclusion is tackled is very, very important. There is no health expert who, if setting up a system today, would include the tax exclusion for employer-provided health insurance. That does not mean that we would all favor getting rid of it in a vacuum, because if you get rid of it in a vacuum you do have the problem that there are many people who are older and sicker who would have trouble finding health insurance in the non-group market. That is why it is very important that it be part of a package of reform, and part of the kind of reform they are talking about here today.

If you move to a new system of the kind that has been outlined by Senator Baucus's white paper or by President Obama, a system where there is reformed insurance markets with guaranteed issue and non-discrimination based on health, where there are new exchanges where people can fairly purchase health insurance, then we do not have to worry about these issues any more.

Then basically we get away from the unfair discriminatory world we have now have in insurance markets towards one where people, even if they are not getting insurance through their employer, can get health insurance in a fair way that does not discriminate against the sick. So that is why taking it away in a vacuum is a problem for that exact reason, but doing it in the context of reform is all right because you deal with that problem.

I think the other issue you mentioned which is important is the notion about, what about employees and employers who negotiated packages? They gave up wages in return for health benefits. That is why I think, if there is one lesson I think I have learned from Massachusetts on the negative side, it is, you need to phase this kind of reform in. This is a fundamental change.

The notion of doing it right now, while it is urgent, it is urgent to pass a law, I think, and to get steps in place. I think we do need a phase-in period so that people who negotiated contracts under the old rules have time for those contacts to play out and so that

everybody is working under a new set of rules that is well understood in advance.

The CHAIRMAN. Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman. Mr. Chairman, I think this highlights the point that the country is spending enough on health care, but we are not spending it in the right places and these tax rules really illustrate it.

Now, on first glance the tax rules clearly look like a sweet deal for the typical middle class person. That middle class person says, hey, health care is not going to be taxed for me and my employer gets a deduction. But what looks sweet actually has some very sour consequences for that typical middle class person.

Mr. Sheils, I want to walk you through an example to highlight this question. If you are middle class, and say you have a modest package from your employer, what you are facing today are more co-payments and your coverage keeps going down, so that middle class person needs more money to make ends meet. But instead of putting more money in your pockets, the Federal Tax Code takes it away from you to subsidize a deluxe health plan held by somebody who, for example, says they want to go out and get a designer smile.

My question to you, Mr. Sheils, is, is it not possible to convert this unfair tax system into a new one that cuts the waste and still protects the middle class family from getting taxed on their health care?

Mr. SHEILS. Yes. Thank you, Senator. You and I have certainly worked on that in developing your bill. Senator Enzi has a bill which would make some of the changes you are describing. In both cases, it really would turn out that most individuals would actually see a net increase in their tax benefit, not a reduction.

It is because in those bills, or certainly in your bill, it was decided the idea was not so much to raise revenues, it was to change the incentives people face, to create incentives for people to go to plans that are perhaps lower cost and better managed; integrated delivery systems like HMOs I think are a good example.

What we found was that it is possible to do it in a way where almost everybody really was better off, at least initially. The middle class and higher income people—well, lower middle income people, those individuals in those groups more or less would come out ahead. I think in your bill it was an average of about $150 a family, if I remember correctly. So you can design this thing. You can purpose build it in a way that will give you the changes in incentives that you want to make, while at the same time not hurting most of the taxpayers out there.

Senator WYDEN. Mr. Chairman, can I just follow that up with Mr. Kleinbard, very briefly?

The CHAIRMAN. Yes. Sure.

Senator WYDEN. Mr. Kleinbard, my understanding is that you found that something like 70 percent of the American people have health expenses of under $15,800. So hypothetically, if someone gave a generous deduction to the middle class, say $17,000, $18,000, take a sum like that, would that not be a way to convert the system today that seems, at least to me, so inequitable to a system that would protect the middle class and honor President

Obama's campaign pledge and still have some extra money left over in order to start the process of health reform?

Mr. KLEINBARD. Yes, sir. What we found in our data is that for someone who is insured, for a family who is insured, the value of the insurance premium at the 70th percentile is in the neighborhood of the $15,800 number that you gave, and that means that if you were to, on the one hand, take away the employer-sponsored insurance exclusion that benefits employees, and on the other hand replace it with a standard deduction of the magnitude you say, you would leave that family at that 70th percentile of premiums with the same pre-tax income tax case as they would have been with the employer-sponsored insurance. So, our numbers, taking all taxes into account, would suggest that at that kind of level a majority of Americans would actually end up with no increase in taxes.

The CHAIRMAN. I appreciate that. Frankly, to be honest, I do not think we are going to repeal the exclusion, which Senator Wyden's bill does. That is just not going to happen. We have got health care reform in front of us right now and we have to, in my judgment, work with what we have got and make what we have work better. We cannot go to a totally new system. Some want to go single pay. I do not think that is going to work in this country. Some want to go the Senator Kyl approach, which is totally different. I do not think that is going to work in this country.

With all due respect, some want to repeal the exclusion for other reasons. I do not think that is going to work either. There are ways to enact health care reform that bend the cost curve in a very significant way that provides health insurance reform, which this country desperately needs, and also to cover all Americans. I very modestly suggested the white paper that we published last November was a very large step in that direction.

Sure, it is not perfect. It needs lots of improvements, but that is our current system. America is a battle ship. We are an ocean liner. We are not a PT boat. We are not a speed boat. We cannot turn on a dime. Americans have expectations about what they have and do not have. It is the devil you know versus the devil you do not know. I just humbly submit, let us work with the system that we have. We are going to really make it a lot better and that is the way we are going to be able to bend the cost curve in a very significant way.

I want to get one more Senator on this subject and then I am going to go over here. Senator Bunning, on the same subject? The same subject?

Senator NELSON. The same subject.

The CHAIRMAN. I would like to ask one Senator on the same subject first and then move on. All right.

Senator Nelson?

Senator NELSON. Well, then what do you do, Mr. Chairman?

The CHAIRMAN. Sorry?

Senator NELSON. What do you do if you cannot touch the tax-favored treatment of employee-sponsored? What are you suggesting?

The CHAIRMAN. First of all, I am suggesting we do not repeal it. We are not going to repeal it.

Senator NELSON. All right.

The CHAIRMAN. We are going to modify it.

Senator NELSON. So how do you modify it?

The CHAIRMAN. Well, that is what our options are all about. You can put a limit on income, you can put a limit on benefits. You have a combination of limits and/or benefits. That is what this is all about here. That is what this roundtable is all about. Let us try to figure out, what is the best way? Is there a way that is better than others? I am against repeal of the exclusion. I do think it makes eminent sense to closely examine the exclusion to see the degree to which it can be improved.

Senator NELSON. All right. So would you take a certain income level and eliminate the exclusion above that particular level?

The CHAIRMAN. That is an option.

Senator NELSON. Would you go at the 70 percent level that they were talking about?

The CHAIRMAN. Well, again, we can dial this any way we want. Basically, my understanding is that the average in business is about the 75th, 76th percentile of actuarial value that companies now provide for their employees.

Mr. Shea, you have been waiving your hand there. Then I will go over here.

Mr. SHEA. Thank you, Mr. Chairman. Your point about this being a radical change is absolutely right. I cannot resist the opportunity to say, if we are going to do a radical change, I think single payor is really the way to go and we could cut out all of this——

The CHAIRMAN. You have a lot of supportive demonstrators here.

[Laughter.]

Mr. SHEA. All of my members, yes. All of this mechanical folderol. But I just wanted to make a couple of points, really going back to Senator Stabenow's issue. I asked our unions what their experience was in terms of the cost of benefits in similar situations. Let me give you one example.

A construction trade fund, two different funds in western States. I have got the following example. Plan A. These are average 50-year-old, similar demographics, rural and urban. Plan A, the cost is $16,600. Plan B, the cost is $10,046. You might think that $16,000 has the better benefit package; it does not. It has higher deductibles, higher co-pays than Plan A. The difference is simply, as it was explained to me by the actuaries, the health experience—that is, the claims experience—of those two funds and the size of the funds.

So in terms of the practical application of this, I do not think you could possibly do it without building an even much more complicated situation. But the bottom line is, this is the Willy Sutton rule being applied, with all due respect. There is an awful lot of money here, as Dr. Gruber said, so it is natural to look at it. But going back to my comment on the charitable hospitals, this would really destabilize the system.

The CHAIRMAN. Yes.

Mr. SHEA. It would also, I would just say, undermine support for health reform. If you have talked with any of your constituents, certainly when I talked with workers about this, they are just flabbergasted at the idea that somebody would tax the benefits they already paid for, because as Senator Stabenow pointed out, this is simply deferred wages.

The CHAIRMAN. Well, there are a lot of banks here. I will recognize Senator Bunning. But in partial answer to Senator Nelson, there are lots of options on the table and modification of the employer-provided exclusion is just one of many, many options. I do not want to leave the impression that that is the only one. It is not the only one. There are many, many, many other options that we are looking at.

Senator Bunning?

Senator BUNNING. Yes. I have a couple of questions for Dr. Greenstein and Michael Jacobson. Both of you seem to favor an increase in the alcohol tax. Are you aware that there has been a loss of 540,000 jobs in the hospitality industry over the last year, and that unemployment in the hospitality industry is now at 11.4 percent? Would it surprise you to learn that indexing alcohol tax for inflation would cause an additional 160,000 jobs to be lost in the hospitality industry?

Both of you speak as if alcohol tax increases would have small impact on the price of alcohol. Are you aware that Federal, State, and local taxes combined already account for 59—59—percent of the cost of the bottle of alcohol? Are you aware that Federal revenues from alcohol taxes *have* actually declined following the last alcohol tax increase in 1991? This meant that Congress collected about $2.4 billion less than expected for the first 5 years of the tax increase. If this is the case, how can this be viewed as a stable way to raise revenue for health care? Either, or.

Dr. GREENSTEIN. I would be happy to start. Could I just, before I do, as the Chairman—as you know there are a number of us who also wanted to make comments on the employer exclusion.

The CHAIRMAN. Sure. Right. Fine. Sure, Dr. Greenstein. If you do not mind, Senator, if he speaks on that subject, too.

Senator BUNNING. You go right ahead. Just so you answer my question.

Dr. GREENSTEIN. I can answer his question, and Dr. Jacobson can answer it. I am just suggesting, after we do, that I——

Senator BUNNING. Because I only have a few minutes.

The CHAIRMAN. Senator Bunning has the floor, so it is his choice.

Dr. GREENSTEIN. All right.

Senator BUNNING. Go ahead and answer whatever you want to first.

Dr. GREENSTEIN. Virtually every major industry in the country has lost a lot of jobs in the past year. We are in the deepest recession since the end of World War II. I do not know that there is something particular here. My assumption is that health care reform of the magnitude that we are talking about will take several years to implement, and certainly I, and I would presume other panel members, who have various recommendations that include recommendations involving the Tax Code, are not suggesting that these changes be immediately instituted now while we are in the middle of the recession. We are talking about what would be instituted several years from now, hopefully when the economy is in a good recovery and when changes in health care reform are instituted.

With regard to alcohol taxes, I would note that in real terms the Federal excise tax on alcohol has fallen 85 percent since 1951, and 37 percent since 1991. The kind of change that——

Senator BUNNING. Can I interrupt you for just a second? Even though there was a major increase in the alcohol tax in 1991?

Dr. GREENSTEIN. There was an increase, but the tax is X amount per gallon. If you have a sales tax at the State level, that is a percentage tax. As the price of goods and services rise, the sales tax rises. The excise tax on alcohol is a given number of cents or dollars per gallon, as a result of which, as inflation over time raises the price of all goods and products, including alcohol, the excise tax falls in real terms and falls as a percentage of total sales. Federal alcohol excise taxes, some years ago, were about 12 percent, I think in 1980, of the gross alcohol sales; they are now about 6 percent.

The main recommendation in my testimony is merely to put in real terms the excise tax on alcohol back to where you put it in the 1990 Deficit Reduction agreement, and in terms of the impact that would have, it would increase the tax on a bottle of beer by 4 cents, on a glass of wine by 3 cents. If you, like myself, following doctors' recommendations, have a drink every night—which I do. I have a glass of wine every night. [Laughter.]

Senator BUNNING. Can I get an answer out of that?

Dr. GREENSTEIN. It would cost me $10.95 over the course of the year if I had a drink every single day of the year. I do not think that is a crushing tax burden or something that is going to cause big dislocation.

Senator BUNNING. So, we had local State taxes increase prior to our discussion here at the national level.

Dr. Jacobson, would you mind answering the question also?

Dr. JACOBSON. I think there are a lot of questions about the various figures you used.

Senator BUNNING. Really?

Dr. JACOBSON. We can provide you with some details about those.

Senator BUNNING. Thank you. Would you do that for me?

Dr. JACOBSON. I would be glad to.

[The information appears in the appendix on page 333.]

Dr. JACOBSON. But I think Mr. Greenstein hit an obvious point, that inflation, every year, erodes the value of the taxes, these excise taxes. Also, our society pays a tremendous toll because of the heart disease, cancers, and other health problems posed by alcoholic beverages that a strong alcohol tax increase would help pay for health reform and marginally reduce these expenses caused by alcoholic beverages. So it should not be, and we are not advocating putting all the costs of health reform on the alcoholic beverage industry.

Senator BUNNING. Just a bit.

Dr. JACOBSON. But as part of a suite of prevention measures, it makes absolute sense. When Alaska raised its alcohol taxes they saw an almost immediate decline in mortality.

Senator BUNNING. All right. I have one more question.

The CHAIRMAN. All right. Then we will go on to Senator Cornyn.

Senator BUNNING. One more question. Joseph Antos, lifestyle taxes. Dr. Antos, would the lifestyle taxes supported by some of our

witnesses be progressive or regressive? In other words, would increased excise taxes on alcohol or soft drinks tend to hit low-income families more harshly than upper income families?

Dr. ANTOS. Thank you, Senator. Yes, they tend to be regressive. They tend to hit lower income families, not just alcohol taxes, but also, taxes on cigarettes. In fact, that is a particularly good example. The middle class has largely overcome its cigarette addiction, but lower income people, for various reasons, do not have necessarily the access to the kinds of assistance that the rest of us have and may have difficulties in life, and frankly a cigarette helps that.

So the fact is that raising taxes in these matters is not going to have a gigantic impact on health style or health care costs simply because the problem is much bigger than that. If we want to deal with this as a health issue then we have to take public health steps.

Senator BUNNING. Thank you very much, Mr. Chairman.

The CHAIRMAN. Next, Senator—on the same subject? Briefly.

Dr. BURMAN. Just a very brief comment.

The CHAIRMAN. Briefly, because I want to recognize Senator Cornyn.

Dr. BURMAN. Thank you. Thank you, Mr. Chairman. I think for all of these proposals you need to think about the whole package together. I mean, anything you do to raise revenues is going to raise taxes on some people. Some of these things might seem regressive, but if you use the revenue raised to cover low-income people, as a group they would be much better off. Thirty-five percent of people with incomes under $10,000 do not have any health insurance.

The CHAIRMAN. Senator Cornyn?

Senator CORNYN. Thank you, Mr. Chairman.

The administration proposed $600 billion as a down payment on an estimated $1.5 trillion health system overhaul. To me it seems counter intuitive that you spend more money in order to save money, to say the least. But I would like to ask Dr. Baicker to talk about what the economic evidence shows, because to me it seems like that is very fundamental to what we are doing here. We cannot make unjustified assumptions that by spending $1.5 trillion we are actually going to bend the cost curve, where now we spend 17 percent of our Gross Domestic Product on health care.

Associated with that, I want to ask Dr. Antos to comment. Yesterday we saw a press conference at the White House where stakeholders said that they would save a lot of money, $2 trillion, over the next 10 years by voluntarily—and I could not find any kind of enforcement mechanism there—reducing their rate of increase in health care costs over the next 10 years.

Can you tell me—Dr. Antos, would you comment on whether you think that is a realistic assumption? Dr. Baicker, first.

Dr. BAICKER. Thank you. I think an exclusive emphasis on how much money measures save can be misleading in that a lot of things we might spend money on would get us a lot better health outcomes and would be well worth the money spent, and a lot of things that might reduce costs might do so at a cost in health that is larger than we want to bear.

So I would focus instead on measures that improve the value that we get from the health care system, and in truth many of those measures are unlikely to accrue budgetary savings in a narrow window. We should invest in them because we think they promote health in an effective way and may save money over the long haul, but not necessarily because they would solve any short-term budget issues.

That brings us back to the employer exclusion. There are not that many opportunities to change the tax treatment of anything in a way that both makes the system more progressive and improves the value that we get from it. I would agree with what Jon Gruber said, that the current system is regressive, not only because the value is worth more to people in higher income tax brackets, but because, as Dr. Burman noted, people in lower income tax brackets are less likely to have access to any employer insurance at all, and when they do are likely to have a policy that has a lower premium.

So by changing that tax treatment you could move towards higher value care by aligning incentives to provide not just more care and not just more expensive insurance, but higher value care that produces more health. We should be looking to improve value, not just lower costs.

The CHAIRMAN. I see a lot of hands here.

Senator CORNYN. Mr. Chairman?

The CHAIRMAN. Yes?

Senator CORNYN. My question went to Dr. Antos. If he could just follow up on the second part of that, please.

The CHAIRMAN. Right.

Dr. ANTOS. Thank you, Senator. The ideas that were presented yesterday were certainly voluntary. These are ideas that we have heard for the last 20 or 30 years. They are fine ideas, but the fact is that most of these—and these are ideas. These are not proposals. As you said, there is no enforcement mechanism, and in fact, no specific steps suggested in the letter yesterday as to how we would achieve savings at any level, much less $2 trillion. So these are fine ideas. We have been talking about them for a long time. We need to continue to work on them. This letter will not suddenly trigger a change in the health care system that we desperately need to promote efficiency.

Now, a better question, or a bigger question is, even if this $2 trillion were achieved, what impact would that have on the Federal budget, which I think is the issue really before this committee? The answer is, a very, very small part of that would end up as savings, at least in the first 10 years of the Federal budget. To give an example, the Congressional Budget Office estimated, with regard to the stimulus package, that there would be approximately three-tenths of 1 percent reduction in health care spending, Federal health care spending, because of what they say is $32 billion spent on health information technology. Three-tenths of one percent. We have a long way to go to get to $2 trillion.

The CHAIRMAN. Well, I think the point is, a lot of this is incremental. Over time we can start to bend the curve a little bit here. One more, then I am going to go to Senator Conrad, on the same subject. All right. Dr. Wilensky?

Dr. WILENSKY. A point was raised that I want to emphasize, and that is that there is a distinction between how to raise the money to expand coverage estimated may at $1.5 trillion for the 15 percent who do not have coverage now, and $635 billion that was suggested by the administration. But the harder question that this committee has wrestled with goes to the other 85 percent of us who have coverage, and that is: what do we do to be able to sustain the spending for Medicare, for Medicaid, and to improve the value, making sure that when you look at how you get the money to expand coverage, whether or not that is helping us improve value for the rest of us or, just as a revenue raiser, becomes very important. I would like to echo my support for the committee's considering it in whatever way it thinks is politically feasible to alter the current tax treatment of employer-sponsored insurance. I appreciate the problems of changing it completely, but to the extent that you can limit it in some way will both raise money and drive some better outcomes in terms of the kind of health insurance that people are likely to choose.

The CHAIRMAN. All right. I am sure we will get back to some of you again. Just do not forget if you want to say something. But I have Senators to recognize, too. The budget question, I think, is a good segue into recognizing the chairman of the Budget Committee, Senator Conrad.

Senator CONRAD. Thank you, Mr. Chairman. And again, thank you for this roundtable, and thanks to each of you for participating.

I have got a question I would like to pose to three or four of the panelists, and that is a question of, if they were to give two or three of their best ideas for financing health care reform, what would those two or three ideas be? I would start with Dr. Wilensky, then Mr. Sheils, Dr. Gruber, and Mr. Greenstein. If I could ask the four of you, if you were to give us your two or three best ideas for financing health care reform, what would they be? Dr. Wilensky?

Dr. WILENSKY. The first one, not to be a broken record, is to go after the tax treatment of employer-sponsored insurance. It is regressive, it is inefficient, and it is a lot of money. How you replace it in terms of how you decide to subsidize, whether moving it to credits, doing it directly to subsidies, will influence how much money you get. I do not think you can avoid taking that on.

Second, I am very appreciative of the work that you and Mr. Baucus did last August in terms of your comparative clinical effectiveness bill. I believe that represents an important way to slow down spending, first investing in the money and then recognizing that we have got to drive change so that we use it.

Concepts like value-based insurance, where you vary the co-payment toward the most clinically appropriate use of care, value-based reimbursement where you reimburse more to the institutions and clinicians that provide good quality and efficient care, can make a large difference. That will take several years, at best, to generate the information and to implement. You will have to change the ability of CMS to make use of these kinds of concepts in terms of how they reimburse. It is an area the private sector can do on its own if it wishes to—you might learn something—but statutory change will be needed for CMS.

Number three is, you have got to go after how we reimburse physicians. The current system is the most broken part of Medicare. We spend a lot of money. We are doing badly for the physicians that are trying to practice in a conservative manner. They have had no fee increases over the decade, and yet we see 10 to 12 percent spending increases, which is unsustainable and unfair. Many of you are from States that take this particularly hard in terms of the current reimbursement under Medicare.

Senator CONRAD. Mr. Sheils?

Mr. SHEILS. Thank you. In the testimony we prepared we actually looked at a few ideas. I guess I would have to say that I am really interested in these ideas that both raise revenues and change incentives for individuals when it comes to health care and their health. For example, the tax exclusion for health benefits. If we were to cap that at, say, the average amount per worker right now, we would raise that, plus a phase-out that is described. You would raise about $700 billion in revenues over 10 years. The health spending would go down by over $300 billion as well, and the reduction in health spending has to do with the fact that we have created incentives for individuals to go into plans that are going to be more efficient.

The second thing we looked at was the tobacco tax. It seems kind of mundane, and everybody points to it, but we played with it a little bit more. We looked at a $2-per-pack cigarette tax. We raised about $250 billion in revenue and we also got almost $200 billion in savings, reduced health spending, some of which went to the Federal Government in Federal programs.

The last thing I looked at was, again, with the mundane. We looked into recovering Federal money that is now in the safety net, and that includes Medicaid disproportionate share hospital funds, the Medicare DSH payments, there is funding for FQHCs, and so on. We heard today that it is important to maintain the safety net system because we are still going to have uninsured people, but if we were to take, perhaps, half of that back in the context of a major expansion that covers almost everyone, you would be able to raise another $130 billion.

Now, I am trying to remember these numbers off the top of my head, but basically we got to $1.2 trillion in Federal revenues, about half a trillion dollars in savings and spending throughout the system. Well, we did analyze the President's proposal during his campaign and at that time we estimated his proposal would cost about $1.2 trillion. So, it pretty much pays for it. But you are going to get 19 different ideas and they are all good.

Senator CONRAD. All right.

Dr. Gruber?

Dr. GRUBER. I like Dr. Wilensky's broken record analogy because this is a wonderful opportunity to see the degree of consensus among a wide array of experts on the win-win nature of using reform of the tax exclusion to finance health care reform. That is at the top of my list as well because it is exactly the right thing to do to finance health care reform, for the reasons I have given, for the reasons others have given.

What I want to do is just talk for one minute about what that means. Senator Baucus has raised the issue of, you can reform, but

there are lots of moving pieces. I think we should talk for just a minute about what the moving pieces are. There is the cap. We talked about, you can cap at a certain level. You could do it income-related. There is also the issue of the rate at which you inflate that cap. So for example, just to give ideas, if you, starting in 2012, capped the exclusion at the 50th percentile, I estimate you would raise about $500 billion.

Now, alternatively you could say, well, that is not fair because that hits everyone with taxes. So, let us say we did something else. Let us say we said that we are not going to touch the exclusion for families below $125,000 of income. We are then going to cap it between $125,000 and $250,000 of income and then get rid of it, but only for families above $250,000 of income. So, that is a progressive cap that raises just the same amount of money without touching families below $125,000 of income.

There is a lot of money there that you can use, that you can get at in very progressive and different kinds of ways, many of which get you the kind of efficiency savings and progressivity that we want to get out of the system. So, I think that is the number-one place to look, and I am thrilled to hear the general support for it today.

I think the second place to look, I just would really echo Dr. Wilensky, on looking at value-based adjustments to the system. I think this is the harder one. I cannot give you numbers; I think it is hard to give numbers on how much different packages can deliver, but obviously thinking about the kind of reforms that she discussed are important.

But I would also echo what Mr. Sheils said. I think we really need to think about lifestyle-based changes, both in taxes and insurance prices. In the State of Massachusetts, a fundamental part of reform was, for the first time, insurers were allowed to rate people's health insurance prices based on smoking status. We need to think about setting up the right kind of incentives for people, both through the prices they pay for the goods and the prices they pay for their insurance, to try to induce healthier lifestyles and raise revenues at the same time.

Senator CONRAD. Dr. Greenstein?

Dr. GREENSTEIN. I think this is a key question. I think the first point is, there is no single mechanism you can pass that can get you all the way, that can probably get you even half of the way towards financing the whole package. So that leads to the conclusion that you are going to have to put together an array of items on both the spending and the revenue side of the equation if this bill is going to be paid for.

Let me start with the spending side. I would absolutely start with the types of reforms in Medicare that the President proposed—I know you discussed a number of them in your delivery roundtable several weeks ago—ranging from reigning in overpayments in Medicare Advantage to raising premiums on affluent Medicare beneficiaries. Some of these have been opposed on one or the other side of the aisle. We are going to need all of them to deal with this important priority of health care reform.

Those kinds of Medicare changes—bundling of payments, changes in hospital readmissions—you really get a triple benefit

from them. They can help finance the bill. A number of them will get picked up by private insurance and will help slow the rate of growth in private sector health care costs as well, and they will help shore up Medicare financing for the long term.

We are going to get a bad report at 2:30 this afternoon from the trustees on Medicare financing. Medicare reforms can do all three, and I would supplement them with some additional reforms in terms of pharmaceutical pricing in Medicaid, as well as Medicare, that can yield some additional savings.

Second, deal with the employer exclusion. Senator Stabenow raised some important issues. But again, I do not see how you can put a package together that is going to get you to fully paying for this unless you touch the exclusion. I would agree that you do not want to eliminate it. I think we need stronger employer-based coverage, not weaker.

However, a well-designed cap, as part of well-designed health care reform, can actually increase employer-based coverage. If you combine it with an individual mandate and perhaps a pay-or-play mechanism like Massachusetts has, you are going to end up, even with a cap, I think, having more people enrolled in employer-based coverage, not fewer.

There were three particular issues that have often been raised. What about people who were sicker? Part of your health care reform plan, I believe—I hope—will have a prohibition on insurers charging higher prices for sicker people than for healthier people.

The CHAIRMAN. It does. Right.

Dr. GREENSTEIN. What about regional variation in cost in firms that have older workforces? I would recommend you have a cap that builds in an adjustment for regional differences in health care costs and an adjustment for the age of the workforce of the firm. You can have an adjustment built into the cap itself.

The third item I would mention is other tax treatments of health care. By the way, I presume that you are going to have subsidies for low- and moderate-income workers, and you are probably, I presume, going to deliver that through a tax credit. So I think it is a mistake to just think of these as tax increases. The goal, really, is to redesign the Tax Code's treatment of health care costs in a much more efficient way. So right now we spend money on flexible spending accounts, which increase health care costs. They are use-it-or-lose-it.

We all have had the experience. At the end of the year you rush out—I did it on March 15th myself. I spent an hour in the CVS loading up on things I did not need because it was use-it-or-lose-it. You also can use your FSA for all kinds of low-priority, elective, unnecessary medical procedures that no insurance would cover. Now, we do not necessarily need to get rid of FSAs, but they were put into place to help people afford coverage in the absence of national health care reform.

In the presence of national health care reform, FSAs should be reformed—and by the way, they really ought to be incorporated into any cap you have, otherwise you could have employer contributions that were over the cap. If the employer reduces them to the cap level and the employee takes the additional amount he or she

pays and puts them all through an FSA, you really have not effectively changed very much in terms of the tax treatment.

The CHAIRMAN. All right.

Dr. GREENSTEIN. Finally, the lifestyle taxes: alcohol, sugared soft drinks, we have talked about. I would hope you would not totally rule out looking at the issue of the itemized deductions. I know the President's proposal is not really still on the table in the form he presented it.

The CHAIRMAN. Yes, it is. It is one of the options.

Dr. GREENSTEIN. All right. Then as sub-options you could look at excluding charitable contributions, or alternatively the criticism has been that people deduct at 35 percent today if they are in the top bracket. What happens if they deduct at 28 percent? Our analyses suggest there would not be a big impact that would cripple charities, but I will put that analysis to the side. My point is, simply, you could deduct at 35 percent. If the top rate goes back to 39.6, that is in the baseline, you get savings just from holding the deduction rate at 35.

The CHAIRMAN. Thank you very much.

Senator Snowe, then Senator Cantwell are on my list here.

Senator Snowe?

Senator SNOWE. Thank you, Mr. Chairman.

Dr. Gruber, I wanted to get back to the single national cap on tax exclusion as well. I know Dr. Greenstein just sort of addressed the question of making regional adjustments. There are marked geographical variations among States in terms of cost. Now, some obviously can be addressed and we are going to be reforming the health care system. Perhaps some changes or drivers of cost are not amenable to change.

So I would like to have you address if you have given any thought to how we could structure such a cap that includes those variations. For example, in my State of Maine it costs $16,000 for a family plan, versus the average nationally of $12,400. That is a $3,600 difference, almost $4,000. In the individual market, it is $24,000 for a family of four.

Now, there are some real cost differences and economies of scale, obviously, for rural areas particularly. So I am wondering if you have given any thought to incorporating some kind of adjustments that include criteria for those costs indexing the cost of coverage, indexing the subsidy to make sure that people have adequate coverage, depending on which State they live in. Obviously we do not give people more than they need, but we do not want to give them less than they require to access this coverage as well.

And Dr. Greenstein, if you have anything in that regard on how you would make those adjustments for regional I would appreciate it. Then there is one other question I have. Thank you.

Dr. GRUBER. I think, Senator Snowe, you are raising a very important issue. There are large variations in the cost of health insurance across the Nation. Part of those will be compressed as part of national health care reform, particularly in non-group markets. You mentioned the higher non-group price in Maine versus other States. A lot of that will go away with reform, but a lot of it will not. So I would personally advocate that we have a cap that is adjusted, at least initially, for premium differences across States.

So, for example, what you could do is you could say in the first year you have a cap which is adjusted fully for premium differences across States, but over time that should phase out to recognize that some of those premium differences are not due to cost of living differences, they are due to inefficiencies in the way medical care is delivered.

So in the long run you could move to a cap which varies just by the underlying cost of living, so you could say, for example, if the cost of living in Maine is 10 percent higher than in Mississippi, the long-run cap would be 10 percent higher.

But if the cost of premiums in Maine is 50 percent higher, you would start at 50 percent higher but over time, giving Maine time to adjust, you would then eventually move down to something that is just reflecting cost of living differences.

That is something which reflects the true cost of living differences that drive your health care costs but which forces States which are higher cost to take the steps towards efficiency that we would all like as a Nation. So, that is the kind of step that I would strongly endorse.

Senator SNOWE. I appreciate that.

Dr. Greenstein?

Dr. GREENSTEIN. I would agree that probably different regional variations in insurance costs is probably the best way to do the adjustment. We have not really looked at the question Dr. Gruber just mentioned about what you do over time. I hope it would be possible over time to limit the adjustment to differences in cost of living. As he suggests, I am not sure it would be possible to go that far.

But certainly in terms of constructing the cap, I think not just for the first year, but for the whole first period, you would want to vary it by differences in insurance costs. And hopefully as various reforms work their way through the insurance system, one hopes that the variations in insurance costs across regions would themselves compress and that a cap adjustment, therefore, naturally would narrow because the differences in cost, one would hope, would narrow.

Senator SNOWE. So a time frame would obviously be important in this, whether it be 5 years, 10 years, or something in phasing it in of some kind.

Another question, Dr. Greenstein.

Senator HATCH. Before you move on, Senator Snowe.

Senator SNOWE. Yes?

Senator HATCH. Could I just ask a question on this precise point?

Senator SNOWE. All right.

The CHAIRMAN. Senator? Sorry?

Senator HATCH. If you would let me——

Senator SNOWE. Yes. I will yield. I have one more question after this point.

The CHAIRMAN. All right. Why do you not go ahead?

Senator HATCH. If I could on this precise point, because I am concerned about it. Under the Sixteenth Amendment, "The Congress shall have power to lay and collect taxes or income. . . ."

The CHAIRMAN. On this point, right, Senator?

Senator HATCH. On this point, yes.

The CHAIRMAN. All right.

Senator HATCH. ". . . from whatever source derived, without apportionment among the several States and without regard to any census or enumeration." That is the exact language.

Now, in Mr. Kleinbard's testimony he points out that the Tax Code does not adjust for variation in cost of living between regions, and some types of variation may be considered unconstitutional. Now what I would like to know is, in the view of the various folks here, would a geographic variation on capping the exclusion based upon the State you live in be unconstitutional?

Now, such an idea seems unprecedented but, in fact, even though the higher cost of living in certain areas is usually accompanied by higher wages, would such a geographical variation mean that people in some areas of the United States would be subsidizing health care for people who are located elsewhere in the United States?

Mr. KLEIN. If I may, Senator. Thank you so much. I have to leave it to constitutional scholars to answer the question as to whether or not it would violate the Constitution, but your question and Senator Snowe's question underscores just one of the challenges that would be involved in capping the employee exclusion. Whether or not it is unconstitutional, I do not know, but I can tell you it would be extraordinarily complex. The geographic variations account for some of the differences in the cost, as does the age of the workforce, as does the claims experience, and so on and so forth. This walks you right back into the Section 89 experience, which should not be underestimated.

I dug out of my filing cabinet yesterday this little button calling for the repeal of Section 89. Some of you may remember the hundreds, if not thousands, of workers and small business people and benefits professionals who marched up to Capitol Hill when they had to deal with this incomprehensible challenge of trying to value this different coverage.

With all due respect to Dr. Gruber, and just in general what I would say—I do not have the sterling qualifications of the academics on the panel who are supportive of capping the exclusion—so I am disadvantaged by the need to sort of tell you how employers and employees will behave in practice rather than in theory.

But I must say that the notion that somehow we are in a different place because of COBRA than we were 20 years ago is simply wrong. It is one thing to make a rough justice approximation of the value of the health benefit in order to know what to charge a former employee toward the premium. It is quite another to be fair to people in terms of the way you are reporting some taxable benefit on their W–2 form.

Senator HATCH. Mr. Kleinbard brought it up.

Mr. KLEINBARD. Yes. If I could, I have some data that I think is relevant to your question, and then I would like to come to the specific problem. The first, the insight that Senator Snowe began with of regional variations is absolutely correct. In our data we discovered, in fact, that variations across regions are larger than variations across income levels. You would think that higher income employees have much more generous plans than lower income employees.

In fact, the variation across income levels—at least when you go by quartiles, which may be too rough a cut, but that is all the data we have—shows less than a 10-percent variation between the bottom quartile and the top quartile of incomes in the value of the insurance premiums. We see a significant larger variation when we look at costs across regions. So the problem is there, there is no question about it.

Then you turn to solutions, and there are two issues that you need to think about. The first, is that the Internal Revenue Service today does not really, frankly, care very much where you live within the United States. Very little turns on whether you are a resident of Maine or you are a resident of Boston with a summer house in Maine.

When we go to regional variations, that is going to matter a lot. That is something that the IRS does not really police today. There are a couple of places in terms of, where is your principal residence or things like that, but as a general matter, the whole question of how we will define who is in which region and how will the IRS police that is going to be a significant issue and we should not overlook the administrative burdens that that will put on the Internal Revenue Service.

The second question you raised is the constitutional one. The issue is the uniformity clause of the Constitution which requires that excises and other taxes be levied uniformly across the States. It is my belief—although there is a good deal more research to do. The great thing about the Constitution is you never get to the end of the research—based on our preliminary research, we believe that one could design regional variations that are constitutional.

It would require, however, a more sophisticated definition than simply going State by State. For example, New York State has some very, very high-cost areas and some relatively low-cost areas. So we do think that you could work with the constitutional constraint, but it would require a more sophisticated approach, which in turn adds further to some of the administrative burdens. But the problem is real, as I have said. There are very substantial variations.

The CHAIRMAN. All right. Senator Grassley, you are asking on geographic variation, correct?

Senator GRASSLEY. No.

The CHAIRMAN. Not on this subject? All right. More on geographic variation? All right. Senator Cantwell?

Senator CANTWELL. I know we are talking about geographic variation. I want to go back to Dr. Wilensky's point about Medicare reform and geographic variation because before I am interested in talking about new sources of revenue, I am interested in talking about how we are going to make this system more cost-effective. Washington State is one of those that you have referred to as a high health outcome State with relatively low cost.

What I do not understand is why this Dartmouth study is not carrying more weight in explaining the transformation that can happen. For example, Washington State beneficiaries, per spending average for a year, is $6,200. So for the U.S. it is $7,400, so roughly a $1,200 difference. For New Jersey, it is $8,512. For Florida, it is $8,462, $2,200 more per Medicare beneficiary.

Now, why should we keep paying for that? Why should we in Washington State keep paying for that? If the entire country went to the general State rate that Washington had per beneficiary rate, we would save close to $55 billion a year. So why is it that we cannot use this study to break through that there are systems throughout the country that are higher outcome, lower cost, and before we spend another dime raising someone's revenue somewhere else we had better implement those efficiencies?

The CHAIRMAN. Good question. Who wants to take it?

Dr. WILENSKY. I would like to respond.

The CHAIRMAN. All right.

Dr. WILENSKY. It actually goes to a point that Senator Hatch made, of are we asking people in one part of the country to pay for health care in another. Of course, in Medicare we do that all of the time. Your State residents pay the same Medicare taxes into the system, but as you have pointed out, Medicare pays very differently according to the practice style and how health care is delivered in these areas.

The differences can be a matter of three-fold, according to some of the estimates that MedPAC and other commissions have done. There is not an association with higher health outcomes or more response to patient preferences in the higher spending areas. They vary within States, as somebody just mentioned. It is not enough to just say one State does this and another one does that. California is an even bigger example. The Los Angeles area is incredibly expensive, and the northern California area is much less so.

There are mechanisms you can use to try to drive spending down in the high-cost areas that have little health value. It would require arming CMS with very different tools in terms of how they reimburse clinicians and institutions rather than paying the same amount with only an adjustment for cost of living.

It will be, if not to CMS, delegating to some other group a lot more authority in terms of how you set up reimbursement systems. I believe it will be very difficult, no matter what tax increases you use, to sustain health care spending and improve the value unless you take on these broader issues.

The CHAIRMAN. Dr. Baicker?

Dr. BAICKER. Thank you. This highlights, I think, the importance of thinking beyond just the insurance structure. I have done some research in the area that you are discussing and the variation that you see is among the people who are all on Medicare fee-for-service, so it is not that people have different types of insurance paying for their care. In fact, in the parts of the country where we spend the most on Medicare beneficiaries, they are the least likely to get high-quality, low-intensity interventions like diabetic eye exams, flu shots, mammograms.

That kind of care may fall through the cracks when people are seeing a lot of specialists and not seeing a lot of general practitioners, and when there is not an integrated infrastructure of information so no one is saying to the patient, "gee, it is time for your flu shot," in between all the specialist visits.

We would like to find a way to promote that low-intensity but high-value care by reforming the payment system such that providers are reimbursed for providing high-quality care, not just more

care—where there is an opportunity to do higher value interventions, providers are reimbursed for phone calls and for answering e-mails, where coordination of care is encouraged, not just through doctors' office visits, but through hospitals and through episodes of care.

Managing a disease like diabetes or hypertension requires coordination across a wide array of providers, and right now we are just reimbursing more for more care and that seems to drive that relationship between higher spending and lower quality care, even in a program where everybody has the same insurance product.

The CHAIRMAN. This is a very important subject. This Dartmouth study has been referred to many, many times by many, many people. CBO did an analysis of it and concluded that there would be a 29 percent savings, $700 billion, roughly.

So I have a couple of questions about it. First, is there any reasonable justification for geographic variation? I mean, I am assuming the Dartmouth study adjusted for lots of different factors to try to get a true sense of the disparity in health care spending versus outcomes.

But my first question is, what justification is there for it? Second, what is the cause? What is the main cause of geographic variation? I think you, Dr. Baicker, started to touch on some of the causes. Third, what are some of the better solutions to attack it? My assumption is that some of the delivery system reforms contained in the white paper will help get at that problem, with health IT, comparative effectiveness, and reimbursement based on quality, and so on and so forth. So I would like just a little discussion on, is there any justification for it? Because it is sure talked about a lot. Second, what are the main causes? Third, what do we do about it?

Dr. Wilensky?

Dr. WILENSKY. This year's report particularly highlights how the variations can impact spending. There is a chapter that looks at the treatment of chronic disease, and also end-of-life care. It compares the Los Angeles area and northern California, Sutter, Intermountain Healthcare, and the Mayo Clinic, and indicates that there are some parts of the country, like the Los Angeles area, that even their lower spending areas are way more than other parts that are not very far geographically. We call it practice style differences.

There is discussion about how you begin to drive change so that the more aggressive interventionists change some of their behavior. It takes a lot of different activities—financial, but also having good data, that the outcomes, in fact, are not improved. The first response, according to other earlier work that Wenburg and others at Dartmouth have done, is that physicians will say, I am different, my patients are different. My patients are sicker, I am having better outcomes.

It is only if you can have good data to show that the patients are not different, that you do not get better outcomes, that you can begin to try and drive change, in addition, having it backed up by financial rewards to those who have good clinical outcomes and practice conservatively.

Very different end-of-life care in terms of how medicalized the last 6 months of life are. Within small areas, it means that it will

require more than just crudely taking a State or multiple States and labeling them "high spending," and that is why I have used the California area—you all have talked about this because you come from States that tend to be quite low-spending.

The CHAIRMAN. Right.

Dr. WILENSKY. And have been appropriately frustrated that you do not see this recognized in a payment.

The CHAIRMAN. Right.

Dr. WILENSKY. But it will mean redefining how we reimburse under Medicare if you want to capture those savings and reward the kind of behavior you want to see.

The CHAIRMAN. All right.

Mr. Sheils?

Mr. SHEILS. Thank you. We have looked into this and have done some research on it. We first got involved in it when we were looking at the question of establishing a comparative effectiveness institute. The question we were faced with was, well, how effective will it be to generate new guidelines? One of the things we found in the literature reviews is that physician adherence to guidelines, medical practice guidelines, evidence-based medicine, is actually quite low. Only about 55 percent of physicians are found to be adhering to the guidelines that apply.

The CHAIRMAN. And why is that?

Mr. SHEILS. Studies have tried to look at that. Some of it is that they do not know about the guideline. That is number one. Number two, they may not agree with the guideline. They may feel that it is wrong. The third, it is always very politely put, but it is difficult, with a guideline, to alter the practice of medicine with a physician. What they found is that things like publishing the guidelines do not really make much difference. They found that doing, what do they call these? Conferences and so on, presenting papers, does not do very much.

The one thing they found was really effective was, as Dr. Wilensky was saying, is when they did profiling to find physicians who seemed to be operating out of bounds and then went in, with a physician, to educate that physician with what is known about it. That was shown to change medical practice. The study we looked at, though, showed that the cost of doing that is about $7,200 per physician, so this is a costly item.

I think the conclusion we came to, and I think CBO sort of is here on this as well, is that generating the information is necessary, but not sufficient, to fix the problem of variation in medical practice. We need changes in incentives that accompany that, and there might have to be some fairly stiff incentives like paying physicians less for doing care that is not indicated under the guidelines. Without incentives, we probably are not going to get very far with it.

The CHAIRMAN. Mr. Klein?

Mr. KLEIN. Yes. I could not agree more. In answer to your question, why does this occur, it is because we have a misalignment here between outcomes and what we pay. Health care may be the only product or service provided in this country where, as a matter of routine, we pay as much, if not more, for poor quality as we do for good quality. So in terms of your initial question about——

The CHAIRMAN. Because we reimburse on basic quantity.

Mr. KLEIN. That is one big part of it, and without regard sometimes to quality whatsoever. I think what you outlined in your white paper are precisely the kind of measures that need to be taken to address this. I just would sort of add the point as well, very briefly, that comparative effectiveness is an area that deserves more attention and it is absolutely essential that these kinds of changes be part of the overall reform effort.

The CHAIRMAN. All right.

Dr. Altman?

Dr. ALTMAN. Yes. One of the things I want to support Senator Cantwell on. One of the major differences that goes on in the State of Washington, the State of Oregon, in Minneapolis, is the organized delivery system, the integrated delivery systems you have there. So I would totally support what I have heard before. In that white paper you are moving towards those integrated delivery systems, and I would support my colleagues. But it is how the system is organized, and we have big differences. Those three States that I would focus on, Washington, Oregon, Minneapolis, and parts of even Massachusetts, are where integrated delivery systems are playing out.

So I would support what others have said. We need to change the incentives. We need to move away from fee-for-service towards integrated bundled payments and we need to sort of penalize those institutions and providers that continue to practice low-quality, high-volume care. You can say, fine, if you are going to continue to practice that way we do not have to pay you the same rates. So what Senator Cantwell was saying is absolutely correct.

The CHAIRMAN. All right.

Senator Lincoln?

Senator LINCOLN. Thank you, Mr. Chairman. I just wanted to go back a little bit to the geographic variation, in that cap. I think it is correct that where wages adjust in regions to account for variations, that when cost of living is higher, pay is higher also, usually, in those areas, appropriately, in some ways to compensate the workers. But I guess what I would like to kind of add onto—I cannot remember which one of you all made the comment, but the variances in health care costs across regions exist for a number of reasons, not just higher costs.

I know, Mr. Kleinbard, you had some of that in your testimony. But is it possible that some of those regional variances result from behavior in practice, as you have mentioned, that could and should be corrected? That is something that we obviously have to look at. Are we rewarding certain regions for less efficient or more expensive health care? Is that a part of the conversation?

To Mr. Kleinbard, I would ask you, do we adjust anywhere else in the Tax Code for geographical variances?

Mr. KLEINBARD. I can address that last part of your question; with respect to practice issues, I would defer to the health economists. Essentially, we do not in the Tax Code. We do make differentiations, of course, on the Medicare spending side, but in the Tax Code we essentially do not make any kind of regional variations. The nearest thing you can see to that would be, for exam-

ple, some of the special benefits for the Gulf Opportunity Zone or something like that. But as a general matter, no.

Dr. BURMAN. But actually there are some. Low-income housing credit allocations vary by State. The sales tax deduction varies by State.

Mr. KLEINBARD. No, the consequences vary by State, Len, I agree with that.

Dr. BURMAN. No. But they are actually designed to vary by State in those cases.

Mr. KLEINBARD. No. The sales tax——

Dr. BURMAN. The sales tax deduction, the tables vary by State. Low-income housing credit allocations are based on population. I do not think there is any reason why, if you had an objective measure to define differences in costs across States, that you could not—and I think you said this in your answer before. For example, the ideal thing would be if you could design an efficient health insurance plan and figure out what costs would be in each State and tie a cap to that, that would be the ideal cap. A second-best measure might be to take something like the lowest-cost plans in the Federal Employees Health Benefit Program, which vary across States, and you could tie the cap to that. So I do not think there would be a problem with that kind——

Mr. KLEINBARD. As I said before, I do not disagree, Len, with the ultimate constitutional question. I do think it is fair to say that we do not, in fact, as a general matter, impose different tax rates based on cost of living. If in fact you have higher income in a State or region that has a higher cost of living, you are paying at a higher marginal rate. We do not give a special adjustment to keep you at the same rate as you would have been had only you been earning less in a lower-cost region. That is my point.

Dr. BAICKER. But your question also is predicated on the distinction between differences between States that we want to take into account and differences between States that we do not want to take into account. Some of those differences are because medicine is practiced in some areas in a much less efficient way, and do we want to continue to subsidize that through the Tax Code by saying the more inefficient you are practicing medicine here the higher the tax benefit your residents will get? I think those are the kind of distinctions we would like the Tax Code to smooth out over time.

The question then is, in the first year that you implement this, do you want to penalize the people who are living in those high-cost areas by having them take a much bigger hit in year one? I would agree with Jon Gruber that you want to smooth it out a little bit over time, especially because contracts have been negotiated and because people do not have control over this, especially in the short run. But in the long run, I do not think the Tax Code should be promoting wildly different bundles of health care in different parts of the country.

Senator LINCOLN. But if your cost of living is so much lower because you live in a poorer area, but all of a sudden you are going to be carrying a heavier part of that burden, because there are other areas where the cost of living is higher for whatever reason, those people in those States are compensated normally by a higher income. So, I mean, my concern is, because I come from a State

that has disproportionately low-income people, but I also have lower-cost plans, if in fact they are going to share a greater burden of covering those States that have higher-cost plans because they have a higher cost of living in those areas. I am already in the tank.

Dr. BAICKER. And that seems like a much bigger tax policy question that, in a way, is not specific to health care. There are a few provisions in the Tax Code that seem to take into account differences in cost of living, but by and large the Tax Code does not adjust for the fact that some parts of the country are just more expensive to live in, whether or not wages keep up commensurately. That is going to be true of health care as well.

So whether you want to just take the cost of living component into account seems like a broad tax policy question.The excess costs above and beyond the cost of living that are driven by differences in the quantity and quality of health services consumed, those are the differences in costs that I think we would want to stop subsidizing over time.

Dr. ALTMAN. Do you need to use the Tax Code? What I think many of us are saying, is you do not need to use the Tax Code. As a matter of fact, what you need to do is change the way Medicare pays for these providers and you can make a major change on that without getting into the tax issues. That is where the dollars will flow directly back into the Federal Government.

Senator LINCOLN. I think that is a good point, but I think it is going to take both.

Dr. BURMAN. But again, if you had a cap that varied by region and you used the money you raised from that to cover low-income people, the people in Arkansas might well be better off. I mean, the current subsidies really provide next to nothing for low-income people, no matter how much you are paying for health insurance.

The CHAIRMAN. All right. Senator Grassley?

Senator GRASSLEY. Yes. Dr. Baicker, on this issue, we have been talking about regional variations. Do you think a flat national cap would achieve the downward pressure on insurance that you discussed?

Dr. BAICKER. Yes. I think if we were to reform the current tax treatment in a way that did not provide a subsidy for more and more expensive plans, that would exert a downward pressure on the cost of insurance and the cost of care more broadly, but would also encourage the kind of value-based insurance that was talked about before where you would want people to see out insurance policies that delivered the highest value care for each dollar of premium they were paying. That incentive is dulled right now by a system that subsidizes more and more and more insurance regardless of the marginal improvement in health it produces.

Now, how you can do that in a way that does not involve a potential degeneration of risk pooling in the employer market would be through a complementary policy I would not want to just reform the tax treatment alone. I would also want to provide an alternative mechanism for risk pooling, such as risk adjusted payments between insurers or risk adjusted vouchers for health insurance, where higher-cost enrollees generated more revenues for insurers so they would not seek to avoid high-cost enrollees, but the enroll-

ees themselves would not have to bear that cost. There would be a social insurance component like the one that we are currently delivering in a really inefficient way through the employer system.

We could, rather, deliver that social insurance component through an alternative mechanism that would create an incentive for insurers to seek out high-cost enrollees and provide them with higher-value care. For example, you could have insurance companies that specialized in diabetes disease management—rather than trying to shed their diabetic enrollees—because they were paid enough to make it worthwhile to insure them. They would strike to provide the most efficient, coordinated diabetic care available, and people would seek out that plan if there were appropriate incentives for them to get high-value care. We do not have right now.

Senator GRASSLEY. Thank you.

The CHAIRMAN. Senator Bingaman?

Senator BINGAMAN. Let me just go back to what I believe Dr. Altman said, just to clarify in my own mind. You are saying the most direct way for us to deal with some of these geographic disparities and to essentially reward lower cost, more efficient delivery of care, is to do it through the Medicare system and instead of doing a regular across-the-board reduction in Medicare benefits, adjust those reductions to reflect the geographic differences that currently exist, and do that over a period of time.

Is that what you were saying?

Dr. ALTMAN. That is what I was saying. I think trying to get at it by putting a cap—I would support some form of a cap on the employer exclusion, but to make it the major item and to sort of push down hard on it beyond a certain point so that we could turn things around, I think is the wrong way to go. The better way to do it is to go into the payment system, to reward the value-based payments, to move towards an integrated delivery system, and to sort of penalize those that continue to practice fee-for-service high-cost, low-value care. You can make it out much faster.

Senator BINGAMAN. All right. Dr. Antos?

Dr. ANTOS. Stuart's suggestion is really a top-down kind of an approach, and certainly we should move in many of those directions. But we should also not forget that people still make decisions about health insurance based largely on what they think they are paying for health insurance. Apparently the latest surveys suggest that they think they are paying $100 a month. So we do have to deal with the tax treatment of health insurance.

There is a way to smooth that transition that has not been suggested, although many suggestions have been very valid and, I think, worth working on. That is, why not give people a choice? Why not let people choose between a capped tax exclusion and a tax credit? With a tax credit you do not run into all of the problems that may exist with legal issues and you can risk adjust it in terms of both the person's income, the person's health status, and the overall cost of health care in that area, applying some pressure where it seems overly expensive. But if you give people that choice, they will make the right choice and it will not necessarily drive people out of employer coverage. They can stay if they want, they can use their tax credit where they want.

Mr. SHEA. Senator, can I comment on this from a different perspective? The point has been well made how complex trying to provide equity within the tax system is if you were to go this route. But there is no question that we could improve the practice of medicine. The Institute of Medicine number is, 30 percent or two of our $2.5 trillion a year is for care that does not really help people.

The beauty of what you have done in your options report the other week about delivery system reform, is you are in tune with what is going on in the health professions and the health field. This has been a long time coming, but people believe that we can do a lot better. We have learned that there are ways to do this. People—physicians, for instance—have become much more comfortable with this.

I would just suggest to you, going way back to Senator Cornyn's question, there was real significance in yesterday's announcement. I understand we ought to take it with a few grains of salt, and really what you need is to get this stuff in scorable numbers. But the significance, I would submit to you, is that the trade associations, which are not necessarily thought leaders but really represent everybody, they are comfortable enough with the idea of big system change because their constituents are ready for that.

I think that is the lesson of the work that has been done over the last 10 years among consumers, purchasers, physician groups, hospitals, and insurers, and goes on today. It is a very, very vigorous and robust enterprise. I think that is the right moment here. It is not nearly as explosive as taxation, believe me.

Senator BINGAMAN. Could I ask a follow-up question, Mr. Chairman? Let me just ask—yesterday's announcement, I applaud that. But my understanding is that much of the increase in the cost of health care is related to technology improvement. It seems to me if that is the case, then it makes it all the more important that if we are going to reduce the growth in health care costs, that we pursue this comparative effectiveness effort. There is no other way we are going to make the kinds of savings that were talked about yesterday or today that the President was championing. We are not going to make them real unless we really get serious about comparative effectiveness. Is that right or wrong?

Mr. SHEA. I think that is absolutely right, Senator. I think, again, the professions are ready for this. There are some outliers. People have to be assured that it is going to be done fairly, but I think people are ready for this. I would suggest to you also that, looking forward, we have to go way beyond comparative effectiveness because, as you mentioned technology, we have a system that has developed a model of competition among providers that is based on more, and more, and more technology. The new heart institute across town begets another heart institute on the other side of town. This is what competition is among providers. It is dysfunctional in the extreme. So we have to go beyond that comparative effectiveness, but that is one of the first places to start because I think people are ready for it.

The CHAIRMAN. Mr. Wojcik?

Mr. WOJCIK. Yes. Thank you. One of the things that the business community does is look at the pipeline of the new medical technologies, medical interventions that are coming down the road, and

that is one of the reasons why, for the past decade and longer, the business community has been very concerned. Because we are seeing what is coming down the road in the next few years in terms of the cost of new medical interventions being applied to common conditions, chronic conditions, cardiovascular disease, diabetes, asthma, many of these which are becoming more and more prevalent.

So we definitely need a strong, vigorous comparative effectiveness effort and more evidence-based medicine, more focus on primary care, more value in the Medicare system and other payment systems for evaluation and management, care coordination, and the hand-offs between hospital care and other settings.

If I can talk a little bit about the tax exclusion. My observation, in listening to the discussion about the geographic adjustments that would have to be made if we capped the tax exclusion, that has major implications for the employer system because right now, especially if it is an employer that is in multiple States, we pride ourselves on having the same benefit for the same employees no matter where they live, and we would have to deal.

That would be another administrative complexity that self-insured employer plans would have to deal with. Especially, the more States or the more regions you have people in, you are going to have to be making all these adjustments and raising all these equity issues, people doing the same job for the same pay, some of whom will be taxed, depending on where they live, on their health benefits, others who will not. So, I just want to make that point, that it is a major complication for the self-insured employer system as well.

The CHAIRMAN. One thing that has always struck me is the testimony of Uwe Reinhart, whom all of us know of, not in this room but in this committee, which pointed out that even in the State of New Jersey, if I recall correctly, he looked at the end-of-life costs in the last 6 months at three different hospitals in New Jersey and found a variation of three-fold. I think one hospital spent three times what another hospital spent in his own State, New Jersey.

So he called them up and asked them, hey, what is going on here? Why are you spending three times more than the other hospital? Answer? That is just the way we do it, just practice patterns and so forth. My guess is that that explains a lot of the disparity around the country: that is just the way we do it here. For whatever reason, that is just the way we do it.

So we are trying to get at that, with all of the things we are talking about here with delivery system reform, health IT, comparative effectiveness, value-based purchasing, and more emphasis on primary care doctors, and so forth, trying to bend the stovepipe so there is more collaboration and bundling, and some integrated care and things like that. But I am just astounded at the variation in the country based on practice patterns, which to me indicates that it must explain a lot of the waste that occurs in the current system.

Dr. ALTMAN. You know, Senator, I think the single biggest difference between the United States and other countries is in just what you just said. When you just look at the high cost of dying in this country—and of course it is geographically different—and you just looked at that, and we have looked at it and compared it

to Canada, England, and places like that; that is where the big differences in our spending patterns are. It has to do with the organized way we deliver care.

The CHAIRMAN. Right. Now, this is a question that many of us have thought about, and Senator Wyden sometimes raises this very question. It is delicate, it is sensitive, but it is important. I would like any of the panelists to address what this country might do about the high cost of end-of-life care. Dr. Wilensky, you raised your hand first, so you are getting called on first.

Dr. WILENSKY. We should not fool ourselves that this is going to help as much as it might sound. I say that because the percentage of Medicare dollars spent on individuals during their last 12 months of life has been pretty constant over the last several decades. About 28 percent of the Medicare dollars are spent in the last 12 months.

Now, that is not to say that there are not strategies that can be used to try to encourage care that meets what the family and the individual wants, that reduces some of the medicalization. I mentioned this year's Dartmouth Atlas showed a three-fold difference in the last 6 months of life between spending in Los Angeles hospitals, northern California, Intermountain, and Mayo. That, along with the other variations, is very important.

The Congress has tried to encourage advanced directives that people say how they want to be treated. That is important. Making hospice more available, shared decision-making, where there is more discussion between the families and the physicians is very important, making sure these benefits are available. But when you look at it within the whole context, these variations occur all across the life scale in all kinds of health care, only some of which is related to the last 6 months.

The CHAIRMAN. All right. Any other points on the last 6 months?

Dr. ALTMAN. Yes. First, Gail's comment about the same percentage really sort of hides what has really happened. Remember, our population is aging. At the very, very elderly, the costs go down, so that percentage should be falling and it is not. Second, the cost of care is growing by so much, so the same percentage is worth a lot more.

So let us go back to the issue of comparative effectiveness, which we are supporting. That is where that can have a big impact. It is not only there, but that is where the waste is. That is where people are using technologies that really either do not work at all or keep people alive for very limited and very high costs.

Hospice is one option, but we do need to take account of the cost/benefit of some of the things we do, and either we can do it directly or we can do it by bundling payments and let the delivery system deal with it. So it is a combination of the delivery system dealing with it and/or you providing more information for people to make the right decisions, both for themselves and for the care.

The CHAIRMAN. Before I go to Senator Carper, does anybody else want to reply?

Mr. KLEIN. Yes, Mr. Chairman.

The CHAIRMAN. Mr. Klein?

Mr. KLEIN. Thank you. You will not hear me saying this often, but this is one area that I think does call out for Congress to com-

mission a study. I honestly think that the realm within which the questions are raised here are in the realm of ethics and faith and other factors that are outside the province of tax policy and health policy.

In order to ensure that we do have patients and caregivers and health care providers better informed about the different options, that is just going to take more time than would be able to be done as part of the very important health care reform initiative that you are under.

But how that links into the technology issue is what sort of gave rise to this. I just have to put in a plug on behalf of technology, since the number of people have identified it here as a reason for increased costs, particularly at the end of life.

Technology can be our friend. I think what you have called for in your white paper in terms of promoting health information technology is the perfect example of that, and I think we only need to look, for example, I will say in closing, at the experience following Hurricane Katrina, where literally overnight hundreds of thousands of people were separated by hundreds of miles from their medical records that were on paper, that were either inaccessible or destroyed.

All these people knew was, gee, in the morning I take a pink pill and in the afternoon I take a yellow pill. If this kind of information were available digitally we would not have that. The health care sector lags seriously behind almost every other industry in this country in terms of its adoption of health care information technology.

The CHAIRMAN. Senator Carper?

Senator CARPER. Just as a segue, the folks that happen to be veterans and those in that part of the country during Katrina who were hospitalized in VA hospitals or in VA nursing homes who were moved out of harm's way to other facilities inland, when they arrived in those new VA facilities the people receiving them knew what medications they were taking, they knew what their medical conditions were, they knew about their lab tests or MRIs, and provided excellent care.

I have a son that goes to MIT, who is a lot smarter than his dad, and he is on this triathlon team there. He was out there riding his bike just before Christmas and he wiped out on some black ice outside of town and really screwed up his hand pretty good. He went to the doctor's office—actually, the hospital there—and had X-rays and so forth. He came home for Christmas a couple of days later and we took him to a hand specialist there.

He went out and worked in San Diego for the month of January and he visited another hand specialist out there. He went to all three of them. Every one of them never talked to the other two physicians. They all took their own X-rays and there was just no way to really figure out what kind of care he had gotten and see if there are any conclusions. There was just no communication.

That sort of thing goes on all the time, I think. It goes on all the time. I was not planning on getting into health information technology. In Delaware we have been standing up something called the Delaware Health Information Network. We have been working on it for a number of years, starting when I was Governor. The

idea is to link our hospitals, our doctors' offices, medical labs, and so forth, and to use some of this stimulus money to really incentivize doctors' offices, especially the smaller offices, to move toward medical electronic health care records. I think we are getting a pretty good uptake on this sort of thing.

Do you all have any specific advice for us as it pertains to effectively using stimulus money? There is $19 billion that has been set aside for harnessing information technology. But I would welcome your thoughts as to how we might spend that money effective. Dr. Wilensky?

The CHAIRMAN. Dr. Wilensky?

Dr. WILENSKY. The VA has been able to demonstrate how important it is to be able to at least pull up records and read what is there. During Katrina, that was a clear example. One of the issues, as you are going forward—there are really two areas that States that are trying to promote health IT need to focus on, as we do in this country. One is interoperability, but the second is standards and terms that are used within the medical records themselves. The VA and the DoD represent our two most advanced areas of electronic medical records, but they have been struggling mightily for the last decade and a half to learn how to talk to each other.

Senator CARPER. I understand they are under orders right now from Bob Gates to work on that.

Dr. WILENSKY. They have been under orders from many——

Senator CARPER. I think this time it is for real.

Dr. WILENSKY [continuing]. From the Congress for basically the last two decades. But trying to make sure before you start, or while you are early, that there is an agreement both about interoperability—but we have talked about comparative effectiveness, and if we are going to make use of the natural variation that occurs in how care is provided—maybe more than we would like but that is occurring—and to try to see the clinical outcomes that occur with that natural variation. It means that not only do you need to be able to look at the record so you do not repeat the test, but researchers need to be able to do a deep dive into the record to be able to see if you treat cardiac disease differently with angioplasty, or with bypass surgery, or medically, and you stage the illness, are you having different clinical outcomes? Getting that kind of decision-making early rather than after you have already invested billions of dollars will be very important and it will be much harder to fix it after the fact.

Senator CARPER. All right. Yes, sir?

Dr. ANTOS. This also drives home the point that there has to be a business case for the use of health IT and for doctors and hospitals to cooperate with each other. Outside of certain kinds of health systems such as Kaiser Permanente, which clearly there is a business reason because the doctors are generally employees, in most of health care in America it is a fee-for-service, atomistic kind of a system. There are, in fact, strong business reasons to not cooperate.

Hospitals do not want to lose—not so much the patients, they do not want to lose the admitting physicians. If it is too easy to move patient records from one hospital to another, from one insurer to another, it is too easy to lose market share. So, that is a big, big

problem. There has to be a business reason. Medicare is providing a little bit of a business reason by imposing a penalty if unspecified standards are not met in a few years, but that is not a positive incentive, that is a negative incentive.

Senator CARPER. I just have one other issue. I do not know if anybody has talked at all about health savings accounts. I think they are being used in a couple of other countries, along with our own. Among the things I found attractive about the health savings accounts is that they had the potential for reigning in the growth of health care costs and they encouraged individuals to make better health-related choices. Are they the end all, be all? Not at all. But as we look at the context of health care reform overall, what place is there, or what can we learn from health savings accounts going forward? Yes, sir? Dr. Gruber?

Dr. GRUBER. First of all, I am glad your son chose wisely for college and I am very impressed. I have trouble enough walking on that black ice. I am impressed he was out biking.

Senator CARPER. I was a junior at Ohio State before I could spell MIT. [Laughter.]

Dr. GRUBER. I think it is very important to separate the concept of a high deductible health plan from a health savings account. I think that as we as a Nation move towards a more rationalized health care system, part of that which we have not really talked about today, is going to be putting more of a burden on patients to make cost-conscience decisions about their health care and high-deductible health plans can play a role in that. That does not mean that we should have a large, regressive tax subsidy attached to them to promote them.

The right way to promote high-deductible health accounts is exactly by saying the U.S. Government will not subsidize excessively generous insurance. They will subsidize a general level of insurance, and that is a level which can be readily met by things like high-deductible plans. But to in some sense say, all right, to make you get a high-deductible plan we are now going to give you an extra tax break, that is what I call two wrongs trying to make a right. It does not work that way. If we want to promote high-deductible health plans, the right way to do it is to stop the subsidies we give that cause people to get excessively generous insurance rather than to try to bribe them with a highly regressive tax break to get those high-deductible plans.

The CHAIRMAN. Do you agree with that, Dr. Greenstein?

Dr. GREENSTEIN. Excuse me?

The CHAIRMAN. Do you agree? Because this subject is going to come up quite a bit, HSAs.

Dr. GREENSTEIN. I very much agree with what Dr. Gruber just said. There actually are aspects of HSAs that promote unnecessary and excessive health care spending. A couple of examples. First, HSAs can be spent on a very broad array of health expenses, all sorts of things that are not covered by a health insurance plan.

Now, there is more justification for that at the present time, but if you have a reformed health care system where you have some kind of creditable minimum benefit standard, maybe that an exchange sets, or some other body sets, then the notion that you are

going to allow all sorts of tax deductibility into an account for all kinds of additional health insurance, health spending is a concern.

There is a second issue, which was when health savings accounts were first enacted in 2003 there was a rule that the amount that an individual could put in an account in any year was limited by the lower of some very high amount or the deductible for your high-deductible plan.

In 2005 or 2006, the law was changed in, I think, a very unwise way, so that now you can put an amount in up to the maximum amount specified in law, even if that is way over your deductible. So for a family plan, family coverage, a deductible plan of $2,300 qualifies you to use an HSA, but you are allowed to put in, on a tax-deductible basis, $5,950. Well, the extra $3,650 is a huge tax shelter.

So I would recommend, first, that you go back to not having an amount be able to be put in on a tax-deductible basis that exceeds the deductible for the plan. Second, I really think you need to deal with the fact that one aspect of HSAs has nothing to do with health, it is really to provide a tax shelter for high-income people in retirement and to evade the limits on IRAs you have put in, because in retirement you can withdraw money for health, you can withdraw it for non-health expenses—if it is non-health it is taxable—and there are no income limits at all on it. So when you put all these features together you have created an incentive for high-income people to use HSAs as one hell of a tax shelter.

The CHAIRMAN. Senator Wyden? I am sorry, there are Senators seeking recognition, too. Senator Wyden?

Senator WYDEN. Thank you very much, Mr. Chairman. Let me also say, I really appreciate what you are doing on regional disparities and end-of-life care. I am looking forward to working with you on it.

On this question of choice, and I think Gerry Shea touched on it, and now we are on the HSA issue, it is very clear to me that with 85 percent of those lucky enough to have health coverage but not getting any choice among plans, that it is going to be critical to reform to give people choices, in effect, with a menu like members of Congress have.

So Mr. Sheils, the question for you is, is it not true that it is a vital cost containment tool that people have a range of choices with at least a standardized minimum package so that insurers and others have to compete for their business and people get rewarded for smart selection?

Mr. SHEILS. Yes. It really would be pointless to create new incentives for people to go into lower-cost plans if they do not have that option available to them, if it is not available to them at work. Lots of people, you might be surprised—myself included—do not have access to an HMO at work. If we are interested in maybe making a step in that direction for purposes of controlling costs, those options, those lower-cost options—HSAs, for example, as well, have to be available to people.

How do you do that when you are dealing with, say, small groups, for example? I have always thought it would be interesting to create the exchanges, as Senator Wyden proposed, and similar to what they have in Massachusetts. Also, I have toyed with the

idea of perhaps asking insurance agents and brokers to present a multiple offering to each employer where there is a choice of health plans. Perhaps that is a way of getting choice to these people. But it would really be, in many cases, fruitless to improve increased incentives to be cost-conscious if people do not have that option to jump to in response to the incentive.

The CHAIRMAN. Would you modify ERISA plans? Companies who are self-insured who provide insurance for their employees, but they are self-insured. Would you delve into that arena and require more choice for the employees?

Mr. SHEILS. Well, I think that requiring—let me put it this way. Many health reform proposals originate in the notion that we have to give choice to people and we have to present them with financial incentives that will get them to make those choices. If we are not going to put everybody in a system where there are exchanges and so on that everybody must go through, we have to look for a second best.

I would think that even self-funded plans have the potential to benefit here on a cost basis providing a range of options to their workers. So the struggle is, particularly if you change the tax incentive, the question is, how are we going to make sure that people have options available to them? With an exchange that is an option to the employer, some people would be——

The CHAIRMAN. Would you require the self-insured to participate in the exchange? That is my question.

Mr. SHEILS. Yes.

The CHAIRMAN. You would?

Mr. SHEILS. I think that one could provide a range of options without having to forfeit the self-funded status, for some of the large employers.

The CHAIRMAN. Senator Stabenow, I think you are next.

Senator STABENOW. Thank you, Mr. Chairman, very much for another very thoughtful discussion.

I need to ask, I guess, a fundamental question, particularly of our business representatives, and with Mr. Shea as well, just to have it out on the record. I have been involved for about 30 years, I hate to say, in health care policy. I started when I was 5 years old. [Laughter.]

Senator SCHUMER. When you went to the doctor.

Senator STABENOW. Yes. Yes. For years now, particularly coming from a State with a large number of large employers providing quality health care, we have talked about losing jobs to international competitiveness issues because health care is on the back of business. For years I have said we have got to get health care costs off the back of business to be more competitive internationally.

As we come to this very important discussion now, we are now hearing from business that is not what is desired. I mean, there are multiple options, from a Medicare kind of system, to taking the employer tax treatment, giving it totally to the employee and addressing issues of choice and so on. But we are now hearing that employers want to be in the business of health care.

I have heard the discussion around that, but for the record, I think, with all of you here, distinguished individuals here, I would

like to have a discussion, or at least comments, regarding the fact that even in light of the international competitiveness issues, it is a desire to build on the employer-based system rather than to choose a different direction.

Mr. WOJCIK. If I could start, if I may. The employer-based system, as you well know, has many merits and provides many advantages to merit the tax treatment. Employer-based plans achieve economies of scale so they can provide health care coverage at a lower transaction cost level and lower administrative cost level to more and more employees.

Senator Stabenow, you had mentioned earlier the concern about the older employees. Employer-based plans cross-subsidize coverage so that the younger and the healthier employees, as you know, subsidize the sicker and the older workers. Also, employer plans, depending on how large they are in the health care markets where they have employees, can leverage that purchasing power on behalf of employees to provide lower health care costs and many quality improvements and innovations, and they have the power to do that for their employees. If employers have the resources, they want to provide health benefits to employees. There are lots of, obviously, health benefits to the employees, productivity benefits, and other reasons for employers offering coverage.

Mr. KLEIN. If I may, Senator, an excellent question. But I think—I know—that the vast majority of employers, certainly major multi-state employers, do not want to abdicate their role in the delivery of health care coverage. We do want the kinds of reforms that have been talked about this morning and this afternoon around ensuring a better alignment of cost and quality and the other ideas that have been put forward. But we believe that it is critically important, both from the employer and from the employees' perspective, that we build upon the employer-sponsored system.

The employer-sponsored system allows large, multi-state employers like my own members to ensure that they are providing benefits equitably to their workforce wherever they may live or work. And we should not gloss over the fact that we have talked a lot about the problems that still exist in the health care system. But where there have been improvements in innovations, those have largely been driven by strong employer engagement. I do not think as a Nation we want to lose that.

Senator STABENOW. Excuse me. I am sorry. Did someone else——

Dr. BURMAN. Can I make just one comment?

The CHAIRMAN. One of the two of you.

Senator STABENOW. I just want to make sure we hear from our employee end as well.

Dr. BURMAN. It is no surprise that large employers like the current system because they can provide health insurance relatively cheaply. Small employers may have to pay twice as much for the same health coverage. Because of the way we tax this, basically they can provide a large share of compensation in tax-free form, where small employers who cannot afford to offer health insurance are all paying compensation as cash wages.

So I think that is a major reason why small employers often do not offer insurance. It is not because they would not like to be able

to provide the benefit, but because they cannot afford it. It actually creates a distortion by favoring large employers over small employers in the Tax Code. That is probably where we get the biggest efficiency cost. It is not so much that employers have to pay for health insurance—employees pay for it though reduced wages—it is that we are basically tilting the playing field in favor of large employers.

The CHAIRMAN. Mr. Shea? Then we will go to Senator Schumer.

Mr. SHEA. Senator, thank you. What employers want—and not just employers, but workers too—is cost containment, is relief from the high costs. Believe me, I can tell you, for 25 years unions and employers have worked together. It has been nothing but damage control. We may have had unlimited tax-preferred treatment. We have not increased benefits. It has maybe been a tiny bit on the margin. We have seen costs go up and up and up, despite the tax deferred.

So I really want to just make a point, without going into detail, I think we have not talked much about the behavior part of the tax treatment and I really just want to suggest, you need to look long and hard about whether or not you are going to get the desired outcome that a lot of people want to theorize will happen: if you tax benefits, therefore you will reduce costs in the system. I do not think that is true.

But cost containment is what we need and there are two structures on the table that really would add to that. One, is the exchange mechanism. If you look at the exchange, John Sheils' data that he did for, I think, The Commonwealth Fund, shows that the administrative costs in the exchange for small business is like one-half the cost in administration for groups of 20 or under, and it is like one-third if it is 10. So it is really a very substantial saving.

Then the other is the public health insurance plan option. What employers say to me is, we want choices. We want real competition in the insurance market, because all of the work that people do, even in very large employers, to restrain costs are not going to work. They will tell you that, down the line, they are not going to work without some national assistance. One piece of that, I would suggest to you, is the public health insurance plan option. The other is what we have been talking about, and where business have been leaders, in fact, and that is on the delivery reform work. They have been a very, very positive force in that.

The CHAIRMAN. Senator Schumer?

Senator SCHUMER. Well, thank you. I agree with you on the public option, Mr. Shea. I have just one question, actually, of you. We are looking for cost savings here today. I saw that whole group at the White House yesterday.

Well, one place for cost containment which could make a significant difference is a pathway for biogeneric drugs, something that myself and others have worked on on this committee. The estimates of cost savings are almost always too low in this area. I worried that yesterday the estimates of cost savings might have been too high or too ephemeral. When Ronald Reagan signed the chemical generics law he said it would save a billion dollars over 10 years. A recent study found that generic utilization saved Americans $734 billion over the 10 years from 1999 to 2008.

So what do you think of putting this in the bill? This would not be our jurisdiction, it would be the Help Committee. But still, while we are on cost savings, I figured I would ask you, and then whatever any of the other panel thinks. That is my only question.

Mr. SHEA. Thank you, Senator. Thank you for your work on this. I think it is an important area to deal with. Whether it is union funds or employers, they now pay for biopharmaceuticals and we are going to have more and more of this, as you know, because of the science. It is great science, but we have to get them into the generic market as soon as possible. We know from the drug market that the Hatch-Waxman Act has been very effective in this area.

When you look at the experience with Medicare Part D, the reason that that has been successful has been because of the entry of generics. So this is really a crucial area. We need to be careful to encourage innovation, but these prolonged periods of exclusivity, I do not think make any sense from our point of view. If that is the price of innovation, we could wind up in the poorhouse, frankly.

The CHAIRMAN. I was interested in your earlier comment—I think it was you, Mr. Shea—talking about the effective, proper way to sort of bend the cost curve. We are here today on this whole subject in large part because health care costs are rising at such a rapid rate. So we are trying to figure out some way to, fancy term, bend the cost curve.

So the question is, what is the most appropriate way, the two or three more important mechanisms sensitive to the quality of health care, that you can come up with that appropriately will start to bend the curve? Now, when you spoke earlier you did not think that limiting benefits in the employer exclusion would have much effect, if I recall correctly.

I also heard you say that maybe the public option would be an enforcer, at least on the insurance companies. But I would just like to ask the panelists here the two or three most effective ways, because this is really where a lot of this is at, is how in the world are we going to begin to get control of the rate of increase in health care costs in this country? Again, in a sensitive way, in an appropriate way, but that also addresses the need for quality and coverage.

Dr. Altman, I see you raised your hand first.

Dr. ALTMAN. Yes. I would like to turn us to Massachusetts. We in Massachusetts did do a two-phase approach, one coverage, and now with seriously looking at cost containment. So we are your guinea pig. We are your poster child. I know the State is taking this very seriously. Where they are pushing and where I would like to suggest that the national should push, is to move towards global payments, bundled payments, and to do it in the context of States, some State systems.

Again, if I could repeat what I said, we need to change the delivery system to support what Senator Cantwell and others said. By doing that, we can also slow down the cost growth without imposing wage and price controls. Wage and price controls just simply limit prices and wages for the existing system. We need to move towards value-based payments.

The CHAIRMAN. All right. Right.

Dr. ALTMAN. Unfortunately, the current balance of power between the hospitals and doctors on the one side and the payors on the other just is not there to do that.

The CHAIRMAN. All right.

Dr. ALTMAN. I am concerned about the public system because I am concerned about Medicare. Medicare has been a real problem in this area. I mean, I am a big supporter of Medicare. I love Medicare. I am on Medicare. [Laughter.]

But I cannot put that up as the number-one insurance model when it comes to redesigning the delivery system.

The CHAIRMAN. Because of administrative pricing and so forth?

Dr. ALTMAN. Well, it is administering pricing fee-for-service, so Medicare needs to get into the act in a really big way. So my suggestion for the number-one cost containment over time is to change the delivery system and squeeze it enough to get out the inappropriate care.

The CHAIRMAN. Dr. Jacobson?

Dr. JACOBSON. Well, I think a major thing is to keep people out of the medical system. I think a major goal, and as you said, the cornerstone of health reform, should be prevention, keeping people out of the medical system. That would save huge amounts of money and it can be done partly through your committee, partly through the Senate Committee on Health, Education , Labor, and Pensions, through things like lowering the sodium levels in food.

According to Rand Corporation, that would save about $20 billion a year in direct medical costs. Getting rid of trans-fat would save the government a couple of billion dollars a year. The taxes, we have talked about. Somebody mentioned tobacco taxes, sugar-sweetened beverage taxes, alcohol taxes would raise a lot of money and help keep people healthier, and reduce obesity in the case of soft drink taxes. Then, more sensible modes of treatment. Then it gets into the comparative effectiveness.

The CHAIRMAN. All right. I guess one part of the calculus here is what is politically palatable, too, in addition to, what is the efficiency and what is the right public policy.

Mr. Sheils?

Mr. SHEILS. I think we know what works in cost control: it is capitation, putting people in situations where they have got a fixed sum of money to work with and they have to maximize efficiency within it. DRGs were a form of capitation. We saw dramatic drops in the length of stay almost instantaneously, way before anyone expected. In 1989, the average rate of growth in spending for employer coverage was 18 percent a year. Employers just freaked and made a tremendous investment in managed care.

Many people were in HMOs, but they made a big transformation in the delivery system, emphasizing those plans where there is a capitated payment and people have to work within it. By 1996, the average rate of growth in health care dropped to eight-tenths of 1 percent for employer coverage. Adjusting for inflation, there was an actual reduction in health spending.

With our own Medicare Part D program, this emphasized competition in market forces and Medicare Part D came in, I believe it was, 37 percent under budget. Whoever heard of a Federal program on health that came in under budget? We know what works.

We know capitation works, we know markets can work. This is what I think about what occurs to me when we talk about changes in incentives. Putting people in integrated delivery systems where they have the right set of incentives to control costs rather than just crank up volume is the answer, and anything that moves in that direction, I think, is important.

The CHAIRMAN. Dr. Gruber?

Dr. GRUBER. We have talked about the role of employers and the role of providers. I think we do need to return to the role of the consumer, which is one other place we have real evidence, is making individuals price sensitive to their use of medical care. We talk in Massachusetts about the example of the pregnant woman who drives by the North Shore Medical Center where the doctor has 30 years experience delivering babies to go to the downtown academic medical center and have a 25-year-old resident deliver her baby at three times the price. There is no incentive for her not to do that.

What we need to do, is we need to both bundle payments and do the other things that Dr. Altman and others have talked about on the provider side, and we also need to make patients sensitive to these cost differentials. We have to make them aware of the cost differentials through our information, but we have to make them sensitive to those cost differentials through, when their incomes are high enough, bearing some of those cost differences themselves. We know that works. We know we can lower health care costs without sacrificing health by making patients more cost sensitive, and I think that is an important part and has to be something we cannot lose sight of as well.

The CHAIRMAN. All right. Mr. Klein?

Mr. KLEIN. If I could just add three other quick ones that have not been previously mentioned, and associate myself in support of many of the ones that have been, since comparative effectiveness and so forth. But first, I think some safe harbor protections for both providers and payors who render care consistent with practices that are evidence-based. We get back to that issue of ensuring that we are paying for good quality.

Second, there is one important lesson that we can take from the Medicare system which has been discussed earlier, and that is, Medicare has rules with respect to the non-payments for so-called "never" events. These are preventible errors, procedures that should not have occurred in the first place. Frankly, all payors should follow that practice. I also think that health care providers should be required to report all of those medical errors as a condition of payment by Medicare.

Then lastly, one of the very positive things that employers and others have been doing is the promotion of wellness, how to reduce costs, keep people healthier. There are issues that arise where Congressional clarification would be very helpful. For example, when employers want to conduct a health care risk assessment to help determine whether or not assistance can be provided to individuals because they may have some genetic predisposition to some disease or some other condition of that sort. Employers right now need some guidance that being able to collect that information, while protecting the privacy of the worker, does not violate the Genetic Information Non-Discrimination Act. Those are some very practical

things that need to be done in order to support the kind of efforts we are talking about.

The CHAIRMAN. Mr. Shea?

Mr. SHEA. I think the integrated care area direction is where we are going. We do not talk about capitation any more because of the problem of the late 1980's and early 1990's, but we do talk about integration, and bundled care is a move in that direction. There are just great examples of what high-performance systems, whether they be Mayo, Geisinger, or Intermountain, or Kaiser, can deliver through an integrated system and coordinated team work, and using IT. You have got to put all these things together. You can get a lot there.

But Dr. Gruber raises a point that has not been talked about and I was hoping it would come up, and that is consumer engagement. I have spent 25 years working with employers about, how do you get individual workers in the game on this? I will tell you, it is a very humbling experience, Mr. Chairman, because people like the idea of getting information, but they have not seen it come in a form that really is very usable for them yet.

Based on my experience, I am convinced that we need to approach this a little bit differently, and that is, bake it into the doctor-patient relationship. We hear from our doctors suggestions about what we should do; we largely follow them. It is a rare person who says, well, excuse me, I printed out this web page with the Medicare data on quality, and could we review it. That is not what most of us do when we think we need some attention.

But if you had a system that built into it regular education, health education through the doctor-patient relationship and you started this in a way or you got close to it with your delivery system reform where you said, to deal with readmissions you would pay for the people in the physicians' office who did that work, it is extra money. You are not asking the physician to go and do that. I think that idea is worth exploring.

I am sure it is worth exploring in terms of consumer engagement. There has been a lot of work done on this by employers and we are pleased to have been part of that. I think it is key to cost containment. I think we are finally at a point where we can have a real discussion, where people will not simply take it as cost shifting, because we are talking about system reform. I mean, that is the beauty of the announcement yesterday. These trade associations are stepping up and saying, we are going to save $2 trillion.

Well, of course you have got to pin them down on it, but even if it is $1 trillion, that is a serious investment. It raises then the question for consumers—it is something that we, for instance, would be happy to say, well, we are achieving the cost containment that we need, let us talk about what our end of this bargain is.

The CHAIRMAN. While you are on the subject, there is so much to cover here. That is the groups that met with the President. They are going to get significant benefits with universal coverage. I mean, the pharmaceutical industry will. Hospitals will, with less charitable care, for example. Insurance companies will sell more policies and so forth.

So I would kind of be interested in, what are some of your ideas if we tell them where they could save? Those were nice-sounding

words yesterday, as somebody said, but there is not much on enforcement. The question is, what is the follow though and follow-up? They are going to get big benefits with universal coverage: insurance companies, pharmaceuticals, hospitals, and so forth. So where should they pony up? Where should they show savings? I will start with you, Dr. Wilensky.

Dr. WILENSKY. Let me say, the first thing you ought to do is to have CBO or others do a scrub for all the specific payments we have put in over the years. We have referenced the disproportionate share payments, uncompensated care, bad debt, et cetera. And there are a lot of specific programs in HHS, some of which may still be important, but some of which may not, or not in their present form in terms of the level of support for specific populations, the maternal and child care, various programs, some of the special population supports.

Again, I am not suggesting this as just a blanket cut, but they ought to be reconsidered as to whether the amounts are appropriate, whether they need to be more targeted, particularly the payments that are going for bad debt and uncompensated care.

As you go forward, people have talked about the importance of moving toward more integrated delivery systems and bundling care. I am very supportive of that notion. Remembering to learn from the mid-1990's experience, people respond much better if they feel the insurance plan is their choice. The kind of backlash we saw to managed care in 1997 and 1998 did not seem present with the Federal employees in Washington because they knew every November they could choose another plan.

Making sure, as much as we think we are moving toward good systems, we want to engage consumers in a complete way, that is, not only reward and encourage better health behavior—and I support a lot of the statements made about trying to both push and pull better behavior from individuals—but if they can have a choice about these health care plans they are much more likely to be forgiving of some changes they might not like because they are able to respond and pick differently.

One final comment. Stuart Altman was emphasizing that Medicare now, although it does many things well in terms of providing access to care, is a very old-fashioned, out-of-date, inappropriate delivery system. It is almost all the things we have talked about needing to be changed: atomistic, á là carte, fee-for-service, no reward for quality and efficiency. That means a lot of change, and having the Congress decide who will be comfortable directing that change and providing very different authorities than have what traditionally happened will be part of the going-forward mechanism if you are going to try to change how health care is delivered in the Medicare system.

The CHAIRMAN. Dr. Gruber?

Dr. GRUBER. Yes. I think on the provider side it does hearken back to Senator Grassley's original point about how we reimburse providers for the uncompensated care they deliver in a much more targeted approach to doing so. But I want to more comment on the insurer's side, which is, I do not think it has to be a system which causes big wins for insurers because I think a key part of the sys-

tem has to be a much more rigorous, competitive environment among insurers.

In Massachusetts we set up this connector mechanism where insurers compete on a web portal that is very transparent, and we have really gotten prices down. In our Commonwealth Care program, which provides care for low-income populations, we have had a very aggressive bidding strategy among five Medicaid managed care organizations to provide care, and we actually have a zero percent cost increase for our Commonwealth Care program this year because of an aggressive competitive bidding strategy.

So I actually think that this does not have to be a situation where there are lots of extra resources going to insurers in particular if we do this in a way which maximizes the competitive forces in the insurance market.

The CHAIRMAN. Dr. Greenstein?

Dr. GREENSTEIN. Let me just take one area of those that you mentioned, which would be pharmaceutical companies. So I think you could start with two measures that the Senate passed on a bipartisan basis in 2005, but that were not enacted. One would have increased the minimum rebate in the Medicaid program.

On a related front, in Medicaid, drug manufacturers are not required to pay rebates for drugs prescribed for beneficiaries in managed care. The theory here was that managed care would negotiate good enough prices on its own. The evidence shows that has not happened. In 2005, you passed legislation that would extend the rebate to managed care.

In addition to those, too, some loopholes have developed whereby manufacturers of brand-name drugs can get around the provision in the law that says that if the average manufacturer's price rises faster than the CPI, that is supposed to be reflected in a higher rebate. There are loopholes that can be closed there. There is a CBO option in the CBO Options Book on that. The HHS Inspector General proposed as well that manufacturers of generic drugs no longer be exempt from the adjustment in the rebate if their manufacturer price rises faster than the CPI.

There is not also one in Medicare. The assumption when the Medicare drug benefit was established in 2003 was that the private plans offering the drug coverage in Medicare would be able to negotiate as low, or lower, drug prices for the dual eligibles, who as you know were shifted from Medicaid drug coverage to Medicare. The assumption was Medicare would get low or lower drug prices than Medicaid did.

Medicare is paying, in some cases, 20 to 30 percent more than Medicaid did because Medicaid had the rebate that I just referred to, and the private plans did not get similar economies in Medicare. You could require that for the dual eligibles, that the prices under the Medicare drug benefit matched what they would be had those people still been in Medicaid and the Medicaid rebate were in effect.

Finally, and I know this is a little controversial, but if we are talking about the pharmaceutical companies, and particularly if you could not get some of those other measures I just mentioned, I think you could look at some of the international tax reforms.

President Bush's IRS Commissioner Mark Everson warned, in 2006, that there was growing evidence of the pharmaceutical companies shifting growing amounts of profits overseas. Their share of sales and of assets that are overseas are about 40 percent of their sales, 40 percent of their assets, but they show on the books 70 percent of their profits overseas, even though drug prices for the same drugs are lower overseas than here. They are engaging in totally legal practices to move a lot of their profits overseas to avoid corporate income tax. They are going to make a lot of money out of universal coverage.

The CHAIRMAN. That is a big one.

Dr. GREENSTEIN. So here is a whole menu of things to look at with regard to pharmaceuticals.

The CHAIRMAN. Thank you. You have been thinking. Thank you very much.

Senator Grassley?

Senator GRASSLEY. Yes. I think this question fits in with what was just discussed, but maybe at a little higher altitude. Dr. Wilensky, Dr. Antos, and Dr. Gruber, we have discussed the need to bend the growth curve of health care spending. We already spend 16 percent of GDP on health care, more than any other country. A statement made, now probably two hours ago, seemed to suggest that we do not need to be as concerned about the new spending or up-front costs.

What is your view on this, and how do we make sure that we do not make things worse instead of better from an economic standpoint?

Dr. WILENSKY. That is a large question. Not making them worse from an economic standpoint, to my mind, is to ignore the cost of funding the expansion and not have it as a funded item. Massachusetts has shown us how quickly coverage can be expanded. In a very admirable way, they have very close to universal coverage now. They had some sources of money that, unfortunately, are not available to the Federal Government, a Medicaid waiver that was about to expire, a pool of money that was previously used for uncompensated care.

So to my mind the challenge will be making good on our commitment to make sure everyone has access to health insurance and coverage, and deep coverage, but recognizing it is a big cost and we need to make sure that our funding is able to match the expansion.

But the second thing is to take advantage of what seems to be widespread agreement by provider communities, payors, and your policy advisors here that reimbursement needs to fundamentally change: bundled payments, trying to reimburse for quality and efficiency, going after the geographic variations that we have talked about for at least the last decade, and using payment reform, along with better information to drive the kind of behavior change, recognizing it is going to take several years to implement these changes and we need to monitor as we are going out to not put ourselves in a very big fiscal bind. We need to be concerned about what is going on at an aggregate level to the deficit and to move as fast as we can, but not faster than we are able to fund.

Senator GRASSLEY. Dr. Antos?

Dr. ANTOS. Yes. Thank you, Senator. CBO points out the overall question of how quickly health care spending is perhaps the single determining factor on our country's fiscal balance over the long term, so it is a very, very serious question.

Perhaps the most important thing we need to do is to make sure that we size the reform right. We do not want to get the promises out ahead of our ability to pay for it and ahead of our willingness on the part of people to be taxed or to make other sacrifices to make all of this happen.

Unfortunately, Medicare is an excellent example of how that has not worked out. You look at what we are doing now with the sustainable growth rate for physician payment. What is that all about? That is, having extended promises to individuals—and to physicians, in this case—for payments and Congress says, well, we want to pull some of that back. We all know how difficult it is to pull back a promise after you have made it. It is almost impossible.

So I think the most important thing we could do is to take a step back and ask, of the various options that we have to promote greater efficiency, how quickly will they come online? What will it take to get them moving, and how does that comport with our willingness to tax ourselves and to make expansions in the availability of health care? What that really calls for is a phase-in. If we jump into this with both feet, then we are going to have serious, serious economic problems, not just now, but over the foreseeable future.

Senator GRASSLEY. Dr. Gruber?

Dr. GRUBER. Yes. I think that is really a fundamental question. Let me offer three points in response. I think the first point is, the way we do reform has to be in the kind of competitive environment that is going to make sure we take advantage maximally of what we are adding to the system, as I mentioned in my last answer, to make sure that we recognize that we are throwing resources into the system and use a competitive solution that redistributes those resources not just to the providers and insurers, but back to consumers.

I think the second feature is to make sure that we use payment structures for this reform that are as win-win as possible. We focused on two today, reforming the tax exclusion and pricing more expensive lifestyle choices. I think that basically those are win-win solutions that we can use to pay for things.

But the fundamental, most important point that I would make is, perhaps a bit in contrast to Dr. Antos, is not to be afraid to do coverage first. I think that to recognize that fundamentally if we are going to reform health care costs in America, the first step is to get everyone covered.

The first step is to get all of us pulling in the same direction rather than some of us fighting for coverage, some of us fighting for cost control, to say, all right, let us move to an equitable system where everyone in America has health insurance, and then let us all work together to make that affordable.

We have a great example of that in Massachusetts, which is, in Massachusetts we had a bill which did not even pretend to be about cost control. I would highly recommend the Congress consider a bill that has much more cost control in it than Massachu-

setts did. But nonetheless, it was a bill that was about coverage. We did that bill.

We got everyone covered, and then everyone sat back and said, wait a second. How are we going to make this sustainable? We have to get costs under control. The result, as has been mentioned by a couple of speakers here, was a fundamental cost control bill passed through our legislature that set up a payment reform commission to look seriously at the over-payments of many of our providers in the State.

It was a bill that would not have been possible—literally would not have happened—if we did not first move to universal coverage and first get everyone to get that topic off the table and get everyone focused on cost control. So, I think the most important lesson is that you can do coverage first, that that is a critical step towards the long-run solution we need of getting costs under control.

Senator GRASSLEY. Dr. Wilensky, you asked to be recognized?

Dr. WILENSKY. I would like to make an important distinction. I agree with not holding coverage expansion hostage until you get cost control, but we do have to worry about how we fund the expansion. Massachusetts funded their expansion through the Medicaid waiver and also with the uncompensated care pool. What I am trying to encourage you is to remember, we have got to fund the expansion and then we are going to figure out how to make the spending sustainable.

I am concerned, and for me the big economic worry is not yet another unfunded major program, large program. That would, I think, be a very serious economic mistake. So do not hold it hostage until you get cost containment in place, but you have got to figure out where the money is going to come from for the 15 percent expansion.

Senator GRASSLEY. If you want to talk on it, that would be fine.

Mr. SHEA. Thank you, Senator. The very, very high-altitude people—I think there is broad agreement that we have to go to evidence-based medicine as opposed to the practice pattern variation that is really driving up costs so much. The question is how you take that and bring it down to actual cost savings.

I would just say to you, your sense of urgency that this committee has had and the President has had is absolutely on target. When you look at the employer-based system, which is what we want to base the expansion of health coverage on, this system is not collapsing, but it is really in serious danger because of high health costs.

I would just suggest to you two mechanisms. One, develop a payment authority within the Federal Government structure that is not CMS that could test out some of these payment cages so you tie quality to payments, but do it in a rapid-cycle kind of way. We do not have years and years and years to do pilots and tests and come back to you and report. I just do not think we have the time. So I think you need a different structure to tie payments to reform.

Then, second, I do think you need the competition of a strong public plan. I would disagree to some extent with my colleagues, Dr. Altman and Dr. Wilensky, about Medicare. They are not the right sort of delivery model, but they have led the way in terms of getting hospitals to report on quality measures. They have led the

way in saying we are not going to pay for some of these things. That was Secretary Thompson, followed by Secretary Leavitt, who did that sort of thing. They showed that hospitals could report on quality measures. They showed that the hospitals' performance improves when they report on quality measures. No private employer was able to do that. We are all kind of scratching around trying to get to that. We need the leadership of a strong, robust public program.

Mr. KLEIN. Senator Grassley, I could not disagree more strenuously with Dr. Gruber. I think it would be a grievous mistake and a tremendous missed opportunity if the Congress were only to focus on one of the three essential components of health care reform, that being coverage. We are all in favor of addressing the issue of coverage and the American Benefits Council support everyone being covered, not simply access to it, but everyone being covered.

But the cost and the quality initiatives that we have talked about today are just as essential, and Congress is frankly up to the job. I think to sort of relegate that and say it needs to be dealt with later is to sell short your own efforts and initiatives, and frankly to potentially exacerbate the problem by not coupling improved coverage, universal coverage with these cost and quality issues.

Lastly, we are only going to get health care reform in this country if the public believes that it is a winning proposition for them. This is a rare moment to be captured. If I may return to the point made earlier about the tax exclusion as it relates to this, there are over 160 million Americans who receive coverage through their employer-provided plans. The notion somehow that the exclusion on employer-provided coverage is regressive is completely upside down.

Of course higher income people who pay at a higher rate and pay greater dollars in taxes will enjoy a benefit from a tax preference. That is true of any preference: the mortgage interest deduction, charitable contributions, deductions for State and local taxes.

But as a percentage of their overall income, this exclusion dramatically benefits lower and middle income people and you do not want to make the political mistake of the Medicare Catastrophic Act where people felt that they were losing something in the short term and any benefits to them were perhaps somewhere off in the distant future. You do not need to do it that way and it would be unfair to the very people that you are hoping to serve.

The CHAIRMAN. Mr. Kleinbard, then Senator Wyden.

Mr. KLEINBARD. Thank you. I just would like to respond on the progressivity point to just give some numbers, give some data here.

It may be that the savings are a smaller percentage of very high-income individuals' total after-tax income, but that simply reflects the fact that that person has lots of income. As I said earlier, medical costs, the amount actually spent on insurance premiums, does not go up proportionately with income.

So, for example, when you look at the savings per tax return you see that people who, say, have a $25,000 a year income might save, on average, $1,900 a year. Somebody at $100,000 income is saving $4,500 a year. So of course the system today is regressive. It is regressive in the sense that someone with the same health plan is getting, in effect, a larger subsidy, even though she is richer and

has a higher income. That is the fundamental upside down nature of the subsidy today. That is inescapably correct. It is also the case that it is not required that a subsidy have that characteristic. A tax credit does not. A tax credit is a lump sum.

Now, it is up to you all what to do with it, but the data are that there is, in fact, a very substantial benefit that goes up with income and, in turn, it is a feature of current law but it is not required of a Federal subsidy.

The CHAIRMAN. Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman. Mr. Chairman, I just want to ask one last question about something that you put on my radar that I think is absolutely key, and that is the transition period, the whole question of sort of what we have today and moving into a very different kind of system.

The President clearly started that in the campaign. He made it clear that everybody in the United States would have a chance to keep the coverage they have. It is going to be written into law and 100 Senators are going to vote for that. He also said that middle class people are not going to get taxed. Gerry Shea has made the point, I think, very eloquently on that point about why that is so important.

So then the question becomes, how do you start moving to a transition to a modern system? Much of today's health care, the question we have gone back and forth on on the Tax Code, comes from the 1940's. So the question then is, how do you, for example, reform the Tax Code so it is fair to the large employers—we have got to be very sensitive about ERISA—but also convert it to something that is modern? I think that is a generous deduction.

There are other changes, administrative cost reductions. Certainly if you have big pools of people, that will hold administrative costs down. Sign up with your employer, the employer wants to do that. Administrative cost reduction is part of the transition. Then most of the ideas that you all have been talking about today: rewarding prevention, buying value, dealing with geographical disparities.

So I think there is a sense of what needs to be done in this transition period, and I thought I would close with you, Dr. Wilensky, because of your background. I am particularly struck by the fact—and you and I have talked about it—you advised John McCain in the campaign, but you have been very supportive of a lot of the ideas of President Obama. I think that is exactly the kind of effort we are going to need to bring the country together.

Why do you not, at least from my standpoint, give us a little bit more insight about how the country can transition from a system that largely came out of the 1940's, and we can pick up on the Chairman's very good point about actually getting from there to here and reforming health care.

Dr. Wilensky?

Dr. WILENSKY. Thank you. Like all of the people in this room and at this table, I most want to see these problems addressed. I want to see people have insurance coverage and I want to try to help develop a health care system that improves value and rewards quality. There is some debate, as you get down to the specifics, about how you go about doing it.

But during the campaign people like Jonathan Gruber and I, and David Cutler and I, and David Blumenthal and I, who were sharing many podiums, commented about how much similarity there existed in terms of the kinds of changes that needed to happen in terms of better promotion, more focus on chronic disease, health IT, et cetera.

I am a little concerned about the expectations. Somebody mentioned earlier of trying to manage expectations now. It is important that we make some aggressive, significant moves. You could actually say you have already done some moves when you reauthorized and expanded the Children's Health Insurance coverage, subsidized COBRA, strengthened Medicaid, but you need to make some other significant expansions with regard to coverage, provided you can pay for them.

I am sympathetic with the politics of the tax exclusion changes. I would hope you can do some of the ones that Jonathan Gruber raised of limiting—just flat limiting—the amount of the deduction, doing it for specific income groups, or otherwise targeting more who you want to have that deduction. Mostly it will depend on how you index it over time. As long as it is not indexed to medical expenditures it will begin to have more impact over time.

You need to decide who you would be comfortable with to help redesign the reimbursement under Medicare. I am appreciative that CMS and HCFA might not be your choice—I do not have any allegiance there to tell you to direct that—but you need to decide how to change the delivery of health care and the reimbursement system under Medicare and to start it quickly, however you can do it, through pilots, as Gerry Shea said, and to recognize, while you will probably move faster on the expansion of coverage, that these are going to take a period to fold in all of these reimbursement and delivery system changes, and that people need to start saying that out loud to help try to not have a sense of disappointment.

So I think there is a tremendous momentum here, and the fact that you had the group yesterday indicates not just for self-protective reasons, but a real agreement that we need to change, and there are a lot of things we can do to make it better. It is figuring out how to harness that energy and to not lose that momentum, but to monitor the expectations. I am a little afraid that one is going to be harder for you as people who have to report back to your constituency.

Senator WYDEN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Frankly, I think that is a good point to wrap up with. We are, I think, making history here. You certainly all are. You have spent so much time thinking about how we reform our system. I do think, and it has been said by others, that the stars are pretty well aligned this time to finally accomplish our objective, which is getting control over the increased costs, second, to reforming the health insurance market, and third, is providing coverage for all Americans. It will not be easy—nothing worthwhile is easy—but we are going to get there. I cannot thank you all enough for all of your work and your help.

I suspect this is not the last time we are going to be conversing on this subject. This is going to take many more weeks, months,

and into the next several years too as we put this together. But my job is to keep the momentum going. My job is to keep people working together as long as we possibly can. My job is just to help all of us together, with no ideological axe to grind, just to get a really good, solid, American health reform put together here.

We need a uniquely American solution here. We are not some other country, we are the United States of America. We are noted for our ingenuity, we are noted for our imagination, we are noted for our can-do spirit, and we are going to put this together in a way that really makes sense. That is certainly my objective, and I know it is all of you, too. I cannot thank you enough for coming and spending about three hours here trying to undertake these next steps.

So, thank you very much. The committee is adjourned.

[Whereupon, at 1:09 p.m., the roundtable was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Testimony

Before the

Committee on Finance

"Financing Comprehensive Health Care Reform"

United States Senate

Tuesday, May 12, 2009

Stuart H. Altman, Ph.D.
Schneider Institutes for Health Policy
The Heller Graduate School for Social Policy and Management
Brandeis University

Mr. Chairman and members of the committee, thank you for giving me the opportunity to participate in this roundtable discussion on methods for financing what I hope will be a comprehensive package of legislative changes to reform our health care system. My name is Stuart H. Altman and I am the Sol. C. Chaikin Professor of National Health Policy at the Heller School for Social Policy and Management at Brandeis University. I have had the privilege over the last 38 years to serve in a variety of positions in Federal and State government including Deputy Assistant Secretary for Health Care Policy and Evaluation in the Department of Health, Education and Welfare, 1971-1976; Chairman of the Prospective Payment Assessment Commission (ProPac) 1984-1996; and a member of the Bi-Partisan Commission on The Future of Medicare 1998-2001.

I understand that there is a strong wish by many to pay for any expansion in health care coverage to the millions of Americans who lack any third party health care coverage with savings generated by either reducing what is now paid for care or by limiting the amount and types of care currently being provided. I share the view that there is substantial waste and excess in our current health care delivery system and that we can save substantial sums by reforming this system. But to attempt significant provider payment cuts before we provide adequate financial coverage for all Americans or in conjunction with expanding coverage would, I believe, be a serious mistake. Moreover, to make the uninsured, who are mostly the working poor, be the victims of our nation's inability to curb health care costs is clearly unfair.

Unless we change the way we provide services, any serious reductions in the payment levels for services will, I fear, lead to a reduction in access to care and/or the quality of the care provided. To change the delivery system we must move away from our current fee-for-service system to a payment system that rewards not more services, but appropriate services. Appropriate services often involve individuals who coordinate care as opposed to deliver services. Such care is most often found in what have been called "integrated delivery systems". By developing integrated delivery systems we have the potential to reduce payment levels for services over time without negatively affecting access and quality. Several members of the first roundtable panel and many of the options

prepared by your staff focused on different ways to restructure the payment system and, therefore, I will not go into detail on how such changes could occur. Nevertheless, permit me again to emphasize that these changes need to precede any serious reduction in payments for services so as to avoid negatively affecting Americans ability to access care and the quality of care provided.

As you know, Mr. Chairman, the Commonwealth of Massachusetts, has legislated a series of changes in the way its citizens are financially protected against the costs of health care services such that almost all residents of the state are now insured. These changes were legislated as the first stage of a two stage process. The second stage, which is now being designed, will attempt to rein in the fast growing cost of health care. In fact, this month a special commission established by the state legislature on Health Care Payment Reform is scheduled to recommend a global payment system that would set a total payment amount for each patient that covers all that person's care for an entire year. In order to make such a system work the State will be seeking CMS' permission to cover Medicare and Medicaid patients as well. The hope is that by creating a global payment, and limiting its growth, health care cost growth in Massachusetts could be reduced from 8 percent a year to 5 percent.

I would propose that your committee contemplate a version of the Massachusetts model by developing a 10 year plan whereby over the course of this period the cost of expanding coverage to all Americans is paid for by health care delivery system reform with the major portion of these savings occurring towards the end of the time frame. This would allow time for the system to adjust to the new structure I discussed above. I realize this is a long phase-in period but past attempts to change our cumbersome health care system quickly have failed because they required too many changes too fast.

RECOMMENDED CHANGES IN HEALTH CARE PAYMENTS

State Administered All Payer Systems

As we phase-in changes to the health care delivery system I would recommend that the federal government encourage more states to establish all-payer systems that would tie Medicare and Medicaid payments for doctors, hospitals and other health care services to payments generated by private insurance. Government payments have become too large to be treated separately from private payments. With the shifting of power at the local delivery level from private payers to hospitals and doctors, health care providers in many localities have been able to make up lower governmental payments with higher private payments. This so called "cost-shifting" has been an important force pushing up annual private insurance rate increases to double digit levels leading many employers, public and private to reduce benefits or eliminate coverage all together. Such all-payer systems should not be thought of as "price control" mechanisms which simply limit the growth in fee-for-service prices. Rather they should be designed to help create the global or bundle payment systems discussed above.

Initially the total amount spent in each state should approximate current spending with the current differential in public and private payment amounts maintained. Over time the increase in payments for each payer could be limited as the delivery system becomes more efficient. In order to insure that the reductions in private payments lead to premium reductions, the medical loss ratios and the administrative costs of private insurers would also need to be regulated. Without such a state run system I don't believe we could link together public and private payments or foster a restructured delivery system except for a few pioneer delivery systems. States should have the flexibility to either require providers to accept these new payment systems or allow voluntary participation. If the approach is voluntary those provider groups that choose to stay in traditional fee-for-service should face more limited payment increases. Providers in states that choose not to participate in such a program should also receive more limited federal payment increases. As an added

inducement for states to establish these All-Payer Systems, the federal government should help support the administrative costs of operating such a system.

Future Hospital Payment Updates

Hospitals play a key role in our health care system and must be a core component of any integrated delivery system. As we transition to more bundled or global payments any future hospital update amounts paid through the Medicare PPS system should recognize that as hospital develop more comprehensive health information technology systems, with the help of federal HIT funding, they should use these systems to develop more efficient and lower cost care. Hence I would recommend that Medpac consider increasing its productivity offset to medical inflation thereby lowering the annual PPS update amount. Again these reductions should be phased in to allow hospitals the time to make the necessary but time consuming changes in their delivery of care.

Disproportionate Share, Critical Access and Community Health Center Payments

Massachusetts used a portion of the funds set aside by the states' (Hospital Uncompensated Care Pool) to support the expansion of coverage. The rationale of course was that when all or almost all individuals are insured the amount of uncompensated care provided by hospitals and other health care providers falls or is even eliminated. We could expect such changes to occur nationally as well as universal coverage is approached. Therefore it is appropriate that those health care providers that currently receive extra payments to help support the care they provide to the uninsured and other low income or hard to treat patients,(i.e., those who do not speak English) should have such payments reduced. However, we have learned in Massachusetts that many of the extra costs associated with providing services to such special populations would continue even if they are insured whether they are in the inner city or in sparsely populated rural areas. Therefore a portion of the current extra payments for such providers need to be

continued. Again I would suggest that Medpac analyze this issue and recommend how and in what amounts such payments be reduced.

High Cost Case Re-insurance

It is well known that 80 percent of US health care expenditures are for the sickest 20 percent of the patients. Some private insurers try to protect themselves against the possibility that they could be responsible for the cost of such patients by developing techniques to limit coverage for individuals that might be in this group. Most insurers also limit their financial exposure by purchasing high cost reinsurance. Clearly the former activities should be outlawed and the purchase of re-insurance is expensive and is ultimately passed on in the form of higher premiums. I would suggest that the US could both reduce the overall cost of treating such high cost patients and reduce the cost of reinsurance by establishing a governmental reinsurance system. Such a system could be established through a state all-payer structure or through local or state health insurance exchanges. Each payer group would be asked to pay for a portion of the expenses in relationship to an actuarial estimate of their likely high cost cases. This new reinsurance entity would be responsible for a proportion of the high cost case expenses, e.g., 75%. So as to reduce the overall costs of treating such patients over time each appropriate state or local entity would be required to develop a high cost disease management system in consultation with the federal government. The federal government would evaluate the success of the different disease management systems and help incorporate those that work the best throughout the country.

Physicians

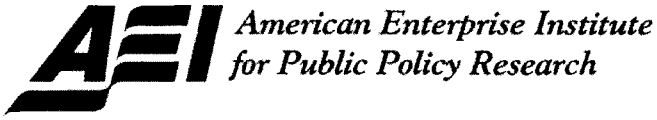
The key to changing the delivery system rests with the physician community. Many physicians seem eager to become part of a new structure for providing care but unfortunately many appear resistant to change. As long as the payment system continues to reward maintaining the status quo I fear that less change will occur than is needed. To help encourage more physician participation in systems that provide higher quality care and more efficient care, I would suggest that your committee consider rewarding those

physicians that help create or join integrated delivery system by paying those systems the full RBRVS payment in the coming years. I would also suggest that you support an extra payment for those groups that show real results in meeting approved quality standards. For those physicians that continue to function in the current fee-for-service system I would recommend that the legislated SGR reductions go into effect. As a final inducement to create these new delivery systems I would suggest that consideration be given to restructuring the medical liability system that governs their services. I will leave it to others to suggest how such a system would function.

SUMMARY

Most importantly we need to develop a system for providing health insurance coverage for all American. And, yes over time we should and can pay for the added costs of such expansion with efficiencies from our current health care delivery system. But such cost savings cannot occur over night and will require some fundamental changes in the way we pay for and deliver care. It would be unfair to ask the millions of uninsured American to wait for those of us who are well insured or who provide health care services to change our system. Instead we should follow the lead of Massachusetts and expand coverage immediately while we set in place mechanism that over a 10 year period will both improve the quality of care and lower its costs.

Thank you Mr. Chairman and members of the committee for giving me the opportunity to express my opinions on these most important social issues.



Statement to the Senate Finance Committee Roundtable

Financing Health Care Reform

Joseph R. Antos, Ph.D.
Wilson H. Taylor Scholar in Health Care and Retirement Policy
American Enterprise Institute

May 12, 2009

The views expressed in this testimony are those of the author alone and do not necessarily represent those of the American Enterprise Institute.

Mr. Chairman and members of the Committee, thank you for inviting me to participate in this roundtable discussion on financing health care reform. I am Joseph R. Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute (AEI), a non-profit, non-partisan public policy research organization based in Washington, D.C. I am also a member of the panel of health advisers for the Congressional Budget Office (CBO). My comments today are my own and do not necessarily reflect the views of AEI, CBO, or other organizations with which I am affiliated.

There is little question about the need to reform America's health care system. The country spent $2.2 trillion for health care last year, but a significant portion of that spending is likely to have provided little if any value to the well-being of patients.[1] Health insurance costs have been rising more rapidly than workers' wages, putting insurance increasingly out of reach for millions of people. Although much public attention has focused on expanding coverage for the uninsured, that goal is tied to our efforts to reform the delivery system and to establish a responsible financing system that is sustainable into the future.

There are two basic ways to finance a reformed health system: raise revenue or reduce health spending. We will undoubtedly do both. What matters is whether we take advantage of this moment in history to promote greater efficiency, greater consumer involvement, and smarter health purchasing—to achieve better health outcomes while living within a realistic budget constraint.

Current Spending Trends are Unsustainable

If current trends continue, national health spending will nearly double over the next decade—rising from $2.2 trillion, or 16.2 percent of gross domestic product (GDP), in 2007 to over $4.3 trillion, or 20.3 percent of GDP, in 2018.[2] Health spending is projected to grow at an average rate of 6.2 percent a year, about 50 percent faster than growth in the economy. By 2035, total health spending could exceed 30 percent of GDP.[3]

This rapid growth in overall health spending is mirrored in the federal budget. In 2007, federal outlays for Medicare and Medicaid totaled $425 billion, or about 15 percent of the budget.[4] By 2035, those programs could grow to more than a third of total federal spending.[5] Because spending is rising much more quickly than program revenue, the Medicare trust fund for Part A is likely to run short of money as soon as 2015.[6]

These spending figures are cause for alarm. The rapid growth of health spending has placed increasing pressure on everyone's budgets—consumers, employers, and all levels of government. Premiums for health insurance offered through employers have doubled since 1999 and outstripped growth in wages.[7] Rising federal health costs threaten to crowd out education, energy, transportation, and other policy priorities. According to the CBO, "the rate at which health care spending grows relative to the economy is the most important determinant of the country's long-term fiscal balance."[8]

Current health spending trends are fiscally unsustainable for the federal government, and they impose a rising burden on families that will ultimately prove unbearable.[9] Moreover, increasing costs make health insurance unaffordable to larger numbers of people. Policies that effectively rein in health spending can promote a more sustainable system and at the same time promote insurance coverage for many more individuals.

Increasing federal insurance subsidies or expanding eligibility for federal programs can make insurance more affordable and accessible to the uninsured. Policies intending to achieve universal coverage could add $1.8 trillion to the nation's health bill over the next decade.[10] But simply asking others to pay more is ultimately self-defeating unless we find ways to reduce health costs while preserving a high-value health system. As Chairman Baucus has written, "excess spending must be eliminated and dollars put to better use, not only to correct the imbalances of the current health system, but to offset the high costs of much-needed comprehensive reform."[11]

Financing Options

There are hundreds, perhaps thousands, of specific proposals that could help finance the health care system. The CBO has provided a useful guide for Congress containing 14 broad categories and 115 separate options, but this only scratches the surface.[12] Each of those options could be specified in legislative language in numerous ways, each of which potentially resulting in very different impacts on the federal budget, the health sector, and the economy.

At the risk of oversimplifying, I focus on several types of proposals (including some that were not explicitly considered by CBO) that have been advanced in various health reform discussions. The proposals discussed here illustrate the trade-offs and challenges facing Congress in designing a financing strategy for health reform.

Raise taxes. Although one of the major objectives of reform is to gain control over the high and rapidly rising cost of health care, accomplishing that goal will require considerable time and effort on the part of everyone. Consequently, most reform proposals include policies to increase federal revenue.

President Obama proposes to limit the rate at which itemized deductions reduce the tax liability of high-income individuals.[13] Rep. John Dingell (D-Mich.) has long proposed a value-added tax to finance universal coverage.[14] Such proposals do nothing to improve the value we receive from our health care dollar since they raise taxes on activities and income largely outside the health sector. Absent other reforms, raising taxes in this manner to pay for expanded health care coverage would reinforce the inefficiency of the current health system and would have a dampening effect on an already depressed economy.

Other tax proposals, discussed below, operate within the health sector. Such proposals, including limiting the current tax exclusion for health insurance, could promote efficiency while raising substantial revenue to support insurance expansions.

Impose mandates. A variety of mandates have been proposed as part of health care reform. Under "play or pay," firms would be required to provide health insurance coverage to their employees or pay a fine. Any fines that were collected could be used to defray the cost of expanding government health programs or subsidies for insurance. Firms choosing to begin offering coverage would use their own funds to accomplish the policy goal of expanded coverage.

The impact of an employer mandate on the federal budget would be negligible, even though employers might spend substantial new sums to provider health insurance to their employees. Although that spending would be treated as private, it is equivalent to a tax on the firm and a subsidy to the workers of the same amount. With a mandate, the IRS middleman is cut out and the cost of expanding coverage is shifted off-budget. This does not represent any savings to the economy even though the federal cost of the expansion is lower on the government's books than it would have been without a mandate.

An employer mandate does not generate free money. It can have damaging effects on the low-income workers it is meant to help. Employers who "play" would seek to recover the now-higher costs of labor by slowing wage increases, cutting other benefits, reducing new hires, and laying off less-productive workers.

An individual mandate to purchase insurance similarly requires individuals to purchase their own health coverage. Because such a mandate may be difficult to enforce (particularly among low-income families), many proposals include subsidies to make the purchase of insurance more feasible. More generous subsidies increase the effectiveness of the mandate in promoting coverage, but they also increase federal outlays.

Other government policies can also impose unfunded mandates that shift the cost of reaching a policy goal to the private sector without incurring a federal budgetary cost. For example, Medicare could require health care providers to institute quality improvement programs or increase reporting requirements without offering additional payment to providers who comply. For this reason, the federal budget can be a poor indicator of the economic impact of complex proposals. Congress should carefully weigh the broader effects of policy as well as the federal budget impact when seeking ways to "pay" for health reform.

Control prices. Medicare and Medicaid have long used price controls to limit the growth of program spending. While such measures can be effective in constraining costs in the near term, they also may have undesirable consequences for enrollees. Medicaid payment rates are substantially below those of other payers, and many health providers refuse to accept Medicaid patients. This leads patients to seek care in the hospital emergency department, which is often the most expensive and least effective way to manage routine health care needs.[15]

Medicare has also limited increases in its reimbursement rates to constrain spending, with mixed results.[16] Provider payments are generally established by formula, not by direct

negotiation with providers. As a result, some prices may be too high, and some too low. This distorts the allocation of resources in health care, and attempts to adjust the payment formulas to ameliorate those distortions are unlikely to succeed. As with Medicaid, the failure of Medicare pricing formulas to accurately reflect both the market demand for specific medical services and the cost of producing those services leads to the misallocation of health resources, less efficiency in delivering health care, and higher program spending.

Price controls can also have serious long-term consequences by discouraging the development of new treatment methods and other medical innovations. For example, proposals that would limit Medicare payments for new drugs to be no greater than the least costly alternative would constrain Medicare costs in the near term. However, such proposals would also discourage the research and development necessary to find and bring to market the next potentially life-saving drug. Price controls can slow medical progress, ultimately resulting in less effective treatments and poorer patient outcomes—real costs that do not show up on the government's ledger.

Other pricing approaches, such as competitive bidding, could promote more efficient resource allocation, minimizing the distortions caused by formula-based pricing. Such market-based pricing methods are discussed below.

Control utilization. Price increases account for perhaps a third of the growth in health spending from year to year. The rest is driven by increases in the use of services, including both newly-introduced medical innovations as well as long-established medical practices. Although most of those services provide real value to patient well-being, there is substantial variation in the use of health services across the U.S. with little detectable differences in mortality and other outcome indicators. If high-cost areas adopted the conservative practice styles of low-cost areas, Medicare spending could be reduced by as much as 29 percent according to one study.[17]

Medicare is prohibited by the Social Security Act from interfering with the practice of medicine, but coverage and payment policies necessary to define the scope of any insurance benefit have powerful influence on what care is available to beneficiaries. Comparative effectiveness research (CER) has been proposed as a way to identify the most clinically effective medical interventions, which could provide a basis for restricting coverage or limiting payments for less effective treatments and thus reduce wasteful variations in practice.

There is considerable debate over the proper government role in this work, with concerns that government control over the research could lead to rationing of care by Medicare and private insurance.[18] Although recent proposals avoid introducing cost comparisons into the research, it is difficult to imagine that *cost* effectiveness would not become part of the *comparative* effectiveness agenda. However, there are serious questions about the ability of CER to yield clear-cut, actionable guidance on best medical practices that would result in substantial savings.[19] Because patients with a specific illness are diverse and often have multiple conditions that complicate medical decisions, the results of CER are more

appropriately a guide to physicians and patients rather than a basis for the blanket exclusion of specific treatments.

Improve efficiency in the delivery of health care. A more efficient delivery system can save money and improve health outcomes. There are a host of proposals—including greater use of health information technology (HIT), comparative effectiveness research, disease management and other forms of coordinated care, and medical homes—that are intended to re-engineer health care delivery. Although such proposals seem to offer a painless solution to rising health costs, the health industry, insurers, and the government have invested billions of dollars over several decades in their attempts to move from concepts to functioning systems.

The CBO has analyzed the most prominent types of delivery reform proposals and found little evidence to suggest that such initiatives would soon yield substantial savings.[20] That does not necessarily imply that additional work on such proposals would be a poor investment, but it does suggest caution is needed in determining appropriate federal action.

Federal policy can provide incentives to promote further development and adoption of delivery system innovations. For example, the stimulus legislation offers a carrot and stick approach to promote HIT. Grants will be available to health care providers who adopt electronic health records, and Medicare reimbursements will be reduced for those who fail to meet requirements on acceptable use of such records. There is a risk, however, that excessive direction from Washington could have a deadening effect on local efforts by providers and health plans to find their own solutions to improve health care delivery.

Other re-engineering efforts more clearly require government leadership. Medical malpractice reform—which could include the creation of specialized health courts or other administrative mechanisms outside the current judicial system, new requirements to ensure timely action, and caps on awards—could reduce costs and lower malpractice premiums. More importantly, such reforms could reduce the practice of defensive medicine, which adds to the cost of care without providing real benefit.

In addition to these approaches to change the delivery system from the provider side, patients can also be given incentives to improve their own health behaviors. Wider access to preventive health services, such as screening for diseases and medications to control chronic diseases, is a component of many reform plans. However, hundreds of studies have found that medical prevention usually adds to health spending.[21] More basic preventive measures, such as changes in diet and exercise, may be more likely to have a pay-off in both better health and lower health spending.

Financial incentives might be useful in promoting healthy lifestyles. Congress increased the federal excise tax on cigarettes from 39 cents to $1 a pack to pay for the expansion of the Children's Health Insurance Program. Proposals have been advanced to impose an excise tax on sugar-sweetened beverages. These "sin taxes" raise the cost of consuming

products that might be bad for your health, which would reduce their consumption—generally to a limited extent. However, their principal purpose is to generate revenue, with an incidence falling most heavily on low-income people. Any savings from improvements in personal behavior generally accrue over long periods of time, well outside the budget window.

Promote competition and informed choice. The system re-engineering approach just discussed has the potential for eventually improving health system efficiency and cutting cost through changes on the supply side of the market. We must also enlist the help of consumers and the demand side of the market if we expect to maintain or improve health care value while permanently reducing the growth of health spending. Cost cutting is not likely to succeed unless the public understands its necessity and agrees with the methods.

I will focus on three major policy options that can promote a more effective competition in the health marketplace that can improve efficiency and reduce spending. Those options are: limiting the tax exclusion for employer-sponsored insurance, using competitive bidding methods to establish payment rates for providers and health plans, and implementing full premium support in Medicare.

First, the tax exclusion. Reducing tax benefits for employer-sponsored health insurance is the largest potential source of money to finance health reform. About two-thirds of the working population and their dependents receive health insurance through an employer, who typically pays a substantial portion of the premium on behalf of the employee. Those premium contributions are excluded from the worker's taxable income, resulting in thousands of dollars of savings for the typical family. In 2007, the tax exclusion reduced federal tax revenue by $246 billion.

The tax exclusion is unfair, providing tax savings to people on the basis of their employment rather than on their need for financial help. Individuals purchasing their own health insurance outside of their employer do not receive the tax break. Moreover, because the amount of the exclusion is not limited, it encourages firms to offer generous health plans with high premiums and minimal cost-sharing. By minimizing the amount that enrollees must pay out of pocket, such plans promote the use of health services whose value to the patient might be well less than the cost of providing the care.

One way to phase in changes in the exclusion is to cap it at a high level (such as the 75th percentile of insurance premiums) and index it to general inflation rather than medical inflation. Another approach would replace the exclusion with a standard deduction. Under both approaches, individuals buying high-cost health insurance would be required to pay a tax on the amount over the cap or standard deduction. That would generate pressure from workers to their employers for less-expensive insurance options. The additional tax revenue collected in this way could be used to fund refundable tax credits or other subsidies to low-income persons for the purchase of insurance.

Second, competitive bidding. Medicare's formula-based pricing methods are imprecise, resulting in excessive reimbursement for some services and insufficient reimbursement

for others. That, in turn, distorts the allocation of resources in the health sector and is a major reason why primary care is in short supply in many parts of the country. Formulas can only guess at the correct structure of prices in a market, and they generally get it wrong.

The solution is competitive bidding, which essentially asks the market to reveal the lowest price Medicare could pay and be assured that beneficiaries would have sufficient access to care. Competitive bidding has been tested successfully for the payment of durable medical equipment (DME). The Centers for Medicare and Medicaid Services (CMS) announced in April that it was ready to proceed with competitive bidding for DME in ten metropolitan areas, but resistance from suppliers has put this project on hold. If political opposition could be overcome, competitive bidding methods could potentially provide substantial program savings.

However, the bidding process must be designed carefully to ensure that savings will be realized. The Medicare Advantage (MA) program has been criticized because bids are set against benchmarks that generally exceed the cost of providing services through the traditional Medicare fee-for-service program. Consequently, MA plans are paid an average of 14 percent more than the fee-for-service costs. Those extra payments guarantee that seniors have a choice of plans no matter where they live, and the additional money supports optional benefits for many enrollees. Nonetheless, from a narrow budgetary perspective, the structure of MA bidding has increased the cost of the program.

In sharp contrast, Medicare prescription drug plans also present bids to CMS but that process does not have an external benchmark. Part D spending has consistently dropped below the initial projections made by the CBO. This is strong evidence that competition, when carefully structured, can reduce program costs.

Third, premium support. As an entitlement, Medicare guarantees a level of health benefits that is not bound by spending limits imposed by other programs through the appropriations process. The entitlement is as much for providers as it is for beneficiaries, since it ensures payment for the wide range of services covered by the program. Moreover, most beneficiaries have supplemental coverage that pays their deductibles and copayments. That insulates patients from the cost of their care, removing a financial incentive to reduce the use of unnecessary services.

A premium support system would set a fixed government contribution for each beneficiary, adjusted for their income and health status.[22] The average contribution level would be determined by a bidding process among private plans participating in Medicare and the traditional fee-for-service program. For example, the government contribution might be set at 85 percent of the cost of the average bid (which is similar to the current level of subsidy in Medicare), or it could be adjusted upward or downward. Beneficiaries would be able to purchase more expensive plans, but the additional cost would be their own responsibility.

Such a system would provide a mechanism to restrain federal spending on Medicare, and it would stimulate greater price competition among health plans by making beneficiaries more cost-conscious. However, a poorly designed premium support program could expose beneficiaries to unacceptable financial burdens.

Premium support met strong resistance when it was advanced in a series of demonstration projects in the late 1990s, and it is not a politically popular idea today. Leading health reform advocates are often more focused on expanding access and coverage than on making the reformed system fiscally sustainable.

Nonetheless, the point remains that top-down cost containment measures—primarily through price controls on provider reimbursements—have not been especially successful in limiting the growth of Medicare outlays. If a reformed health system is to succeed, it will have to engage consumers to take more responsibility for their health spending decisions.

Conclusion

Congress would be well advised to take a hard look at the options available to finance a reformed health system. Contrary to what is often claimed, there is no "low-hanging fruit." Many options, including those that would re-engineer the delivery system, will require further investment of time and money before we can begin to see greater efficiency, improved quality, and lower cost. Much of that work must be done in local markets among providers and health plans that know best what the biggest challenges are in providing high-value health care. Top-down controls are likely to impede our evolution toward a more functional health system.

Realistic health reform recognizes the need to make compromises among competing goals and find a balance among conflicting demands. We can have a system that provides higher quality care and greater economic value, but we cannot continue to ignore the resource limits that constrain all human endeavors. We have an historical opportunity this year to take major steps to promote a high-value health system that we can, in fact, afford.

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[1] Micah Hartman et al., "National Health Spending In 2007: Slower Drug Spending Contributes To Lowest Rate Of Overall Growth Since 1998," *Health Affairs*, January/February 2009; 28(1): 246-261; CBO, *Geographic Variation in Health Care Spending* (Washington: CBO, February 2008) and references cited therein.

[2] Andrea Sisko et al., "Health Spending Projections Through 2018: Recession Effects Add Uncertainty To The Outlook," *Health Affairs*, March/April 2009; 28(2): w346-w357.

[3] CBO, *The Long-Term Outlook for Health Care Spending* (Washington: CBO, November 2007).

[4] CBO, *The Budget and Economic Outlook: An Update*, (Washington: CBO, September 2008).

[5] Author's calculation based on CBO, *The Long-Term Budget Outlook* (Washington: CBO, December 2007), Table 1-2 ("Alternative Fiscal Scenario").

[6] In 2008, the Medicare trustees projected that the Part A trust fund would have insufficient funds to cover expenses by 2019. Partly because of the severe recession, that date is likely to be moved up to 2015.

[7] Henry J. Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits: 2008 Annual Survey* (Menlo Park: Kaiser Family Foundation, September 2008).
[8] CBO, *Key Issues in Analyzing Major Health Insurance Proposals* (Washington: CBO, December 2008), p. 20.
[9] Alice M. Rivlin and Joseph R. Antos (eds.), *Restoring Fiscal Sanity 2007: The Health Spending Challenge* (Washington: Brookings Institution, 2007).
[10] Author's calculation based on Jack Hadley, et al., "Covering The Uninsured In 2008: Current Costs, Sources Of Payment, And Incremental Costs," *Health Affairs*, September/October 2008; 27(5): w399-w415. Calculation assumes an average growth rate of 7 percent a year for the incremental health spending from extending coverage to everyone.
[11] "Finance Chairman Baucus Unveils Blueprint for Comprehensive Health Care Reform," press release, November 12, 2008.
[12] CBO, *Budget Options Volume I: Health Care* (Washington: CBO, December 2008).
[13] Office of Management and Budget, *A New Era of Responsibility: Renewing America's Promise* (Washington: U.S. Government Printing Office, February 2009).
[14] Meena Seshamani et al., *Financing the U.S. Health System: Issues and Options for Change* (Washington: Bipartisan Policy Center, June 2008).
[15] Peter J. Cunningham, "What Accounts For Differences In The Use Of Hospital Emergency Departments Across U.S. Communities?" *Health Affairs*, September/October 2006; 25(5): w324-w336.
[16] One study found that Medicare spending has grown less rapidly over long periods of time than private insurance spending; see Cristina Boccuti and Marilyn Moon, "Comparing Medicare And Private Insurers: Growth Rates In Spending Over Three Decades," *Health Affairs* March/April 2003; 22(2): 230-237. Other analysts argue that adjustments to reflect differences in covered benefits between Medicare and private coverage reverses that conclusion; see Joseph R. Antos, "Comparing Medicare and Private Health Insurance Spending," Heritage Foundation *WebMemo* no. 250, April 8, 2003; and Joint Economic Committee, *Health Insurance Spending Growth – How Does Medicare Compare?* June 10, 2003.
[17] John E. Wennberg et al., "Geography And The Debate Over Medicare Reform," *Health Affairs* Web Exclusive, February 13, 2002: w96-w114.
[18] For example, Sen. Jon Kyl (R-Ariz.) stated in the confirmation hearing for Secretary Sebelius that "the government can misuse comparative effectiveness research to deny coverage." See Taylor, Lynne. "Obama's Pick for Health Secretary in 'US NICE' Row". PharmaTimes: 23 April 2009. <http://www.pharmatimes.com/WorldNews/article.aspx?id=15733> Accessed 4 May 2009. For an analysis of the potential risks of CER, see Scott Gottlieb, "Promoting and Using Comparative Research: What Are the Promises and Pitfalls of a New Federal Effort?" *AEI Health Policy Outlook*, February 2, 2009. <http://www.aei.org/outlook/100010> accessed May 7, 2009.
[19] CBO, *Research on the Comparative Effectiveness of Medical Treatments: Issues and Options for an Expanded Federal Role* (Washington: CBO, December 2007).
[20] See CBO, *Evidence on the Costs and Benefits of Health Information Technology*, May 2008; CBO, *Research on the Comparative Effectiveness of Medical Treatments*, December 2007; and CBO, *Budget Options Volume I: Health Care*, December 2008.
[21] Louise B. Russell, "Preventing Chronic Disease: An Important Investment, But Don't Count On Cost Savings," *Health Affairs*, January/February 2009; 28(1): 42-45.
[22] CBO, *Designing a Premium Support System for Medicare* (Washington: CBO, December 2006).

Questions for the Record
Roundtable on Financing Health Care Reform

Questions for Dr. Antos

1. Medicare's unfunded liabilities over the next 75 years are $36 trillion—equaling a $320,000 IOU for every American household.[1] Last year's Medicare Trustee's report announced that the Part A Trust Fund will be depleted by 2019, the Congressional Budget Office said in December that date will be 2017, and this afternoon we'll get statistics indicating that date will be even sooner. Before expanding government programs, I believe Congress needs to implement real solutions to meet our current obligations. Dr. Antos, can you discuss the consequences of a failure to address current obligations? How would spending another $1.5 trillion on federal programs exacerbate on current entitlement crisis?

2. Dr. Antos, this Committee spent some time considering various delivery system reforms. Your testimony states that, "The CBO has analyzed the most prominent types of delivery system reform proposals and found little evidence to suggest that such initiatives would soon yield substantial savings." What other policy solutions do you recommend in order to bring down health care costs for the American people?

[1] The Heritage Foundation: "Congress Must Not Ignore the Medicare Trustee's Warning," March 2008, http://www.heritage.org/Research/HealthCare/wm1869.cfm#_ftn6.

Response to Question 1:

Medicare's financial situation has further deteriorated since last year. The 2009 Trustees report reports unfunded obligations totaling $37.8 trillion through 2083. The Part A trust fund is projected to run short of money in 2017. That means Medicare will be unable to pay in full for the hospital care of more than 57 million beneficiaries in that year, and the deficit will grow every year thereafter. Just as important, the trust fund that pays for physician services (under Part B) and prescription drugs (Part D) will continue to require general revenue financing and charges on beneficiaries that grow substantially faster than the economy and beneficiary incomes over time. Medicare will be an increasingly heavy burden on both workers and beneficiaries unless changes are made.

The current recession is only partly responsible for the decline in the program's financial outlook. The shortfall in Medicare revenue between the amount projected for 2008 in last year's Trustees report and the actual amount collected was $5.1 billion, about a 1 percent decline that is expected to continue for a few years. The fundamental sources of Medicare's financing problem are the aging population and the open-ended nature of the program's promise to pay for covered health services.

By 2030, Medicare enrollment is projected to reach 79 million people—up from about 45 million beneficiaries today. The number of workers supporting each Part A beneficiary will decline from 3.7 in 2008 to 2.4 in 2030. More older or disabled persons will be entitled to Medicare-financed care, but the economy will be less able (in a relative sense) to support those needs. More of the federal budget will go toward Medicare, and less will be available for other priority areas such as education, energy, and infrastructure development.

Because of Medicare's size—it will spend over $500 billion in 2009, accounting for about 15 percent of federal outlays—and rate of growth—expected to increase at least 8 percent this year—it is imperative that Congress take actions to align the program's promises with fiscal reality. We have relied on foreign borrowing to make up the difference between federal budget outlays and revenues, but that merely delays the day of reckoning. The bill will come due, and that means higher taxes and less consumption for all Americans. The question is, does it make sense to mortgage our future by ignoring the obvious structural flaws in Medicare that will rapidly drive up spending as the baby boomers enter retirement?

Adding another $1.5 trillion in spending over 10 years for a new health insurance entitlement would exacerbate the fiscal crisis we already face. We have an obligation to help the less fortunate, including those who are unable to afford health insurance. But we also have an obligation to spend taxpayers' money prudently, seeking the best value we can and ensuring long-term fiscal sustainability. The Congressional Budget Office reports that federal health spending will reach 17 percent of GDP by 2050, if past trends continue. Adding a large new health entitlement without major structural changes in existing programs would require sizeable tax increases or massive amounts of additional foreign borrowing. Tax increases of the magnitude required would seriously retard economic growth; foreign borrowing defers the need for a tax increase, but eventually tax rates would have to be even higher. In either case, such policies would have a significant dampening effect on the economy.

Response to Question 2:

Although delivery system reform is sorely needed, there is little evidence that we know how to systematically improve the efficiency and effectiveness of our health system. Various proposals—including health information technology, comparative effectiveness research, disease management and other forms of coordinated care, and medical homes—are appealing conceptually, but billions of dollars of private and public investment have yet to produce a reliable template for restructuring the way health care is provided. It is sensible to continue to explore such avenues to improve care and reduce costs, but we cannot expect them to provide significant savings in the near term.

If we expect to hold down the growth of health spending while maintaining access to high-value services, we must enlist the help of consumers and promote informed choice and effective competition in the market. There is a pervasive sense of entitlement throughout the health system, a product of generous subsidies, first-dollar insurance, and a lack of transparency that leads to excessive use of services that, at the margin, provide less value than they cost. This is true for beneficiaries of federal health entitlements, including Medicare, and for beneficiaries of private insurance, which is heavily subsidized through the tax system.

The entitlement mentality also affects providers, who make clinical decisions secure in the knowledge that they will be paid by an insurer. A doctor's first impulse is to do no harm, but we also want our doctors to ask whether an intervention will do any good—and whether it's worth the cost in money and personal suffering. That's a judgment that can only be made jointly between physician and patient.

I will highlight three proposals that would have a powerful leveraging effect on health care spending:

Limit the tax exclusion. Employers obtaining health coverage through their employers saved $226 billion in 2008 because their employers' contributions were not taxed. Placing a cap on the maximum amount that could be excluded from the workers' income for tax purposes would put pressure on insurers to offer good coverage at a better price. The tax subsidy could be shifted to provide greater benefit to low-income families through a tax credit, which would be fairer and would encourage more people to buy insurance.

Improve competition in Medicare. Fee-for-service Medicare should operate on a business-like basis, accountable for its costs and able to operate responsibly without being micromanaged by Congress. Instead of relying on pricing formulas, the program should be allowed to make greater use of competitive bidding to establish reimbursement rates that do not distort the market. Medicare Advantage plans should compete fairly through a new bidding process with a reformed fee-for-service program, and neither option should be given an advantage through legislation.

Premium support. To reduce the incentives of the current system to overutilize services, Medicare's open-ended entitlement should be converted to a fixed government contribution, adjusted for income and health status. This premium support approach, coupled with better information on plan options and other steps to promote effective competition, would make

beneficiaries more value-conscious. More importantly, health plans (including a reformed fee-for-service program) would face new pressure to manage their benefits effectively and drive hard bargains with providers.

HARVARD SCHOOL OF PUBLIC HEALTH
DEPARTMENT OF HEALTH POLICY AND MANAGEMENT

KATHERINE BAICKER
PROFESSOR OF HEALTH ECONOMICS

March 24, 2009

My name is Katherine Baicker, and I am a Professor of Health Economics in the Department of Health Policy and Management at the Harvard School of Public Health. I would like to thank Senator Baucus, Senator Grassley, and the Members of the Committee for giving me the opportunity to participate in this roundtable discussion of how we can address the crucial policy challenge of financing health care reform. This testimony is derived in large part from recent academic work with my colleague Amitabh Chandra that appeared in the journal *Health Affairs*. I summarize that work here.

I would like to discuss several general principles about the nature of health insurance. Misunderstandings about these principles have the potential to impede the development of a much-needed consensus on how to engineer reform. Uncovering the kernels of truth that underlie these misperceptions can help focus reform efforts on the critical challenges facing our health system.

A key distinction should be made between health care and health insurance. Insurance works by pooling risks: many pay a premium up front, and then those who face a bad outcome (getting sick, being in a car accident, having their home burn down) get paid out of those collected premiums. The premium is the expected average cost of treatment for everyone in the pool, not just the cost of treating the sick. Because not everyone will fall sick at the same time, it is possible to make payments to those who do fall sick even though their care costs more than their premium. And this also why it is particularly important for people to get insured when they are healthy – to protect against the risk of needing extra resources to devote to health care if they fall ill.

Uncertainty about when we may fall sick and need more health care is the reason that we purchase insurance – not just because health care is expensive (which it is). Many other things are expensive, including housing and college tuition, but we do not have insurance to help us purchase them because they are not uncertain in the way that potentially needing very expensive medical care is. The more uncertainty there is, the valuable insurance is.

THE PROBLEM OF THE SICK AND UNINSURED

Insured sick people and uninsured sick people present very different issues of public policy. People who have already purchased insurance and then fall sick pose a particular policy challenge: insurance is not just about protecting against unexpected high expenses this year, but also about protecting against the risk of persistently higher expenses in the case of chronic illness. This kind of protection means that once insured, enrollees' premiums would not rise just because they got sick, but this is not always the case today. In fact, insurers have an incentive to shed their sickest enrollees, suggesting a strong role for regulation protecting them. Nor are insurers held responsible when inadequate coverage raises the costs of a future insurer, such as

Medicare for those over 65. These problems highlight the limited availability of true long-run insurance offerings, a reform issue that is often glossed over in the conflation of health care and health insurance.

Uninsured Americans who are sick pose a very different set of problems. They need health *care* more than health *insurance*. Insurance is about reducing uncertainty in spending. It is impossible to "insure" against an adverse event that has already happened, for there is no longer any uncertainty. If you were to try to purchase auto insurance that covered replacement of a car that had already been totaled in an accident, the premium would equal the cost of a new car. You would not be buying car insurance – you would be buying a car. Similarly, uninsured people with known high health costs do not need health insurance – they need health care. Private health insurers can no more charge uninsured sick people a premium lower than their expected costs. The policy problem posed by this group is how to ensure that low income uninsured sick people have the resources they need to obtain what society deems an acceptable level of care and ideally, as discussed below, to minimize the number of people in this situation.

This highlights one of the many reasons that health insurance is different from car insurance: the underlying good, health care, is viewed by many as a right. Furthermore, we may want to redistribute money from the healthy to the sick, in the same way that we redistribute money from the rich to the poor. This kind of redistribution is fundamentally different from private insurance: it is social insurance, and it is hard to achieve through private markets alone.[1] Medicare, which insures the aged and disabled, is an example of a social insurance program. Private markets can pool risk among people starting out with similar health risks, and regulations can ensure that when some members of those risk pools fall ill, insurers cannot deny them care or raise their premiums, but transferring resources to people who are already sick and uninsured or transferring resources from lower health risk groups to higher health risk groups requires social insurance.

How then do we provide the sick and uninsured with socially acceptable care? Private health insurance alone is unlikely to achieve this goal: no insurer will be willing to charge a premium less than enrollees' likely health costs. Instead, they could be provided with health care directly or a premium subsidy equal to their expected health care costs. Alternatively, we could force sick people and healthy people to pool their risks, such as through community rating coupled with insurance mandates (to preclude healthy people from opting out of subsidizing sick ones). These kind of transfers are based on social choices about redistribution.

The advantage of social insurance programs, including a nationalized health care system, is that they can achieve redistribution that private markets alone cannot. They may also provide benefits with lower administrative costs (although, in the case of moving to a single payer system, the size of administrative savings relative to overall health care cost growth is likely to be small).[2] There are, of course, costs associated with social insurance programs as well. First, there is the drag on the economy imposed by raising revenues to finance them. Second, there is the loss of competition, diverse offerings for diverse preferences, and market discipline that private provision brings – and that promote higher value and innovation. This means that the social insurance program may be both expensive and inefficient, and thus impose an even larger burden on already strained public budgets. These pressures have, perhaps unsurprisingly,

spawned additional misconceptions that suggest that the costs of expanded insurance are lower and the benefits higher than the data support.

THE COST OF COVERING THE UNINSURED

A common and deceptively appealing argument for expanding insurance coverage is that we could both spend less and achieve better health by replacing the inefficient emergency room care received by the uninsured with an insurance plan. Unfortunately, this argument finds little empirical support. ER care for the uninsured is indeed inefficient and might have been avoided through more diligent preventive care and disease management. Diabetes treatment is a good example; it is much cheaper to manage diabetes well than wait for a hospitalization which requires a leg amputation. Having health insurance may lower the costs of ER and other publicly provided care used by the uninsured through better prevention and medical management. But empirical research also demonstrates that insured people consume more care (and have better health outcomes) than uninsured people – so universal insurance is likely to increase, not reduce, overall health spending.[3]

Why does insurance cause greater consumption of health care? Insurance, particularly insurance with low cost-sharing, means that patients do not bear the full cost of the health resources they use. This is a good thing – having just made the case for the importance of the financial protections that insurance provides – but comes with the side-effect of promoting greater consumption of health resources, even when their health benefit is low. This well-documented phenomenon is known as "moral hazard," even though there is nothing moral or immoral about it. The RAND Health Insurance Experiment (HIE), one of the largest and most famous experiments in social science, measured people's responsiveness to the price of health care. Contrary to the view of many non-economists that consuming health care is unpleasant and thus not likely to be responsive to prices, the HIE found otherwise: people who paid nothing for health care consumed 30 percent more care than those with high deductibles.[4] This is not done in bad faith: patients and their physicians evaluate whether the care is of sufficient value to the patient to be worth the out-of-pocket costs. The increase in care that individual patients use because of insurance has even greater system-wide ramifications. R&D in new medical technologies responds to the changes in aggregate incentives driven by health insurance. While these technologies may improve welfare, they also raise premiums because of larger armamentarium of treatments available to the sick. There is evidence of these system-wide effects: when Medicare was introduced in 1965, providers made spectacular investments beds in high-tech care, and hospital spending surged over 25 percent in 5 years.[5]

Even increases in preventive care do not usually pay for themselves: in general prevention is good for health, but does not reduce spending. Some preventive care has been shown to be cost-saving – such as flu vaccines for toddlers or targeted investments like initial colonoscopy screening for men aged 60-64 – but most preventative care results in greater spending along with better health outcomes. Indeed, some money spent on preventive care may not only cost money, but may be no more cost effective than some "high-tech" medical care For example, screening all 65-year-olds for diabetes, as opposed to only those with hypertension, may improve health but costs so much (about $600,000 per Quality Adjusted Life Year) that that money might be better spent elsewhere.[6]

All of this suggests that insuring the uninsured would raise total spending. This doesn't mean that it would not be money well spent (which I believe it would be). Spending more to attain universal insurance is not a problem if it generates more value than it costs, and the view that health care is a right is not inconsistent with this framework. First, and sometimes overlooked, is the security that insurance provides against the uncertainty of unknown health care expenses. The value of this financial smoothing alone is estimated to be almost as much as the cost of providing people with insurance.[7] Second, much of the additional health care that the newly insured would receive is likely to improve health. (But this is by no means automatic, for as discussed below, being insured is not enough to guarantee good health care.) Extending health insurance coverage is worth it for these reasons – but not because it would save money.

GETTING HIGH-VALUE CARE

Having insurance may increase the quantity of care patients receive, but it is no guarantee that they will receive high quality care. A recent study found that Americans received less than 60 percent of recommended care, including preventive, acute, and chronic care, and including such low-cost interventions as flu vaccines and antibiotics for surgical patients.[8] Beginning with the work of John Wennberg at Dartmouth, an immense literature in medicine and economics has found that even among Medicare enrollees, there are enormous differences in the quality of care received: in fact, in areas where the *most* is spent on Medicare beneficiaries, they are the *least* likely to get high quality care. The use of mammograms, flu-shots, beta-blockers and aspirin for heart attack patents, rapid antibiotics for pneumonia patients, and simple laboratory tests to evaluate the management of diabetes are all lower in higher-spending areas.[9] Higher spending is not even associated with lower mortality, which suggests that more generous insurance provision does not necessarily translate to better care or outcomes.

When these results showing the lack of relationship between spending and quality were first reported there were two predictable responses by skeptics: that high spending areas had sicker patients who were (appropriately) less likely to receive these therapies, and that patients in high-spending had higher satisfaction even if their measurable health outcomes were the same. Neither claim is supported by the evidence.

What, then, do patients in high-spending areas get? Evidence suggests that this higher intensity is driven by greater use of procedures with questionable clinical value – that may even be associated with underuse of high value, less-intensive care. Patients in high-spending areas are no more likely to receive surgery, but see more specialists more frequently, have more diagnostic and imaging services, and get more intensive care in the end of the life – none of which has been shown through clinical trials to improve health.[10] "Coordination failures" in delivery may both raise costs and lower quality, even among the insured. Investments in health services research can help shed light on how we can consistently deliver higher-value care.

Thus, while health insurance increases the quantity of care patients receive, being insured alone is not sufficient to ensure high quality care. Insuring the uninsured will give them access to the sort of health care that the rest of us receive: a combination of valuable care, overuse of some costly interventions with little proven benefit, and underuse of some vitally important therapies, care that is sometimes coordinated but often fragmented. This is better than no care, but it

highlights the problem of collapsing the entire debate about U.S. health care reform down to the issue of uninsurance: health insurance alone does not guarantee good health care.

THE ROLE OF EMPLOYERS

Employees ultimately pay for the health insurance that they get through their employer, no matter who writes the check to the insurance company. The view that we can get employers to shoulder the cost of providing health insurance stems from the misconception that employers pay for benefits out of a reservoir of profits. Regardless of a firm's profits, valued benefits are paid primarily out of workers wages.[11] While workers may not even be aware of the cost of their total health premium, employers make hiring and salary decisions based on the total cost of employment, including both wages and benefits such as health insurance, maternity leave, disability and retirement benefits.[12] They provide health insurance not out of generosity of spirit, but as a way to attract workers – just like wages. When the cost of benefits rises, wages fall (or rise more slowly than they would have otherwise), leaving workers bearing the cost of their benefits in the form of lower wages.[13]

The uncomfortable arithmetic of this wage-fringe offset is seen in other contexts – for example, workers bear the costs of workers compensation, and mandated maternity benefits primarily reduce the wages of women of child-bearing age.[14] When it is not possible to reduce wages, employers may respond in other ways: employment can be reduced for workers whose wages cannot be lowered, outsourcing and a reliance on temp-agencies may increase, and workers can be moved into part-time jobs where mandates do not apply. These adjustments are neither instantaneous nor one-for-one for every person (depending, for example, on wage rigidities, how much individuals value the insurance benefit, and how heterogeneous the employees' income and health are) – a fact that obscures the underlying connection. This also means that the claimed connection between health care costs and the "international competitiveness" of U.S. industry is murky at best: higher health costs primarily lower current workers' non-health compensation, rather than firms' profitability (although the same trade-off cannot operate in retiree health benefits, making their effects more complicated).[15]

Why, then, do we have a private health insurance system based primarily on policies offered through employers? There is a preference in the tax code for premiums paid by employers relative to premiums paid by individuals or direct payments for health care. This tax preference drives both the predominance of employment-based policies and the prevalence of policies with low cost-sharing, because care paid for in the form of higher employer premiums comes at a lower after-tax price than care paid for out-of-pocket. Of course, this tie between employment and insurance comes at a well-known cost: workers who leave or lose a job risk losing their insurance or facing much higher premiums, sometimes forcing them to stay in a job to retain health insurance.[16]

This is not to say that there are not important advantages to getting insurance through an employer instead of on the individual non-group insurance market (especially given the current state of individual market), including better pricing and risk pooling. The employer market is the primary mechanism for maintaining cross-subsidization from low-risk populations to high-risk ones, with tax subsidies adding an element of social insurance (albeit one that is not particularly

progressive).[17] It is these benefits that are the main advantages of access to employer policies, not the fact that employers nominally pay part of the premium.

EFFICIENT INSURANCE

Greater patient cost-sharing could help improve the efficiency of health care spending, but it is not a cure-all It is certainly true that first-dollar insurance coverage (that is, insurance coverage for the first dollar of health care expenditures or insurance with very low cost-sharing more broadly) encourages use of care with very low marginal benefit and that greater cost-sharing would help reduce the use of discretionary care of questionable value. But there is also evidence that patients under-utilize drugs with very high value when confronted with greater cost-sharing (whether because they lack resources or information). Worse, there is evidence that even $5 - $10 increases in copayments for outpatient care can result in some patients getting hospitalized as a result of cutting back too much on valuable care, offsetting the reduced spending.[18] Capping total insurance benefits is also short-sighted and imprudent: not only does evidence suggest that such caps result in adverse clinical outcomes, worse adherence, and increased hospital and ER costs, but the presence of caps means that patients are not insured against catastrophic costs – exactly what insurance is supposed to protect against the most.

There is no reason to think that the optimal insurance structure would look like the typical high-deductible plan. Rather, it might subsidize high-value care such as treatments to manage diabetes or asthma, while imposing greater cost-sharing on care of lower value, such as elective surgeries with limited health benefits. People would choose the insurance plans that offered them the best benefit mix – trading off higher premiums for plans that covered care of diminishing marginal value. Of course, what may be valuable to one patient could be wasteful for another, and the key challenge for 'value based insurance design' policies is to differentiate these cases. Many firms are experimenting with these plans.[19] Focusing exclusively on high-deductible plans that rely on a blunt structure of patient cost-sharing and perfectly forward-looking patients may forestall the development of even more innovative plans.

This does not mean that competition and cost-sharing have no role in driving higher value spending, however. Competition between insurers to offer plans that have the mix of benefits enrollees find most valuable could drive the kind of innovative plans described above. Increased cost-sharing such as that promoted by high deductible policies coupled with health savings accounts can also be an important tool for improving the value of care. As the evidence from the RAND HIE discussed above shows, the low-cost sharing plans fostered by the current tax treatment of health insurance (which look more like pre-paid health care than true insurance) promote the use of care that is of limited health benefit. While most spending is indeed done by people with very high total costs, well-designed cost-sharing programs could still have substantial effects on spending decisions. Most spending is not done in emergency settings, and even limited cost-sharing can have an effect on a substantial share of total spending.[20] This suggests that carefully designed incentives could have a big effect on improving the value of care delivered.

CONCLUSION

We know that our health care system is not delivering the consistently high-quality, high-value care that we should expect. While there are many open questions in the design of the ideal system, with millions uninsured and rising costs threatening to swamp public and private budgets alike, we cannot afford to wait to act.

Focusing on the underlying issues discussed here suggests that the fundamental problems facing our health insurance system are unlikely to be cured by the extremes of either a single payer system or an unfettered marketplace. On the one hand, the unregulated marketplace is unlikely to provide long-run stable insurance. Private insurers will always have an incentive to try to shed their highest cost enrollees, so without regulatory safeguards even the insured sick will be at risk of losing the insurance protections to which they are entitled. Private insurance fundamentally cannot provide the kind of redistribution based on underlying health risk or income that social insurance can. On the other hand, a single payer system does not automatically provide high quality care: the provision of low-value care is as pervasive in the single payer Medicare system as it is elsewhere. Single-payer systems are also slow to innovate – as suggested by the fact that it took Medicare 40 years to add a prescription drug benefit, long after most private insurers had done so. Nor do calculations of the costs of a single-payer system measure the utility loss from forcing people with different preferences into a monolithic health insurance plan. The private facilities that have sprung up in Canada to meet the demands of those who want more health care than the public system provides fundamentally undermine the "single payer" nature of the system.

How one balances these trade-offs is likely driven as much by philosophy as economics, and any reform will involve tough choices between competing values. Serious reforms would focus not exclusively on lowering costs, but on increasing the value that we get from health insurance and health care.[21] Reforms that promoted higher-value insurance could both extend coverage so that more people benefit from the protections that insurance affords and ensure that those protections are secure for those who fall ill. These reforms would not be enough to achieve uniformly high-quality care, however. The frequent failure of the use of best practices and the tremendous geographic variation in the use of costly care of uncertain medical benefit are often obscured in the focus on the uninsured. That many nations, including both the U.S. and Canada, struggle with these challenges suggests that reforms of the payment system alone are unlikely to solve all of these problems. A comprehensive reform proposal that aimed both to extend insurance protections to those who lack them and to improve the value of care received by those who are insured would be more likely to succeed at each goal than proposals that focused on just one.

Thank you again for the opportunity to meet with you. I would be happy to answer any questions that you might have.

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HARVARD SCHOOL OF PUBLIC HEALTH
DEPARTMENT OF HEALTH POLICY AND MANAGEMENT

KATHERINE BAICKER
PROFESSOR OF HEALTH ECONOMICS

May 25, 2009

To the Senate Committee on Finance:

Thank you for the opportunity to participate in the Roundtable on Financing Health Care Reform on May 12, 2009. Below are my responses to the questions for the record posed by Senator Cornyn. I have reproduced the questions in *italics* before each of my answers.

1. *The Administration has proposed more than $600 billion as a "down payment" on an estimated $1.5 trillion health system overhaul. We've been told that this "upfront investment" is required in order to save costs in the long run. Not only does this "spend more to save more" concept challenge common sense, my understanding of history tells me it won't work. A Monday article in the Wall Street Journal noted that "In 1965, Congressional actuaries expected Medicare to cost $3.1 billion by 1970. In 1969, that estimate was revised to $5 billion, and it actually came in at $6.8 billion... Things have gotten worse since, and Medicare today costs $455 billion and rising." The Massachusetts health reform plan has also come in higher than expected. Dr. Baicker, can you shed some light on what the economic evidence says about whether or not this $600 billion or $1.5 trillion "upfront investment" will be any different than what history has taught us? Will universal insurance reduce or increase health care spending?*

   I believe that expanding insurance coverage will not fundamentally reduce spending on health care. While much of the care received by the uninsured is indeed inefficient (such as emergency department visits that might have been avoided through better preventive care and disease management), empirical research also demonstrates that insured people consume more care (and have better health outcomes) than uninsured people.[1] Covering the uninsured is likely to be very good for their health, but will on its own increase, not decrease, total health spending.

2. *We're here today to discuss how to pay for an estimated $1.5 trillion in new spending to overhaul our health care system. That will be $1.5 trillion on top of what we're spending now, which is twice what other industrialized nations spend on a per capita basis. Dr. Baicker, your testimony mentions the lack of relationship between health care spending and quality in this country. I am convinced that before imposing new taxes to expand a broken system, we need to transform our system into one that promotes high value, personalized care. Are there specific policy solutions regarding the tax treatment of health care that will get us higher value for our health care dollars?*

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[1] John M. McWilliams, Ellen Meara, Alan Zaslavsky and John Z. Ayanian, "Use of Health Services by Previously Uninsured Medicare Beneficiaries," *New England Journal of Medicine* 357, no. 2 (2007): 143-153; Jack Hadley, John Holahan, Teresa Coughlin and Dawn Miller, "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," *Health Affairs* (2008): hlthaff.27.25.w399.

Our tax code currently subsidies private health insurance in a particularly inefficient way: the largest subsidies are reserved for the highest income people with the most expensive policies. This is not only inequitable, but promotes particularly low-value forms of insurance at the expense of those who do not have access to even a basic policy. The tax code favors insurance policies with low cost-sharing. While the protection that insurance provides is incredibly valuable, these low cost-sharing plans come with the side-effect of promoting greater consumption of health resources, even when their health benefit is low. The RAND Health Insurance Experiment (HIE) measured people's responsiveness to the price of health care. It found that people who paid nothing for health care consumed 30 percent more care than those with high deductibles.[2] This is not done in bad faith, but the increase in care used can have system-wide ramifications that drive growth in premiums. R&D for new medical technologies responds to the changes in aggregate incentives driven by health insurance. There is evidence of these system-wide effects: when Medicare was introduced in 1965, providers made spectacular investments beds and in high-tech care, and hospital spending surged over 25 percent in 5 years.[3] This suggests that reforming the tax code in a way that stopped disproportionately favoring these kinds of plans could substantially improve the value we get from the system. I give more specifics in the answers to the following questions.

3. *American families and American businesses are struggling with skyrocketing health care costs. As a nation, I do not believe that we can afford to spend 17 percent of our GDP on health care any longer. One of the options on the table for discussion today is capping the employee tax exclusion. Beyond just being a revenue source, would such a policy have an impact on systemic health care costs?*

The current uncapped exclusion disproportionately favors those in higher income tax brackets, those with access to employer policies, and those with the most expensive policies – which is why so few of the benefits go to those families earning below $50,000.[4] Capping the exclusion would both limit the benefits that accrued to those with the most expensive policies, but also limit the subsidization of ever-more-expensive policies with rapidly diminishing health benefits. Of course, premiums are driven not just by the generosity of the policy but also by many other factors (some of which are fixed in the short run), so it is important to think carefully about the transition any a new system. I believe that there are other options that might have even greater effects on improving value (such as a tax benefit that did not vary based on premiums, but could be greater for those with higher health risks), but capping the exclusion would be a step in the direction of higher value.

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[2] Joseph P Newhouse, and the Insurance Experiment Group, *Free for All?: Lessons from the Rand Health Insurance Experiment* (Cambridge, MA: Harvard University Press, 1993).

[3] Amy Finkelstein, "The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare," *Quarterly Journal of Economics* (2007)

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4. *Some have proposed capping the exclusion based on the value of health care benefits and some have proposed capping the exclusion based on an individual's income. Which option would have a greater impact on getting higher value for our health care dollar and bringing costs under control?*

   There are several ways that the tax code can be reformed. I believe that such reforms could promote higher-value use of health resources while maintaining or increasing the progressivity of the tax codes. One class of reforms would create a tax benefit that did not vary based on where people got their insurance or what premium they paid: the tax benefit would be fixed, and people who had more expensive plans would not receive higher tax benefits. One of the key advantages of such a "flat" tax credit or tax deduction is that the tax code would not subsidize more expensive insurance plans relative to cheaper ones, removing an incentive to get ever-more-costly insurance. (These benefits could also be risk-adjusted – meaning that they could be higher for individuals with greater health risk – without undermining this advantage.) The main difference between a flat credit and a flat deduction is the distribution of the benefits based on income: more of the benefits of a flat credit go to lower income groups, making the tax code more redistributive and also likely increasing insurance coverage by more, since more of the benefits would be going to people who are currently uninsured. Capping the exclusion of health insurance premiums (so that premiums above the cap would be taxed but those below would not) would have a similar effect on driving higher-value care for those who would otherwise be above the cap, but would have limited effect for those below the cap. Basing that premium cap on income would affect the distribution of taxes paid, and would mean that fewer people would be "above the cap" – the region in which the subsidy for increasingly low-value insurance was removed. Basing the cap on income would thus make it less effective albeit more progressive.

Thank you for this opportunity to follow up with you. Please do not hesitate to contact me if I can be of further assistance.

Sincerely,

Katherine Baicker

Statement of

Leonard E. Burman
Director, Tax Policy Center
Institute Fellow, The Urban Institute
http://www.taxpolicycenter.org

Before the
Senate Committee on Finance

Roundtable on Financing Healthcare Reform*

May 12, 2009

* I thank Fiona Blackshaw, Stu Kantor, and Bob Williams for helpful comments and advice. Surachai Khitatrakun, Katie Lim, and Jeff Rohaly developed the models and provided the estimates.

Senator Baucus, Ranking Member Grassley, and Members of the Committee. Thank you for inviting me to present my views on financing health care reform. Views expressed are my own and do not represent those of the Tax Policy Center or the Urban Institute.

I applaud the committee for its leadership in finding ways to expand access to health care in a fiscally responsible manner. The latest statistics show that 46 million Americans were uninsured in 2007. In the current economic downturn, millions more have likely lost their health insurance either because they have lost their jobs or because their employer cannot afford to continue offering health insurance. All told, 50 million or more people in the richest country in the world may lack health insurance coverage

People without health insurance often delay seeking medical care when ill, and when they do visit an emergency room, they often receive substandard care. Those who have savings can get better care, but at the risk of financial ruin from any serious illness. And the uninsured impose costs on the rest of society. For example, I'd like to think that everyone infected with the H1N1 virus ("swine flu") would contact their medical provider, but people without health insurance often do not have a primary care provider and will postpone seeking care until they are very ill. This puts them at heightened risk of death and puts everyone they come into contact with while they postpone receiving care at risk of infection.

I especially applaud the committee and the president for insisting that health reform be accomplished in a fiscally responsible manner. As you well know, health care costs threaten to bankrupt the nation if we can't figure out a way to slow their growth and pay for the government's growing share. Adding to the government's unfunded health care obligations would be reckless and irresponsible.

In this brief statement, I will discuss some issues involved in measuring the impact of health care financing options, discuss an option to pay for universal health care coverage with a value added tax (VAT), and examine several incremental options to pay for all or part of health care coverage expansions.[1]

Issues in Designing and Measuring the Impact of Health Care Financing Options

One major issue to be addressed in evaluating options to pay for expanding access to health care is how to assess the distribution of benefits and costs. It is important to look at the effects of the coverage expansion and the revenue offset together, as a package. Otherwise, the coverage expansion looks unrealistically good (ignoring the fact that someone has to pay for it) and the revenue offsets look especially bad (ignoring the fact that they pay for a valuable new benefit).

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[1] The Tax Policy Center has analyzed a number of ways to expand revenues. These estimates were prepared specifically for this hearing. They are very preliminary and subject to revision. A much more extensive set of revenue and distribution tables for the options presented here is available on our web site at http://www.taxpolicycenter.org/taxtopics/health_financing_options.cfm.

Examining tax and spending together should be done whether the health care expansions are accomplished via tax credits or spending programs. Otherwise there will be a bias in favor of tax subsidies, which may not be the most efficient mechanism. For example, a voucher and refundable tax credit may be economically equivalent, but the credit may result in less coverage because tax credits are generally paid after the taxpayer has filed a tax return, whereas a voucher can be advanced or transferred directly to the insurer or health provider. There are ways to make tax credits look more like a direct spending program, but this is often at the cost of unnecessary complexity.

There will be a strong temptation to target new health care expansions directly at those with low incomes. Obviously, lower-income people most need help in affording health care, and the current system is heavily skewed in favor of those with high incomes. And, targeting any subsidies can significantly reduce their cost.

But targeting itself comes at a cost. First of all, tying eligibility to income can create large implicit taxes: households whose incomes increase may lose eligibility for a valuable subsidy. Just like direct taxes, the tax implicit in income-testing can discourage labor force participation or extra work effort, which can undermine efforts to build self-sufficiency among low-income households. There are also timing problems. Low-income households often have very volatile incomes. Presumably policymakers want insurance to be available and affordable when incomes are low, but tax information is only available with a lag. This raises the possibility that the subsidy may come too late to help a family in distress.

A better option would be to make health insurance broadly available and pay for it with broad-based taxes. This carries the political disadvantage of replacing a hidden tax (income eligibility requirements) with an explicit one, but the explicit program is far simpler to administer. Everyone is eligible for health insurance, and people pay according to their ability to do so. It spreads the pain over more taxpayers rather than just on families who are on the cusp of attaining a moderate income.

VAT to Pay for Health Care

In my view, the best option to pay for universal health care is a value-added tax (VAT). A value-added tax is basically a sales tax on all goods and services that is collected in stages from all the producers in the supply chain. Almost every country in the world, with the notable exception of the United States, has a VAT. TPC estimates that a VAT of less than 10 percent would be sufficient to pay for health care for all people who are not currently covered by government provided health insurance (under Medicaid, SCHIP, Medicare, and veterans' health programs).

Here are the main advantages of a VAT to finance health care reform:

- It is the only plausible revenue source that could pay for universal access to health insurance without very tight targeting by income.

- Although a VAT by itself is regressive (falls most heavily on those with lower incomes), a VAT combined with free health insurance is highly progressive.
- Although a VAT by itself might fuel the growth in government, a VAT that is earmarked to pay for health care would serve as a brake on health care spending because otherwise the VAT rate would tend to increase.
- Announcing a *future* VAT would stimulate spending in the short term and help boost the economy out of the current recession.
- When fully phased in, a VAT would encourage saving (since it is untaxed by the VAT), which will boost long-term economic growth and provide a cushion against future recessions.

Table 1 estimates the cost and required VAT rate to finance providing health insurance to everyone who is not covered by a government-run plan (Medicaid, Medicare, S-CHIP, and veterans' programs). It is assumed that households receive a voucher whose value equals the cost of insurance for each eligible individual. The voucher varies by age and gender and may be transferred to an employer who provides qualifying insurance or directly to an insurer. Insurers would have to offer insurance to all applicants to qualify for the voucher (to avoid cherry picking). The voucher would replace the income and payroll tax exclusion for employer-sponsored health insurance as well as the income tax deduction for premiums paid by the self-employed.[2]

We estimate that such a program would cost roughly $600 billion in 2009 (Table 1). The cost would double over the budget period, to $1.2 trillion by 2019. The required VAT rate, assuming a comprehensive VAT base, would be about 6.7 percent in 2009 and 8 percent in 2019. The rate increases because health spending grows faster than other consumption. If the rate of growth of health costs could be slowed by 1 percentage point a year, the VAT rate would increase much more slowly, reaching only 7 percent in 2019.

The VAT plus a voucher is highly progressive (Table 2). The bottom 60 percent of households would gain far more in health insurance than they would lose from the VAT. The top 20 percent would pay significantly more on average. Because they spend so much, the highest-income 0.1 percent would face an average tax increase of $243,000 over and above the value of the health insurance voucher.

Some low-income households would be made significantly worse off, however, because they already receive free health insurance and would thus not benefit from the voucher. This could be rectified by providing a refundable tax credit for every individual. Table 3 shows the distribution of tax changes assuming a $500 per person refundable tax credit.[3] To offset the cost of the tax credit, the VAT rate would have to be 8.4 percent in 2009. Under this option, 60 percent of households would receive benefits in excess of the

[2] Tax subsidies for flexible savings accounts and health savings accounts should probably also be eliminated, but we lack the data necessary to estimate the effect of those programs. JCT tax expenditure estimates suggest that their revenue cost is very small compared with the ESI exclusion, so the error from excluding them is small.

[3] This is similar to the "prebate" proposed by advocates of the national retail sales tax (or FairTax). A VAT is preferable to a sales tax because the latter is very easy to avoid.

VAT tax paid, and more than 90 percent of households in the bottom 20 percent would be better off.

The actual VAT rate would have to be higher to account for the IRS's cost in administering it and the fact that, like all taxes, there would be some evasion. Assuming that the VAT could be applied to a very broad base, a 10 percent rate would probably be sufficient at the outset to pay for the health insurance voucher and tax credit.

For several reasons, the VAT should probably be phased in slowly. One important one is that a VAT during a recession would discourage consumption and potentially deepen the economic slide. However, when the end of the recession is in sight, the prospect of a *future* VAT would boost current consumption as people would accelerate purchases to avoid the tax increase.

That is, the VAT can be a powerful fiscal policy tool, and it could be used in future recessions. Indeed, the United Kingdom cut its VAT rate in an effort to boost spending during the downturn. When the economy is fully recovered and the VAT is fully phased in, it could provide an incentive to save more, which would boost our long-term economic growth and cushion the effects of future recessions (since taxpayers with savings need cut their spending by less than those without).

Repeal or Cap the ESI Exclusion

Under current law, employer contributions toward their employees' health insurance (employer-sponsored insurance, or ESI) are exempt from income and payroll taxes. Insurance purchased by self-employed individuals is deductible from taxable income.[4] Together, TPC estimates that these provisions will reduce individual income tax revenues by about $240 billion in 2010 (Table 4).

The ESI exclusion has been very successful in one sense—most working-age individuals and families get insurance through an employer—but it also suffers from serious flaws. The subsidy is very poorly targeted. High-income people get federal income and payroll tax subsidies worth on average more than 35 percent of income, while low-income households only benefit from the payroll tax exclusion (and saving on the payroll tax is a mixed blessing since reduced payroll taxes translate into substantial reductions in future Social Security benefits for low earners). (Figure 1.) Meanwhile, premiums are a much, much bigger burden for low-income people than for those with high incomes. It is no wonder that most low-income workers do not get ESI and many are uninsured.

[4] In addition, contributions to flexible spending accounts (FSAs) to pay for the employer portion of health insurance premiums and out-of-pocket expenses are also excluded from income, as are are retiree health insurance, supplemental insurance, and contributions to Health Savings Accounts. Lacking data, we did not model these provisions. Those tax expenditure are dwarfed by the exclusion for ESI, so this omission is unlikely to substantially affect our estimates.

The open-ended subsidy encourages employees to demand more generous insurance, which contributes to the rapid growth of health care costs. Individuals who have to pay little or nothing out of pocket for medical care are likely to overconsume such services.

The ESI system is especially burdensome for small employers and their workers since insurance typically costs much more for small than for large groups, and it can become prohibitively expensive if one worker in a small group experiences an expensive medical condition. Tying insurance to employment means that a job loss can lead to loss of insurance. COBRA and tax credits for workers who lose their jobs are aimed at mitigating this effect, but many workers fall through the cracks. And there is little recourse for a worker whose employer stops offering insurance in response to a decline in profits—likely a significant problem now.

Eliminating ESI would raise a lot of revenue—an estimated $240 billion in 2010 and over $3.5 trillion over 10 years (Table 4). This policy would be undesirable as a stand-alone measure because tens of millions of Americans would likely lose their health insurance. However, as a way to finance universal access to health care with a more progressive subsidy mechanism (as proposed by both Senator McCain and President Obama), this option has much to recommend it.

Alternatively, the exclusion could be capped. We estimated the effect of two sets of options. Under one variant, the exclusion would be capped at the average cost of health insurance in 2009, which we estimate to be $5,370 for single coverage, $10,227 for single plus one other person coverage, and $13,226 for family coverage. If those caps are held fixed in nominal terms, the option would increase income and payroll tax revenues by about $1.1 trillion over 10 years. Initially, few people would be affected—only 30 percent of households would pay higher taxes in 2010. However, because health care costs grow fast, by 2019, 43 percent of households—virtually all of those with ESI coverage—would be paying higher taxes. The actual effect of the policy and the distribution of winners and losers will depend on how the revenue gained is used.

We also show estimates assuming that the cap grows with at rate of overall price inflation (CPI) and at the rate of health care costs inflation. These options would reduce10-year revenues to $848 billion and $165 billion, respectively. The number of people who would face higher taxes would also decrease.

In isolation, a cap would reduce the number of people with ESI. It would also disproportionately affect those who live in high-cost areas, those who work for small firms, the self-employed, older workers, and people with poor health since they all tend to face higher premiums. It would be feasible, although not easy, to adjust the caps for all these factors, but we do not have sufficient information in our tax model to estimate the effect of such a cap. One option might be to set up a publicly sponsored market, like the Federal Employees' Health Benefits Program, where anyone could purchase inexpensive insurance and tie the cap to the cost of such insurance in each market.

Both repeal and caps on the ESI exclusion are very progressive because higher-income people are much more likely to get ESI than those with lower incomes, and their tax savings are greater because they are in higher brackets.

A less draconian variant would be to cap the ESI exclusion and deduction for the self-employed at the 90th percentile for premiums. At this premium level, 90 percent of households with ESI get insurance with lower premiums. We estimate the 90th percentile premiums to be $6,004 for single coverage, $11,974 for single plus one, and $15,290 for family coverage in 2009. Table 4 shows that the revenue raised with the higher caps would, not surprisingly, be smaller, but still substantial. For example, with an unindexed cap, the option would raise almost $500 billion over 10 years, even though few would be affected initially.

Other Financing Options

We examined a number of other options to raise significant revenue to help finance health care reform (Table 5). The first option would replace itemized deductions with a 15 percent tax credit for those who choose not to take the standard deduction. The rationale for the change—as with the Obama administration's proposal to limit the benefit of itemized deductions to 28 percent—is that itemized deductions largely represent subsidy programs rather than adjustments in the ability to pay tax. Thus, there is no good reason in principle to provide a larger subsidy rate for donations to Princeton by a millionaire than for donations to a house of worship by a lower earner.[5] The president's proposal, however, is quite complex. It is effectively an "alternative maximum deduction."

A nonrefundable 15 percent credit would raise $141 billion in 2011 and $1.5 trillion over 10 years compared with current law. If refundable, the credit would raise revenues by $113 billion in 2011 and $1.3 trillion over the budget period. The proposal, however, would generate opposition from charities, home builders, realtors, and state and local governments, all of which benefit from the current arrangement.

Two options would increase payroll taxes. Option 3 would increase the Social Security payroll tax rate on both employers and employees by 1 percentage point. It would raise $101 billion in 2011 and $1.1 trillion over 10 years. Option 4 would eliminate the earnings cap on earnings subject to Social Security tax. It would raise about $944 billion over 10 years. Option 4 would affect only relatively high-income people, whereas option 3 would affect those with modest incomes. All would raise marginal tax rates on work. Also, the revenues gained in the short run from Option 4 would be partially offset by higher Social Security benefits paid when the affected workers retire.

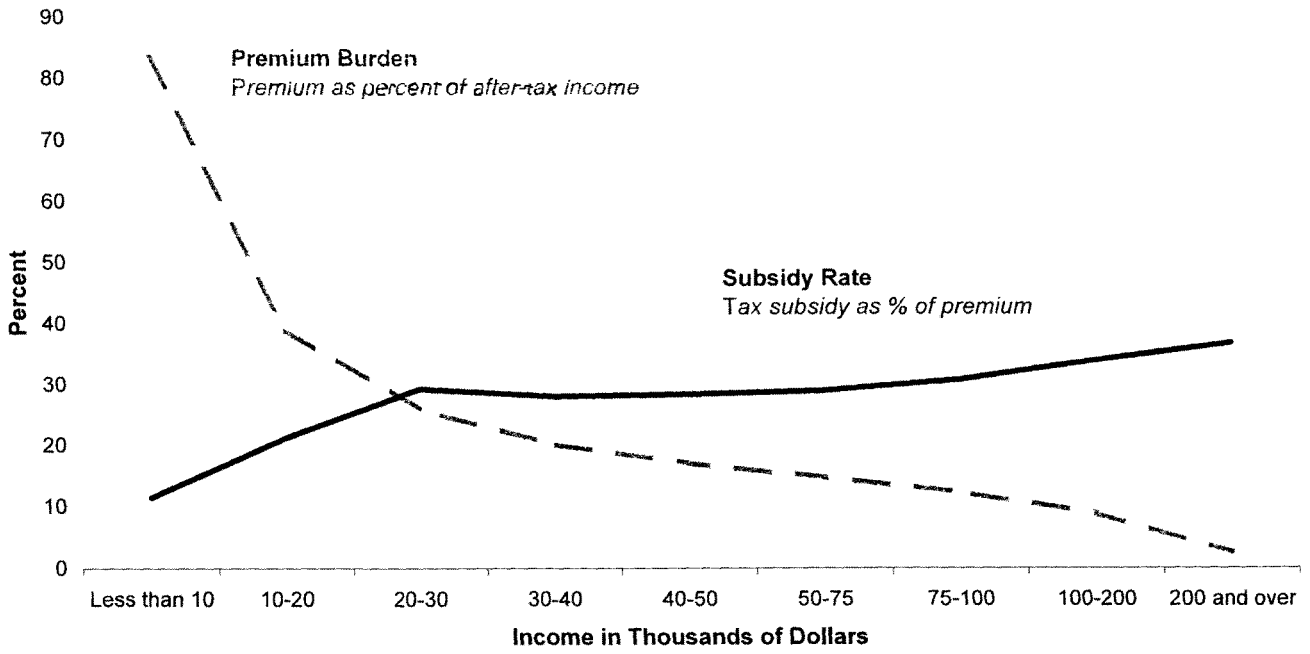
Option 5 would reduce the rate at which income tax parameters are indexed for inflation by 1 percentage point. (CBO considered an option to cut the CPI by about 0.3 percentage points.) The rationale is that the CPI overstates the effect of inflation on living

[5] Some miscellaneous itemized deductions actually do represent costs of earning income and probably should be allowed as a deduction. .

standards if price changes are not uniform. People substitute away from higher-priced items in favor of those with smaller price increases, which reduces the impact of inflation. The drawback is that more and more people would drift into higher tax brackets over time—a phenomenon known as bracket creep. This proposal has the advantage of raising more and more revenue over time—$54 billion in 2019 versus less than $8 billion in 2011.[6]

[6] The revenue gained is significantly more under the administration's baseline because the AMT parameters would be indexed under that baseline. Thus, a proposal to reduce the rate of indexing raises revenues under both the ordinary income tax and under the AMT. Under current law, the AMT is not indexed and those on the AMT would be unaffected. Also, many more people are subject to the AMT under the current law baseline.

Figure 1. ESI Subsidy Rate versus Premium Burden, 2004



Source: Urban-Brookings Tax Policy Center.
Note: Subsidy includes income tax and Medicare payroll tax savings.

Table 1. Replace ESI Exclusion and Self-Employment Health Insurance Deduction with Voucher to Purchase Private Insurance[a]

	Calendar Year											5 Year	10 Year
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010–14	2010–19
Revenue Loss Assuming Baseline Growth (billions$)	602 9	640 9	670 9	717 1	768 4	825 2	884 1	948 6	1,016 5	1,090 2	1,167 8	3,622 5	8,729 8
Required VAT Rate[b]	6 7%	6 9%	6 9%	6 9%	7 0%	7 1%	7 3%	7 5%	7 6%	7 8%	8 0%		
Revenue Loss Assuming Lower Growth Rate for Medical Costs (billions$)	602 9	632 6	653 4	688 9	728 2	771 4	815 2	862 7	911 8	964 3	1,018 3	3,474 5	8,046 8
Required VAT Rate	6 7%	6 8%	6 8%	6 6%	6 6%	6 7%	6 7%	6 8%	6 9%	6 9%	7 0%		

Source Urban-Brookings Tax Policy Center Microsimulation Model (version 0309-2)

a Calendar year Baseline is current law Proposal replaces the ESI exclusion and health insurance deduction for the self-employed with a voucher to purchase private insurance, either directly or through an employer Individual voucher value depends on age and gender, the total voucher for each tax unit is the sum of each individual's voucher Only individuals not covered by public insurance receive a voucher

b The rate is based on a VAT applied to a comprehensive consumption base

Table 2
Replace ESI Exclusion and Self-Employment Health Insurance Deduction With Voucher to Purchase Private Insurance
Impose Comprehensive VAT at Tax Exclusive Rate of 6.7%
Distribution of Federal Tax Change by Cash Income Percentile, 2009
Summary Table

Cash Income Percentile[a]	Percent of Tax Units[b]		Percent Change in After-Tax Income[c]	Share of Total Federal Tax Change	Average Federal Tax Change ($)	Average Federal Tax Rate[d]	
	With Tax Cut	With Tax Increase				Change (% Points)	Under the Proposal
Lowest Quintile	61 5	36 0	22 1	-6,370 8	-2,464	-22 1	-22 4
Second Quintile	53 1	46 3	6 1	-3,692 2	-1,585	-5 6	2 3
Middle Quintile	49 3	50 7	2 0	-1,818 9	-865	-1 7	12 8
Fourth Quintile	42 5	57 4	0 0	28 1	16	0 0	17 2
Top Quintile	21 8	78 2	-4 3	12,161 5	7,739	3 3	25 8
All	48 0	51 2	0 0	100 0	10	0 0	18 0
Addendum							
80–90	30 7	69 3	-2 3	1,818 5	2,285	1 9	21 1
90–95	17 8	82 2	-3 4	1,788 9	4,688	2 7	23 6
95–99	8 3	91 7	-5 3	3,818 6	12,150	4 1	26 8
Top 1 Percent	5 6	94 4	-5 8	4,735 4	59,344	4 3	30 3
Top 0.1 Percent	2 7	97 3	-5 8	1,949 7	243,260	4 2	32 3

Source Urban-Brookings Tax Policy Center Microsimulation Model (version 0309-2)

Number of AMT Taxpayers (millions) Baseline 3 8 Proposal 4 1

Notes Calendar year Baseline is current law Proposal replaces the ESI exclusion and health insurance deduction for the self-employed with a voucher to purchase private insurance, either directly or through an employer Individual voucher value depends on age and gender, the total voucher for each tax unit is the sum of each individual's voucher Only individuals not covered by public insurance receive a voucher The proposal imposes a revenue-neutral comprehensive VAT at tax exclusive rate of 6 7% to finance the voucher The VAT is distributed to labor earnings plus all capital

a Tax units with negative cash income are excluded from the lowest income class but are included in the totals For a description of cash income, see http //www taxpolicycenter org/TaxModel/income cfm The cash income percentile classes used in this table are based on the income distribution for the entire population and contain an equal number of people, not tax units The breaks are (in 2009 dollars) 20% $19,792, 40% $38,213, 60% $65,692, 80% $104,318, 90% $150,433, 95% $203,190, 99% $522,025, 99 9% $2,131,606

b Includes both filing and nonfiling units but excludes those that are dependents of other tax units

c After-tax income is cash income less individual income tax net of refundable credits, corporate income tax, payroll taxes (Social Security and Medicare), and estate tax

d Average federal tax (includes individual and corporate income tax, payroll taxes for Social Security and Medicare, and the estate tax) as a percentage of average cash income

Table 3
Replace ESI Exclusion and Self-Employment Health Insurance Deduction With Voucher to Purchase Private Insurance
Impose Comprehensive VAT at Tax Exclusive Rate of 8.4% With $500 Individual Cash Subsidy
Distribution of Federal Tax Change by Cash Income Percentile, 2009
Summary Table

Cash Income Percentile[a]	Percent of Tax Units[b]		Percent Change in After-Tax Income[c]	Share of Total Federal Tax Change	Average Federal Tax Change ($)	Average Federal Tax Rate[d]	
	With Tax Cut	With Tax Increase				Change (% Points)	Under the Proposal
Lowest Quintile	90 5	9 5	27 8	-8,032 1	-3,106	-27 9	-28 1
Second Quintile	71 2	28 8	8 1	-4,863 0	-2,087	-7 4	0 5
Middle Quintile	56 0	44 0	2 5	-2,310 2	-1,099	-2 2	12 3
Fourth Quintile	45 2	54 8	-0 1	133 0	74	0 1	17 3
Top Quintile	19 6	80 4	-5 4	15,400 8	9,801	4 2	26 7
All	60 7	39 2	0 0	100 0	10	0.0	18 0
Addendum							
80-90	28 3	71 7	-2 9	2,265 2	2,847	2 3	21 6
90-95	14 5	85 6	-4 3	2,270 6	5,950	3 4	24 3
95-99	7 4	92 6	-6.7	4,841 2	15,403	5 2	27.9
Top 1 Percent	5 2	94 8	-7 4	6,023 7	75,488	5 5	31 5
Top 0.1 Percent	2 5	97 5	-7 4	2,483 1	309,804	5 3	33.5

Source Urban-Brookings Tax Policy Center Microsimulation Model (version 0309-2)
Number of AMT Taxpayers (millions) Baseline 3 8 Proposal 4 1

Notes Calendar year. Baseline is current law Proposal replaces the ESI exclusion and health insurance deduction for the self-employed with a voucher to purchase private insurance, either directly or through an employer Individual voucher value depends on age and gender, the total voucher for each tax unit is the sum of each individual's voucher Only individual not covered by public insurance receive a voucher. The proposal imposes a revenue-neutral comprehensive VAT at tax exclusive rate of 8 4% to finance the voucher and $500 individual cash subsidy The VAT is distributed to labor earnings plus all capital

a Tax units with negative cash income are excluded from the lowest income class but are included in the totals For a description of cash income, see http //www taxpolicycenter org/TaxModel/income cfm The cash income percentile classes used in this table are based on the income distribution for the entire population and contain an equal number of people, not tax units The breaks are (in 2009 dollars) 20% $19,792, 40% $38,213, 60% $65,692, 80% $104,318, 90% $150,433, 95% $203,190, 99% $522,025, 99 9% $2,131,606

b Includes both filing and nonfiling units but excludes those that are dependents of other tax units

c After-tax income is cash income less individual income tax net of refundable credits, corporate income tax, payroll taxes (Social Security and Medicare), and estate tax

d Average federal tax (includes individual and corporate income tax, payroll taxes for Social Security and Medicare, and the estate tax) as a percentage of average cash income

7-May-09

Table 4. Revenue Gained from Modifying the ESI Exclusion (billions$)

	Calendar Year										
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010–19
1. Remove Exclusion											
Individual Income Tax	144 8	161 0	179 4	196 7	213 6	231 4	250 2	269 6	292 7	316 6	2,255 9
Payroll Tax	95 7	100 5	108 4	116 4	123 9	131 9	140 6	149 3	159 8	170 5	1,297 1
Total	240 5	261 4	287 8	313 1	337 6	363 3	390 8	418 9	452 5	487 1	3,553 0
2. Impose Unindexed Cap on ESI Exclusion											
Individual Income Tax	10 8	18 2	29 6	41 7	55 2	69 9	86 2	103 4	124 0	145 8	684 6
Payroll Tax	7 4	11 8	18 6	25 7	33 2	41 3	50 1	59 1	69 7	80 7	397 8
Total	18 2	30 1	48 2	67 4	88 4	111 2	136 2	162 5	193 7	226 5	1,082 4
3. Impose Cap on ESI Exclusion Indexed by CPI											
Individual Income Tax	10 3	16 2	24 9	33 8	43 6	54 2	66 3	79 2	95 1	112 2	535 8
Payroll Tax	7 1	10 5	15 7	20 8	26 3	32 1	38 6	45 4	53 7	62 4	312 6
Total	17 4	26 7	40 6	54 6	69 9	86 3	104 9	124 6	148 8	174 6	848 4
4. Impose Cap on ESI Exclusion Indexed by Medical Expenses											
Individual Income Tax	6 1	6 7	8 2	9 1	10 0	10 9	11 8	12 4	13 8	15 3	104 3
Payroll Tax	4 1	4 2	5 1	5 5	5 9	6 3	6 8	7 0	7 7	8 4	61 0
Total	10 2	10 9	13 3	14 6	15 9	17 2	18 6	19 3	21 5	23 6	165 2
5. Impose 90th Percentile Unindexed Cap on ESI Exclusion											
Individual Income Tax	3 0	6 4	13 4	22 6	34 5	48 1	63 5	80 1	100 0	121 3	492 8
Payroll Tax	2 0	4 1	8 4	13 9	20 9	28 6	37 2	46 1	56 6	67 5	285 2
Total	4 9	10 5	21 8	36 6	55 4	76 7	100 7	126 1	156 5	188 8	778 0
6. Impose 90th Percentile Cap on ESI Exclusion Indexed by CPI											
Individual Income Tax	2 8	5 3	10 1	15 8	23 0	31 6	42 1	53 6	68 0	83 8	336 0
Payroll Tax	1 8	3 4	6 3	9 7	13 9	18 8	24 7	30 9	38 7	46 9	195 1
Total	4 6	8 7	16 4	25 5	36 8	50 5	66 8	84 5	106 7	130 7	531 1
7. Impose 90th Percentile Cap on ESI Exclusion Indexed by Medical Expenses											
Individual Income Tax	1 5	1 6	2 1	2 3	2 5	2 7	3 0	3 1	3 4	3 8	26 0
Payroll Tax	1 0	1 0	1 2	1 3	1 4	1 5	1 6	1 7	1 8	2 0	14 5
Total	2 4	2 6	3 3	3 6	3 9	4 2	4 6	4 7	5 3	5 8	40 5

Source Urban-Brookings Tax Policy Center Microsimulation Model (version 0309-2)

Notes Baseline is current law The 2009 caps based on average premiums are $5,370 for single coverage, $10,277 for single-plus-one coverage, and $13,226 for family coverage The 2009 caps based on the 90th percentile of premiums are $6,004 for single coverage, $11,974 for single-plus-one coverage, and $15,290 for family coverage

Table 5
Revenue Raising Options
Impact on Tax Revenue ($ billions), 2010–19

	Fiscal Year										
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010–19[a]
Current Law Baseline											
Option 1: Replace Itemized Deductions with 15 Percent Nonrefundable Credit	16 7	141 1	130 3	141 4	152 0	161 9	171 3	180 6	190 4	200 8	1,486 6
Option 2: Replace Itemized Deductions with 15 Percent Refundable Credit	11 6	112 6	115 7	124 6	132 7	139 4	145 5	152 3	159 9	168 5	1,262 7
Option 3: Increase Social Security Payroll Tax Rate by 1 Percent[b]	80 0	101 4	98 8	102 7	108 0	112 9	117 7	122 4	127 3	132 1	1,103 4
Option 4: Eliminate Social Security Earnings Cap	53 9	83 8	84 4	87 2	93 1	98 4	103 1	108 7	113 1	118 8	944 4
Option 5: Index Individual Income Tax Using CPI - 1%[c]	3 6	7 8	14 5	20 1	25 6	30 1	35 6	40 9	48 3	53 8	280 3
Administration Baseline[d]											
Option 1: Replace Itemized Deductions with 15 Percent Nonrefundable Credit	16 3	124 0	104 2	114 4	124 1	133 1	141 3	149 3	157 7	166 2	1,230 4
Option 2: Replace Itemized Deductions with 15 Percent Refundable Credit	12 1	93 2	80 5	90 0	98 6	106 2	113 0	119 4	126 2	133 2	972 5
Option 3: Increase Social Security Payroll Tax Rate by 1 Percent[b]	83 1	108 9	108 5	113 4	119 2	124 6	130 0	135 2	140 7	146 2	1,209 8
Option 4: Eliminate Social Security Earnings Cap	56 7	94 8	99 2	103 2	109 9	115 8	121 1	127 5	132 6	139 2	1,100 2
Option 5: Index Individual Income Tax Using CPI - 1%[c]	5 6	10 3	19 1	27 3	36 2	44 6	55 3	66 6	81 0	94 4	440 5

Source Urban-Brookings Tax Policy Center Microsimulation Model (version 0309-2)
Notes Estimates include microdynamic behavioral response Estimates assume an elasticity of taxable income with respect to (1 - marginal rate) of 0 25, a labor supply response elasticity for changes in payroll tax rates of 0 1, and that increases in the employer share of payroll taxes are passed along to workers as lower nominal wages The latter effect is assumed to occur gradually over the first three years of the proposal Payroll and indexing options assume a 75-25 fiscal split, itemized deduction options assume a 20-80 split for the first year of the proposal and a 60-40 split for future years All proposals are effective 01/01/10
a Numbers might not add due to rounding
b Proposal increases both the employee and employer rate by 1 percent
c All individual income tax parameters that are currently indexed to inflation using the Consumer Price Index for All Urban Consumers (CPI-U) would instead be indexed using the CPI-U less 1 percentage point All unindexed parameters would remain unindexed
d Administration baseline extends all the individual income tax provisions in EGTRRA and JGTRRA that are set to expire on 12/31/10, maintains the estate tax at its 2009 parameters, extends the 2009 AMT patch including the allowance of personal nonrefundable credits against the AMT, and indexes the AMT exemption, rate bracket threshold, and phase-out exemption threshold for inflation

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CONGRESSIONAL TESTIMONY

Coverage Issues in Health Reform

Statement to the
Finance Committee Roundtable
United States Senate

May 5th, 2009

Stuart M Butler
Vice-President
The Heritage Foundation

My name is Stuart Butler. I am the Vice President for Domestic and Economic Studies at The Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

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There is broad agreement on the broad goals of health reform. We all want to achieve significant progress this year towards the vision of an America in which everyone has coverage that is adequate, accessible, and affordable – to households and to the nation – and portable.

Coverage Issues to be Resolved

Two major landmines on the road to consensus. Those of us who agree on the goals are making good progress towards resolving the "engineering questions" to achieve the agreed objectives. I will discuss some of these together with a broad outline of how I believe Congress can achieve a broad consensus for action on coverage. But I am very concerned about two proposals that have entered the picture: a "competing" public plan and a federal health board. These are like nuclear landmines on the road to broad agreement. They could be lethal to the prospects for consensus and even to the passage of any significant legislation.

Some say that within an exchange there must be a default plan that will be a "safe harbor," and that plan should be a **public plan** – perhaps one modeled on Medicare. But it is important to remember an old sporting adage – if the umpire works for one of the teams you should be suspicious of the score. The simple fact is that if the government is sponsoring a competition within an exchange, and also is the owner of one of the plans, there can be little doubt that the rules and regulations promulgated by Washington will favor the government-sponsored plan. A "competing" public plan as a choice will inevitably become a public plan for all, and is unacceptable. Fortunately, as I note below, there are alternatives to achieve the same stated purpose.

A powerful **federal health board** could also undo any consensus. It's one thing to have a body to spur and distribute cost-effectiveness research, as the new Federal Coordinating Council for Comparative Effectiveness Research will do. It's quite another to have a board, as others have urged, that is not really answerable to anyone and starts to determine how medical care is to be provided. To be acceptable, any such board must not be a monopoly of information – other clearinghouses should be established in the private sector. And it must not promulgate rules for coverage and professional conduct in the private sector.

There are other coverage issues to be resolved, where I believe agreement is quite possible.

A benefits package. If we are to assure Americans of adequate coverage, we must of course define in some way what that level and type of coverage actually is. That leads some to insist that future coverage, and perhaps existing plans, must include a specific, federally determined comprehensive benefits package. But others point to the dangers in that approach. There will be provider pressure on Congress to add services to the mandatory package, for instance. And many Americans will face the sticker shock of plans that contain expensive benefits they do not need or want.

The solution would be to copy the approach used in the program covering members of Congress. The Federal Employees Health Benefits Program (FEHBP) not only does not include a public plan, but it also does not have a standard benefits package. Instead it simply requires plans to include broad categories of coverage, such as emergency care and major medical, and allows plans to offer a variety of benefits within these categories. This approach can and should be the basis of any subsidized benefits package developed by Congress.

A Health Insurance Exchange. There is broad support for the concept of a health insurance exchange to improve the functioning of a competitive market for plans. Such an exchange would, among other things, aggregate premium payments to simplify and reduce the costs of insurance transactions, set broad marketing rules, and provide a source of standardized plan information to help facilitate plan choice. (These are all functions carried out by the FEHBP). In addition, exchange operations would dovetail with state actions to organize **insurance pools**, including perhaps high-risk pools for expensive enrollees, and with **risk adjustment** or **reinsurance** systems as methods to distribute risk and reduce adverse selection. In keeping with this model of an exchange, it should not set benefits, payment rates or premiums.

But should an exchange be at the national level, or at the state level, and should there be overlapping exchanges?

A national exchange may seem attractive but it is accompanied by many problems. In particular, there could be a mismatch between national rules and the pooling, risk pool and even existing exchanges (e.g. in Massachusetts) at the state level. It would also be difficult for states to explore creative approaches for delivering efficient coverage if they always had to comply with national rules.

The solution would be for the federal government to do two things. First, set out broad objectives for exchanges, and allow states to propose designs for state or regional exchanges to be certified by the federal government. That would enable a state like Massachusetts to continue its Connector, and other states to develop exchanges that best fits their situations. And second, the federal government could provide technical assistance and perhaps develop a plan information system to be used by all states.

While single risk-adjustment mechanisms would have to arranged to cover particular geographic areas, that is not true of exchanges. Since exchanges provide a set of services

to enrollees, permitting competing exchanges would sharpen customer service. But even if Congress or a state chose to set up non-overlapping exchanges, it is important to allow organizations offer "Expedia-style" navigation, advisory and enrolment services tailored to the needs and preferences of Americans. Thus even if an exchange has monopoly status, it should be required by law to provide plan information and access to the enrolment to such organizations.

Mandates. The issue of coverage mandates has become increasingly divisive. Some argue that the only way to achieve near universal coverage is to make people buy insurance, and others claim that the only way to maintain a stable insurance pool that includes healthier individuals is through a mandate. Another line of argument is that employers should pay their "fair share" towards coverage through a mandate to provide some specified level of coverage.

Both forms of mandate are problematic and pose threats to a consensus on coverage. An **employer mandate** is damaging because it continues the illusion that employers actually pay for a worker's insurance. But in reality health insurance is just one element of total compensation and "employer-provided" insurance just means there is more compensation in that form and less employer-provided cash income. So an employer mandate is nothing more than a hidden way of making employers pay for their own coverage. It is not a true subsidy, and it is regressive.

An **individual mandate** also poses problems. Even those who agree in principle that individuals should take responsibility for their coverage worry that individual mandates force people to buy something they may not want and cannot afford. They also worry that such a mandate will open the door to requiring a government-designed coverage.

The solution would be to encourage voluntary coverage in two ways, and to see how close to full coverage we get before we consider prosecuting people for not buying insurance.

The first way to do this would be to reform the subsidy system as part of overall reform. The inability to afford available coverage is the major reason working families are uninsured. Policy analysts, as well as members and staff on both sides of the aisle, recognize that the current tax benefits for coverage provide large subsidies for affluent Americans and little or no help for lower-paid working families. The **capping** or **elimination of the tax exclusion** and replacing it with **tax credits** to help lower-income taxpaying families better afford coverage, is thus a critical step.

The second step would be to make **automatic enrollment** in private plans the default for working families. In this arrangement, working families would be automatically signed up to the employer's plan or to one of a group of plans chosen by the state and would have to actively decline coverage if they did not want it. It turns out that default enrollment sharply increases sign-ups for pension plans. Inertia is very powerful. According to John Sheils at Lewin, auto-enrolment with more rational subsidies could

boost insurance sign-up rates to above 85%. Peter Orszag has also raised the importance of this feature of behavioral economics in the health field.

The Future of ESI. There are huge gaps in the employer-sponsored insurance (ESI) system. Many smaller employers do not even offer coverage. So we do face a momentous policy choice. Do we try to expand coverage by somehow encouraging or forcing more employers to provide coverage, such as though mandates (with the problems noted above) or subsidies to firms? Or do we rethink the future role of employer in health care, at least in the case of smaller firms?

I believe the right foundation for wider coverage in the future is not employer-sponsored insurance. There is a reason America is unique in trying to maintain such a system – it does not work for an increasing number of Americans. Artificially tying the sponsorship of insurance to the place of work (which is kept in place mainly by the discriminatory tax exclusion) means a family's coverage depends on the preferences, knowledge and economic fortunes of the employer. And it inhibits portability of coverage. If we were starting anew, we would never tie this crucial part of family well-being to the place of work.

The solution, however, does not mean overlooking some advantages of employment-based insurance, nor does it mean closing down successful employer-based plans. Instead, it means two things.

First, it means creating a parallel system of plans available through health exchanges, with the same tax benefits available to those enrolling in such plans as are enjoyed by those with traditional ESI (ideally with the tax reforms described earlier). To avoid any damaging disruption to existing, successful ESI plans, each employer currently offering insurance would decide if his/her workers would continue with their ESI or obtain coverage through the exchange. Workers not offered ESI could choose from the exchange plans.

Second, all employers in the future would function as **facilitators** of insurance. In other words, people typically would sign up for coverage at the place of work – even though many employers would not sponsor coverage – much as they sign up for tax withholding or make contributions to 401 (k) plans, or congressional staff sign up for their chosen FEHBP via their member's office. In most cases employers would institute a payroll deduction system and send premiums to the exchange for distribution to the chosen plans (much like the mechanism used in the FEHBP). If an automatic enrolment system were in place the employers would administer that for most working-age families.

State innovation. Our system of federalism is intended to allow states to determine the best ways to achieve objectives we share as a nation, as well as to innovate, thereby appropriately limiting the role of the central government and fostering creative diversity. We value that principle of federalism in such areas as education and welfare. It is important to utilize it fully in health care. But to do so we would need to marry the

national goals we set with a procedure to enable states to try innovative approaches to reach those goals.

The solution is for Washington to identify the broad goals of a health system and to encourage states to devise the best ways to achieve those goals. That can be done in a bold way by making it possible for states to obtain congressional approval for significant changes in existing laws and programs – i.e. by granting the states **waivers from federal laws**, not just from regulations – so that they can restructure programs and try creative ways of expanding affordable coverage. Three bipartisan bills were introduced last year to permit such state-based experimentation – the *Health Partnership Act* (S.325), the *Health Partnership Through Creative Federalism Act* (H.R. 506), and the *State-Based Health Care Reform Act* (S. 1169). These bills would provide temporary waivers, and in some instances federal grants, for an experimental period. Depending on how successful the state was in reaching agreed outcome measures that period could be extended. I worked together with Henry Aaron of the Brookings Institution developing this bipartisan concept of creative federalism. Our proposal is designed to permit not only insurance exchanges but other innovative proposals as well, and to encourage reasonable ideas from across the spectrum to be tried and compared in order to find the best answers to the challenge of uninsurance.[1]

Charting a Way Forward

How might these elements come together in a health strategy this year to achieve substantial progress towards portable coverage that is adequate, affordable, and accessible?

The Federal Role

- Congress establishes the overall national **objectives of coverage**, including the general categories of coverage. These would serve as the benchmarks for state action.

- The federal government establishes a set of **metrics to guide state action** and to **evaluate their success**. These would include such measures as the reduction of uninsurance levels among categories of residents, and mileposts for quality and affordability improvements.

- The federal government establishes a default or **fallback coverage** mechanism for states that chose not to design a plan to meet the national goals, or whose proposals or performance fell short. This might take the form of allowing residents in these states to obtain coverage through the national FEHBP plans, using a separate pool. In

[1] See Henry J. Aaron and Stuart M. Butler, "A Federalist Approach to Health Reform: The Worst Way, Except For All Others," *Health Affairs*, May/June 2008.

addition, as an alternative to a public plan, the federal government and state officials could negotiate with the national FEHBP plans or other major insurers to offer **benchmark private plans** in each state. But the aim is to encourage states to take action, and so adopting the fallback should not mean states merely transfer costs to the federal government.

- The federal government provides technical assistance and start-up grants to facilitate **state exchanges** and **risk adjustment mechanisms** to reduce adverse selection while making affordable premiums available in the state.

- The federal government provides a modest tax credit for smaller firms to set up a payroll reduction, premium payment and **automatic enrolment** system for their employees. Firms could use this system either for employer-sponsored insurance or to enroll employees in a state-designated default plan or a chosen exchange plan.

- The federal government establishes **"creative federalism" procedures** to permit a state to propose ways of achieving the national goals for coverage through an alternative strategy involving the suspension or alteration of existing laws and programs.

- The federal government enacts a tax reform/subsidy system to completely or partially replace the current tax exclusion and Schedule A deductions for health care insurance. A **non-refundable credit** would be available to taxpayers, financed from limiting the exclusion and deductions, and a **refundable credit or equivalent subsidy** for others financed by savings in programs.

The State Role

- States design approaches, or accept the federal fallback, to meet the goals of **accessibility** (including underwriting and issuance rules to achieve continuous coverage); **adequacy** (the FEHBP benefit categories); **affordability** (including a negotiated FEHBP or other benchmark plan); and **portability** (including an exchange or similar mechanism).

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Business Roundtable

Statement for the Record

John J. Castellani

President

Business Roundtable

Senate Finance Committee

Roundtable Discussion on Health Care Coverage

Tuesday, May 5, 2009

I am John J. Castellani, President of Business Roundtable, an association of chief executive officers of leading U.S. companies with $5 trillion in annual revenues and almost 10 million employees. On behalf of the Roundtable, I am submitting this testimony for the Committee's review. Member companies comprise nearly a third of the total value of the U.S. stock markets and represent over 40 percent of all corporate income taxes paid to the federal government. Collectively, Business Roundtable companies returned $114 billion in dividends to shareholders and the economy in 2006. Business Roundtable appreciates the invitation to participate in the roundtable discussions and looks forward to working with Chairman Baucus, Senator Grassley and other Senators on this Committee, in discussing ways to improve our health care system so that all Americans can have access to affordable health care coverage.

As the provider of health coverage to almost 35 million Americans, Business Roundtable companies play a significant role in helping American workers and their families obtain medical care. Health care costs are a key issue for us as they are inhibiting job creation and damaging our ability to compete in global markets. They are also imposing a major strain on the household incomes of many Americans. In these times of financial insecurity, maintaining jobs and retaining the health care benefits is an enormous strain for many Americans. We believe health care reform should be addressed now as we work our way through these difficult financial times.

Divided We Fail

We appreciate the opportunity to be here today with our colleagues involved in Divided We Fail (DWF). Together, we have called on Congress to enact bipartisan health care reform. DWF represents more than 50 million people; this organization includes Business Roundtable, AARP, the Service Employees International Union (SEIU) and the National Federation of Independent Business (NFIB). The group was launched over two years ago to call on Congress to enact bipartisan health care reform and to improve the long-term financial security of all Americans. We have principles that we believe all Americans should have access to affordable health care;

that wellness and prevention efforts should be priorities; and that a focus on long-term care is necessary.

On long-term financial security, we believe Social Security must be strengthened, there should be financial incentives to save, and we need to provide all Americans with the tools to help manage their finances. DWF provides constructive input on the changes that are needed on health care reform. Most Members of Congress have joined in our pledge, along with more than one million Americans. And, we have worked together in support of various pieces of legislation.

Health Care Reform

Today, *all* employers make difficult economic decisions about whether to offer health insurance and face enormous increases year after year. For employers with 200 or more employees, over 98 percent offer health benefit coverage. But the cost pressures are tremendous.

First, one-sixth of our economy is spent on health care. In 2007, total national health expenditures were expected to rise 6.9 percent — two times the rate of inflation. Total spending was $2.3 trillion in 2007, or $7,600 per person. Total health care spending represented 16 percent of the gross domestic product (GDP). U.S. health care spending is expected to increase at similar levels for the next decade reaching $4.2 trillion in 2016, or 20 percent of GDP.

Second, over 177 million Americans get health insurance coverage through their employer. We must build upon our employer-based system. Today, 55 percent of private sector employees get their coverage through "self-insured" plans; 45 percent receive benefits through the "fully-insured" market. However, there are many Americans who do not have health insurance coverage.

Finding ways to expand health coverage, with balancing the impact of any reforms on those who do have coverage, requires deliberate discussions. As a society, we cannot afford to put $1 trillion in subsidies into a health care system that is flawed. We need broad reforms that meet four key objectives:

1. Creating greater consumer value and efficiency in the health care marketplace;
2. Providing more affordable health insurance options for all Americans;
3. Placing an obligation on all Americans to have health insurance coverage and encouraging all Americans to participate in prevention and chronic care programs; and
4. Offering assistance to uninsured, low-income families to meet their obligation.

Health Care Reform – Business Roundtable's Principles

Today, these four principles are the building blocks of Business Roundtable's plan for improving the health care marketplace for all Americans. In September of 2008, we released a document entitled "Health Care Reform in America: A Business Roundtable Plan." We all recognize that the American health care system is among the best in the world. However, the high cost of health care imposes an enormous burden on all Americans – raising the cost of health coverage for those who have coverage and those who do not have coverage. Business Roundtable supports policies that will provide greater accountability, enhance efficiency, and create value for all consumers of health care services.

We have had many discussions with the Committee about ways to create greater value in our health care system. And, we applaud your commitment to identify options that are key to the success of reform. We support:

- Continued adoption of uniform, interoperable health information technology standards and incentives to use health information technology;
- Dissemination of consumer information on the cost and quality of health care and comparison of the effectiveness of health care services and supplies; and

- Promotion of changing payments by public and private payers, including Medicare, to reward value of services provided, not volume.

In addition, Business Roundtable strongly urges that any plan adopted by Congress reinforce the existing employer-based system through which Americans currently receive health benefits. The federal ERISA statute that governs these plans gives employers the flexibility to design and finance plans that meet their employees' needs – a system that has proven successful in making coverage widely available to workers. Tampering with this law at this time could cause massive dislocations for those 132 million Americans who have private workplace coverage.

When it comes to heath care reform, the federal Employee Retirement Income Security Act, or ERISA, isn't broken and does not need fixing. What is broken is that there are 45 million Americans without insurance coverage – because their employers don't offer it, they don't elect it, they can't afford it, they don't enroll in programs where they are eligible, or they can't get it in the private marketplace. We must address this issue now. Let me provide more detail about our principles on health care coverage and subsidies for those who are low-income and uninsured.

Providing More Affordable Health Insurance Options for All Americans

Over 177 million Americans obtain health insurance coverage through their employers – almost 133 million through private employers. Almost all private employers offer plans that are governed under ERISA. This law establishes fiduciary requirements, administrative requirements, and procedures to resolve problems in the plans. We encourage the Senate Finance Committee to continue supporting this federal framework for those employers who offer their employees health care benefits. We need flexibility to continue offering innovative benefits for our employees. This is the primary benefit of ERISA for employer – flexibility in offering our employees the benefits that they need, that we can afford, and that are consistent across-state lines.

Many Americans, who do not have access to employer-sponsored coverage, must rely on the health insurance marketplace for their coverage. The structure of the market itself is state-by-state. This marketplace has become inflexible, is overly prescriptive, creates market segmentation, and is afflicted with dueling mandates, rules and regulations. We believe that there should be national rules governing the insurance marketplace that could be enforced by the state. Certain state rules, such as state solvency requirements and consumer protections, would continue to apply. This would allow for greater consistency in applying other rules, such as rate setting, guaranteed issue requirements, and risk adjustments and reinsurance issues would need to be explored.

We need a better marketplace for all Americans to get ***affordable*** and ***portable*** health insurance coverage. We would like to work with you on finding the right balance for individuals who do not have coverage through their employer or to help small employers find affordable coverage for their workforce if they choose to offer benefits.

Placing an Obligation on All Americans to Have Health Insurance Coverage

While many Americans do have health insurance coverage through their employer, millions of Americans do not have coverage at all. At Business Roundtable, we have been educated on who are those Americans who do not have health insurance coverage. Today, there are some 45 million Americans who do not have coverage.

- 4.7 million are college students;
- Just fewer than 10 million are non-citizens;
- About 11 million are currently eligible for public programs, such as Medicaid and SCHIP, but they have not enrolled; and
- More than 9 million have household incomes over $75,000, yet they do not purchase or elect employer-sponsored coverage.

We believe a "one-size-fits-all" solution will not work because this group is far from monolithic. For many of these Americans, obtaining coverage isn't so much financial, as it is structural. We need to have a competitive system that provides Americans with ***affordable*** options that are suitable for their families. However, we believe that all Americans should have health insurance coverage – as an obligation through auto-enrollment or some other mechanism.

For example, we support the concept of auto-enrollment by individuals who are eligible for benefits. Many large employers auto-enroll their employees into employer-sponsored health insurance coverage. This could be a way to ensure broader coverage for many of those who are not electing. Other ideas that have been discussed include imposing a penalty for those who can afford insurance, but do not elect coverage. We are open to suggestions so that we can achieve broad coverage.

We also support encouraging all Americans to participate in employer- and community-based prevention and chronic care programs. Many Business Roundtable employers offer prevention and chronic care programs to their employees and there are many worthwhile efforts in which Americans can participate. More needs to be done to educate and encourage participation.

Offering Health Coverage and Assistance to Low-Income, Uninsured Individuals and Families

For some low-income uninsured families, health care coverage is unaffordable. We believe that the government should provide financial assistance so that low-income individuals and families can purchase coverage from the private market. These targeted subsidies would be funded from the cost efficiencies in improving the health care marketplace and by expanding the number of lives that are covered by the less fragmented health insurance marketplace. We want this assistance to be used either in the newly established health insurance marketplace or by paying the individual's portion of the premium if they are eligible for employer-sponsored health insurance coverage.

Health Care Reform Cautions

While there are a lot of positive opportunities to create the right balance between improving the delivery system and expanding coverage, we do have some cautions that we want to share with the Committee.

First, we urge the Committee to proceed cautiously in discussions about minimum or essential benefit packages, especially as it applies to employer-sponsored coverage. The state mandated benefit laws have increased costs in the states and limited choice in plan offerings. Large employers have innovative plan designs that promote wellness and health promotion, chronic care services and other necessary benefits.

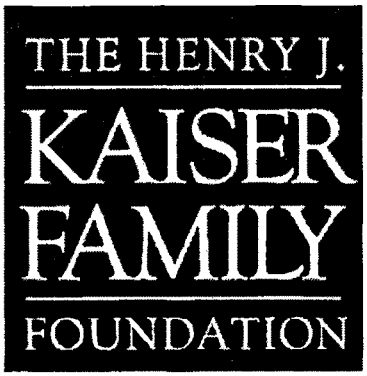
Second, we are very concerned about "public plan" proposals that would compete in the private marketplace. We do support national rules to create a more competitive and affordable insurance marketplace for individuals and small businesses. We believe that you must tackle issues relating to transition that will expand the availability of these affordable options over time.

Conclusion

- We want to work with you on finding solutions – and our plan is also to use the power of the market to drive down costs, drive up quality and improve access to health care for all Americans. All ideas are good and we want to discuss the pros and cons of each idea – but we know that this legislation will require individuals, employers, providers, insurers, and the government to participate in finding the right balance in sharing the responsibility and successes of health care reform. We want to work with you, and all Members of this Committee, to find realistic solutions to improve our current fragmented system.

- Our principles and ultimately your proposal must emerge from the uniquely American principles that drive our economy: competition, innovation, choice and a marketplace that serves everybody. We want to work with you to find practical, common sense solutions.

Thank you for the opportunity to participate at the roundtable.



Statement by

Gary Claxton

Vice President, Henry J. Kaiser Family Foundation

Director, Health Care Marketplace Project

Before the U.S. Senate

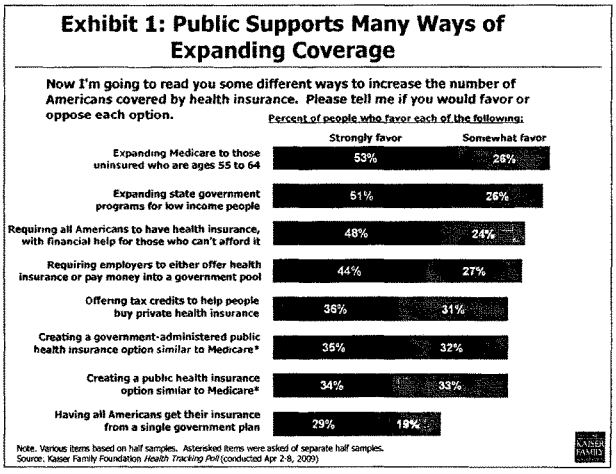
Committee on Finance

Roundtable on Health Care Coverage

May 5, 2009

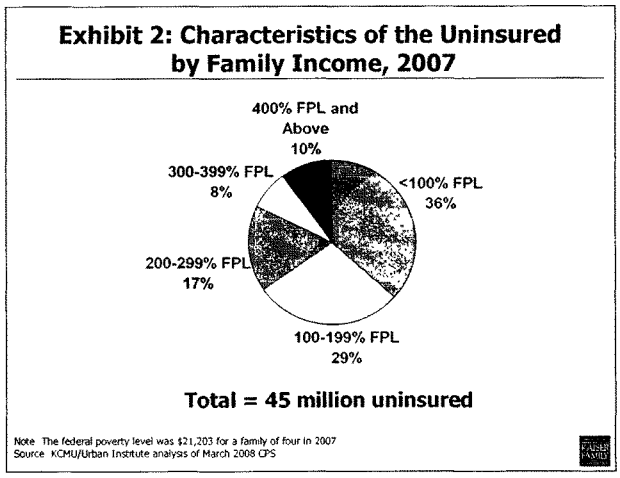
Thank you for the opportunity to participate in this roundtable discussion on health insurance coverage and the challenge of ensuring access to quality and affordable coverage for all Americans. I am Gary Claxton, a Vice President of the Kaiser Family Foundation, and Director of the Foundation's Health Care Marketplace Project. The Kaiser Family Foundation is a non-profit, private operating foundation that provides facts, information and analysis about the major health care issues facing the nation. Our work documents the public's continuing concern about access to and the cost of health insurance, as well as the health and financial consequences for those without adequate coverage.

A recent Kaiser poll shows that a majority of Americans continue to support health reform despite extremely difficult economic conditions. A majority of the public (59%) believes health care reform is more important than ever, compared with the 37% who say we cannot afford health reform given the serious economic problems facing the country.[1] Respondents expressed support for a variety of approaches to expand coverage, including expanding public programs for the poor and requiring individuals to have health insurance with financial assistance for the poor (Exhibit 1). These findings suggest that, with a depressed economy and rising unemployment, people understand that their access to affordable health care is fragile. The support for reform also may reflect people's experiences with the cost of medical care. Almost 3 in 10 (29%) of poll respondents reported that they or a member of their household did not fill a prescription because of cost, and 27% reported skipping a recommended medical test or treatment. Roughly a quarter said that in the past year they or a family member had problems paying medical bills; this percentage rises to more than 40% among people who are uninsured, report fair or poor health, earn less than $30,000 per year, are African American, or have put off health care due to costs.



Research demonstrates that health insurance is a key link to ensuring that people receive the health care they need when they need it.[2] Having coverage helps to improve access to basic primary and preventive care and lowers the likelihood of postponing or foregoing needed care and medications due to costs. It helps to promote more stable health care arrangements leading to early detection and preventive care. The uninsured use fewer preventive and screening services, are sicker when diagnosed, receive fewer therapeutic services, have higher mortality and disability rates, and lower annual earnings because of poorer health than those in better health.[3] The uninsured are less likely to have a usual source of care and be connected to the health care system for ongoing preventive and primary care. They are also less likely to receive critical screening services that could lead to early detection and better treatment options for cancer.[4] On all measures, those with health insurance have better access to care than the uninsured.

More than 45 million people do not have health insurance, and millions more have coverage that does not protect them from high medical costs if they become seriously ill. Extending access to meaningful coverage to all of those without it is an enormous challenge and will mean addressing several difficult issues. The primary issue that will need to be addressed is the cost of coverage. About two-thirds (66%) of the uninsured in 2007 were in families with incomes below twice the federal poverty level (or $42,400 for a family of four in 2007), and another 17% had family incomes between two and three times the poverty level (Exhibit 2). Health insurance is expensive – the average premiums for employer-sponsored coverage in 2008 were $4,704 for single coverage and $12,680 for family coverage[5] – which means that many of the uninsured will not be able to afford health insurance without significant financial assistance. Although current premiums for nongroup coverage are much cheaper and apparently more affordable than group premiums, the costs in the nongroup market reflect the better than average health of non-group enrollees (coverage is underwritten for health) as well as the relatively high cost sharing and coverage limitations that characterize many policies in that market.[6] Analysis by researchers at the U.S. Department of Health and Human Services (HHS) found that in 2003, over half of nonelderly people (53%) with nongroup coverage were in families with out-of-pocket health spending for premiums and cost-sharing that exceeded 10% of their disposable income, including 21% in families where out-of-pocket spending exceeded 20% of disposable income.[7] While premium payments, which nongroup enrollees must pay entirely out-of-pocket, were an important factor in this out-of-pocket burden, higher out-of-pocket spending for health services also contributed. About 13% of people with nongroup insurance were in families where out-of-pocket spending for medical services exceeded 10% of disposable income, including 6% with family out-of-pocket spending for medical services that exceeded 20% of disposable income.[8] This raises the question of whether the out-of-pocket liability associated with current nongroup coverage would provide sufficient financial protection and access to services for the low and moderate income families reform proposals are trying to reach.[9]



A second issue is assuring that health insurance provides the range of services that people need and protects them from too-high out-of-pocket costs when they need care. While having insurance is clearly better than being uninsured, the scope of currently available health insurance coverage varies widely across plans and can result in costs and limits that leave some of the insured ill-equipped to afford the care they or a family member needs.

In order to understand more about the circumstances and the financial and health care challenges facing low- and middle-income working families, the Kaiser Family Foundation interviewed the heads of household in 27 diverse working families across the U.S. in the spring of 2008 to learn more about their ability to pay for health care.[10] We found that out-of-pocket costs can be steep even for families with private coverage. Families that had private coverage through their jobs or had purchased it on their own, in several cases, faced copayments, deductibles, and out-of-pocket costs for care not covered by the insurer that posed a severe financial strain. While copayments for prescription drugs and doctor visits were often nominal on a unit basis, families who had ongoing or multiple needs were confronted with large cumulative costs. Deductibles reaching as high as $6,000 exposed some families to medical costs their budgets could not absorb, resulting in large medical debts. When private insurers limited coverage, as for mental health care or prescription drugs, or excluded particular services, such as dental care, families – although insured – were uninsured for this care, and like the uninsured, avoided seeking care due to cost.

One of the clearest examples of the holes in health care coverage is the experience of families where cancer has taken a toll. The majority of cancer patients under age 65 have private health insurance. Yet, despite having private health insurance some face high health care costs that can put both their treatment and

physical and financial well-being at risk. In our 2006 Kaiser/Harvard/USA Today survey of households affected by cancer in 2006, nearly a quarter reported the plan paid less than expected for a medical bill for their family member and one in ten reached the limit the plan would pay for cancer treatment. Nearly a quarter of those with insurance reported that as a result of the financial cost of dealing with cancer they had used up all or most of their savings and one in ten turned to relatives for help. Although those without insurance faced significantly more challenges, 7% of people who said the person with cancer was insured reported being unable to pay for basic necessities and 3% said they needed to declare bankruptcy. Cost considerations not only affected financial stability for the family but in some cases compromised treatment for the cancer – 5% of the insured and 27% of the uninsured said they had delayed or decided not to get care due to costs. These are people who stopped or postponed treatment for a deadly disease, putting their life and survival at risk due to costs not covered by insurance.[11, 12]

A recent report which we conducted jointly with the American Cancer Society highlights some of the serious challenges that cancer patients can face in paying for life-saving care, even when they have private health insurance. The report profiles the situations faced by 20 cancer patients who had called in to the American Cancer Society Health Insurance Assistance Service. Their stories show that a cancer diagnosis can lead to large medical debts, personal bankruptcy, or delayed or forgone medical treatment due to high out of pocket expenses, and can threaten a patient's access to employer-sponsored health insurance if they become too sick to work and are unable to afford COBRA premiums. In addition to the cost-sharing and deductibles, which can add up to large amounts for patients during the course of cancer treatment, people can face maximum limits on their benefits or find that their policy does not pay for treatments recommended by their doctor. One profiled patient faced a cap of $250 per illness for coverage of radiation and another had an annual limit of $10,000 for outpatient costs – amounts easily exceeded in the course of treatment for many cancers.[13]

As the cancer patient profiles point out, having health insurance does not always protect patients from high costs. The analysis by HHS researchers of 2003 health spending, discussed above, found that almost 9% of the nonelderly were in families with out-of-pocket spending for health services (not including premiums) exceeding 10% of disposable income. For about half of these people (4% of the nonelderly), family out-of-pocket spending for health services exceeded 20% of disable income. Protection from high out-of-pocket costs varied significantly among people with different types of coverage. For people with employer-sponsored insurance, 6% were in families where out-of-pocket spending on health services exceeded 10% of disposable income, while 13% of people with nongroup insurance had family out-of-pocket spending for health services exceeding 10% of income. An even higher percentage (17%) of people with public coverage were in families with high out-of-pocket spending for health services; people with public coverage had much lower average levels of out-of-pocket spending on services, but because their incomes are so low, a relatively high percentage exceeded 10% of disposable income.[14]

These studies, and many others, highlight the consequences for families when their health insurance does not protect them from the high out-of-pocket costs that can result from severe or chronic illness. Assuring that health insurance premiums are affordable is not a sufficient assurance that health care is accessible and affordable. High levels of cost-sharing and caps on covered benefits can compromise the level of protection health insurance provides and lead both to reduced access to needed care and to serious financial burdens and medical debt.

A third issue is assuring that people who have access to financial assistance also have a place to purchase coverage, even when they are in poor health. People without access to employer-sponsored coverage or Medicaid generally must purchase nongroup coverage, either directly from an insurer or through an association. In most states insurers are able to deny coverage to applicants with health problems, and in some states may charge them higher premiums, limit available benefits, or both. In many cases more general pre-existing condition exclusion provisions permit insurers to deny claims for a specified period that are associated with conditions that can be shown to have existed when the coverage was issued. These practices protect insurer risk pools and help lower premiums, but they inhibit movement across the marketplace, subject applicants and policyholders to uncertainty about their coverage, and limit meaningful access to coverage for people that have developed health problems. State high risk pools in a number of states and the portability provisions in the Health Insurance Portability and Accountability Act (HIPAA) provide access to coverage for people with health problems, although premium costs can be high and coverage options are limited. A few states require nongroup insurers to cover all applicants without varying rates by health status. These states are able to assure access to people with health problems, but have had a difficult time maintaining affordable premiums rates for healthier people.

Many health reform proposals would eliminate restrictive practices, ending the use of health status in coverage decisions and rating. Proponents envision creating a competitive market where carriers compete on price, service and quality rather than on risk selection. This type of transformation is feasible if health reform can substantially increase participation by those without group coverage so that nongroup insurers are getting a reasonable mix of healthy and less-healthy people. If access is assured, less-healthy people will seek coverage, so the goal must be to make coverage attractive for healthier people as well. This will require meaningful premiums subsidies to make coverage affordable for the significant number of lower and moderate income people currently without insurance. Other policies, such as legal requirement to have coverage, automatic enrollment of uninsured people unless they opt-out, or meaningful penalties for people who decline opportunities to enroll, may be needed to protect the reformed market from adverse selection and higher premiums, and to permit the desired type of competition among insurers.

The changes envisioned for the nongroup market are transformative, but they are likely to cause some dislocation for people who have benefited from current market

practices. There is understandably a desire to move forward with reform while finding ways to cushion the impact on people who like their current arrangements. Preserving some of the current market practices during a phase-in period is one option, but this may not make sense given the tens of millions of previously uninsured people who may come into the nongroup market under some reform scenarios. It is quite likely that the number of new participants will match or exceed the number of people currently insured in the nongroup market. Further, many people who currently have nongroup coverage also may want to change the coverage they have when premium subsidies become available. Permitting these new enrollees to join a more open and freely operating nongroup market would seem to be a desirable policy goal. A potential approach, which is similar to how federal changes in the Medicare supplemental insurance market were enacted, would be change market rules for newly enrolling people while permitting people with nongroup coverage already to maintain it, perhaps for a limited period of time. This could cushion the impact that rating reforms and any new benefit rules may have on people who are not covered in this market, while allowing less restrictive practices to be implemented.

The Committee faces a number of difficult challenges as it develops legislation to ensure that all Americans have access to quality and affordable health care. As the Committee and the Congress move forward on this critical task, budget constraints and the high cost of health insurance will undoubtedly lead to pressure to limit the scope of coverage and impose substantial cost-sharing to hold down federal costs. To achieve the goal of making quality health care affordable for all, however, cost concerns will need to be balanced against the expectation that health reform will bring improved coverage and lower health spending for families. Financial assistance will be needed if we want low and moderate income families to purchase coverage, and reasonable limits on out-of-pocket costs will be necessary if we want the coverage that is attained to provide meaning financial protection and access to services.

Thank you for your consideration.

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[1] Kaiser Family Foundation *Health Tracking Poll* (conducted Apr 2-8, 2009).
[2] Rowland, D. "The Adequacy of Health Insurance." Testimony before the Health, Education, Labor, and Pensions Committee of the U.S. Senate. *Addressing Underinsurance in National Health Reform,* Hearing, (February 24, 2009).
[3] Kaiser Commission on Medicaid and the Uninsured, "The Uninsured: A Primer," October 2008.
[4] Ward E, Halpern M, Schrag N, Cokkinides V, DeSantis C, Bandi P, Siegel R, Stewart A and A Jemal. 2008. "Association of Insurance with Cancer Care Utilization and Outcomes." *A Cancer Journal for Clinicians*, 58:9-31.
[5] Employer Health Benefits 2008 Annual Survey, *Kaiser Family Foundation and Health Research & Educational Trust (HRET)*, September 2008.
[6] Kaiser Family Foundation, "Comparison of Expenditures in Nongroup and Employer-Sponsored Insurance," February 2007.
[7] The analysis calculates out of pocket burden at the family level and assigns that burden to each person in the family. Because people are them categorized by their primary type of insurance coverage, in some instances the family out-of-pocket burden associated with a person will include spending by family members with different types of insurance.

[8] Banthin J and DM Bernard. 2006, "Changes in Financial Burdens for Health Care." *Journal of the American Medical Association,* 296(22): 2712-2719.
[9] Altman, D. "Pulling It Together, From Drew Altman: What Do We Want Insurance To Be?" *Kaiser Family Foundation*, September 2008.
[10] Kaiser Commission on Medicaid and the Uninsured, "Snapshots from the Kitchen Table: Family Budgets and Health Care," February 2009.
[11] USA Today/Kaiser Family Foundation/Harvard School of Public Health *National Survey of Households Affected by Cancer* (conducted Aug 1-Sept 14, 2006).
[12] Rowland, D. "The Adequacy of Health Insurance." Testimony before the Health, Education, Labor, and Pensions Committee of the U.S. Senate. *Addressing Underinsurance in National Health Reform*, Hearing, (February 24, 2009).
[13] Schwartz K, Claxton G, Martin K, and C Schmidt, "Spending to Survive: Cancer Patients Confront Holes in the Health Insurance System," *Kaiser Family Foundation and American Cancer Society,* February 2009.
[14] Banthin J and DM Bernard. 2006, "Changes in Financial Burdens for Health Care." *Journal of the American Medical Association,* 296(22): 2712-2719.

National Federation of Independent Business

Statement on Healthcare Reform

Senate Finance Committee

May 5, 2009

Healthcare Reform
Roundtable on "Coverage"

Our current system of health insurance and healthcare is financially unsustainable and threatens the health and financial security of the American people. Small business owners and their employees are especially vulnerable to the weaknesses of our current system. More than 80.6 percent of small business owners say accessing affordable healthcare for themselves and their employees is a challenge.[1] The National Federation of Independent Business (NFIB) supports comprehensive healthcare reform that addresses the needs of small employers, their employees and the self-employed. Any effort to reform the system must have at its foundation a strategy to control costs and ensure meaningful insurance market reform.

It is important to note the facts about why small business is key in this discussion. Small firms represent 99.7 percent of all employers.[2] Small business produces roughly half of the private Gross Domestic Product (GDP)[3] and creates, on average, about about two-thirds of net new jobs annually.[4] Small employers care about access to healthcare coverage for themselves and their workers and provide coverage to nearly 68 million people.[5] The Medical Expenditure Panel Survey (MEPS) reports show that, on average, small employers who offer health insurance coverage pay more in employer contributions than large firms.[6]

However, data shows that as costs continue to soar, employers and employees are struggling to find ways to afford coverage. Small employers are having the most difficultly offering and maintaining health insurance for their employees. Since 1999 health insurance premiums for small firms have increased by 113 percent.[7] The Kaiser Family Foundation reports employer-based coverage has dropped six percent from 2000-2008.[8] Clearly cost has played a key factor in this downturn.

When premium costs rise as fast "as much" for small groups, employers devote enormous resources to shopping for better deals. But changing plans has both good and bad results. Good because the new plan may provide care at a lower cost to the employer and to the employees. Bad because the new plan may force employees to change doctors, fill out all new underwriting forms and receive poorer service in some respects. Looking forward, a more stable employer-insurer relationship would be desirable. This would mean less volatile, more stable premiums and less "churn." Today, small employers feel helpless, with little ability to impact the premiums they pay, to take advantage of the law of large numbers, to negotiate plan characteristics, and to purchase wellness plans. For,

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[1] NFIB National Survey (February 15-19, 2008)

[2] U.S. Small Business Administration, Small Business Share of Economic Growth, 2001.

[3] Joel Popkin and Company, Small Business Share of Economic Growth, 2001, Office of Advocacy, U.S. Small Business Administration

[4] U.S. Small Business Administration.

[5] EBRI Report, Employee Benefit Research Institute Estimates from the March 2005 to march 2008 Current Population Surveys, March 2008.

[6] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2006 Medical Expenditure Panel Survey-Insurance Component.

[7-8] Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2008

say, an eight-employee catering shop, these qualities that large firms take for granted are out of reach.

Whatever its faults, however, the nexus between employer and health insurance is deeply entrenched in the American healthcare system and satisfies the wishes of a great number of firms and employees. The employer role remains deeply integrated in the system and will remain a necessary piece in transforming and enhancing employer-sponsored insurance. Employer-sponsored insurance works reasonably well for large firms – very well for some – but it can be disastrous for small business owners and employees. Our heavy reliance on employers as a central provider of insurance is especially problematic for those who have no full-time employees (the unemployed, self-employed, part-timers or early retirees) and those whose employers cannot afford to provide insurance. Employers of all sizes need flexibility to choose what works for their workforce. What works for one well-established restaurant might not for a start-up coffee shop. Employers want to and will continue to play a role in the system. Steps should be taken to both ease costs for offering firms and to incentivize non-offering firms.

Empowering small business employees to decide what is best for themselves and for their families should be a top priority. Recent NFIB-sponsored research suggests that employees are better off choosing their own insurance plans rather than leaving the decision to their employers.[9] No matter how smart and well-intentioned the employer, the employee has a better grasp of his or her family's needs and desires. The best approach is to give individuals the option to use employer contribution dollars to pick the plans of their choice. Many employers may want to retain the traditional method of purchasing coverage through local agents or brokers, and that choice should remain available. By the same token, individuals, including the newly self-employed or early-retiree, must have a vibrant and secure marketplace in which to purchase coverage. Transitioning to parity between the employer-based market and the individual market is a must-do for all these reasons.

NFIB strongly supports policy reforms that put affordable coverage within reach of all employees (and non-employees). Any successful reform must allow people to balance the competing goals of access to quality care, affordability, predictability, and consumer choice. Below are the key components that can help attain this goal.

Delivery System Reform

Reducing long-term costs is essential to maintaining the quality of healthcare and to expanding its reach to those currently lacking coverage. Lower costs require us to fundamentally alter the delivery systems and the incentives that drive them. Our medical education system reflects early 20th Century realities; the result is an excess of specialists and a shortage of primary care physicians, nurse practitioners, and other physician extenders. Our modes of treatment are driven by inflexible, mechanical reimbursement systems designed nearly half a century ago and only moderately tweaked since then. The result is uncoordinated providers prescribing fragmentary care, rather than coordinated

[9] Rassenti, Stephen and Carl Johnston, Health Insurance Reform in an Experimental Market, March 2009

teams focusing as a unit on the good of the patient. Alternative models like those practiced by Geisinger and Mayo suggest possible approaches, though it is likely that real savings will come from, as yet, "undreamed" of models of care. We can see the beginnings of such reforms in programs already on the table: medical homes, outcome-based compensation, health information technology initiatives and alternative provider compensation schemes. Any lasting reform must permit and encourage such delivery system experimentation, because as we have seen from the industries like computers and telecommunications, the greatest advances will come from the most unexpected places.

Enact reforms enabling all individuals to obtain quality, affordable health insurance

Getting everyone into the system is a necessary step toward achieving the goal of affordable quality coverage for all. Addressing the affordability of health insurance coverage must be done first to achieve this goal. There should be a parallel commitment to identifying and enrolling current eligibles in the programs for which they qualify.

Provide advanceable refundable credits or other subsidies for low-income Americans

All Americans, regardless of income, need access to quality affordable health insurance. This requires some form of assistance for those unable to afford such coverage. Steps should be taken to ensure people wanting private coverage can easily access all options available to them.

Guaranteed issue in the individual market

In today's individual and small group market, individuals make choices about where to get their healthcare coverage. Having guaranteed issue in the group market and not in the individual market creates perverse incentives. For example, if an individual is searching for employment and happens to have a health problem, chances are that he will look for an employer offering group insurance. This is one manifestation of job lock – where one's employment decision is made on the basis of health insurance, rather than on the qualities of the job itself. Research by Gruber and Madrian shows how employer-provided health insurance plays a significant role in decisions on job change. [9] Ensuring access to the individual market will go a long way to level the playing field for health insurance purchasers in all of the different marketplaces where they purchase policies.

Implement national standards on rating practices for the individual and small group market. Health status rating should be prohibited in the individual and small group market

National rating rules are long overdue for the individual and small group market. Currently, individuals in most states can either be denied coverage based on health status (rating) or can be priced out of the marketplace due to an illness. Under small group law in most states, the onset of illness in one enrollee can push the business's rates up by 50 percent at renewal. In both scenarios, people become uninsurable, they lose coverage due to cost, or the employer is hit with an excessive rate increase. Reformed rating will provide better parity between two marketplaces that are frequently visited by individuals

and small group lives. While certain rating characteristics should be set nationally, states should retain significant discretion over some specifics, such as the width of rating bands.

Establish state-wide or national health insurance exchanges for individuals and small employers that allow individual choice of coverage options on a pre-tax basis

The current individual market makes it difficult for insurers to reach purchasers and makes it difficult for purchasers to rationally assess options. Today's small group market similarly limits choices by employers and employees. Employers are hamstrung by participation rate requirements. Shopping for policies excessively distracts them from running their businesses. And employees generally have only one employer-chosen policy available. Health insurance exchanges can reduce some of these shortcomings by serving as a clearinghouse of options for individuals, employers, and employees. An employer can voluntarily designate the exchange as its employer group "plan" for employees. This arrangement qualifies as an employer-sponsored plan for purposes of federal law, allowing employees to purchase coverage of their choice through the exchange on a pre-tax basis.

Make it permissible for states to enter into voluntary multi-state exchanges

GAO recently released its third study focused on marketplace concentration. The report confirmed a marked increase in the concentration in state markets. The report found that the five largest carriers in the small group market, when combined, represented at least three-quarters of the market in 34 of the 39 states responding to the survey, and they represent 90 percent or more in 23 of these states.[10] Allowing states to have the option to combine efforts in purchasing more affordable, quality coverage should be available as an option. Small states like Maine, Montana or Wyoming may see merit in combining efforts to increase the size of their pool and to attract more competition in the marketplace.

Administrative cost savings

Insurers must streamline the process of enrolling in an insurance plan or changing plans. Today's administrative inefficiencies render this process complicated, time-consuming and excessively expensive. Most of these inefficiencies lay at the state level. Congress should work with the states to implement models that promote streamlined regulatory structures.

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[10] GAO, Private Health Insurance 2008 Survey Results on Number and Market Share of Carriers in the Small Group Health Insurance Market

Create greater portability of coverage

People should be able to move from one job to another, between a job and no job, and from state to state without losing insurance coverage or encountering excessive cost increases, whether costs are borne by the individual or by an employer. In part, this goal can be met through more affordable, transparent policies and lower administrative costs. The goal is an insurance market in which subscribers experience relatively seamless transition when moving between group and non-group policies.

Tax equity for individuals and the self-employed

Tax laws should not push individuals into employer-provided or government-provided insurance programs and hobble the market for individually purchased policies. Tax laws riddle the health insurance market with inefficiencies. An employer who buys insurance for employees can write off the cost on its taxes. But if employees wish to purchase different policies on their own, they receive no tax benefit. Individuals should be allowed to utilize pre-tax dollars to purchase the health insurance policy of their choice. The self-employed should also have equal tax treatment for purchase of health insurance.

Roadblocks to reform

Some reform ideas may sound appealing but, in fact, would have severe negative effects both on healthcare markets and on the economy in general. For example, employer mandates (with minimum contribution requirements), or equivalent pay-or-play requirements or payroll taxes, are bad for small employers, bad for low-income workers, and bad for the economy. They adversely affect small employers by raising payroll costs, eroding competitive positions, and increasing start-up costs, making it particularly difficult for firms operating on small margins. Employer mandates adversely affect the low-income employees because they result in lost employment, depressed wages, and lost work hours. They adversely affect the economy because they discourage production – often in firms with the most vulnerable employees and employers. Recent NFIB research data shows an employer mandate would cause the economy to lose over 1.6 million jobs.[11] Overall, mandates are bad for any size employer but this research shows small firms would be most adversely affected by the mandate and account for approximately 66 percent of all jobs lost.[12]

Any successful reform must create a marketplace that works for all purchasers. Building on the strengths of the current system while ensuring new competitive marketplaces to purchase coverage will truly transform the system for the better. Getting overall healthcare costs down needs to remain a major priority in this reform effort. Balancing these two goals will go a long way toward enabling everyone to secure quality affordable coverage.

[11-12] Chow, Michael and Bruce Phillips, Small Business Effects of a National Employer Healthcare Mandate, NFIB, January 2009

Statement of Paul J. Diaz
President and CEO, Kindred Healthcare, Inc.

Senate Finance Committee Roundtable on Healthcare Delivery System Reform
Washington, D.C.
April 16, 2009

Kindred Healthcare is pleased to submit these comments in advance of the Senate Finance Committee's Roundtable on April 21, 2009. As the nation's largest provider of post-acute care, Kindred is honored to participate in the Roundtable on delivery system reform. We commend the Chairman, the Ranking Member and the entire Committee for soliciting the input of various stakeholders as Congress considers different approaches to healthcare reform. In 2008, Kindred's 53,700 employees provided care to over 32,000 patients and residents in our Nursing and Rehabilitation Centers, 28,000 patients in our Long Term Acute Care Hospitals, and 115,000 patients receiving rehabilitation services. We also are expanding our offerings in assisted living, homecare and hospice services. We care for the most chronically ill, medically complex Medicare and Medicaid beneficiaries who are the highest users of resources in our healthcare system. We partner with public and private payers to deliver cost-effective services and have the perspective of operating under a range of service delivery models.

While my comments will focus primarily on issues concerning post-acute care, I wanted briefly to share my perspective on broader healthcare reform and delivery system design.

First, as a provider of diversified post-acute care services and an employer providing health insurance coverage to our workers in over 40 states, we support Congress' and the President's efforts to enact comprehensive healthcare reform. The first priority for healthcare reform should be to ensure that every American has adequate health insurance coverage. We also share the President's, the Chairman's and the Ranking Member's commitment to contain healthcare cost growth, both to preserve a sustainable healthcare system and also to facilitate economic recovery. At the same time, policy measures to stem the growth in healthcare costs should be targeted so as to minimize disruption to the system, preserve jobs, prevent unintended access and quality problems, and be implemented in such a way as to promote progressive reform of the payment and delivery systems.

Second, healthcare reform should be guided by the overriding principle that our healthcare delivery should be patient-centered. An integral attribute of a patient-centered system is active engagement of physicians in overseeing care delivery and nurses facilitating better care coordination. Healthcare reform on the one hand should address barriers to patient-centered care such as defensive and volume-based care practices, and on the other hand actively support key enablers such as adoption of health information technology and dissemination of proven evidence-based healthcare practices.

Third, we commend the Administration, the Chairman and Ranking Member for including the coordination of post-acute care services as part of the healthcare reform discussion. Kindred supports expanding this discussion to include long-term and post-acute care reform as an integral part of comprehensive healthcare reform. The reality is that a growing number of Medicare beneficiaries with multiple chronic conditions account for a disproportionate percentage of healthcare spending. This compels the conclusion that healthcare reform should not ignore long-term and post-acute care.

Fourth, Kindred supports the policy goals of improving post-acute care coordination and increasing efficiency in payments in the post-acute care delivery system. The Medicare payment and care delivery systems too often operate in silos, resulting in a lack of needed care coordination and inefficiencies in payments. A silo approach can contribute to unnecessary re-hospitalizations, poor quality, payment redundancies, and higher than necessary costs. These are important and legitimate policy issues that should be addressed by policymakers, payers and providers through a variety of approaches.

One approach being considered by policymakers is "bundling" of post-acute payments. The President's budget contains a proposal to "bundle" payments to post-acute providers into a single payment to the acute care hospital. Under this proposal, the acute care hospital would be responsible for all costs and care coordination for Medicare beneficiaries following hospital discharge. While Kindred agrees that the policy issues a bundling policy seeks to address are important, we urge policymakers to adopt an incremental approach. Bundling should be just one of several policy approaches that should be evaluated and carefully considered before major system redesign is implemented. As noted by MedPAC, bundling could produce unintended consequences, so Kindred supports an incremental approach through use of pilots and/or demonstration projects. Because of our diverse post-acute service lines and experience with a range of care delivery models, Kindred is well situated to help policymakers develop approaches that promote quality care and efficient payments. Based on our experiences with public and private payers, Kindred encourages the Committee to consider the following issues when evaluating the bundling policy, or other approaches to improving care coordination and promoting efficiency in Medicare's post-acute payment systems.

Important threshold issues should be considered and tested before implementing a bundling policy.

One threshold issue policymakers should evaluate is whether entities other than acute care hospitals should be considered as viable options to manage a bundled payment and coordinate care. While a limited number of integrated health systems may be in a position to implement bundling, the reality is that many acute hospitals, especially in rural areas, lack the infrastructure to coordinate post-hospital care for chronically ill patients because their mission is to stabilize and treat acute conditions, then move patients downstream as quickly as possible. Changing payment incentives alone will not

address the infrastructure and system investments needed to effectively coordinate post-hospital care.

An increasing body of research suggests that enabling community-based physicians through appropriate incentives to serve as "medical homes" for certain chronically ill patients should be considered as a policy alternative, or supplement to, bundling. For example, researchers at Johns Hopkins School of Public Health, Roger C. Lipitz Center for Integrated Health Care, have tested a "guided care" model for chronically ill patients. Under this model, community-based physicians with the support of trained nurses and health information technology implemented a range of "guided," or coordinated care approaches that yielded substantial cost savings and quality gains. Specifically, this guided care approach not only covered its own costs but also reduced insurance expenditures by $1,600 per patient per year.[1]

Finally, notwithstanding other concerns, many managed care and other organizations (e.g., PACE entities) have the infrastructure to coordinate care for chronically ill Medicare beneficiaries. In fact, these entities already function in a type of "bundled" world. Kindred has worked with various entities involved in coordinating post-acute care, ranging from fully integrated systems such as Kaiser, to specialty programs such as "EverCare," to other payers who partner with us to help manage patients throughout our various post-acute service offerings. The shared goal in these partnerships is to coordinate patient care by identifying the most cost-effective setting that is able to deliver quality care. The ultimate goal is to facilitate patients' return to home as soon as possible, without experiencing hospital readmissions. In fact, in Kindred's nursing and rehabilitation centers, nearly half of our patients are able to return home in about 30 days after admission. A key component to achieving this result and effectively manage this transition in care is that these patients have access to home health and community-based care, a critical part of the post-acute care delivery system. These service delivery models should be evaluated by policymakers as alternatives to, or complements of, a bundled payment policy.

Important prerequisites in the payment and care delivery systems should be addressed incrementally before implementing full-scale bundling or similar approaches.

Public and private sector entities are currently engaged in a variety of activities that are testing approaches to coordinated care that will serve as important building blocks to support a bundling policy. Specifically, there are several existing policy activities that are midstream in addressing some of the prerequisites that are needed before implementing bundling in different forms. These activities should not be overlooked or abandoned by policymakers by implementing bundling too quickly.

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[1] Boult, Chad, Rider, Lisa, Frey, Katherine, et al "Early Effects of 'Guided Care' on the Quality of Health Care for Multimorbid Older Persons: A Cluster-Randomized Controlled Trial." Journal of Gerontology: Medical Services Vol. 63A, No. 3, (2008): 321-327

1. ***Patient Criteria and Appropriate Patient Placement.*** Objective tools are needed to help determine how to place patients in the most appropriate care setting based on their needs and the probability of producing quality outcomes. At the direction of Congress, CMS has contracted with the Research Triangle Institute (RTI) to develop a Uniform Patient Assessment Instrument as part of a large-scale demonstration project involving the range of post-acute providers, including Long Term Acute Care Hospitals, Inpatient Rehab Facilities, Skilled Nursing and Rehab Facilities and Home Health providers. Without the tools to determine which settings are most appropriate for chronically ill Medicare beneficiaries, a bundled payment approach can produce some of the unintended consequences noted by MedPAC such as poor quality and, for certain patients, higher episodic costs.

2. ***Facility Criteria to Ensure Quality Care.*** In addition, mechanisms are needed to ensure that facilities have the requisite capabilities to care for patients with different needs. For example, as recommended by MedPAC, Long Term Acute Care Hospitals should have certification criteria, first to ensure that only those patients who need LTAC care are admitted and next to ensure that facilities holding themselves out as having the capacity to treat medically complex patients have invested in the infrastructure, staffing, and physician support to provide quality care. Facility criteria can help address one possible unintended consequence of bundling or any "capitated" payment approach, namely, patients being inappropriately placed in care settings that are low cost but not equipped to meet patient needs.

3. ***Alignment of Payment with Patient Characteristics.*** Payment policies must align reimbursement levels, including outlier adjustments, with patient needs and characteristics. The goal is that the payment system should support quality care in the lowest cost setting. In post-acute care, more evidence-based research is needed to understand which settings are capable of treating chronically ill patients with different characteristics to produce desirable outcomes. For example, as noted above, Kindred and other nursing and rehabilitative care centers are able to transition a large percentage of people into their homes. How does this result compare with other provider types, for what types of patients and at what cost? Which patients are susceptible to re-hospitalization if moved too quickly to lower cost settings? This type of comparative effectiveness research is needed to help shape and implement a bundling policy, including being able to calculate episodic payment levels to produce desirable quality outcomes.

4. ***Transparency, Comparative Effectiveness, and Development of Post-Acute Quality Measures that are Common Across Sites of Service.*** As noted by MedPAC, providers, payers and regulators need adequate information in order to effectively coordinate care between settings to achieve quality improvements and cost savings. Likewise, consumers need access to understandable information to be part of care decision-making. In post-acute care, it is vital to have quality measures that transcend sites of care and for there to be a high level of

transparency on these performance measures. Currently, the post-acute space lacks a common set of quality indicators to evaluate care outcomes as patients move across sites of service. Without a common set of quality indicators, it is difficult to evaluate the comparative effectiveness of different post-acute providers for certain patients.

Unfortunately, the comparative effectiveness literature is especially thin when it comes to chronically ill patients. A recent New York Times article reported that because so little research includes chronically ill patients, physicians have little scientific evidence on which to base their care.[2] A 2005 study found that fewer than half of evidence-based clinical practice guidelines used to treat nine of the most common chronic diseases specifically addressed patients with multiple illnesses. And a 2007 study found that 81 percent of the randomized trials published in the most prestigious medical journals excluded patients because of coexisting medical problems. Being able to compare quality performance and cost-effectiveness across post-acute sites of care is critically important under any kind of bundled payment system, both to ensure quality and also to enable providers to effectively coordinate care and manage transitions.

5. ***Health Information Technology as a Key Enabler of Care Coordination.*** Many experts have observed that to manage transitions in care effectively requires a certain level of investment in health information technology. While many post-acute providers, including Kindred, have begun making these investments, the reality in many parts of the country is that the level of health information technology infrastructure is thin. Unfortunately, only a tiny portion of the billions of dollars available for health information technology in the Stimulus Package is available to post-acute providers, so the investment in HIT for this sector will lag other healthcare sectors.

6. ***Review and Revision of Existing Regulatory Requirements.*** A variety of existing regulations would need to be reviewed and possibly revised before proceeding with bundling. These include: 1) 3-day prior hospital stay requirement before Medicare pays for post-acute care; 2) various LTAC regulations such as the 25-day length of stay requirement, "25% rule" restricting patient referrals, and others that are inconsistent with integrated care delivery and payment; 3) IRF "60 percent" rule; 4) various state Certificate of Need and licensure regulations; and 5) Stark physician referral regulations and prohibitions.

Policy approaches in addition to bundling should be tested and evaluated through demonstration projects and/or pilots.

Kindred encourages Congress to evaluate the feasibility and desirability of bundling and similar policies through demonstration projects and pilots. We also urge

[2] Carpenter, Siri. "Treating an Illness Is One Thing. What About A Patient With Many?" The New York Times 31 March 2009:

Congress to maintain a strong oversight role specifically by requiring CMS to report the results of bundling-related demonstrations and pilots so that Congress retains the responsibility to craft legislation based on objective evidence and stakeholder input. We acknowledge that demonstration projects can take time and that the magnitude of our policy problems require expeditious attention. At the same time, Congress should balance the need to move expeditiously on policies proven to be comparatively effective with the prudence advocated by MedPAC of incrementally testing different approaches to avoid system disruption and unintended consequences. Congress can achieve this balance by requiring frequent reports on demonstrations and pilots. Where proven effective, Congress can then move quickly on policies in the short-term that are consistent with comprehensive reform in the long-term. In addition to bundling, Congress should actively evaluate the following alternatives.

1. ***Site Neutral Payment.*** CMS is midstream in an important demonstration project to develop and test a uniform post-acute assessment instrument. Kindred nursing and rehab facilities and LTACs have participated in this project at all stages, from initial tool development, to I-S system development, to testing the instrument. The development of an assessment instrument is an important prerequisite to placing patients in the most appropriate clinical setting, identifying their care needs, aligning payment with those needs, and ultimately developing a "site neutral" payment system. The report to Congress on this demonstration project will provide valuable information to policymakers regarding whether a site neutral approach, as an alternative or supplement to a bundled payment approach, is the best solution for Medicare. Congress should support complementary demonstrations and pilots related to bundling.

2. ***"Medical Homes" for Chronically Ill Patients through Physician-Coordinated Care.*** As noted above, there is a growing body of research, including at Johns Hopkins University, on physician directed and nurse supported models of coordinated care and "medical homes." Congress and policymakers should carefully evaluate the effectiveness and characteristics of these various approaches as part of its work to improve care coordination and payment efficiency. These approaches are not necessarily inconsistent with a bundled payment approach, but they should also be considered as a possible alternative.

   It is very important for Congress to evaluate approaches such as physician and nurse "guided care," especially as compared to other approaches that have not proven to be effective. A recent analysis in the Journal of the American Medical Association of 15 randomized trials testing different models of "coordinated care" for Medicare beneficiaries found that "none of the 15 programs generated net savings" to Medicare.[3] The researchers' core conclusion is very instructive as Congress evaluates the effectiveness of different bundled payment approaches: "Viable care coordination programs without a strong transitional care component

[3] Peikes, Deborah; Chen, Arnold, Schore, Jennifer, et al. "Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries: 15 Randomized Trials." 2009 American Medical Association. (Reprinted) JAMA Vol. 301, No. 6 (February 11, 2009): 603-618.

are unlikely to yield net Medicare savings. Programs with substantial in-person contact that target moderate to severe patients can be cost-neutral and improve some aspects of care." This type of "comparative effectiveness" research is important to consider before implementing a full-scale bundling policy.

3. ***CMS "Care Transitions Program" Pilot to Improve Quality As Patients Move Across Care Settings.*** Just three days ago CMS announced an important pilot project pursuant to which 14 communities throughout the United States have been funded to reduce rates of hospital re-admissions and improve "fragmentation of care" in Medicare. Under this pilot, local Quality Improvement Organizations are charged with mobilizing local communities and providers to "refine care delivery systems to make sure all Medicare beneficiaries get the high-quality, high value healthcare they deserve." [4] The results of this pilot will provide Congress with valuable information about how to structure the care delivery and payment system to produce the outcomes that are sought to be achieved by a bundling policy. It is important to get this type of information before implementing full-scale bundling.

4. ***ACE Demonstration Project.*** CMS also recently embarked on the "Acute Care Episode" (ACE) demonstration project. The stated goal of the ACE demonstration project is to use a global payment to better align the incentives for both hospitals and physicians leading to better quality and greater efficiency in care. According to CMS, the ACE demonstration project will also test the effect that transparent price and quality information has on beneficiary choice and provider referrals for select inpatient care. This demonstration will provide Congress with useful information about the effectiveness and unintended consequences of different bundling or episodic approaches to care delivery.

5. ***Policymakers Should Consider Comprehensive Reform Proposals for the Post-Acute and Long-Term Care System.*** The Alliance for Quality Nursing Home Care and The American Healthcare Association, of which Kindred is a member, will shortly release a comprehensive long-term care reform proposal that improves access, expands consumer choice, promotes care coordination, and achieves substantial savings. I look forward to sharing this proposal with the Committee as one option to advance healthcare and long-term care policy.

Policymakers should avoid adopting short-term, budget-driven policies that are inconsistent with the goal of improving post-acute care coordination and payment efficiency.

Policymakers should not perpetuate the disjointed nature of the current payment and service delivery systems by enacting silo-based policies that would inhibit progress towards improving the post-acute care service delivery and payment system. In a recent article on "episodic" payments, the authors caution: "Before provider payments are reduced, our payment system must be reformed to encourage the more efficient delivery

[4] "Medicare Announces Sites for Pilot Program to Improve Quality as Patients Move Across Care Settings." April 13, 2009. www.cfmc.org/caretransitions.

of care...so that new delivery models can gain traction."[5] There are several examples of short-term payment policies currently under consideration that could perpetuate our silo system and interfere with post-acute rationalization. The following examples are not meant to be exhaustive and Kindred urges policymakers to evaluate short-term policies for all Medicare and post-acute providers given the interconnectedness of the healthcare delivery system from the patients' perspective.

*1. **Various Pending Policies Related to SNFs***

"Forecast Error": Payments to Skilled Nursing Facilities may be reduced on grounds that original forecasts of Medicare expenditures underestimated the numbers of patients that would seek and receive more intensive rehab and medically complex services in SNFs. This proposed adjustment would be inconsistent with one goal sought by the bundled payment approach, i.e., to facilitate placement of patients in the lowest cost, quality setting. In this case, SNFs have invested heavily into increasing capabilities to admit, treat and return to home a growing number of patients requiring intensive rehabilitative care and care for patients with multiple chronic illnesses. The growing number of patients seeking care in SNFs is largely a result of policies that have shifted patients to lower cost settings such as SNFs. Implementing the forecast error payment reduction would inhibit continued investments in cost-effective care that serves as an incremental step towards bundling, site neutral payment, or other post-acute rationalization policies.

RUGs Refinement and STRIVE: Likewise, possible revisions to the Medicare RUGs payment system could limit the ability of SNFs to continue making the investments to provide quality medically complex and rehab intensive care in a cost-effective setting. While Kindred supports improvements in payment systems, the practical effect of these changes could be inconsistent with the overall goal of supporting access to quality care in the least costly setting.

Linkages between Medicare and Medicaid for Dually Eligible Beneficiaries: Even with the successful passage of the Stimulus Bill that provided relief to states for Medicaid expenditures, many states are still cutting provider payment rates in these economic times. Reductions in SNF Medicare payments should also be evaluated in the larger context of overall funding adequacy for SNFs. While Medicaid and Medicare funding are often viewed as distinct policy silos, SNFs providing care to individuals at the bedside cannot so distinguish between sources of funding especially for dually eligible beneficiaries. Instead, overall payment adequacy for SNFs—from all public and private sources—enables SNFs to structure operations and hire staff to meet the needs of patients and residents. The reality today is that overall SNF margins are the lowest of any provider type, hovering just above zero because

[5] Mechanic, Robert E.; Altman, Stuart H. "Payment Reform Options: Episode Payment is a Good Place to Start." Health Affairs – Web Exclusive (2009): 262-271.

Medicaid pays nursing homes well below cost. Today, Medicare literally props up the long term care delivery system by paying rates that cross-subsidize inadequate Medicaid payments. As we seek to pursue a rational long-term care system, the adequacy of payments from all sources should be the benchmark against which the reasonableness of any specific policy proposal is evaluated.

2. ***LTAC Certification Criteria***. The LTAC provider community has strongly supported MedPAC's recommendation to implement expeditiously "certification criteria" to ensure that only medically complex patients are admitted to LTACs and to advance the goal of aligning payments to LTACs with patient characteristics. Expeditious implementation of LTAC certification criteria supports incremental progress towards post-acute bundling, site neutral payment or other policies that seek to advance the dual goals of coordinated care and payment efficiency. It does so by: 1) facilitating appropriate patient placement and ensuring that only those who need LTAC care are admitted; 2) defines requisite facility criteria to ensure that facilities are capable of meeting the needs of a medically complex patient population; and 3) through the existing LTAC prospective payment system aligns payments with patient characteristics. As noted above, these are all prerequisite steps towards implementing a bundled or site neutral payment system.

On behalf of Kindred, I would like to thank the Chairman and the Ranking Member again for the opportunity to share our perspective on healthcare reform and the design of the care delivery system. We support the President's and Congress' commitment to pursue comprehensive healthcare reform and the primary goal of providing every American with healthcare coverage. We also recognize the rate of growth in healthcare costs is unsustainable. We appreciate the inclusion of post-acute care in the healthcare reform discussion and hope that some of the ideas we shared today can help contribute to improvements in our delivery system and containment of costs through better care coordination for chronically ill people, greater efficiencies in payment, and short-term reductions in cost through reduced hospitalizations and gains in quality. We stand ready to assist the President, the Chairman, members of this Committee and Congress to advance progressive healthcare and post-acute policy.

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

for the

SENATE COMMITTEE ON FINANCE

ROUNDTABLE ON FINANCING

May 12, 2009

Thank you for inviting me to discuss health care reform financing issues. This is an important aspect of health care reform.

Financing Is Critical

Some 46 million Americans are uninsured, a problem that other western industrialized nations have been able to address. In addition, rising health care costs threaten the nation's long-term fiscal and economic health. If health costs per beneficiary simply rose at the same rate as per capita economic growth, rather than growing considerably faster, nearly three-fourths of the massive long-term fiscal gap we face would be closed.

There is a strong argument that national health care reform should be our highest domestic priority. And, if it is this important, then it is worth paying for. Moreover, given the deeply problematic fiscal outlook, we should pay for the upfront costs of health reform.

I commend the Committee for devoting a full roundtable to financing.

No Easy or Painless Answers

I wish there were a number of painless options. There aren't. As you well know, some types of improvements in health care hold promise as ways to slow health care cost growth, but either we don't have firm knowledge about the savings they would produce or the savings would be unlikely to materialize on a substantial scale for a number of years. In other words, these initiatives don't "score."

To finance badly needed health care reform, all sides will need to make sacrifices. Tough measures will be needed — on both the spending and the revenue sides of the budget.

Moreover, the number of spending and revenue offsets that will be needed is likely to be substantial. There appears to be no single option that is politically viable and that can, by itself, produce most or all of the savings needed.

This leads to my first recommendation, in the form of a plea to the Committee. Please do not take any offset options off the table at this time. I believe you ultimately will need to put together a

package that contains an array of spending and revenue offsets. The more that options are taken off the table now, the harder this will be to do. You will need to make tough choices in a number of areas. If Congress can step up to the plate and put together a package of offsets that pay for health care reform legislation — and health care reform then is enacted — the nation will benefit greatly for decades to come. If this occurs, you will go down in history for your foresight and your courage.

I would like to divide my statement into two sections — one discussing spending offsets and the other discussing revenue offsets. Given the importance of this legislation, I don't think options should be limited to those that are directly health related. Particular attention should be accorded, however, to those options that would not only produce savings to help finance health reform but also improve the U.S. health care system by slowing health care cost growth, curbing the use of unnecessary care, or improving the health of our people.

Spending Offsets

The President's budget proposes a series of reforms in health care programs, primarily in Medicare, that CBO estimates would save $295 billion over ten years. Many of these reforms are consistent with the findings and recommendations of Congress' Medicare Payment Advisory Commission (MedPAC). These proposals merit serious consideration.

- They would produce substantial savings to help finance health care reform.
- A number of these measures also could lead to cost-saving reforms in the *private* sector, as private insurers followed Medicare's lead in such areas as the bundling of payments, reducing hospital readmissions, and basing provider payments on quality of care.
- In addition, these reforms would help strengthen Medicare's finances, wh*ich had*ly need shoring up for the long term.

These proposals thus would yield a triple benefit.

A newly released survey of health care leaders conducted by the Commonwealth Fund found strong support for these proposals. Large majorities of the health care leaders surveyed voiced approval of eight of the nine Administration Medicare proposals they were asked about.

In its March 2009 report to Congress, MedPAC issued several additional Medicare recommendations related to other provider payment rates that would generate savings. These should be considered as well.

Additional Medicare and Medicaid Proposals that Would Produce Savings

The Finance Committee explored a number of Medicare proposals in its roundtable on health care delivery reform and discussed some of these in the paper it produced following that roundtable. Let me suggest consideration of three additional savings proposals — two in Medicaid and one in Medicare.

1. Delivery system reforms in Medicaid

As noted, the Administration and MedPAC have proposed various Medicare delivery system reforms. Congress could consider applying these similar delivery system reforms in Medicaid as well, where that is appropriate.

State Medicaid programs could be encouraged to establish bundled payments and to structure their Medicaid payments to reduce hospital readmission rates. The federal government also could facilitate the further use of pay-for-performance both in Medicaid fee-for-service and in Medicaid managed care. In addition, states could be encouraged to institute promising care-management programs for certain high-risk populations, including high risk pregnant women (to reduce the number of neonatal intensive care unit admissions), children with asthma, and people with chronic illnesses. Finally, more state Medicaid programs could be encouraged to limit Medicaid payment for medical conditions acquired during stays in a hospital; this is already required under Medicare and in some state Medicaid programs.

2. Lowering the Cost of Medicaid Drug Coverage

Congress could take steps to lower federal costs for drugs prescribed under Medicaid. This could be done through several measures.

First, the minimum Medicaid drug rebate could be increased.

Second, the rebate could be applied to drugs dispensed by Medicaid managed care plans. Drug manufacturers currently are not required to pay rebates on drugs dispensed to beneficiaries enrolled in Medicaid managed care plans. This exception was based on the assumption that managed care plans could negotiate discounted drug prices as favorable as those required under the Medicaid drug rebate. However, recent evidence shows this likely is not the case.[1] Applying the Medicaid drug rebate to drugs dispensed through managed care plans would ensure that these plans get the best prices available, and it would allow the federal government and the states to achieve savings in their managed care capitation rates.

Both of these proposals to secure savings in Medicaid were passed by the Senate in 2005. Both also are included in President Obama's budget (and are reflected in the $295 billion in savings referred to above that CBO estimates the President's proposals would produce).

Several other steps also could be taken that would yield additional savings. Manufacturers of *brand-name* drugs are required to pay additional rebates under Medicaid if prices for those drugs rise faster than the Consumer Price Index. The Office of Inspector General at the Department of Health and Human Services has recommended applying a similar rebate adjustment to *generic* drugs.[2]

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[1] Center for Health Care Strategies, Inc., "Comparison of Medicaid Pharmacy Costs and Usage Between the Fee-for-Service and Capitated Settings," January 2003 and The Lewin Group, "Extending the Federal Drug Rebate Program to Medicaid MCOs: Analysis of Impacts," May 2003.

[2] Daniel Levinson, "Review of Generic Drug Price Increases," Office of Inspector General, Department of Health and Human Services, October 2007.

The federal government could also encourage states to adopt Medicaid best practices in managing their prescription drug costs. Some states conduct periodic reviews of prescription drug usage, particularly among high users, to ensure that the drugs prescribed are medically necessary and thereby to limit fraud and abuse and improve patient safety. These states also monitor prescribing patterns by physicians and initiate general provider education efforts known as "counter-detailing" or "academic detailing," which have been shown to reduce costs that stem from inappropriate prescribing. Some states intervene with specific providers who prescribe an unusually high number of prescriptions.[3]

3. Reducing Costs for Drugs Prescribed through Medicare to "Dual Eligible" Beneficiaries

Prior to the establishment of the Medicare Part D drug benefit, *Medicaid* provided prescription drug coverage to more than 6 million "dual eligibles" (low-income Medicare beneficiaries who also are enrolled in Medicaid). In 2006, drug coverage for these dual eligibles was shifted to Medicare. When Congress enacted the drug benefit, it assumed that the private insurers participating in Part D would be able to negotiate greater rebates from drug manufacturers than the rebates the manufacturers had been required to pay, under Medicaid, for drugs dispensed to the dual eligibles.[4]

An increasing body of research demonstrates, however, that the rebates negotiated by Medicare Part D plans actually are well below the rebates that would have been required under Medicaid. As a result, the federal government is now incurring higher drug costs for the dual eligibles than it previously incurred under Medicaid.

Harvard health economists Richard Frank and Joseph Newhouse examined SEC filings among manufacturers of drugs used heavily by dual eligibles, such as anti-psychotic medications. They found that that Medicare Part D plans were *not* obtaining prices that approximated the prices for these drugs net of the Medicaid rebates. As a result, they found "manufacturers have realized significant gains simply from the change in responsibility for purchasing from Medicaid to Medicare."[5]

Similarly, Stephen Schondelmeyer, a University of Minnesota expert on prescription-drug pricing, has estimated that most of the publicly released Medicare Part D prescription drug prices are *20 to 30 percent higher* than the estimated prices in Medicaid net of the manufacturers' rebates.[6] In addition, in a July 2008 report, the majority staff of the House Committee on Oversight and Government Reform found that had the dual eligible beneficiaries remained in Medicaid in 2006 and 2007, the

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[3] See Jeffrey Crowley and Edwin Park, "Advancing Efficient Management and Purchasing of Prescription Drugs in Medicaid," Center for Children and Families at the Georgetown University Health Policy Institute, March 2008.

[4] Under Medicaid, drug manufacturers must pay rebates for drugs dispensed to Medicaid beneficiaries equal to the higher of a minimum statutory rebate (15.1 percent of the Average Manufacturer Price) or the "best price" or discount provided to any private purchaser.

[5] Richard Frank and Joseph Newhouse, "Mending the Medicare Prescription Drug Benefit: Improving Consumer Choices and Restructuring Purchasing," The Hamilton Project at the Brookings Institution, April 2007 See also Richard Frank, Testimony before the U.S Senate Committee on Finance, January 11, 2007.

[6] Stephen Schondelmeyer, Statement before the Minority Office of the House Committee on Government Reform Briefing on the Medicare Drug Plan, January 20, 2006.

federal government would have saved $3.7 billion on the 100 drugs most often used by this population.[7] This figure was derived from the Committee's review of confidential pricing documents provided by insurers and drug manufacturers at the Committee's request.

To help finance health reform and lower Medicare costs, Congress could require drug manufacturers to provide, at a minimum, the same level of rebates for prescription drugs provided to dual eligibles under Medicare Part D as would have been required under the Medicaid program. There is no Congressional Budget Office estimate for this policy option, but the House Oversight and Government Reform Committee staff estimated it would produce savings of as much as $86 billion over ten years.[8]

Chairman Baucus' "white paper" on health reform stated that Congress should consider extending the Medicaid price discounts to Part D-covered drugs dispensed to the dual-eligible population.[9]

Revenue Offsets

This part of my statement covers four types of revenue options:

1. Capping the tax exclusion for employer-sponsored health care
2. Other health-related tax expenditures
3. Health-related excise taxes
4. Capping itemized deductions for high-income filers

Let me preface this discussion by noting that while these options would raise revenues, health care reform likely also will include tax credits to make health care affordable and enable an individual mandate to be put in place. The tax code currently features extensive spending on health care, with the tax code being used as the delivery system for these subsidies. Debate over reforms in this area should seek to avoid old ideological battles and simplistic dismissals or endorsements of options as "tax increases" or "tax cuts." The primary goal here is to reform health tax expenditures to make them more efficient and effective, more conducive to restraining health care costs, and less regressive.

1. The Employer Exclusion

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[7] House Committee on Oversight and Government Reform, Majority Staff, "Medicare Part D: Drug Pricing and Manufacturer Windfalls," July 2008, http://oversight.house.gov/documents/20080724101850.pdf

[8] In 2006 and 2007, covering the top 100 drugs used by dual-eligible beneficiaries cost an average of 30 percent more in Medicare Part D than it would have in Medicaid. The cost estimate cited here assumes that the price differential would remain at 30 percent over the next ten years and applies that differential to all drugs that the dual eligible beneficiaries are expected to use. See House Committee on Oversight and Government Reform, *op cit.*

[9] Senator Max Baucus, "Call to Action, Health Reform 2009," Senate Finance Committee, November 12, 2008.

The employer tax exclusion is the single largest subsidy in the tax code. According to the Joint Committee on Taxation, the exclusion of employer-sponsored health care reduced federal tax collections by $246 billion in 2007.[10]

As is well known, the tax exclusion is poorly targeted. It gives the greatest benefit to those with the highest incomes, although they are the group that least needs help paying for health insurance. The 24 percent of tax units with incomes over $75,000 in 2004 received almost half of the benefits of the exclusion, while the 27 percent of tax units with incomes under $20,000 received 6 percent of the benefits.[11] This result arises for three reasons: (1) low- and moderate-income people are less likely to have jobs that offer health insurance; (2) low- and moderate-income individuals offered employer-sponsored insurance are less likely to participate than people at higher income levels, because they cannot afford to pay their share of the premiums; and (3) people with modest incomes benefit less from the tax exclusion than people at high income levels because they are in lower tax brackets.

The tax exclusion also exacerbates the problem of high and rising health care costs. Like any subsidy, the exclusion encourages more spending on the item that is subsidized. By reducing the after-tax price of health insurance, the exclusion provides an incentive for employers and individuals to select more generous coverage than they otherwise would purchase. Along with other factors, this leads to an increase in the demand for health care services, drives up prices in the health-care sector, and ultimately makes health care and health coverage less affordable.[12]

Because of these problems, many analysts have recommended that the tax exclusion be scaled back. Capping the tax exclusion at some dollar level could change incentives in ways that would encourage people to seek, and providers to practice, more cost-effective health care and thereby slow the growth in health care costs.

But there also are legitimate concerns about such a course. Unless limits on the tax exclusion are combined with other changes, modifying the exclusion could weaken employer-sponsored insurance, which is the predominant source of health coverage for people of working age and their dependents. The tax subsidies provided through the exclusion are a primary reason why employer-based coverage is so widespread, along with the economies-of-scale and the risk pooling function that employer-based coverage provides.

What to Do?

A cap on the tax exclusion could make an important contribution to health-care reform by providing a significant source of financing without eroding employer-sponsored insurance or

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[10] The estimate assumes that if the exclusion for employer-sponsored insurance were repealed, employees would not be permitted to deduct the premiums as medical expenses. If such behavior were permitted, the cost of the exclusion would fall to about $200 billion a year

[11] Leonard E. Burman, Bowen Garrett, and Surachai Khitatrakun, "The Tax Code, Employer-Sponsored Insurance, and the Distribution of Tax Subsidies," in Henry J. Aaron and Leonard E. Burman, *Using Taxes to Reform Health Insurance* (Washington: Brookings Institution, 2008), p. 43.

[12] JCT, *Tax Expenditures for Health Care*, p.12.

causing other undesirable effects — if both the cap and the rest of the health care legislation are well designed. The design issues are crucial.

First, most health-reform proposals include a requirement that individuals obtain health insurance for themselves and their families. This is important: faced with having to meet an individual requirement, many workers would find employer-sponsored health insurance even more attractive than it is now even if part of the benefit effectively became taxable for a minority of workers. Employers would have every reason to continue offering health insurance, and employees would have every incentive to accept the offer. In Massachusetts, the individual mandate has resulted in an increase in employer-sponsored coverage.

Second, some health-reform proposals also include a requirement that employers of more than a certain size offer insurance to their employees or pay some sort of charge. Such a requirement — commonly called "play-or-pay" — would discourage employers from dropping health insurance coverage if it became partly taxable for some people.

Third, appropriate adjustments in the cap could be made. Since critics of capping the tax exclusion have correctly observed that the premiums for the insurance that some firms offer may be high *not* because a plan provides particularly generous benefits but because 1) the covered workers are located in an area with high health-care spending or insurance costs, 2) the covered workers are older or sicker than average, or 3) the firm is of smaller size and a greater portion of the premium is attributable to administrative costs than is the case for larger firms.

Some of these concerns can be addressed by other components of health reform — in particular, by barring insurers from continuing to vary premiums based on beneficiaries' health status or on firm size. The other concern can be addressed by building appropriate adjustments into the cap itself. The cap could be adjusted based on a firm's location and the age of its workforce, so that workers would not pay more because they live in an area with higher-than-average health costs or because their firm has an older workforce. The IRS could issue a set of geographical adjustment factors. If a new system of health insurance exchanges is established, the geographic areas used to adjust the tax cap could correspond to the areas used to set premiums within the exchanges.[13]

Structuring a Cap

A cap could be based on the cost of insurance. Under this approach, only contributions to the most expensive insurance plans would be taxable. Contributions that employers and employees make for health insurance and health care costs would be included in taxable income only if, and only to the extent that, they exceeded a certain amount (which as noted, could be subject to several adjustments).

Alternatively, a cap could be based on the income of the taxpayer. Under this variant, only people with incomes above a certain threshold would face taxation on their employer's contributions to the cost of their health insurance.

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[13] The IRS could be directed to issue a set of geographic adjustment factors that firms would apply to the raw premium amounts in order to determine the amounts reported on W-2 forms. Appropriate modifications could be made for firms whose workforce is spread over several locations.

Or, a cap could be based on both the amount of the insurance and the income of the taxpayer. Under this approach, only upper-income taxpayers whose tax-favored health contributions exceeded a certain amount would be subject to the cap.

If properly designed, a limit on the tax exclusion for employer-sponsored insurance could be administered in an equitable fashion and without imposing large compliance burdens on employers or workers,[14] could contribute significantly to financing health care reform, and could be a useful tool in helping to restrain health care costs.

2. Other Health-related Tax Expenditures

The tax code contains a plethora of tax expenditures that have been added in piecemeal fashion over the years, primarily to help people afford insurance or moderate their out-of-pocket costs. Some of these provisions would be unnecessary or duplicative under a reformed health insurance system. In addition, continuation of certain tax expenditures would be counterproductive because these tax breaks encourage unnecessary and wasteful health care spending. Continuation of some other tax expenditures could weaken a new system of health care exchanges by fostering adverse selection (the separation of healthy and less-healthy people into different insurance arrangements). Finally, current health tax expenditures tend to be highly regressive.

Accordingly, reform of these health tax expenditures could provide a source of financing for health care legislation while strengthening a reformed health care system that seeks to extend coverage and restrain health care costs.

A comprehensive assessment of health tax expenditures lies beyond the scope of this testimony. I will cover three such tax expenditures here: flexible spending accounts, the itemized deduction for health care costs in excess of 7.5% of adjusted gross income, and health savings accounts.

Flexible Spending Accounts

Individuals with access to flexible spending accounts may elect to have a portion of their wages or salaries placed in such an account, with that income being exempt from income and payroll taxes. Individuals then withdraw funds from the account (by submitting claims to their employer or to a firm with which their employer has contracted to manage the account) in order to secure reimbursement for out-of-pocket health costs for deductibles, co-payments, and elective health care costs and health-related products that their insurance does not cover.

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[14] Different approaches would be required for employers who purchase insurance and firms that self-insure. Small employers generally purchase insurance from an insurance company and pay a clearly identifiable premium to an insurer for each employee and dependent. Employers could easily report the current premium amount, or a specified portion thereof, on workers' pay stubs and W-2 statements. Large employers generally act as their own insurer and do not actually pay premiums to an insurance company. Such self-insured employers, however, must calculate premiums charged to former employees eligible for continuation of health insurance coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). These employers could report the most recently determined COBRA premium (excluding the additional 2-percent administrative charge), or a specified portion, for the employee's coverage type (individual, family, individual plus spouse, or individual plus child) on workers' pay stubs and W-2 statements. See Paul Fronstin, *Capping the Tax Exclusion for Employment-Based Health Coverage: Implications for Employers and Workers.* Washington Employee Benefit Research Institute, January 2009. EBRI Issue Brief No. 325.

FSAs are designed to make health care more affordable. If a reformed health care system provides access to affordable coverage, however, with subsidies for people who need such assistance with the costs (and possibly with an out-of-pocket limit, perhaps set as a percentage of income), FSAs should not be essential.

Moreover, FSAs have several undesirable effects.

- The accounts directly encourage excessive and unnecessary health care spending. FSA accounts thus create incentives at odds with health reform goals. People who have these accounts lose all of the wages or salaries remaining in them at the end of the plan year. This prompts bursts of year-end spending on health items and elective procedures that people otherwise would not purchase. People purchase those items and procedures at the end of the year because the items and procedures seem free under FSAs' "use it or lose it" nature.

- The accounts subsidize utilization of health care services and items not typically covered by health insurance. While some of these services may be medically necessary and cost-effective, other services purchased may be elective and of little value. This aspect of FSAs, as well, encourages excess health care spending.

- FSAs are highly regressive and provide only modest benefits to most people of ordinary means who use them;

- FSAs are time consuming to use, involving considerable paperwork with a host of small receipts (in economists' terms, the "transaction costs" imposed on individuals who use these accounts can be considerable);

- Finally, FSAs actually hurt some low- and moderate-income workers. The Tax Policy Center reports that for lower-income people, the eventual loss in Social Security benefits due to lower payroll tax contributions as a result of FSA participation generally outweighs the immediate tax savings. People affected in this way usually have no idea that they are lowering their lifetime disposable income by participating in an FSA.

Consider the following. The average contribution to a FSA was $1,208 in 2006. Someone in the 15 percent tax bracket would get a tax savings of approximately $270 if he or she contributed this amount — but, the typical benefit for middle-income households is less than this because people at higher income levels tend to place larger amounts of money in FSAs, thereby boosting the average contribution up to the $1,208 level just mentioned. The typical middle-income participant contributes less than $1,208. And to gain these relatively modest tax benefits, individuals generally must spend hours stockpiling receipts and filling out forms. Finally, Aetna found that 14 percent of its FSA customers *forfeited* an average of $723 in 2007 because of funds that remained unspent in FSA accounts at the end of the year.

That FSAs encourage excessive health care spending is undeniable. The following advice from the "Frugal Dr. Mom" website in promoting a humidifier is illustrative: *"If you have FSA money to burn, humidifiers generally count as an FSA purchase."* Or this from the "planforyourhealth" website: *"If you have an FSA, spend that money!"*

Moreover, FSAs encourage spending on types of health treatments or volumes of procedures that are beyond recommended medical practice and are not covered by insurance. In a world where insurance coverage can be flimsy, the case for FSAs is stronger, though not compelling. With health care reforms that set standards for creditable coverage and involve subsidies and some type of limit on out-of-pocket costs, the case for FSAs is much weaker.

In short, FSAs are labor-intensive for taxpayers but yield only modest tax savings for most participants. They are regressive and distort consumption choices in a wasteful direction, both because they can be used for health care services *irrespective* of cost-effectiveness or clinical effectiveness, and because the "use or lose it" feature of FSAs encourages people to make unnecessary purchases at the end of the plan year. And well-designed health care reform would remove much of the rationale for health FSAs.

The preferred option would be to eliminate health care FSAs at the time that the reformed health care system takes effect. Other options include imposing an annual FSA contribution limit (e.g., $1,000), setting an income limit on FSA participation (e.g., at the income limits used for deductible IRAs), and including FSAs under a cap on employer-related health care subsidies (i.e., instead of a cap on employer health care contributions, placing a cap on total tax benefits associated with employer-sponsored coverage.)

A related issue concerns the current tax expenditure for the employee share of health care premiums for employer-sponsored insurance, which also can be paid out of pre-tax income that isn't subject to income or payroll tax. If the employee share of the premium is $100 a month, a high-income individual effectively pays $64 because of this tax expenditure, while an employee in the 10 percent tax bracket pays $82. (These figures reflect the effect on the employee share of the payroll tax as well as the income tax.) One option is to fold this tax benefit into an overall cap on the tax benefits associated with employer-based coverage.

The Tax Deduction for Costs Exceeding 7.5% of AGI

The tax code helps to protect people against catastrophic health care costs by providing a deduction for health costs that exceed 7.5% of AGI. This deduction may no longer be needed in full under health care reform, depending on the shape that reform takes.

If benefit packages are adequate, subsidies are provided to people of modest means, and there are reasonable limits on total out-of-pocket costs, this deduction should no longer be needed — with one important exception. The deduction will continue to be needed for long-term care costs. (A refundable tax credit would be superior to a deduction for long-term care costs, but that lies beyond the scope of this testimony.)

Health Savings Accounts

Health Savings accounts are another tax mechanism that is intended to help make health care costs more affordable but would not mesh well with a reformed health insurance system. HSAs could make a system of health care exchanges less effective and efficient. Also of concern, some features of HSAs may foster excess health care consumption.

A particular concern about Health Savings Accounts attached to high-deductible health insurance plans is that such plans can pose a significant risk of "adverse selection," because they tend to be disproportionately attractive to healthier and more affluent individuals who do not need much in the way of health care and consequently are less concerned about the higher out-of-pocket costs required under a high-deductible plan, but who benefit the most from the unprecedented tax-sheltering benefits that HSAs provide.[15] (Unlike any other tax-preferred savings account in the tax code, contributions to HSAs are tax-deductible *and* withdrawals are tax free if used for out-of-pocket medical expenses. Other accounts, like IRAs, permit deductible contributions but tax the withdrawals or allow tax-free withdrawals but do not allow tax-deductible contributions.)

If high-deductible plans attached to HSAs can be offered within the new health insurance exchanges and significant numbers of healthier-than-average individuals enroll in such plans, that likely will drive up premiums for the more comprehensive plans offered in the exchanges since those plans would tend to be left with sicker-than-average groups of enrollees. As a result, the federal government would *either* have to increase the subsidies available to enable lower-income individuals, particularly those who are in poorer health or have chronic illnesses, to continue enrolling in comprehensive plans, *or* such individuals would be forced to enroll in HSA plans even though such plans require substantial upfront deductibles and other cost-sharing that low-income individuals generally are not able to afford.

Options for how to deal with these issues as part of health care reform include the following:

- Bar high-deductible plans attached to HSAs from being offered in the exchanges. As noted, such plans are likely to lead to adverse selection within the exchanges, which would lessen the ability of the exchanges to pool risk effectively over the long term and provide broad access to affordable, comprehensive coverage.

- Limit HSAs' tax-sheltering benefits, at least for HSAs offered through the exchanges. In the version of their health reform plan that Senators Wyden and Bennett offered last year and presented to the Congressional Budget Office for evaluation, individuals enrolled in HSAs would no longer be permitted to make tax-deductible contributions to HSAs and thereby to use HSAs in substantial part as tax shelters. The only contributions allowed would be those made by insurers to comply with an actuarial value standard required of all health insurance plans. Such HSA reforms would make HSAs less disproportionately attractive to healthy, higher-income individuals and thus would moderate the risk of adverse selection that HSAs would otherwise pose to the exchanges, although some risk would remain.

In addition to these options, one change in HSAs should surely be made. The HSA contribution rules in place before 2006 should be restored.

When HSAs were first enacted as part of the Medicare drug law in 2003, individuals could contribute to their HSAs on a tax-free basis the lower of the deductible amount under their health insurance plan or the annual HSA contribution limit the legislation set. This rule was changed in 2006, however, to allow individuals to contribute (on a tax-deductible basis) the full amount up to

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[15] See Edwin Park and Robert Greenstein, "Latest Enrollment Data Still Fail to Dispel Concerns about Health Savings Accounts," Center on Budget and Policy Priorities, Revised January 30, 2006 and Edwin Park, "Informing the Debate about Health Saving Accounts," Center on Budget and Policy Priorities, June 13, 2006.

the annual contribution limit, *even if the limit substantially exceeds the deductible in their health plan.* In tax year 2009, the minimum high deductible required for family coverage in a plan tied to a HSA was $2,300, while the annual HSA contribution limit was $5,950. Thus, an individual could sock away *$3,650 more* in an HSA than the amount of the deductible under his or her health plan. This substantially increased the tax-sheltering opportunities of HSAs, particularly for high income taxpayers, who were the people who benefited most from the change since they can best afford to contribute the additional amounts.

This change also encourages people with HSAs to increase the amounts they spend on health care. Individuals with HSAs now can "overfund" their HSAs and spend a portion of their excess HSA balances on virtually any health care item or service, including unnecessary care that normal medical practice would not advise and health insurance would not typically cover.[16]

3. Health-related Excise Taxes

Another set of financing options involves excise taxes on products that can undermine good health and impose costs on society. The most obvious such product is tobacco; its deleterious effects on health and the costs that it imposes are well known. Congress significantly increased taxes on tobacco products earlier this year as part of children's health insurance legislation. Whether Congress would be willing to return to this issue again this year is unclear. A case can be made on the merits for further action here.

Since the issue of taxes on tobacco products has so recently been debated and is so well known, I will not discuss it further here. This section of my testimony focuses on issues and options related to: 1) taxing soda and other highly sweetened soft drinks; and 2) adjusting the federal excise tax on alcohol, which has eroded very substantially as a result of inflation since it was last adjusted in the bipartisan deficit reduction agreement of 1990.

To be sure, these excise taxes are regressive. We are talking, however, of options for financing national health care reform that includes universal coverage. The bulk of the Americans who are uninsured have low or moderate incomes. The net effect on this part of the population would be a substantial gain in well-being. Low- and moderate-income households who reduced their consumption of unhealthy products as a result of changes in tax policy also would benefit from improved health outcomes.

A Tax on Highly Sweetened Soft Drinks

Mounting evidence indicates that high-sugar soft-drink consumption has increased sharply in recent years and that this has contributed markedly to increased obesity, which results in higher health costs and increased morbidity. A recent article in *The New England Journal of Medicine,* "Ounces of Prevention: The Public Policy Case for Taxes on Sugared Beverages," makes a strong health case for a federal tax on soft drinks. A few disturbing statistics are worthy of note:

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[16] Joel Friedman, Robert Greenstein and Edwin Park, "Last-Minute Addition to Tax Package Would Make Health Savings Accounts More Attractive as Tax Shelters for High-Income Individuals," Center on Budget and Policy Priorities, September 26, 2006.

- Per capita consumption of sugar-sweetened beverages *nearly tripled* from 1977-78 to 2000. By 2003, the average American consumed nearly one gallon of soft drinks a week (46 gallons per year). Americans now consume about 250-300 more calories per day on average than they did several decades ago. The increased consumption of high-sugar soft drinks accounts for *nearly half* of this increase.

- According to a 2001 USDA study, 32 percent of adolescent girls and 52 percent of adolescent boys consume three or more eight-ounce servings of soda per day.

- The increase in obesity, to which has increased soft-drink consumption has contributed heavily, is a significant factor in the higher incidence of diabetes and other diseases. According to the Centers for Disease Control, obesity raises the risk of heart disease, diabetes, stroke, hypertension, certain cancers and other diseases.

- Being overweight as a child increases the risk of developing diabetes, hypertension, respiratory problems and orthopedic problems. Another study published in the *New England Journal of Medicine* concluded that, because of the increase just through 2000 in adolescent obesity, heart-disease deaths by 2035 will rise 6 to 19 percent above what they would have been *without* the increase in obesity.[17]

- Another study found that women who consumed one or more soft drink servings per day were twice as likely to develop diabetes during the eight-year study as women who consumed less than one serving per month.[18]

- Increased obesity also imposes costs on the health care system and taxpayers. Researchers at Emory University have estimated that the "rising prevalence of obesity and [the] higher relative per capita [health] spending among obese Americans accounted for 27 percent of the growth in real capita [health] spending between 1987 and 2001."[19] Increased obesity accounted for 15 percent of the increase in Medicare costs between 1987 and 2002.[20]

- A tax on high-sugar soft drinks would reduce consumption of such beverages — and thereby improve health outcomes. The authors of the recent *New England Journal of Medicine* article estimate that a 10 percent price increase would cut consumption by 7.8 percent.

States are out in front of the federal government here. While only 14 states levied a sales tax on food for home consumption in 2007, some 39 states imposed a sales tax on at least some soda purchases. In some of these states, the tax on soda is simply part of the sales tax that applies to

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[17] "Adolescent Overweight and Future Adult Coronary Heart Disease," *New England Journal of Medicine*, December 6, 2007, http://content.nejm.org/cgi/content/full/357/23/2371#F1

[18] "Sugar-Sweetened Beverages, Weight Gain, and Incidence of Type 2 Diabetes in Young and Middle-Aged Women," *Journal of the American Medical Association*, August 25, 2004, http://jama.ama-assn.org/cgi/content/full/292/8/927

[19] See "The Impact of Obesity on Rising Medical Spending," *Health Affairs*, October 20, 2004, http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.480v1

[20] "The Rise In Spending Among Medicare Beneficiaries: The Role of Chronic Disease Prevalence And Changes In Treatment Intensity," *Health Affairs*, August 20, 2006, http://content.healthaffairs.org/cgi/reprint/25/5/w378

food; in others, it is a separate or a higher tax. Some 28 states impose a higher sales tax on vending machine soda sales than on food generally (in most of these states, vending machine snack foods also are subject to the tax), and 20 states impose a higher tax on soda purchased at grocery stores than on other food purchases.

The best option to consider here would be to establish an excise tax on the value of soda, as Arkansas and West Virginia have done. In these states, the tax is levied on distributors, manufacturers, and wholesale dealers. (Both states also levy an equivalent tax on soft drink syrup or dry mix used to make soft drinks.) Health concerns argue for a tax levied in this "upstream" manner — the higher price that results operate as a nudge to reduce consumption of high-sugar beverages.[21]

The *New England Journal of Medicine* article proposed that a tax be set on those products at the rate of a penny per ounce. That would add 12 cents to the price of a 12-ounce soft drink. The authors of the article estimated this would reduce soft-drink consumption by more than 10 percent. On a back-of-the envelope basis, such a proposal should raise something over $10 billion a year, based on a Center for Science in the Public Interest estimate of a similar proposal.

Alcohol Taxes

Federal excise taxes on alcohol now stand at their lowest level in decades. The tax on distilled spirits has been reduced *85 percent* in real terms since 1951 (i.e., after adjusting for inflation). Just since 1991, when alcohol taxes were last adjusted, these taxes have been reduced 37 percent across the board, when inflation is taken into account.

Taxes on alcohol are projected to fall another 8 percent in real terms by 2019.

Looked at another way, federal excise taxes on alcohol equaled 12 percent of gross alcohol sales in 1980. They now amount to about half that, with the percentage falling further every year.

To be sure, moderate alcohol consumption can be neutral or even beneficial for health. But excess alcohol consumption imposes large costs. A study conducted for the National Institute of Alcohol Abuse and Alcoholism by the Lewin Group found that the economic costs of alcohol abuse amounted to an estimated $185 billion in 1998. Such costs include direct medical costs, lost productivity and earnings, and increased crime.

For these reasons, a large group of economists, including four Nobel laureates and three former presidents of the American Economics Association, issued a statement in 2005 calling for increases in excise taxes on alcohol. In addition, the National Academy of Sciences has recommended raising alcohol excise tax rates to discourage underage drinking. Similarly, a 2007 report issued by the Surgeon General noted that increasing the costs of alcohol use (i.e., raising the tax on alcohol) could influence teenagers to drink less.

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[21] A soda tax could be administered by the Alcohol and Tobacco Tax and Trade Bureau (TTB), which is housed within the Treasury Department. Under federal law, tobacco products are taxed but are not subject to the level of regulation imposed on alcohol products. The TTB administers tobacco taxes by issuing permits to tobacco manufacturers, importers, and exporters. A parallel system of permits could be instituted for manufacturers, importers, and exporters of soda and soda products.

According to the Centers for Disease Control and Prevention, excessive alcohol use causes about 79,000 deaths per year in the United States.

Raising alcohol taxes to help pay for health care reform also appears to enjoy public support. The Kaiser health tracking poll for April 2009 reports that 68 percent of Americans support increasing wine and beer taxes to help pay for health care reform.

There are various options to raise revenue in this area. As noted, taxes on alcohol were last increased in the 1990 bipartisan budget reconciliation bill, with these increases taking effect in 1991, and have effectively been reduced by 37 percent since then because of inflation. One option would be to raise tax rates back to where Congress set them in 1990 — i.e., to put them at the 1991 level, adjusted for inflation since that time. Under this option, taxes would increase by 4 cents on a bottle of beer, to a total of 9 cents per bottle. They would rise by 3 cents on a glass of wine, to 7 cents per glass.

Another option is one included by the Congressional Budget Office in its recent health care options volume — to set alcohol taxes at a uniform $16 per proof gallon. This CBO option is designed to tax alcohol equally whether it is found in distilled spirits, beer, or wine. Currently, distilled spirits are taxed more heavily.

The current tax on spirits is $13.50 proof per gallon. This CBO option would raise that to $16 per proof gallon and also apply it to beer and wine. Under this option, the tax on a bottle of beer or a glass of wine would rise to about 14 cents — the increase would be 9 cents on a bottle of beer and 10 cents on a glass of wine. According to CBO, this option would raise $60 billion over ten years ($28 billion over five years).

A third option, and the one that would raise the most revenue of the three outlined here, would be to combine the first two options. Under such an approach, alcohol would be taxed across the board at the level that distilled spirits were taxed in 1991, when Congress last acted, with that level adjusted for inflation since 1991 and going forward. Under this option, the tax on a bottle of beer or a glass of wine would be about 18 cents. The increase would be 13 cents per bottle of beer and 14 cents per glass of wine.

An argument may be made in response to these options that unlike tobacco, moderate alcohol consumption is not injurious to health and may even be beneficial. But people who are moderate consumers of alcohol would only be very lightly touched by these proposals. For example, under the first option outlined above, someone who drank a glass of wine with dinner every night throughout the entire year would face a total annual tax increase of $10.85 over the year. Even under the second option under which the tax on wine would rise by 10 cents a glass, the total impact on someone drinking a glass of wine every day of the year would be just $36.50.

4. Capping Itemized Deductions

The President's budget proposes to set a cap of 28 percent on the deduction rate that households with incomes over $250,000 may use. This is the same rate that applied to deductions taken by high-income households in the late 1980s, following enactment of the Tax Reform Act of 1986.

This proposal has attracted criticism for its impact on charities. In fact, the impact on charitable contributions would be relatively modest. Moreover, there is reason to believe that the charitable sector as a whole could be a net gainer if this proposal is combined with effective health care reform.

- Analysis by the Urban Institute-Brookings Tax Policy Center shows that only 1.4 percent of all households would be touched by this proposal.

- Based on the economic research in the field, total charitable contributions would be expected to decline by slightly less than 2 percent.

And there would be some benefits for charities.

- Universal coverage would relieve the charitable sector of the need to finance billions of dollars a year in charity health care.

- Small non-profits that now must pay high health care premiums likely would be able to obtain health coverage for their employees at lower cost through a health insurance exchange.

This is why I believe charities as a whole would be more likely to be net winners than net losers from the combination of this proposal and health care reform.

A criticism that this would place too heavy a tax burden on high-income households also seems misplaced. Analysis by the Tax Policy Center shows that if the various tax measures President Obama has proposed were adopted — including the itemized deduction cap — the effective tax rate on each income group, up through and including the top 1 percent of households, would be lower than it was in late 1990s when the economy boomed and high-income households did well.

Despite the strong criticisms that have been made of the Administration's proposal, I would urge the Committee not to take this approach entirely off the table. There are alternative options, designed to address the criticisms that have been voiced of the Administration's proposal, that warrant serious consideration. Two such options are:

- Exempt charitable contributions from the President's proposal; or

- Apply a cap to all itemized deductions but set the cap at 33% and/or 35%, rather than at 28%.

Today, filers deduct at the 33% rate if they are in the next-to-the-top tax bracket, and at 35% if they are in the top bracket. The tax rates in these two brackets are slated to go back to 36% and 39.6% in 2011. Congress could cap itemized deductions at the rates that *currently apply*. Or Congress could simply cap deductions at 35% (rather than at the 28% level the President proposed).

Under such an approach, the value of itemized deductions — and the incentive to donate — ***would not change*** from what it is today. The criticisms that have been voiced of the Administration's proposal — that it would increase the cost of donating, relative to what it is today — would not be applicable. Meaningful savings would still be generated to help finance health care reform, although at a considerably lower level than the Administration's proposal envisions.

Another alternative would be to dispense with an itemized deduction cap and instead to place a tax surcharge on income about a very high level.

Statement of Professor Jonathan Gruber

May 12, 2009

Thank you for inviting me to testify today on the sources of financing for health care reform. The Congress is presented with a terrific opportunity to provide universal health care coverage to all Americans. But it also faces a major stumbling block in financing that coverage.

There is an inescapable logic of reform that lies behind the search for financing sources. First, moving to universal coverage is now acknowledged to require a mandate on individuals to have insurance coverage. Second, such a mandate is inhumane without subsidies to make health insurance affordable for lower income individuals. Third, these subsidies will require a large amount of new financing, on the order of one trillion dollars or more over the next decade.

How can the government finance such a massive new expenditure? There are a number of possible sources. In my testimony today I will move briefly through several of them, and then focus on the best candidate: reforming the tax subsidy to employer-provided health insurance.

In particular, I would highlight five "classes" of revenue sources for financing universal coverage:

Cost Control: The first is reductions in existing government spending on health care through cost controls. President Obama proposed over $300 billion of such cost controls in his budget. The advantage of this source of financing is that it is well-matched to the budgetary needs of the program: savings from medical cost controls rise at the same rate as the spending required under this new program. The disadvantage of this source of financing is that the major approaches to controlling costs, such as greater use of disease management or medical homes, have yet to demonstrate large reductions in medical spending. As a result, it is difficult to find substantial savings from cost controls beyond those proposed by the President.

Sin Taxes: The second is increased taxation of "sin good" whose use raises the cost of health care for all Americans. This would include cigarettes, alcohol, and high sugar or fat foods that cause obesity. There is a strong public policy argument for raising taxes on all of these goods. In particular, the tax rate on alcohol is well below the level that would account for the damage that drinking does to society, in particular through drunk driving. Yet it is difficult to raise sufficient revenues from these sources, and these revenues will not rise at the rate of health care spending; indeed, they are likely to fall over time if we move the population towards healthier lifestyles.

Provider Assessments: Hospitals in the U.S. currently spend over $30 billion/year on uncompensated care. Best estimates suggest that two-thirds of that amount is due to the uninsured. Thus, as we move towards universal coverage, there is a sizeable bonus to

hospitals that could be recaptured to finance insurance subsidies; indeed, moving money from back end care of the uninsured to up front subsidies to insurance was the notion behind the Massachusetts reform. Once again, this is a well-matched source of financing as it rises with hospital revenues. On the other hand, this is once again a fairly small source of financing.

Outside Sources: Another alternative is to turn to sources that are not health care related. For example, President Obama proposed that the ability of high income families to itemize their deductions be limited, raising over $300 billion over the next decade. Income taxes could be increased in many other ways as well to finance health care reform. Alternatively, new sources of revenues could be found, such as a Value Added Tax or revenues from a carbon cap-and-trade system. While there are many options here, they all suffer from the problem noted thus far, which is that the revenues will generally rise at some rate slower than the rate of growth of health care premiums, so that ever increasing tax rates will be required to finance universal coverage.

This brings us to a final source of revenues, which is the exclusion of employer-sponsored insurance (ESI) spending from individual income taxation. This is both the most natural source of financing for health care reform, as well as one of the few that is clearly large enough to finance the subsidies needed for reform. I will devote the remainder of my testimony to discussing this important financing source.

We all know the two largest government health insurance expenditures, on Medicare and Medicaid. Less well known, and even less well understood, is the government's third largest health insurance expenditure: the $250 billion/year in foregone tax revenues from excluding employer expenditures on health insurance from taxation. When MIT pays me in cash wages, I am taxed on those wages. But the roughly $10,000 that MIT will spend this year on my health insurance is not taxed, amounting to a tax break of about $4000 to me. To be clear, this exclusion is a tax break to individuals, not to firms; firms are indifferent between paying me in wages and in health insurance. But I am not indifferent about getting paid in wages or health insurance; I pay taxes on the former but not the latter.

The tax exclusion of employer expenditures from individual taxation has three flaws. First, $250 billion/year is an enormous sum of money which could be more effectively deployed elsewhere, especially through alternative approaches to increasing insurance coverage. Even if we consider just the income tax exclusion, ignoring the payroll tax component, $2.3 trillion in federal revenues will be lost over the next decade through this subsidy to employer-sponsored insurance. Second, this is a regressive entitlement, since higher income families with higher tax rates get a bigger tax break; about three-quarters of these dollars go to the top half of the income distribution. Third, this tax subsidy makes health insurance, which is bought with tax-sheltered dollars, artificially cheap relative to other goods bought with taxed dollars, leading to over-insurance for most Americans.

As result of these limitations, *no health expert today* would ever set up a health system with such an enormous tax subsidy to a particular form of insurance coverage. So why don't we just remove it? There are four counterarguments to using the exclusion as a financing source. I review each in turn:

Administrative Difficulties: Some have argued that it would be administratively infeasible to reduce this tax subsidy. This is simply wrong, as the process of including ESI spending in individual income taxation is quite straightforward. Employers would simply report the amount of their spending on an individual's insurance on that person's W-2 form. If the employer buys insurance, the premium is provided directly by the insurer; if the employer is self-insured, they simply use the premium amount they are required to calculate for COBRA purposes. If the exclusion is capped, rather than removed (as discussed below), then individuals would simply pay tax on the difference between the reported premiums and the cap.

Erosion of ESI: The existing predominance of employer-sponsored insurance is predicated on this tax exclusion, so policy makers must be wary about simply removing it. Many employers currently only offer health insurance because of this "tax bribe", and ending the exclusion would lead to a large erosion of employer-sponsored insurance.

There are two reasons why this might be a problem – one is wrong and one is right. The one that is wrong is the concern that we will "lose employer dollars" when ESI erodes. Both economic theory and a large body of economic evidence show that *there are no employer dollars*: the money that employers spend on insurance would otherwise just be spent on worker wages. If MIT stopped offering insurance, over a several year period my wages would rise by $10,000 to offset the lost insurance compensation, and MIT's bottom line would remain the same. The notions of "shared responsibility" or "keeping employers in the game" are political notions, not economic ones.

The right reason to worry about the erosion of ESI is that sick and older individuals are treated much more fairly in employer groups than they will be in today's non-group insurance market. Under ESI, all individuals pay the same for insurance regardless of age or health. But in most states those who are sick or older must pay much more for their non-group insurance, and in many cases it is simply unavailable. So as employer-sponsored insurance falls we could end up with a large new set of uninsured who cannot afford, or cannot obtain at any price, non-group insurance.

This is an important reason to be concerned about reducing the exclusion of ESI from taxation in a vacuum. But it is not an important concern when the policy is financing a broader universal coverage plan. In that case, individuals will face group rates on their insurance regardless of where it is purchased, and they will be subsidized if insurance is not affordable. Thus, any displacement from ESI will not lead to uninsurance, just a shift to a new exchange.

Middle-Class Tax Increase: The third concern raised about removing the exclusion is that it would be an across the board tax increase. As highlighted earlier, removal would represent a progressive tax increase, with 62% of the revenues raised from families with incomes above $100,000 per year. Yet, there would still be a sizeable increase in taxation for middle income families, with 10% of the revenues coming from families below $50,000 in income, and 28% from families with $50,000 to $100,000 of income.

For this reason, and given that the entirety of revenues from removing the exclusion is not necessary to finance reform, we should focus our attention in reducing, rather than removing, the tax exclusion. The exclusion can be reduced, for example, by *capping* the amount of employer-sponsored premiums that are excluded from taxation, so that individuals are not taxed on premiums below some level (say the average value of ESI premiums), and pay tax only on premiums in excess of that level. This has the advantage of addressing the bias towards excessively generous insurance without raising taxes from those who have basic insurance. Moreover, this is more progressive than an across the board removal of the exclusion, since higher income individuals tend to have the more expensive insurance. This policy still raises non-trivial revenues from middle income taxpayers, however.

Alternatively, the exclusion could be reduced in an income-targeted manner, by scaling back the exclusion only for higher income groups. This could be designed to protect middle-income taxpayers from any increase in tax payments. There are many possible combinations of caps and income limits that could be used, with varying implications for revenues raised from limiting the exclusion.

Another important consideration is how caps and income cutoffs are inflated over time. Given the rapid rise in health insurance premiums, a cap level that is inflated more slowly than premiums will mean that the cap is eroding over time. For example, a cap at the average ESI premium that is fixed in nominal terms is equivalent to a complete removal of the exclusion over an 11-12 year period. On the other hand, a cap indexed to ESI premium growth would not erode at all over time, so that a cap that excluded the least expensive 50% of ESI plans would continue to do so over time. A cap that rises, but at a lower rate than ESI premium growth, would erode over time, but more slowly than with no indexing.

It is useful to consider some examples of possible tax exclusion policies to understand the magnitude of the dollars involved. For example, suppose the government were to cap the exclusion at the typical ESI premium ($4700 single / $12,800 family today), starting in 2012, and were to index that cap at the rate of growth of the consumer price index (so that the cap rose, but at a slower rate than premiums). Such a policy would raise $500 billion by 2019. Even if this cap were indexed to premium growth, so that in every year the government taxed only premiums above the typical ESI premium level (with no erosion over time), the policy would raise $360 billion over the 2012-2019 period.

There are considerable revenues to be raised even at higher levels of the cap. A cap at the 75th percentile of the distribution of ESI premiums, so that only the top quarter of most expensive plans would be subject to some taxation, would raise $330 billion over the 2012-2019 period if indexed to the CPI, and $220 billion over that period if indexed to premiums.

Alternatively, the government could consider a more progressive structure. Consider a policy that capped the ESI exclusion at the typical ESI premium, but only for families with incomes above $125,000 per year. Such a policy would raise $340 billion over the 2012-2019 period if the cap were indexed to the CPI, or $240 billion in indexed to premium growth. Additional "brackets" could be added so that the extent of taxation varied further with different income levels.

Unfairness of Reducing Tax Exclusion for High Cost Groups: A final criticism of reducing the tax exclusion, for example through a cap on the amount that can be excluded from taxation, is that it is unfair to high cost groups, for example those in states with expensive insurance or who are in workplaces with an older workforce. A fixed national cap on the exclusion, for example, would raise much more revenue in Rhode Island (where average single ESI premiums are about $7000) than in New Mexico (where those premiums are about $3500).

But this problem is readily addressable by adjusting the cap to account for differences in underlying cost factors across firms. For example, the cap could be adjusted upwards in high cost states to mitigate the disproportionate revenue increase for those states. Of course, to maintain the revenues raised from the cap, it would also have to be adjusted downwards in lower cost states; alternatively, the adjustment could be one-sided (upwards for expensive states only) at the cost of some lost revenue.

Similarly, the cap could be adjusted upwards in firms with older workers (and potentially downwards in firms with younger workers). Employers know their workers' ages and it would be straightforward for them to compute an adjustment factor based on the ages of their workers that could be used to adjust the cap.

In summary, there are a variety of financing sources to which the Congress can turn to achieve the critical goal of universal health insurance coverage. It is clear to me, however, that one source of financing dominates the others: reducing the expensive, regressive, and inefficient subsidization of employer-sponsored insurance. Financing coverage expansions by scaling back the exclusion would be highly progressive and would reduce a major driver of overinsurance and excessive health spending in the U.S. This is truly a win-win solution to your problem, in that it reduces a fundamental flaw in our existing system of health insurance financing, while raising the revenues required to cover the uninsured.

Thank you again for allowing me to testify today and I look forward to your questions and to helping the committee further as you tackle these difficult issues.

Responses to Questions for the Record
Roundtable on Financing Health Care Reform

Questions for Dr. Gruber

1. Dr. Gruber, your advance testimony states, "To be clear, this [employee] exclusion is a tax break to individuals, not to firms; firms are indifferent between paying me in wages and in health insurance." Then you go on to say that, "If MIT stopped offering insurance, over a several year period my wages would rise by $10,000 to offset the lost insurance compensation, and MIT's bottom line would remain the same....The notions of 'shared responsibility' or 'keeping employers in the game' are political notions, not economic ones." Is it fair to say that employees are already paying for their health benefits through the employer-based system, but in the form of lower wages? What has been the impact of skyrocketing health care costs on workers' wages?

Answer: The evidence is quite clear on this point: over the medium to long term, higher health insurance costs are reflected directly in lower worker wages. So the rapid rise in health care costs over the past decade has led to flat or declining wages for U.S. workers.

2. One of the options on the table for financing health reform is the idea of a "soda tax" or other types of "sin taxes." Since this roundtable is about financing, I'm going to leave the discussion about whether or not these taxes are an effective prevention tool for another day. What I'm concerned about in the context of financing is: will these types of "sin taxes" be a stable revenue source to offset part of the costs of what may be $1.5 trillion in new spending. I am also concerned that these types of new taxes are highly regressive meaning they hurt low-income workers the most.

   Dr. Gruber, your testimony states that, "It is difficult to raise sufficient revenues from these sources, and these revenues will not rise at the rate of health care spending; indeed, they are likely to fall over time if we move the population towards healthier lifestyles." Given that statement can we count on "sin taxes" as a stable revenue source to fund new spending obligations for health reform?

Answer: Any source of financing that does not rely on medical spending itself (as does capping the tax exclusion) will not rise as rapidly as the spending program it is financing. This is true for sin taxes as well as for other forms of financing such as income tax increases. But sin taxes do have an offsetting advantage: they improve the health of the population, which lowers the costs of any health program. So while sin taxes may not rise enough to finance the program in the long run, their offsetting benefit in terms of lowering the long run cost of the program may be even more valuable.

STATEMENT

Reforming America's Health Care Delivery System

April 21, 2009

Statement of
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Chairman
Medicare Payment Advisory Commission

Before the
Senate Finance Committee Roundtable on
Reforming America's Health Care Delivery System

Chairman Baucus, Ranking Member Grassley, distinguished Committee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be part of the panel this morning and to share MedPAC's views on delivery system reform.

The Medicare Payment Advisory Commission (MedPAC) is an independent Congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program. The Commission's statutory mandate is quite broad: In addition to advising the Congress on payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare. The Commission's 17 members bring diverse expertise in the financing and delivery of health care services.

MedPAC meets publicly to discuss policy issues and formulate its recommendations to the Congress. In the course of these meetings, Commissioners consider the results of staff research, presentations by policy experts, and comments from interested parties. Commission members and staff also seek input on Medicare issues through frequent meetings with individuals interested in the program, including staff from congressional committees and the Centers for Medicare & Medicaid Services (CMS), health care researchers, health care providers, and beneficiary advocates.

Two reports – issued in March and June each year – are the primary outlet for Commission recommendations. In addition to these reports and others on subjects requested by the Congress, MedPAC advises the Congress through other avenues, including comments on reports and proposed regulations issued by the Secretary of the Department of Health and Human Services, testimony, and briefings for congressional staff.

Our health care system today

The health care delivery system we see today is not a true system: Care coordination is rare, specialist care is favored over primary care, quality of care is often poor, and costs are high and increasing at an unsustainable rate. Part of the problem is that Medicare's fee-for-service (FFS)

payment systems reward more care, and more complex care, without regard to the value of that care. In addition, Medicare's payment systems create separate payment "silos" (e.g., inpatient hospitals, physicians, post-acute care providers) and do not encourage coordination among providers within a silo or across the silos. We must address those limitations—creating new payment methods that will reward efficient use of our limited resources and encourage the effective integration of care.

Medicare has not been the sole cause of the problem, nor should it be the only participant in the solution. Private payer rates and incentives perpetuate system inefficiencies, and the current disconnect among different payers creates mixed signals to providers. This contributes to the perception that one payer is cross-subsidizing other payers and further exacerbates the problem. Private and other public payers will need to change payment systems to bring about the conditions needed to change the broader health care delivery system. But Medicare should not wait for others to act first; it can lead the way to broader delivery system reform.

Because this roundtable discussion is intended to spark dialogue on the solutions, I will focus on the recommendations the Commission has made to reform the health care delivery system and to strengthen the Medicare program. MedPAC has testified previously before Senate Finance Committee on problems of our health care delivery system and a detailed discussion of these problems is in the attached Appendix.

Commission recommendations to increase efficiency and improve quality

In previous reports, the Commission has recommended that Medicare adopt tools to surmount barriers to increasing efficiency and improving quality within the current Medicare payment systems. These tools include:

- *Creating pressure for efficiency through payment updates.* Although the update is a somewhat blunt tool for constraining cost growth (updates are the same for all providers in a sector, both those with high costs and those with low costs), constrained updates will create more pressure on those with higher costs. In our March 2009 Report to the Congress, the Commission offers a set of payment update recommendations that exert fiscal pressure on providers to constrain costs. For example, the Commission

recommends a zero update for home health agencies in 2010, coupled with an acceleration of payment adjustments due to coding practices, totaling a 5.5 percent cut in home health payments for 2010. Another example is the Commission's recommendation to reduce overpayments to MA plans by setting the MA benchmarks equal to 100 percent of Medicare FFS expenditures. This recommendation is consistent with the Commission's commitment to retaining high-quality, low-cost private plans in Medicare.

- *Improving payment accuracy within Medicare payment systems.* In our 2005 report on specialty hospitals, the Commission made recommendations to improve the accuracy of DRG payments to account for patient severity. Those recommendations corrected distortions in the payment system that—among other things—contributed to the formation of hospitals specializing in the treatment of a limited set of profitable DRGs. In another example, in our June 2008 and March 2009 Reports to the Congress, the Commission recommended increasing fee schedule payments for primary care services furnished by clinicians focused on delivering primary care. This budget-neutral adjustment would redistribute Medicare payments toward those primary care services provided by practitioners—physicians, advanced practice nurses, and physician assistants—whose practices focus on primary care. This recommendation recognizes that a well functioning primary care network is essential to help improve quality and control Medicare spending (MedPAC 2008, MedPAC 2009).

- *Linking payment to quality.* In a series of reports, we have recommended that Medicare change payment system incentives by basing a portion of provider payment on the quality of care they provide and recommended that the Congress establish a quality incentive payment policy for physicians, Medicare Advantage plans, dialysis facilities, hospitals, home health agencies, and skilled nursing facilities. In March 2005, the Commission recommended setting standards for providers of diagnostic imaging studies to enhance the quality of care and help control Medicare spending.

- *Measuring resource use and providing feedback.* In our March 2008 and 2005 Reports to the Congress, we recommended that CMS measure physicians' resource use per episode of

care over time and share the results with physicians. Those who used comparatively more resources than their peers could assess their practice styles and modify them as appropriate.

- *Encouraging use of comparative-effectiveness information and public reporting of provider quality and financial relationships.* In our June 2007 Report to the Congress, we found that not enough credible, empirically based information is available for health care providers and patients to make informed decisions about alternative services for diagnosing and treating most common clinical conditions. The Commission recommended that the Congress charge an independent entity to sponsor credible research on comparative effectiveness of health care services and disseminate this information to patients, providers, and public and private payers. Second, the Commission recommended public reporting to provide beneficiaries with better information and encourage providers to improve their quality. Third, the Commission has recommended that manufacturers of drugs and medical devices be required to publicly report their financial relationships with physicians to better understand the types of financial associations that may influence patterns of patient care.

The need for more fundamental reform

The recommendations discussed above would make the current Medicare FFS payment systems function better, but they will not fix the problems inherent in those systems for two reasons. First, they cannot overcome the strong incentives inherent in any fee-for-service system to increase volume, thus it will be difficult to make the program sustainable. Second, they cannot switch the focus to the patient rather than the procedure because they cannot directly reward care coordination or joint accountability that cut across current payment system "silos," such as the physician fee schedule or the inpatient prospective payment system.

There is evidence that more fundamental reforms could improve the quality of care and potentially lower costs. For example, patient access to high-quality primary care is essential for a well-functioning health care delivery system. Research suggests that reducing reliance on specialty care may improve the efficiency and quality of health care delivery. States with a

greater proportion of primary care physicians have better health outcomes and higher scores on performance measures (Baicker and Chandra 2004). Moreover, areas with higher rates of specialty care per person are associated with higher spending but not improved access to care, higher quality, better outcomes, or greater patient satisfaction (Fisher et al. 2003, Kravet et al. 2008, Wennberg 2006). Countries with greater dependence on primary care have lower rates of premature deaths and deaths from treatable conditions, even after accounting for differences in demographics and GDP (Starfield and Shi 2002). Changing the balance in the delivery system between primary and specialist care may have high payoffs for Medicare.

Evidence points to other potential reforms:

- *Greater care coordination.* Evidence shows that care coordination can improve quality. As we discussed in our June 2006 Report to the Congress, studies show self management programs, access to personal health records, and transition coaches have resulted in improved care or better outcomes, such as reduced readmission for patients with chronic conditions.
- *Reducing preventable readmissions.* Savings from preventing readmissions could be considerable. About 18 percent of Medicare hospital admissions result in readmissions within 30 days of discharge, accounting for $15 billion in spending. The Commission found that Medicare spends about $12 billion on potentially preventable readmissions.
- *Increasing the use of bundled payments.* The Medicare Participating Heart Bypass Center demonstration of the 1990s found that bundling hospital DRG payments and inpatient physician payments could increase providers' efficiency and reduce Medicare's costs. Most of the participating sites found that, under a bundled payment, hospitals and physicians reduced laboratory, pharmacy, and ICU spending. Spending on consulting physicians and post-discharge care decreased and quality remained high.

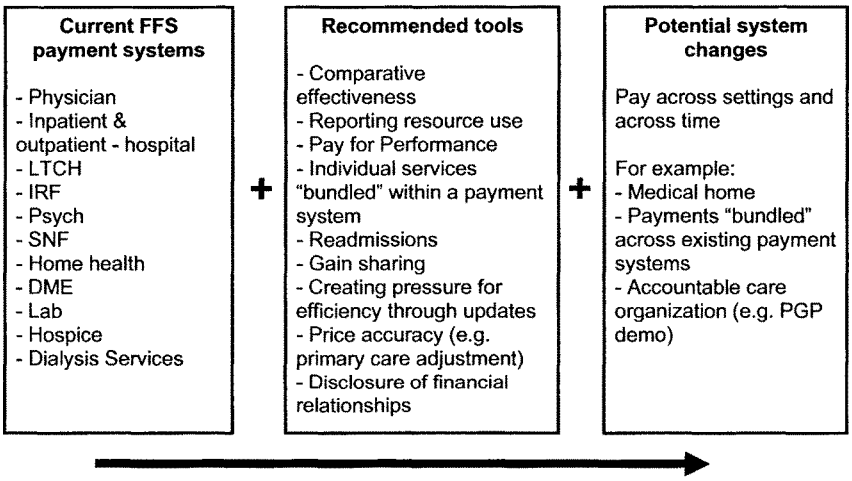
A direction for payment and delivery system reform

To increase value for the Medicare program, its beneficiaries, and the taxpayers, we are looking at payment policies that go beyond the current FFS payment system boundaries of scope and time. This new direction would pay for care that spans across provider types and time and would hold providers jointly accountable for the quality of that care and the

resources used to provide it. It would create payment systems that reward value and encourage closer provider integration—delivery system reform. For example, if Medicare held physicians and hospitals jointly responsible for outcomes and resource use, new efficiencies—such as programs to avoid readmissions and standardization of operating room supplies—could be pursued. In the longer term, joint responsibility could lead to closer integration and development of a more coordinated health care delivery system.

This direction is illustrated in Figure 1. The potential payment system changes shown are not the end point for reform and further reforms could move the payment systems away from FFS and toward systems of providers who accept some level of risk, driving delivery system reform.

Figure 1. Direction for payment and delivery system reform



History provides numerous examples that providers will respond to financial incentives. The advent of the inpatient prospective payment system in 1983 led to shorter inpatient lengths of stay and increasing use of post acute care services. Physician services have increased as payments have been restrained by volume control mechanisms. Finally, a greater proportion of patients in skilled nursing facilities (SNFs) were given therapy, and more of it, in response

to the SNF prospective payment system incentives. Financial incentives can also result in structural changes in the health care delivery system. In the 1990s, the rise of HMOs and the prospect of capitation led doctors and hospitals to form physician–hospital organizations whose primary purpose was to allocate capitated payments. Paying differently will motivate providers to interact differently with each other, and—if reforms are carefully designed for joint accountability—to pay more attention to outcomes and costs. To be sure, implementing these changes will not be easy. Changes of this magnitude will undoubtedly be met with opposition from providers and other stakeholders. In addition, the administrative component of the proposed payment system changes will require refinement over time.

Recommended system changes

We discuss three recommendations the Commission has made that might move Medicare in the direction of better coordination and more accountable care: a medical home pilot program, changing payments for hospital readmissions, and bundling payments for services around a hospital admission.

Medical home

A medical home is a clinical setting that serves as a central resource for a patient's ongoing care. The Commission considers medical homes to be a promising concept to explore. Accordingly, it recommends that Medicare establish a medical home pilot program for beneficiaries with chronic conditions to assess whether beneficiaries with medical homes receive higher quality, more coordinated care, without incurring higher Medicare spending. Qualifying medical homes could be primary care practices, multispeciality practices, or specialty practices that focus on care for certain chronic conditions, such as endocrinology for people with diabetes. Geriatric practices would be ideal candidates for Medicare medical homes.

In addition to receiving payments for fee-schedule services, qualifying medical homes would receive monthly, per beneficiary payments that could be used to support infrastructure and activities that promote ongoing comprehensive care management. To be eligible for these monthly payments, medical homes would be required to meet stringent criteria. Medical homes must:

- furnish primary care (including coordinating appropriate preventive, maintenance, and acute health services);
- use of a team to conduct care management;
- use health information technology (IT) for active clinical decision support;
- have a formal quality improvement program;
- maintain 24-hour patient communication and rapid access;
- keep up-to-date records of beneficiaries' advance directives; and
- maintain a written understanding with each beneficiary designating the provider as a medical home.

These stringent criteria are necessary to ensure that the pilot evaluates outcomes of the kind of coordinated, timely, high-quality care that has the highest probability to improve cost, quality, and access. The pilot must assess a true intervention rather than care that is essentially business as usual. In rural areas, the pilot could test the ability for medical homes to provide high-quality, efficient care with somewhat modified structural requirements.

Beneficiaries with multiple chronic conditions would be eligible to participate because they are most in need of improved care coordination. About 60 percent of FFS beneficiaries have two or more chronic conditions. Beneficiaries would not incur any additional cost sharing for the medical home fees. As a basic principle, medical home practitioners would discuss with beneficiaries the importance of seeking guidance from the medical home before obtaining specialty services. Participating beneficiaries would, however, retain their ability to see specialists and other practitioners of their choice. Under the pilot, Medicare should also provide medical homes with timely data on patients' Medicare-covered utilization outside the medical home, including services under Part A and Part B and drugs under Part D.

A medical home pilot provides an excellent opportunity to implement and test physician pay-for-performance (P4P) with payment incentives based on quality and efficiency. Under the pilot project, the Commission envisions that the P4P incentives would allow for rewards and penalties based on performance. Efficiency measures should be calculated from spending on Part A, Part B, and Part D, and efficiency incentives could take the form of shared savings

models similar to those under Medicare's ongoing physician group practice demonstration. Bonuses for efficiency should be available only to medical homes that have first met quality goals and that have a sufficient number of patients to permit reliable spending comparisons. Medical homes that are consistently unable to meet minimum quality requirements would become ineligible to continue participation.

It is imperative that the medical home pilot be on a large enough scale to provide statistically reliable results with a relatively short testing cycle. Additionally, the pilot must have clear and explicit results-based thresholds for determining whether it should be expanded into the full Medicare program or discontinued entirely. Focusing on beneficiaries with multiple chronic conditions and medical homes meeting stringent criteria should provide a good test of the medical home concept.

Readmissions and bundled payments around a hospitalization

Evidence suggests there is an enormous opportunity to improve care and address the lack of coordination at hospital discharge. Discharge from the hospital is a very vulnerable time for patients, and in particular for Medicare beneficiaries, who often cope with multiple chronic conditions. Often they are expected to assume a self-management role in recovery with little support or preparation. They may not understand their discharge instructions on what medications to take, know whom to call with questions, or know what signs indicate the need for immediate follow-up care. Often they do not receive timely follow-up care and communication between their hospital providers and post-acute care providers is uneven. These disjointed patterns of care can result in poorer health outcomes for beneficiaries, and in many cases, the need for additional health care services and expenditures.

The variation in spending around hospitalization episodes suggests lower spending is possible. There is a 65 percent difference in spending on readmissions between hospitals in the top quartile and the average of all hospitals; the top quartile is almost four times higher than the bottom quartile. The spread between high- and low-use hospitals is even larger than spending for post-acute care. These high-spending hospitals often treat the beneficiaries with the costliest care. Greater coordination of care is needed for this population, and changing incentives around their hospital care could be the catalyst.

How can Medicare policy change the way care is provided? First, the Commission recommends that the Secretary confidentially report to hospitals and physicians information about readmission rates and resource use around hospitalization episodes (e.g., 30 days post-discharge) for select conditions. This information would allow a given hospital and the physicians who practice in it to compare their risk-adjusted performance relative to other hospitals, physicians, and post-acute care providers. Once equipped with this information, providers may consider ways to adjust their practice styles and coordinate care to reduce service use. After two years of confidential disclosure to providers, this information should be publicly available.

Information alone, however, will not likely inspire the degree of change needed. Payment incentives are needed. We have two recommendations—one to change payment for readmissions and one to bundle payments across a hospitalization episode. Either policy could be pursued independently, but the Commission views them as complementary. A change in readmissions payment policy could be a critical step in creating an environment of joint accountability among providers that would, in turn, enable more providers to be ready for bundled payment.

Readmissions

The Commission recommends changing payment to hold providers financially accountable for service use around a hospitalization episode. Specifically, it would reduce payment to hospitals with relatively high readmission rates for select conditions. Conditions with high volume and high readmissions rates may be good candidates for selection. Focusing on *rates* rather than *numbers* of readmissions serves to penalize hospitals that consistently perform worse than other hospitals, rather than those that treat sicker patients. The Commission recommends that this payment change be made in tandem with a previously recommended change in law (often referred to as gainsharing or shared accountability) to allow hospitals and physicians to share in the savings that result from re-engineering inefficient care processes during the episode of care.

Currently, Medicare pays for all admissions based on the patient's diagnosis regardless of whether it is an initial stay or a readmission for the same or a related condition. This is a

concern because we know that some readmissions are avoidable and in fact are a sign of poor care or a missed opportunity to better coordinate care.

Penalizing high rates of readmissions encourages providers to do the kinds of things that lead to good care, but are not reliably done now. For example, the kinds of strategies that appear to reduce avoidable readmissions include preventing adverse events during the admission, reviewing each patient's medications at discharge for appropriateness, and communicating more clearly with beneficiaries about their self-care at discharge. In addition, hospitals, working with physicians, can better communicate with providers caring for patients after discharge and help facilitate patients' follow-up care.

Spending on readmissions is considerable. We have found that Medicare spends $15 billion on all-cause readmissions and $12 billion if we exclude certain readmissions (for example, those that were planned or for situations such as unrelated traumatic events occurring after discharge). Of this $12 billion, some is spent on readmissions that were avoidable and some on readmissions that were not. To target policy to avoidable readmissions, Medicare could compare hospitals' rates of potentially preventable readmissions and penalize those with high rates. The savings from this policy would be determined by where the benchmark that defines a high rate is set, the size of the penalty, the number and type of conditions selected, and the responsiveness of providers.

The Commission recognizes that hospitals need physician cooperation in making practice changes that lead to a lower readmission rate. Therefore, hospitals should be permitted to financially reward physicians for helping to reduce readmission rates. Sharing in the financial rewards or cost savings associated with re-engineering clinical care in the hospital is called gainsharing or shared accountability. Allowing hospitals this flexibility in aligning incentives could help them make the goal of reducing unnecessary readmissions a joint one between hospitals and physicians. As discussed in a 2005 MedPAC report to the Congress, shared accountability arrangements should be subject to safeguards to minimize the undesirable incentives potentially associated with these arrangements. For example, physicians who participate should not be rewarded for increasing referrals, stinting on care, or reducing quality.

Bundled payments for care over a hospitalization episode

Under bundled payment, Medicare would pay a single provider entity an amount intended to cover the costs of providing the full range of care needed over the hospitalization episode. Because we are concerned about care transitions and creating incentives for coordination at this juncture, the hospitalization episode should include time post-discharge (e.g., 30 days). With the bundle extending across providers, providers would not only be motivated to contain their own costs but also have a financial incentive to better collaborate with their partners to improve their collective performance. Providers involved in the episode could develop new ways to allocate this payment among themselves. Ideally, this flexibility gives providers a greater incentive to work together and to be mindful of the impact their service use has on the overall quality of care, the volume of services provided, and the cost of providing each service. In the early 1990s, Medicare conducted a successful demonstration of a combined physician–hospital payment for coronary artery bypass graft admissions, showing that costs per admission could be reduced without lowering quality.

The Commission recommends that CMS conduct a voluntary pilot program to test bundled payment for all services around a hospitalization for select conditions. Candidate conditions might be those with high costs and high volumes. This pilot program would be concurrent with information dissemination and a change in payment for high rates of readmissions.

Bundled payment raises a wide set of implementation issues. It requires not only that Medicare create a new payment rate for a bundle of services but also that providers decide how they will share the payment and what behavior they will reward. A pilot allows CMS to resolve the attendant design and implementation issues, while giving providers who are ready the chance to start receiving a bundled payment.

The objective of the pilot should be to determine whether bundled payment for all covered services under Part A and Part B associated with a hospitalization episode (e.g., the stay plus 30 days) improves coordination of care, reduces the incentive for providers to furnish services of low value, improves providers' efficiency, and reduces Medicare spending while not otherwise adversely affecting the quality of care. The pilot should begin applying payment changes to only a selected set of medical conditions.

Conclusion

The process of reform should begin as soon as possible; reform will take many years and Medicare's financial sustainability is deteriorating. That deterioration can be traced in part to the dysfunctional delivery system that the current payment systems have helped to create. Those payment systems must be fundamentally reformed, and the recommendations we have made are a first step on that path. They are, however, only a first step; they fall far short of being a "solution" for Medicare's long-term challenges. MedPAC has begun to consider other options, such as accountable care organizations (ACOs). In addition, MedPAC will consider steps to alter the process by which payment reforms are developed and implemented, with the goals of accelerating that process. I thank the Committee for its attention, and look forward to working with you to reform Medicare's payment systems and help bring the health care delivery system into the 21st century.

APPENDIX

The Case For Fundamental Change

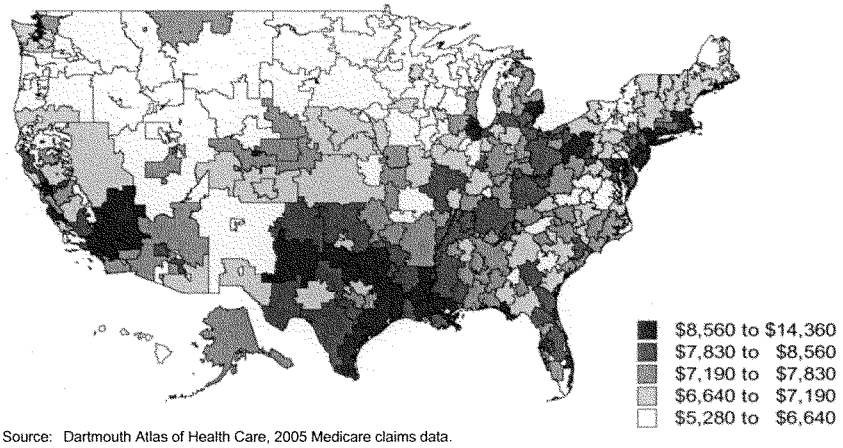
The Medicare program should provide its beneficiaries with access to appropriate, high quality care while spending the money entrusted to it by the taxpayers as carefully as possible. But too often that goal is not being realized, and we see evidence of poor-quality care and spending growth that threatens the program's fiscal sustainability.

Poor quality

Many studies show serious quality problems in the American health care system. McGlynn found that participants received about half of the recommended care (McGlynn et al. 2003). Schoen found wide variation across states in hospital admissions for ambulatory-care-sensitive conditions (i.e., admissions that are potentially preventable with improved ambulatory care) (Schoen et al 2006). In *Crossing the Quality Chasm*, the Institute of Medicine pointed out serious shortcomings in quality of care and the absence of real progress toward restructuring heath care systems to address both quality and cost concerns (IOM 2001).

At the same time that Americans are not receiving enough of the recommended care, the care they are receiving may not be appropriate. For 30 years, researchers at Dartmouth's Center for the Evaluative Clinical Sciences have documented the wide variation across the United States in Medicare spending and rates of service use (Figure 1). Most of this variation is not driven by differences in the payment rates across the country but instead by the use of services. Dartmouth finds most of the variation is caused by differing rates of use for supply-sensitive services—that is, services whose use is likely driven by a geographic area's supply of specialists and technology (Wennberg et al. 2002). Areas with higher ratios of specialty care to primary care physicians also show higher use of services.

Figure 1. Total Medicare spending by Hospital Referral Region



Source: Dartmouth Atlas of Health Care, 2005 Medicare claims data.

The higher rates of use are often not associated with better outcomes or quality and instead suggest inefficiencies. In fact, a recent analysis by Davis and Schoen shows at the state level that no relationship exists between health care spending per capita and mortality amenable to medical care, that an inverse relationship exists between spending and rankings on quality of care, and that high correlations exist between spending and both preventable hospitalizations and hospitalizations for ambulatory-care-sensitive conditions (Davis and Schoen 2007). These findings point to inefficient spending patterns and opportunities for improvement.

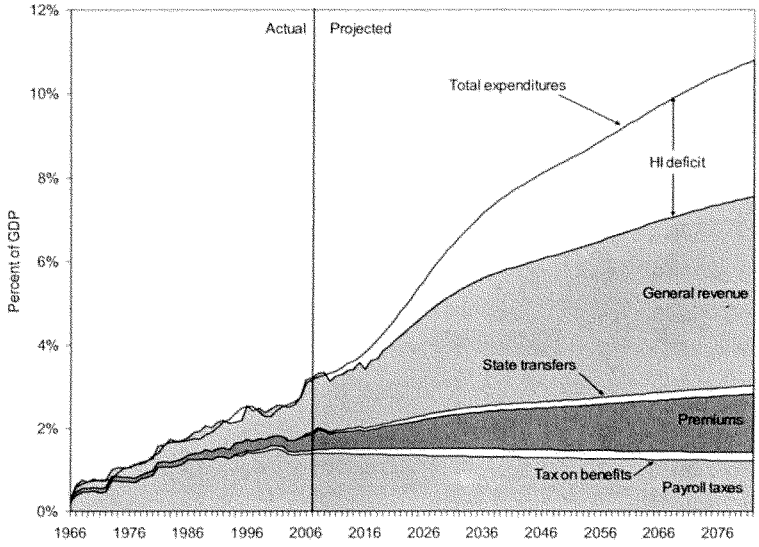
Sustainability concerns

This inefficiency costs the federal government many billions of dollars each year, expenditures we can ill afford. The share of the nation's GDP committed to Medicare is projected to grow to unprecedented levels, squeezing other priorities in the federal budget (Figure 2). For example, the Supplementary Medical Insurance Trust Fund (which covers outpatient and physician services, and prescription drugs) is financed automatically with general revenues and beneficiary premiums, but the trustees point out that financing from the

federal government's general fund, which is funded primarily through income taxes, would have to increase sharply to match the expected growth in spending.

In addition, expenditures from the Hospital Insurance (HI) trust fund, which funds inpatient stays and other post-acute care, exceeded its annual income from taxes in 2008. In their most recent report, the Medicare trustees project that, under intermediate assumptions, the assets of the HI trust fund will be exhausted in 2019. Income from payroll taxes collected in that year would cover 78 percent of projected benefit expenditures. (The recent downturn in the economy is expected to move the HI exhaustion date closer by one to three years in the next Trustees' Report (BNA 2009).)

Figure 2. Medicare faces serious challenges with long-term financing



Note: GDP (gross domestic product), HI (Hospital Insurance). These projections are based on the trustees' intermediate set of assumptions. Tax on benefits refers to a portion of income taxes that higher income individuals pay on Social Security benefits that is designated for Medicare. State transfers (often called the Part D "clawback") refer to payments called for within the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 from the states to Medicare for assuming primary responsibility for prescription drug spending.

Source: 2008 Annual Report of the Boards of Trustees of the Medicare Trust Funds.

Rapid growth in Medicare spending has implications for beneficiaries and taxpayers. Between 2000 and 2007, Medicare beneficiaries faced average annual increases in the Part B premium of nearly 9.8 percent. Meanwhile, monthly Social Security benefits grew by about 4 percent annually over the same period. The average cost of SMI premiums and cost sharing for Part B and Part D absorbs about 26 percent of Social Security benefits. Growth in Medicare premiums and cost sharing will continue to absorb an increasing share of Social Security income. At the same time, Medicare's lack of a catastrophic cap on cost sharing will continue to represent a financial risk for beneficiaries. Almost 60 percent of beneficiaries (or their former employers) now buy supplemental coverage to help offset this risk and Medicare's cost sharing.

Barriers to achieving value in Medicare

Many of the barriers that prevent Medicare from improving quality and controlling costs—obtaining better value—stem from the incentives in Medicare's payment systems. Medicare's payment systems are primarily fee-for-service (FFS). That is, Medicare pays for each service delivered to a beneficiary by a provider meeting the conditions of participation for the program. FFS payment systems reward providers who increase the volume of services they provide regardless of the benefit of the service. As discussed earlier, the volume of services per beneficiary varies widely across the country, but areas with higher volume do not have better outcomes. FFS systems are not designed to reward higher quality; payments are not increased if quality improves and in some cases may increase in response to low-quality care. For example, some hospital readmissions may be a result of poor-quality care and currently those readmissions are fully paid for by Medicare.

While this testimony focuses on changes to Medicare FFS payment systems that would encourage delivery system reform, the payment system for Medicare Advantage (MA) plans also needs reform, as we have previously reported. In aggregate, the MA program continues to be more costly than the traditional program. Plan bids for the traditional Medicare benefit package average 102 percent of FFS in 2009, compared with 101 percent of FFS in 2008. In 2009, MA payments per enrollee are projected to be 114 percent of comparable FFS spending for 2009, compared with 113 percent in 2008. Many MA plans have not changed

the way care is delivered and often function much like the Medicare FFS program. High MA payments provide a signal to plans that the Medicare program is willing to pay more for the same services in MA than it does in FFS. Similarly, these higher payments signal to beneficiaries that they should join MA plans because they offer richer benefits, albeit financed by taxpayer dollars. This is inconsistent with MedPAC's position supporting financial neutrality between FFS and MA. To encourage efficiency across the Medicare program, Medicare needs to exert comparable and consistent financial pressure on both the FFS and MA programs, coupled with meaningful quality measurement and pay-for-performance (P4P) programs, to maximize the value it receives for the dollars it spends.

MedPAC has identified five specific problems that make it difficult for Medicare to achieve its goals: lack of fiscal pressure, price distortion, lack of accountability, lack of care coordination, and lack of information. These are discussed below.

Lack of fiscal pressure. Medicare payment policies ought to exert fiscal pressure on providers. In a fully competitive market, this happens automatically through the "invisible hand" of competition. Under Medicare's administered price systems, however, the Congress must exert this pressure by limiting updates to Medicare rates—or even reducing base rates in some instances (e.g., home health). MedPAC's research shows that provider costs are not immutable; they vary according to how much pressure is applied on rates. Providers under significant cost pressure have lower costs than those under less pressure. Moreover, MedPAC research demonstrates that providers can provide high-quality care even while maintaining much lower costs.

Our analysis shows that in 2007 hospitals under low financial pressure in the prior years had higher standardized costs per discharge ($6,400) than hospitals under high financial pressure ($5,800). Over time, aggregate hospital cost growth has moved in parallel with margins on private-payer patients. Due to managed care restraining private-payer payment rates in the 1990s, hospitals' rate of cost growth in that period was below input price inflation. However, from 2001 through 2007, after profits from private payers increased, hospitals' rate of cost growth was higher than the rate of increase in the market basket of input prices. All things being equal, increases in providers' costs will result in lower Medicare margins. We also

found that hospitals with the highest private payments and most robust non-Medicare sources of revenues have lower Medicare margins (–11.7 percent) than hospitals under greater fiscal pressure (4.2 percent).

Price distortion. Within Medicare's payment systems, the payment rates for individual products and services may not be accurate. Inaccurate payment rates in Medicare's payment systems can lead to unduly disadvantaging some providers and unintentionally rewarding others. For example, under the physician fee schedule, fees are relatively low for primary care and may be too high for specialty care and procedures. This payment system bias has signaled to physicians that they will be more generously paid for procedures and specialty care, and signals providers to generate more volume. In turn, these signals could influence the supply of providers, resulting in oversupply of specialized services and inadequate numbers of primary care providers. In fact, the share of U.S. medical school graduates entering primary care residency programs has declined in the last decade, and internal medicine residents are increasingly choosing to sub-specialize rather than practice as generalists.

Lack of accountability. Providers may provide quality care to uphold professional standards and to have satisfied patients, but Medicare does not hold them accountable for the quality of care they provide. Moreover, providers are not accountable for the full spectrum of care a beneficiary may use, even when they make the referrals that dictate resource use. For example, physicians ordering tests or hospital discharge planners recommending post-acute care do not have to consider the quality outcomes or the financial implications of the care that other providers may furnish. This fragmentation of care puts quality of care and efficiency at risk.

Lack of care coordination. Growing out of the lack of accountability, there is no incentive for providers to coordinate care. Each provider may treat one aspect of a patient's care without regard to what other providers are doing. There is a focus on procedures and services rather than on the beneficiary's total needs. This becomes a particular problem for beneficiaries with several chronic conditions and for those transitioning between care providers, such as at

hospital discharge. Poorly coordinated care may result in patient confusion, over-treatment, duplicative service use, higher spending, and lower quality of care.

Lack of information and the tools to use it. Medicare and its providers lack the information and tools needed to improve quality and use program resources efficiently. For example, Medicare lacks quality data from many settings of care, does not have timely cost or market data to set accurate prices, and does not generally provide feedback on resource use or quality scores to providers. Individually, providers may have clinical data, but they may not have that data in electronic form, leaving them without an efficient means to process it or an ability to act on it. Crucial information on clinical effectiveness and standards of care either may not exist or may not have wide acceptance. In this environment, it is difficult to determine what health care treatments and procedures are needed, and thus what resource use is appropriate, particularly for Medicare patients, many of whom have multiple comorbidities. In addition, beneficiaries are now being called on to make complex choices among delivery systems, drug plans, and providers. But information for beneficiaries that could help them choose higher quality providers and improve their satisfaction is just beginning to become available.

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TESTIMONY SUBMITTED TO THE

SENATE FINANCE COMMITTEE ROUNDTABLE

ON

EXPANDING COVERAGE IN HEALTH CARE REFORM

May 5, 2009

AARP

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Government Relations & Advocacy

Chairman Baucus, Ranking Member Grassley, distinguished Committee members, thank you for inviting AARP and our Divided We Fail allies to this timely discussion on expanding health care coverage. I am AARP President Jennie Chin Hansen. On behalf of AARP's more than 40 million members, we commend you for your bipartisan leadership and commitment to enacting comprehensive health care reform this year.

Comprehensive reform to provide affordable coverage to all Americans could not be more urgent, as coverage losses are snowballing in our current economy. In just the first quarter of this year, two insurers alone – UnitedHealth Group and Wellpoint – reported that 900,000 and 500,000 of their enrollees, respectively lost coverage. One recent report estimated that 4 million Americans have lost coverage since the recession began, and as many as 14,000 may be losing coverage every day.[1] This is on top of 46 million who lacked coverage in 2007.[2] Others suggest that nearly 87 million were uninsured for some part of 2007-2008.[3]

We simply cannot fix our broken economy without fixing our broken health care system.

Just 63% of employers now offer coverage, leaving over 55 million workers unable to get coverage at work.[4] This is especially hard on AARP members aged 50-64 who often cannot find affordable coverage on their own because insurers charge exorbitant rates based on age and/or deny coverage altogether to those with pre-existing health conditions. The AARP Public Policy Institute found that over 7 million Americans aged 50-64 were uninsured in 2007 – a 36 percent increase from 2000 – and more have undoubtedly lost coverage since.[5]

Job-based coverage itself is increasingly unaffordable.

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[1] Center for American Progress, Health Care in Crisis: 14,000 Losing Coverage Each Day, February 19, 2009.
[2] U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 2007.
[3] Families USA, Americans at Risk: One in Three Uninsured, March, 2009.
[4] HRET/Kaiser Family Foundation, 2008 Employer Health Benefits Survey.
[5] AARP Public Policy Institute, Health Care Reform: What's at Stake for 50-to-64Year-Olds? March 2009.

In the past eight years, premiums for a family of four have grown faster than both earnings and inflation.[6] Average annual premiums for job-based family coverage were $12,680 in 2008, almost double the 2000 figure,[7] and the more employees must pay, the less likely they are to enroll.[8]

People with private non-group insurance are worse off, often spending over 10% of their income on health care.[9] For those aged 50-64 more than two thirds spend that much or more out of pocket.[10] And Institute of Medicine research shows that large numbers of uninsured threaten even those who have coverage, as privately insured adults in areas with high uninsurance rates have lower rates of access to and satisfaction with care.[11]

Despite declining coverage rates, total health care spending is skyrocketing. Without reform, the Centers for Medicare and Medicaid Services (CMS) estimates that national health expenditures will nearly double over ten years, rising to $4.3 trillion by 2017.[12] Medical price inflation is by far the largest driver of this increase, and accounts for 51% of this health care spending growth; population increase accounts for only 15%.[13]

This unsustainable cost growth places a huge burden on governments, families, and business, threatens our global competitiveness and makes coverage increasingly unaffordable. Some may advocate delaying health reform given the economy and the fundamental challenges it presents. However, we believe we cannot afford to delay and applaud you for making enactment of health reform this year a top priority this year.

For AARP, key priorities that we must address in health reform include:

- Providing affordable coverage options to all Americans, especially those aged 50-64;

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[6] HRET/Kaiser Family Foundation, 2008 Employer Health Benefits Survey
[7] Ibid.
[8] Kaiser Family Foundation. February 2007, Snapshots: Health Care Costs, Insurance Premium Cost-Sharing and Coverage Take-up.
[9] Jessica Banthin, Agency for Healthcare Research & Quality, "Out-of-Pocket Burdens for Health Care: Insured, Uninsured, and Underinsured" presentation. September 23, 2008.
[10] AARP Public Policy Institute, Health Care Reform: What's at Stake for 50- to 64-Year-Olds?, March 2009.
[11] IOM: America's Uninsured Crisis: Consequences for Health and Health Care, Feb. 24, 2009.
[12] Centers for Medicare and Medicaid Services, National Health Expenditure Projections 2007–2017.
[13] California HealthCare Foundation. Snapshot, Health Care Costs 101, 2008.

- Strengthening Medicare by lowering health costs and improving benefits;
- Helping people stay in their homes and out of costly institutions; and
- Ensuring that both the benefits and costs of reform are shared by all generations.

We believe that the best way to meet these goals is through comprehensive reform to ensure that all Americans have access to high quality, affordable coverage.

Making Affordable Coverage Available to All

Health reform must make affordable coverage choices available to all Americans, especially those aged 50-64 who are not yet eligible for Medicare. The AARP Public Policy Institute estimates that 13% or 7.1 million adults aged 50-64 were uninsured in 2007 – 1.9 million more than in 2000.[14] People in this age range who lose job-based coverage often find it impossible to get affordable individual coverage because insurers consider age and pre-existing conditions when setting rates and most Americans in this age range have one if not several such conditions. Industry data show that insurers reject between 17% and 28% of applicants aged 50-64.[15] Those who can find individual coverage tend to receive less generous benefits than those with employer coverage, yet on average pay premiums that are three times higher and total out-of-pocket spending that is over twice that of those with employer coverage.[16]

The best way to help 50-64-year-olds is to make coverage affordable for everyone by:

- Guaranteeing that all individuals and groups wishing to purchase or renew coverage can do so regardless of age or pre-existing conditions;
- Prohibit charging higher premiums because of health status or claims experience;
- Providing a choice of qualified plans through an Exchange or Connector;
- Providing subsidies based on income so coverage is affordable for everyone;

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[14] AARP Public Policy Institute, Health Care Reform: What's at Stake for 50- to 64-Year-Olds?, March 2009.
[15] AHIP, "Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits," December 2007.
[16] AARP Public Policy Institute, Health Care Reform: What's at Stake for 50- to 64-Year-Olds?, March 2009.

- Addressing costs system-wide through prevention and wellness, care coordination, fighting fraud, waste, and abuse, and revising incentives to reward quality rather than quantity of care; and
- Ensuring that any cost-sharing obligations do not create barriers to needed care.

As Congress considers health care reform, several interrelated and complex issues will need to be decided to ensure that consumers receive quality, affordable health care coverage. For example:

Subsidies: The administration and amount of subsidies is critical. People need subsidies up front, rather than as after-the-fact tax credits that would leave many individuals unable to afford premiums while they wait for reimbursement. Subsidies should be set on a sliding scale so individuals and families pay no more than a certain percentage of incomes on out-of-pocket costs – including premiums. Those with more limited incomes should pay even less, with hardship exemptions for the poorest for whom any cost sharing can create insurmountable barriers to care.

Underwriting and Age rating: In general, AARP supports community rating, where insurers do not charge higher rates or deny coverage based on age or pre-existing conditions. However, we understand that banning age rating altogether would raise premiums for the young who now generally pay several times less than older people. We appreciate that some in the insurance industry are offering to no longer disqualify or increase premiums based on pre-existing conditions. If age rating is not also seriously constrained, insurers will likely charge higher rates to older people to substitute for rating based on medical condition – in which case older Americans will bear the brunt of the cost shift. Therefore, if any age differential is allowed it should be narrow – ideally no greater than 2-to-1. In addition, adequate subsidies will be necessary to ensure that age rating does not make coverage unaffordable for older Americans.

Mandates: Some are proposing that individuals be required to purchase insurance, and/or that employers be required to offer it. Mandates are appealing to many because they greatly reduce insurers' interest in underwriting based on age or health status and because they ensure that healthier individuals are included in the risk pool.

However, AARP can support mandates, but only with the assurance of adequate subsides. We cannot support mandated coverage that people cannot afford – subsidies must be adequate, available, secure and administratively feasible. In order to ensure that subsidies remain affordable and sustainable, we must also enact measures to manage skyrocketing costs while improving quality.

Exchange: There are important questions about how an Exchange would operate and the Federal Employees Health Benefit Program and the Massachusetts health reform model show this to be a viable option. An Exchange could function effectively at either a federal, regional, or state level, but there should be a clear standard federal benefit package that defines the benefits to be included (e.g. physician care; chronic care coordination; hospitalization, mental health, and drugs).

Protecting and Improving Medicare

Because health reform affects Americans of all ages, including those over 65 and those with insurance, coverage proposals must also improve quality and efficiency in Medicare. Medicare helps millions of older and disabled Americans, but many parts of this vital program need improvements. More than half of all beneficiaries have annual incomes below $20,000.[17] They spend on average about 30% of their out-of-pocket spending on health care – six times more than people with job-based coverage,[18] and those who lack supplemental coverage face bankruptcy from high medical bills because Medicare has no upper limit on cost sharing.

To ensure that Medicare is affordable and effective for beneficiaries, Congress should:

- Begin closing the Part D drug benefit's coverage gap (doughnut hole) in which beneficiaries must pay the full cost of drugs and act to lower drug costs through drug price negotiation, safe importation, creating a pathway for generic biologics and requiring drug companies to provide Medicaid rebates for dual eligibles in Part D;

[17] U.S. Census Bureau 2008 Current Population Survey, Annual Social and Economic Supplement, Table PINC-01.
[18] Health Affairs, Setting a Standard of Affordability for Health Insurance Coverage, June 4, 2007

- Establish a Medicare transitional care benefit to help patients transition from the hospital to their homes, which can prevent re-hospitalizations and reduce overall costs.
- Strengthen the patchwork of programs that help low-income beneficiaries afford prescriptions, premiums, and deductibles by raising the low-income threshold, eliminating asset tests that penalize people who did right thing and saved a small nest egg for retirement, making sure beneficiaries know these low-income programs exist, and simplifying the application process;
- Take steps to address racial and ethnic disparities in care by issuing comprehensive requirements for collecting racial and ethnic data, strengthening the Office of Civil Rights and providing resources to enforce language access requirements, ensuring adequate reimbursement for language services, and increasing cultural diversity and competencies in the health workforce; and
- Helping all beneficiaries with rising Medicare out-of-pocket costs by imposing a cap on catastrophic costs which would help people who have high hospitalization costs or who depend on costly medications such as cancer drugs.

Congress also needs to wring waste and inefficiencies out of Medicare – while improving quality and protecting beneficiaries – to keep it affordable for both beneficiaries and taxpayers. The Congressional Budget Office (CBO) has found that skyrocketing costs throughout our health system far outweigh growing enrollment from an aging population in driving unsustainable Medicare spending increases.[19] Without reform, Part B premiums – which have more than doubled since 2000 – will continue to far outpace Social Security cost of living increases.[20] The Medicare Trustees last year estimated that total expenditures will increase from $432 billion in 2007 to $882 billion in 2017, and that the Medicare hospital trust fund would be exhausted by 2019.[21]

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[19] Congressional Budget Office, *The Long-Term Outlook for Health Care Spending*, November 2007.

[20] Centers for Medicare and Medicaid Services, 2008 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Fund, Table V.C1 and V.C2.

[21] Centers for Medicare and Medicaid Services. 2008 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. Table III.A1.

The current economic crisis is deteriorating Part A Trust Fund solvency even further.

Fortunately, many proposals to improve quality in Medicare save money for both beneficiaries and taxpayers in the long run. These include:

- Revising payment incentives to rewarding quality rather than quantity of care;
- Bundling payments to increase efficiency and encourage coordinated care; and
- Implementing health information technology.

Proposals to reign in excessive payments to plans and providers also help to keep the program affordable.

A key step to wring out waste and inefficiency while improving quality would be to establish a transitional care benefit. A recent study found that one in five beneficiaries discharged from a hospital were back in the hospital within 30 days and about one-third were re-hospitalized within 90 days.[22] Half of those re-hospitalized within 30 days had not seen a physician since discharge, and Medicare spent $17.4 billion in 2004 on these largely preventable re-hospitalizations.

Under a transitional care benefit, for example, nurse-led interdisciplinary teams could reduce unnecessary hospital readmissions by ensuring that beneficiaries receive necessary follow-up services, supports, and education, coordinating communication among all members of the care team and management of medications, and supporting beneficiaries' family caregivers who coordinate their care.[23]

Addressing Chronic and Long-Term Care

A cornerstone of comprehensive reform is improving care coordination across all settings and ensuring access to home-and-community-based services (HCBS) so people can stay in their homes and out of costly institutions. This is essential for improving quality and achieving savings.

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[22] Jencks et al, *New England Journal of Medicine*, 360:1418-28, April 2, 2009.
[23] *American Journal of Nursing*: September 2008 - Volume 108 - Issue 9 p. 58-63.

More than 70 million Americans ages 50 and older – four out of five older adults – have at least one chronic condition.[24] People with chronic diseases often have difficulty with basic life activities such as bathing, dressing, or eating, and have significantly higher hospitalization rates and emergency room visits. Their health care spending (shared among patients and payers) is higher than that for people without a chronic disease.[25] CBO reports that about 75% of Medicare spending is for beneficiaries with five or more chronic conditions who see an average of 14 physicians each year.[26]

Uncoordinated care for people with chronic conditions results in poor quality, including costly medical errors and unnecessary tests and hospital and nursing home stays. This increases costs to individuals, family and other informal caregivers, as well as public and private payers. Additionally, Medicaid is the largest payer of long-term care (LTC) in this country, but it requires coverage of generally more costly institutional care and only covers HCBS at the states' option. Yet states that invest in HCBS can, over time, slow their rate of Medicaid spending on LTC.

Support for family caregivers, who often serve as "de-facto" care coordinators and are the backbone of the LTC system, is essential. Family members help loved ones get needed care while risking their own health and financial security to provide unpaid care – with an estimated economic value of about $375 billion in 2007.[27] Family caregivers can reduce Medicare inpatient expenditures, as well as expenditures for home health and skilled nursing facility care.

To improve care for those with multiple chronic conditions and/or LTC needs, health reform should:

- Encourage and support better care coordination across all settings;
- Work to keep individuals out of hospitals, emergency rooms, and nursing homes;
- Provide individuals with supports to live independently in their homes and communities;

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[24] AARP Public Policy Institute, Beyond 50.09, Chronic Care, A Call to Action for Health Reform.
[25] Ibid.
[26] Congressional Budget Office, *Budget Options Volume I: Health Care*, December 2008.
[27] AARP Public Policy Institute, *Valuing the Invaluable: The Economic Value of Family Caregiving*, 2008 Update, November 2008.

- Support family caregivers so they can help keep loved ones healthy at home;
- Improve Medicaid long term care coverage by making improvements in the Medicaid HCBS state plan option, raising income eligibility levels, providing an enhanced match and requiring spousal impoverishment protections for Medicaid HCBS;
- Better coordinate care and reduce costs for individuals eligible for Medicare and Medicaid; and
- Modernize Medicare funding for nursing education to ensure there are enough properly skilled nurses to coordinate the care of Medicare beneficiaries.

Conclusion

Various stakeholders continue to disagree on the specific provisions of comprehensive health care reform. More important, however, is the broad and growing consensus that we cannot allow these differences to stop us from finding common ground and enacting reform legislation this year. AARP and our Divided We Fail allies are working diligently to find workable solutions to bridge these differences, and we will continue to do so because we all understand that we cannot afford to fail. We cannot fix our broken economy if we do not fix our broken health care system, and we will all need to work together in order to succeed. We again commend this Committee's leadership and look forward to working with both sides of the aisle to make enactment of meaningful, comprehensive health reform a reality this year.

Statement for Roundtable Discussion
on
Health Care Coverage

Submitted by

Karen Ignagni
President and CEO
America's Health Insurance Plans

for the
Senate Finance Committee

May 5, 2009

I. Introduction

Chairman Baucus, Ranking Member Grassley, and members of the committee, I am Karen Ignagni, President and CEO of America's Health Insurance Plans (AHIP), which is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. Our members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

We thank the committee for holding this roundtable discussion on the topic of health care coverage, and we appreciate this opportunity to outline our proposals for addressing this priority. We also applaud President Obama for laying out a bold framework for comprehensive health care reform. We believe that legislation needs to be enacted and signed into law this year, and we are committed to playing a productive role in this debate.

In December 2008, AHIP announced a comprehensive proposal for moving the nation toward a restructured health care system that achieves universal coverage, reduces the growth of health care costs, and improves the quality of medical care. In March 2009, we announced our support for additional steps with respect to rating reforms, addressing the needs of small businesses, achieving cost containment, and reforming delivery and payment structures. Recognizing that the issues of coverage, affordability, and quality are interconnected, we believe they must be addressed simultaneously with market reforms that build upon the strengths of the current system and recognize that both the private sector and public programs have a role to play in meeting these challenges.

AHIP's proposals are the culmination of three years of policy work by our Board of Directors, which has focused on developing workable solutions to the health care challenges facing the nation. They also respond to the concerns and incorporate the ideas that were raised by the American people during a nationwide listening tour we conducted last year as part of AHIP's "Campaign for an American Solution." This listening tour included roundtable discussions involving Americans from all walks of life, including people with and without insurance, small business owners and their employees, union leaders and members, elected officials, and community leaders.

The statement we are submitting for this forum responds to issues on which the committee is seeking input and, additionally, discusses a series of comprehensive proposals we have developed in an effort to ensure that no one falls through the cracks of the U.S. health care system. These policy changes, if implemented in coordination with strategies to contain costs

and enhance value, will help build a high quality, affordable health care system for all Americans.

II. The Responsibilities of Individuals, Employers, Government, and Health Insurance Plans

Developments in the states demonstrate why it is important for individual market reforms to be pursued in conjunction with universal coverage. A report by Milliman, Inc. found that the enactment of guarantee issue and rating restrictions in the absence of an individual coverage requirement allows people to defer seeking coverage until they have health problems – a situation which unfairly penalizes those who are currently insured and raises premiums because the costs of caring for the uninsured are shifted by providers to people who have coverage. According to the Milliman report, states that implemented these guarantee issue and rating restriction laws without adopting a policy that requires all individuals to participate in the system, experienced a rise in insurance premiums, a reduction of individual insurance enrollment, and no significant decrease in the number of uninsured.

The approach we are proposing recognizes that it is necessary to bring everyone into the system to make guarantee-issue coverage work. It also emphasizes that all stakeholders have a role to play in helping the nation transition to a high quality, affordable, patient-centered health care system.

Because we believe health insurance plans have a responsibility to advance meaningful reforms, our members have demonstrated strong leadership in proposing specific policy solutions that directly address the challenges of coverage, quality, and affordability. Our proposals include a strong focus on issues within our sector – including insurance market reforms – that need to be addressed by any comprehensive strategy for health care reform.

Additional responsibilities lie with the federal government, which needs to maintain a strong health care safety net for persons who are financially vulnerable and provide assistance to make coverage affordable for working families. The government also has a responsibility to improve regulatory structures to strengthen consumer protections and promote innovation and competition, while ensuring that regulations are clear, consistent, and equitable across the states.

Employers have long played an important role in offering a range of health insurance options to their employees. Under the reforms we are proposing, we envision a system in which employers will continue to view employee health benefits as a valuable tool for attracting and retaining a skilled workforce.

Finally, within the context of a modernized health care system that offers affordable coverage options, we believe consumers have a personal responsibility to obtain health coverage. An April 2009 survey by Hart Research, conducted on behalf of AHIP, found that 72 percent of respondents would support a requirement for all Americans to have health insurance coverage, provided that two conditions are met: (1) the government provides tax credits or other financial assistance to make coverage affordable; and (2) health insurance plans are prohibited from denying coverage or charging higher premiums for persons with pre-existing conditions.

III. The Role of Public Programs

Improving the public safety net is an important priority that must be addressed in the health care reform debate. We strongly supported the funding that is committed to this priority by H.R. 2, the "Children's Health Insurance Program Reauthorization Act of 2009" (CHIPRA). We also support extending Medicaid eligibility to all individuals with incomes at or below 100 percent of the Federal Poverty Level. In addition, adequate support should be provided to community health centers, recognizing the critical role they play in providing access to services for vulnerable populations and to ensure they can continue this role in the future.

To achieve comprehensive health care reform, AHIP has proposed a plan that provides universal coverage, cost containment, and quality improvement. Our plan focuses on fundamentally overhauling regulation in the marketplace, improving information and transparency for consumers, taking bold steps to ensure that coverage is affordable, and clearing obstacles to the next generation of quality improvement innovations. As discussed below, this strategy would achieve universal coverage *without* jeopardizing quality improvement initiatives that are working in the system today, *without* exacerbating cost shifting already occurring, and *without* undermining employer-based coverage.

In addition to recognizing that a new public plan is not necessary to achieve successful health care reform, we believe it is important for policymakers to consider the unintended consequences that could result from establishing a public plan to compete against existing private health insurance plans under a reformed health care system. To illustrate our concerns about how we move toward an integrated, high quality, health care delivery system under a public plan option, the committee should consider the success of the private market in offering innovative care management programs, and the difficulty associated with achieving similar results in a new government plan.

Medicare has not effectively coordinated care, addressed chronic illness, or encouraged high performance. The private market has a well-established infrastructure in place that is moving rapidly to collaborate with providers on new models that promote value and enhance quality. As noted in the recently released AHIP publication, *Innovations in Recognizing and Rewarding Quality*, plans are implementing strategies that reward physicians and hospitals for achieving national benchmarks, demonstrating outstanding performance, and making measureable improvements over time.

IV. Ensuring Portability and Continuity of Coverage for Consumers in the Individual Market

We are proposing to combine guarantee-issue coverage with an enforceable individual health insurance requirement and premium assistance to make coverage affordable, while eliminating preexisting condition exclusions and eliminating rating based on health status in the individual market.

We envision a rating system based on the following demographic factors: geography, age, and product type. The product type factor addresses the issue that the actuarial value of benefits differs across products reflecting, for example, differences in co-pays and deductibles and differences in provider reimbursement rates (i.e., the cost differences that would exist if the same person were to enroll in one plan versus another). We also encourage Congress to provide flexibility for plans to offer premium discounts to individuals who make healthy choices, such as not smoking, participating in wellness programs, and adhering to treatment programs for chronic conditions.

Another key element of our proposal calls for premium assistance to ensure that coverage is affordable for lower-income individuals and working families. We are proposing refundable, advanceable tax credits that would be available on a sliding scale basis for those earning less than 400 percent of the Federal Poverty Level. Additional steps are needed to promote tax equity for individuals purchasing health insurance on their own.

V. Helping Small Business Provide Health Care Coverage More Affordably

Small business owners find themselves in an increasingly difficult marketplace for health insurance because of constantly rising health care costs and the limited ability of most small businesses to bear risks, contribute a substantial share of costs, or support administrative

functions. A policy statement approved by AHIP's Board of Directors in March 2009 outlines solutions, some of which also apply to individuals, for helping small businesses:

- **Essential Benefits Plan:** We propose the creation of new health plan options that are affordable for small employers and their employees, as well as individuals. These "essential benefits plans" would be available nationwide and would include coverage for primary care, preventive care, chronic care, acute episodic care, and emergency room and hospital services. Alternatively, "essential benefits plans" should include coverage that is at least actuarially equivalent to the minimum federal standards for a high-deductible health plan sold in connection with a health savings account, along with the opportunity to include enhancements such as wellness programs, preventive care, and disease management. Allowing benefit packages to vary based on actuarial equivalence is crucial to ensure that any package can evolve based upon new innovations in benefit design and the latest clinical evidence. To maintain affordability, the essential benefits plan should not be subject to varying and conflicting state benefit mandates (and that do not apply to the generally larger employers that enter into self-funded health care coverage arrangements).

- **Tax Credits or Other Incentives to Assist Small Business:** We support the establishment of tax code incentives or other types of assistance that encourage both small business owners to offer coverage to their employees and employees to take up coverage. We recognize the special challenges, both administrative and financial, that small businesses face in offering contributions toward their employees' coverage. Providing assistance can encourage these contributions and help enable employees to take up coverage which improves predictability and stability in the small group market.

- **Improving Coordination of Private and Public Programs Strengthens Small Group Coverage:** Premium or other assistance offered to low-income individuals and working families can be applied to and work with employer-sponsored coverage. This is important whether the assistance is provided through Medicaid, the Children's Health Insurance Program (CHIP), or other expanded programs designed to help individuals and families obtain coverage. Improved coordination allows workers to take up coverage offered by small businesses by leveraging both public and private sources of assistance, and benefits the firms' employees as a whole by increasing rates of participation in the small group plan.

- **Micro-firms:** "Micro-firms" (those with fewer than 10 employees) face special challenges in offering coverage. Statistics show that only about one-third of these firms offer coverage. This reflects the administrative, financial, and logistical challenges many micro-firms face in setting up and establishing plans and offering and contributing to their employees' coverage. To help these firms meet these challenges, enhanced tools could be developed that would

allow those micro-firms that have found it impractical to offer coverage, to contribute to coverage purchased on a pre-tax basis by individual employees. As part of comprehensive health care reform, employees could then use these contributions to help purchase coverage in a reshaped health care system that combines an individual requirement to obtain coverage with reforms in the individual market.

- **One-stop information source:** All small firms will benefit from collaborative efforts between health plans and the public sector (e.g., insurance commissioners) to ensure that small employers and individuals have one-stop access to clear, organized information that allows them to compare coverage options. This "one-stop shop" also could allow individuals to confirm eligibility for tax credits or other assistance and even provide a mechanism to aggregate premium contributions from multiple sources. By providing a mechanism to combine even modest contributions from multiple sources (public and private), this new one-stop shop could be especially helpful to employees who may hold multiple jobs.

VI. Strengthening the Large Group Market

We support building upon the existing employer-based system, which currently covers 177 million Americans according to the U.S. Census Bureau. It is a key part of our economic fabric. Although the employer-based system faces challenges, more than 90 percent of employers report that offering high-quality coverage is important to their ability to recruit and retain valuable workers and enhance employee morale. Thus, as a first priority, the nation's reform agenda should be committed to a policy that "first does no harm" to that system and limits strategies that would reduce employer coverage. Focus should be placed on retaining a national structure for the large group market that continues to promote uniformity and ensures the smooth functioning of the employer-based system.

At the same time, the nation's economic uncertainties and job losses underscore the need for new strategies to assist individuals who become unemployed or are transitioning from job to job. While a Congressional Budget Office (CBO) study found that nearly 50 percent of the uninsured go without coverage for four months or less, additional protections are still needed. We propose ensuring that tax credits are available to individuals on an advanceable basis to help them through job transitions along with access during these times to more affordable coverage options consistent with our proposal for a basic benefits plan.

VII. Structural Changes Needed for a Reformed System to Function Better

Employers and individuals may find the current system difficult to navigate with a lack of simple, streamlined information about multiple coverage and care options and related assistance programs. To address this concern, we are proposing modifications to introduce greater simplicity to the system through technology and regulatory reform. These proposed efforts will benefit all participants in the health care system and, at the same time, help a reformed health care system function better.

In our December 2008 Board statement, we emphasized that any health care reform proposal should include recommendations to streamline administrative processes across the health care system. Success will require advances in automating routine administrative procedures, expanding the use of decision support tools in clinical settings, and implementing interoperable electronic health records. Using technology to help streamline administrative processes will improve care delivery, enhance the provider and patient experience, and speed claims submission and payment. Done right, streamlining can also help reduce costs system-wide, leading to improved affordability.

As part of this effort, we have committed to developing a multi-payer online portal to give providers a uniform method to communicate with health plans and afford them access to current information on eligibility and benefits. This will ease the administrative challenges that physicians and other providers face, and will help them and their patients better understand coverage and predict out-of-pocket costs. We also are working with providers on a standard data aggregation approach with the goal of giving providers and consumers useful performance information. Administrative streamlining should be viewed through the eyes of consumers, with the goal of making the health care system easier to navigate and more consumer friendly. A key part of this effort is our focus on the reform of market rules to enhance access for consumers and provide them with clear, useable information on coverage and care options.

Another important priority is to rethink regulatory structures to make them work better and provide for a more consistent approach in areas such as external review, benefit plan filings, and market conduct exams. In a reformed market, policymakers should be driven by striking a balance between the traditional roles of the federal government and the states, and the objectives of achieving clearer and "smarter" regulation that promotes competition and avoids duplication of existing functions. Greater consistency in regulation and focusing on what works best will enhance consumer protections across states and help improve quality, increase transparency, and increase efficiency leading to reduced administrative costs.

VIII. Confronting the Cost-Shifting Surtax and Moving Toward a System That Pays for Value Rather than Volume

As part of any national health care reform initiative, Congress must address the fact that reducing outlays in one area inevitably means shifting costs elsewhere. Underpayment of physicians and hospitals by public programs shifts tens of billions in annual costs to those with private insurance. A December 2008 study by Milliman, Inc. projects that this cost shifting essentially imposes a surtax of $88.8 billion annually on privately insured patients, increasing their hospital and physician costs by 15 percent. This study concluded that annual health care spending for an average family of four is $1,788 higher than it would be if all payers paid equivalent rates to hospitals and physicians. The transfer of these costs to those with private coverage cannot be sustained and is critical to addressing concerns over affordability.

The impact of cost-shifting is dramatically illustrated by the tables below, which use real data showing that hospitals in California recorded significant losses in 2007 by serving Medicare and Medicaid beneficiaries. These losses are offset, however, by higher costs charged to commercial payers. This cost shifting translates into higher premiums for working families and employers.

Hospital Net Income Figures in California (millions)

Year	*Medicare and Medicaid*		*Commercial*		*Total*	
	DSH	Non-DSH	DSH	Non-DSH	DSH	Non-DSH
2001	256	(1051)	137	1621	(825)	853

Hospital Payments to Non-DSH Hospitals Relative to Costs in California (percentages)

Year	*Commercial*	*Medicare*	*Medicaid*
2001	117	98	67
2007	142	85	56

Non-DSH Hospital Margins in California (billions)

Year	*Commercial*	*Medicare*	*Medicaid*
2001	2.0	(0.2)	(0.9)
2007	6.2	(2.4)	(1.9)

In addition, the U.S. currently spends approximately $50 billion each year to provide health services to those without coverage, leading to high levels of uncompensated care. This too results in cost-shifting to those with coverage in the form of higher premiums and other related costs. According to a 2005 Families USA study, the cost-shift due to uncompensated care adds $922 annually to family premiums. When these costs associated with uncompensated care are combined with the cost shifting that results from the underfunding of Medicare and Medicaid, the impact for families with private coverage is an overall surtax of $2,710 annually due to cost-shifting.

Ultimately, the success of health reform and getting all Americans covered will depend upon implementation of strategies that enhance value by improving quality and reducing costs, in conjunction with key insurance market reforms. Only by realigning incentives that drive improved outcomes will the system be placed on a long-term sustainable path. As noted earlier, a recent AHIP publication, entitled "Innovations in Recognizing and Rewarding Quality," highlights key private sector initiatives that have been implemented throughout the country to move the system toward a value-based structure. This publication demonstrates that innovative care coordination programs that enhance outcomes and reform payment incentives are in place in a private market with appropriate infrastructure, which is often lacking in public programs, to reform the health care system.

IX. Conclusion

AHIP appreciates this opportunity to outline our suggestions for extending health care coverage to all Americans as part of a comprehensive health care reform package. Our complete set of policy proposals – including innovative strategies to contain costs and improve quality – are outlined in a series of Board statements we have released since December 2008. We are strongly committed to working with committee members and other stakeholders to develop solutions for ensuring that all Americans have access to high quality, affordable health care coverage.

Michael F. Jacobson, Ph.D. Executive Director
Center for Science in the Public Interest

Senate Finance Committee
Roundtable Discussion on Financing Comprehensive Health Care Reform
May 12, 2009

Health Care Reform: *Prevention* is Essential

1875 Connecticut Avenue, NW, Suite 300 • Washington, DC 20009-5728 • tel 202 332 9110 • fax 202 265 4954 • www.cspinet.org

Executive Summary

To promote health and reduce health-care costs, health-reform legislation should include strong, specific prevention measures. This testimony focuses on employing five long-neglected, high-leverage, diet-related means of preventing chronic diseases; treating serious diseases in a more economical, yet still effective, manner; and levying taxes that would both promote health and generate revenues that could help fund expanded health-care coverage.

1. Raise Taxes on Alcoholic Beverages

Because alcoholic beverages are a major cause of illness, addiction, death, injury, and psychosocial problems, Congress should raise alcohol excise taxes, tax all products equally on the basis of their alcohol content, and index tax rates for inflation. Boosting the tax on distilled spirits by 50 percent and equalizing the beer and wine rates would generate $12 billion in new revenues annually. Simply adjusting tax rates for the inflation that has eroded revenues since the last increase (in 1991) would raise $5 billion in new revenues per year. Higher taxes and prices would dampen alcohol consumption and lead to additional health-care and other cost savings to the federal government and to the economy generally.

Federal revenues generated - $5 billion to $12 billion/year

2. Tax Soft Drinks

Because soft drinks have been a major contributor to obesity in recent decades, and because obesity is a major cause of diabetes, hypertension, strokes, heart attacks, and cancer, Congress should impose a new excise tax on non-diet soft drinks, including both carbonated and non-carbonated beverages. A tax of one cent per 12-ounce can would raise about $1.5 billion per year; a tax of one cent per ounce would raise about $17 billion per year. The higher rates would reduce consumption and help slow the obesity epidemic.

Federal revenues generated - $1.5 billion to $17 billion/year

3. Get Artificial Trans Fat out of Foods

Because artificial trans fat (from partially hydrogenated oil) is a potent cause of heart disease, Congress should pass legislation to eliminate artificial trans fat from our food supply, thereby saving lives and health-care dollars. While much trans fat has already been eliminated, removing the remaining roughly one-third would save about 15,000 to 25,000 lives and $2 billion in direct medical costs annually.

Cost savings to the federal government - $2 billion/year

4. Reduce Sodium Levels in Packaged and Restaurant Foods

Because it raises blood pressure and increases the risk of hypertension, strokes, heart attacks, and kidney disease, salt is arguably the most harmful ingredient in our food supply. Gradually

reducing sodium levels in packaged and restaurant foods by half would ultimately save an estimated 150,000 lives and billions of dollars annually. Congress should pass legislation to require the Secretary of Health and Human Services to develop and implement a plan for a 50 percent reduction in the sodium content of the food supply over no more than 10 years.

Cost savings to the federal government – $9 billion/year in direct medical costs (for about an average 25% reduction in sodium levels over 10 years)

5. Reduce Medical Costs through Lifestyle Treatment of Heart Disease

The medical and surgical treatment of chronic diseases is a major cause of high health-care costs. In some cases, though, equally or better patient outcomes result from relatively inexpensive modification of lifestyle, particularly diet, exercise, and smoking, which could save several tens of billions of dollars annually. Studies have demonstrated that intensive lifestyle counseling of patients with heart disease can often substitute for costly angioplasties and coronary artery bypass procedures.

Cost savings to the federal government **- $21 billion/year in direct medical costs**

The proposed measures would generate total savings or income to the federal government of $38 billion to $61 billion per year.

Health Care Reform: Prevention is Essential

As Congress develops legislation to ensure that all Americans have access to quality health care, it is critical that Congress include a strong prevention title. Preventing illness is the best way to promote health and hold down costs. The preventive approach must become the default—from breastfeeding the young to physical activity among the old. Indeed, considering the soaring costs of medical care, funding expanded coverage (or even maintaining current levels of coverage) will be impossible without making a comprehensive effort to prevent illnesses and, in some cases, treat them more economically.

While "prevention" covers everything from immunizations to seat-belt usage, this memorandum focuses on neglected diet-related means of preventing chronic diseases; treating them in a more economical, yet still effective manner; and generating revenues that could help pay for prevention activities and expanded health-care coverage. The measures discussed are "high-leverage," because they offer a significant health or revenue benefit at little or no net cost to government.

I. Generating New Revenues to Fund Health Care

A. Raise Excise Taxes on Alcoholic Beverages

Congress has long considered it appropriate to tax alcoholic beverages, which are responsible for widespread and severe health problems: about 85,000 deaths[1] and $185 billion in societal costs annually.[2] For the first 120 years or so of our nation's existence, taxes on alcoholic beverages were the major source of revenues. The federal government (and every state) still taxes alcoholic beverages, but now those revenues account for less than 0.4 percent of total revenues[3] (down by half from the percentage in 1992). The federal government currently receives about $9 billion annually from alcohol excise taxes.

The tax rates on alcoholic beverages have been raised only twice since 1951, most recently in 1991. Since then, inflation has robbed the Treasury of more than one-third the value of the taxes—and, year by year, alcoholic beverages have become relatively cheaper.

To compensate society for the costs of alcohol abuse and alcoholism and to marginally reduce problem drinking, Congress should raise taxes on alcoholic beverages and tax the alcohol in all products equally. For instance, boosting the tax on distilled spirits by 50 percent to $20.25 per proof gallon and boosting the beer and wine rates to that level would generate $12 billion in new revenues annually. (Other scenarios would yield smaller revenues: adjusting for inflation since 1991 would generate about $5 billion; adding five cents per drink would generate about $6 billion; raising the liquor tax from $13.50 to $16 per proof gallon and equalizing beer and wine tax rates would generate about $7.5 billion.) Congress should include an annual inflation adjustment to prevent the inexorable erosion of tax revenues by inflation.

Raising alcohol taxes would marginally reduce alcohol consumption and problem drinking. The highest tax increase suggested above would reduce consumption by several percent. That would

lead to less drinking, less harm associated with problem drinking, and cost savings for our health-care system.

Some parties (usually industry) express concern about the regressivity of alcohol taxes, but the actual problem is much exaggerated. In fact, compared to upper-income consumers, lower-income families buy much less alcoholic beverages. People in the lowest quintile of incomes consume only 8 percent of alcoholic beverages; those in the top quintile consume 38 percent.[4] Overall, only 1 percent of Americans' total expenditures are for alcohol, regardless of income.[5]

Most people would be little affected by higher alcohol taxes. More than one-third of adults do not drink at all, and half of all drinkers drink sparingly.[6] For instance, using the highest-increase scenario discussed above, half of all beer drinkers would pay less than $10 per year—under three cents a day—in new taxes.[7] Because alcohol consumption is heavily concentrated among the top 20 percent of drinkers who consume 85 percent of all the alcohol, most of the tax increases would be paid by those who drink excessively.[8] Using some of the revenues for alcoholism treatment, prevention, and public education would further reduce the toll of alcohol problems and would probably disproportionately benefit low-income problem drinkers. Opinion polls show that a strong majority of Americans supports alcohol tax increases, particularly when the revenue supports alcohol prevention and treatment programs.[9]

Raising alcohol excise taxes is well-justified, painless for the vast majority of consumers, and good for public health.

Recommendation:

Congress should raise taxes on alcoholic beverages and tax the alcohol in all products equally. Boosting the tax on liquor by 50 percent (from $13.50 to $20.25 per proof gallon) and equalizing the beer and wine rates would increase revenues by $12 billion annually, or $120 billion over 10 years. The tax rates should be indexed for future inflation.

B. Tax Soft Drinks

More than two-thirds of Americans are overweight or obese.[10] While many factors promote weight gain, soft drinks are the only food or beverage that has been shown to increase the risk of overweight and obesity, which, in turn, increase the risk of diabetes, stroke, and many other health problems.

Soft drinks are nutritionally worthless, but add a lot of calories to the diet. Several scientific studies have shown that soft drinks are directly related to weight gain, partly because beverages are more conducive to weight gain than solid foods.[11,12,13] And countless studies have shown that excess weight is a prime risk factor for type 2 diabetes, heart attacks, strokes, cancer (colon, breast, and others), sleep apnea, and many other problems. Frequent consumption of soft drinks also contributes to osteoporosis, tooth decay, and dental erosion.[14]

Americans spend $90 billion a year on medical expenditures related to obesity, of which half is paid with Medicare and Medicaid dollars.[15] While obesity should be addressed through a wide

variety of actions, one action would be for governments to levy a tax on soft drinks to recoup some of those expenses. The revenues could help fund health care, but also should be used to support programs to promote healthy diets and exercise. Besides providing revenues, depending on the rate, a tax might marginally affect consumption and slow the obesity epidemic.

Beverage companies market more than 14 billion gallons of calorie-laden soft drinks annually.[16] That is equivalent to about 506 12-oz. servings per year, or 1.4 servings per day, for every man, woman, and child. Those figures include non-diet carbonated sodas, energy drinks, sports drinks, fruit drinks, and ready-to-drink teas.

Many state governments have recognized that soft drinks do not deserve to be treated, for tax purposes, like ordinary foods. States as diverse as Arkansas and California, New York and West Virginia, along with others plus the City of Chicago, have imposed special excise or sales taxes on soft drinks to generate revenues. Those taxes are too small to reduce consumption, but collectively they generate over a billion dollars a year in revenues.

A federal excise tax on soft drinks would not prohibit people from buying sugary beverages. And people could avoid the tax by switching to diet sodas, tap or bottled water, seltzer, or low-fat milk, and benefiting their health in the process.

A federal tax of one cent per 12-ounces would raise about $1.5 billion annually. A tax of one cent per ounce, as suggested recently by New York City Health Commissioner Tom Frieden and Yale obesity expert Kelly Brownell, would raise about $17 billion per year.[17]

Lower-income consumers would be especially affected by a soft-drink tax. However, they would be especially *helped* by any health-care or prevention programs funded by the taxes and by the health benefits from drinking less soda.

Recommendation:

Congress should impose an excise tax on non-diet soft drinks, both carbonated and non-carbonated. A tax of one cent per 12-ounce can would raise about $1.5 billion annually; a tax of one cent per ounce would raise about $17 billion per year, reduce consumption, and slow rising rates of obesity.

II. Reducing Health-Care Costs by Preventing Cardiovascular Disease

A. Get Artificial Trans Fat out of Foods

Artificial trans fat is a potent, and totally unnecessary, cause of heart disease and also appears to contribute to diabetes and obesity. Trans fat is produced when an oil is "partially hydrogenated" to make it more solid, like traditional margarine or shortening.

In 2006, Harvard School of Public Health researchers estimated that each year trans fat was causing 72,000 to 228,000 heart attacks,[18] including roughly 50,000 fatal ones.[19] Fortunately, because of several factors—food labeling, local and state (including California and New York City) laws phasing out artificial trans fat from restaurants, litigation, and massive publicity—the toll is probably two-thirds smaller today. The remaining trans fat may be causing "only" about 15,000 to 25,000 deaths annually.

The FDA rejected the Center for Science in the Public Interest's 2004 petition to require restaurants to disclose the presence of trans fat in their foods and has not responded to a second 2004 petition asking that partially hydrogenated oils no longer be considered Generally Recognized As Safe (GRAS), but regulated as food additives and severely restricted in foods. Because of that inactivity, it is time for Congress to protect the public's health.

Recommendation:

Congress should pass legislation to largely eliminate the partially hydrogenated oil – and artificial trans fat – from our food supply. That would save about 15,000 to 25,000 lives and $2 billion annually.

B. Reduce Sodium Levels in Packaged and Restaurant Foods.

Salt—sodium chloride—is arguably the most harmful ingredient in our food supply. While a small amount of sodium is necessary for health, the large amount in the typical diet is a major cause of high blood pressure (hypertension), heart attacks, and strokes.

Sodium reduction is especially important for the 65 million American adults who have high blood pressure[20] and the 45 million who have pre-hypertension.[21] Ultimately, about 90 percent of Americans develop hypertension.[22] African Americans experience a 60 percent greater rate of hypertension and a 40 percent higher rate of stroke deaths than the general population.[23]

The government's Dietary Guidelines for Americans states that people with hypertension, people who are middle-aged or older, and African Americans should consume no more 1,500 milligrams (mg) of sodium daily.[24] Those groups account for about 70 percent of the population.[25] Other adults should consume no more than 2,300 mg of sodium (about a teaspoon of salt). Unfortunately, the average adult consumes about 4,000 mg per day, or twice the recommended level.[26] Only about 10 percent of that comes from the salt shaker, and about the same percentage occurs naturally.[27] Three-quarters of all sodium comes from the salt (and other sodium-containing additives) in processed and restaurant foods.

The extraordinary importance of lowering sodium consumption was highlighted in a 2004 paper coauthored by the Director of the National Heart, Lung, and Blood Institute (NHLBI) and two colleagues.[28] They estimated that reducing the sodium content of packaged and restaurant foods by 50 percent would prevent about 150,000 deaths due to cardiovascular disease per year.

Reducing sodium consumption also would save billions of dollars in medical costs. A preliminary RAND Corp. study estimates that reducing sodium consumption by 1,100 mg per

day (about one-fourth of average intake) would reduce medical costs by $18 billion per year. A reduction of 1,900 mg per day was estimated to reduce costs by $26 billion per year. About half of those savings would accrue to the federal government.

Consuming less sodium is one of the single most important—and feasible—ways to prevent cardiovascular disease. Indeed, the United Kingdom has made salt reduction a top priority and is both educating consumers about excessive salt intake and pressuring the food and restaurant industries to lower sodium levels to specified targets. The first interim survey found about a 9 percent reduction in sodium intake (the five-year goal is 33 percent). The U.S. government should be at least as aggressive in protecting the public's health as the U.K. government.

Recommendation:

Congress should pass legislation to require the Secretary of Health and Human Services to develop and implement a plan to reduce the sodium content of the American diet over the next 10 years to the levels, and by means of strategies, recommended by the Institute of Medicine and other authorities.

III. Reducing Medical Costs through Lifestyle Treatment of Heart Disease

The medical and surgical treatment of chronic diseases is a major cause of high health-care costs. In some cases, though, equal or better patient outcomes result from relatively inexpensive modification of lifestyle, particularly diet and exercise. Much greater use of lifestyle treatments would save the federal government several tens of billions of dollars annually.

According to the American Heart Association, each year more than one million angioplasties are performed at an average cost of about $50,000 each, and almost half a million coronary artery bypass grafts are performed at an average cost of about $100,000 each.[29] The total annual cost of just those two procedures is about $100 billion—much of which is avoidable.

Studies have demonstrated that intensive diet-lifestyle counseling of patients with heart disease can often alleviate the need for costly angioplasties and coronary artery bypass procedures.[30] From the heart patient's perspective, lifestyle therapy is far more benign than bypass surgery: nutritious meals and invigorating walks substitute for general anesthesia, major invasive surgery, possible brain damage from the heart-lung machine, and a two percent chance of dying on the operating table. Surgery provides relief from chest pain (angina), but little, if any, increase in life expectancy. In contrast to angioplasties and bypasses, a diet-lifestyle approach reverses the underlying atherosclerosis in the entire circulatory system—without side effects and at low cost.

Lifestyle interventions provide tremendous savings to the health-care system. One study with health-insurance providers found that the average savings in the mid-1990s from lifestyle intervention was $29,500,[31] or $49,000 when adjusted to 2009 dollars.[32] Because of such proven savings, Medicare now provides reimbursement for lifestyle interventions. The same diet-

lifestyle approach can also often treat hypertension and diabetes, two other costly medical conditions that predispose to cardiovascular disease and premature death.

Inadequate reimbursement is a major barrier to wider use of intensive lifestyle treatment. The Centers for Medicare & Medicaid Services (CMS) (as well as a few private insurers) offers reimbursement for lifestyle interventions, but the rates (on the order of $30 per hour or less[33]) are far too low to encourage doctors to prescribe and hospitals to encourage such interventions. Surgical and medical approaches are simply far more remunerative to the medical system.

Another barrier is that many doctors are not sufficiently familiar with lifestyle interventions to discuss them with patients. Medical schools and residency programs have simply failed to teach that fundamental part of human medicine, and probably won't without legislative action to normalize lifestyle interventions.

To overcome one of those barriers, Washington State is sponsoring a demonstration project to encourage patients to make "genuinely informed, preference-based treatment decisions."[34] An alternative approach proposed in a bill in the California Assembly would require physicians to inform their patients of the option of intensive lifestyle therapy for heart disease or diabetes, "including a description of the potential risks, consequences, and benefits of this treatment relative to other medical treatment options."[35]

We estimate that if only half of the patients scheduled for surgery opted instead for (but did not always succeed with) lifestyle treatment, the savings would amount to $43 billion per year. About half of those savings, or $21 billion, would accrue to the federal government. Substantial savings also could be obtained from using lifestyle interventions to treat diabetes, hypertension, and other conditions. Private insurers and their policyholders also would benefit from offering patients treatment through relatively inexpensive, but effective, lifestyle changes.

Recommendation:

To reap the cost-savings from lifestyle interventions, health-reform legislation should include measures to overcome several existing obstacles:

- **Congress should set higher reimbursement rates. Even large increases would still save CMS substantial amounts of money per patient.**
- **Congress could require that (a) doctors seeking reimbursement through Medicare and Medicaid for treatment of heart disease and specified other illnesses provide patients with objective information about lifestyle interventions, and (b) hospitals at which heart surgeries are done frequently establish and promote programs for intensive lifestyle treatment.**
- **To hold down non-governmental medical costs, Congress should require all health insurers to provide adequate reimbursement for lifestyle-change programs and require physicians to provide patients with object information about that approach.**

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May 13, 2009

Senator Jim Bunning
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Washington, D.C. 20510

Dear Senator Bunning:

During the Finance Committee Roundtable on May 12 you asked for information regarding alcohol excise taxes, in particular data related to claims of massive job losses following the last increase in federal alcohol taxes in 1991. At that time, the tax rate on distilled spirits rose from $12.50 to $13.50 per proof gallon, or about 8%.

CSPI has examined relevant employment data from the Bureau of Labor Statistics, and we conclude that alcoholic-beverage industry claims of job losses associated with tax increases are wildly exaggerated. According to that data (a summary of which is enclosed), few jobs were lost in the industry (temporarily), or job losses had been occurring for years before taxes increased. In all likelihood, job losses at that time were recession-related, rather than caused by the first federal tax increases on beer and wine in 40 years, and only the second during that period on liquor.

Please let us know if you would like additional information.

Sincerely,

Michael F. Jacobson, Ph.D.
Executive Director

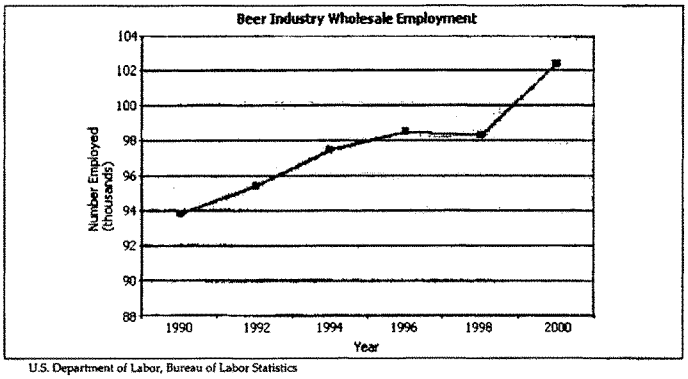
1875 Connecticut Avenue NW Suite 300 • Washington DC 20009-5728 • tel 202 332 9110 • fax 202 265 4954 • www.cspinet.org

Beer-Industry Jobs

Beer-Industry claims that tax increases have destroyed jobs are not supported by the facts

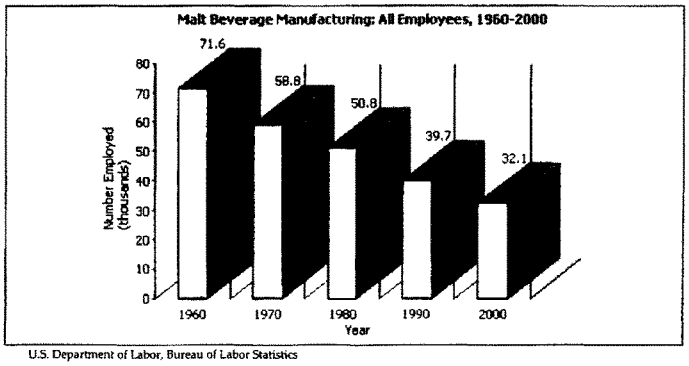
Beer industry spokesmen claim that increases in beer taxes harm the economy, punish consumers and the industry, and lead to massive reductions in employment. The Beer Institute's website **[http://beerinstitute.org/pp_fedexcisetax.htm]** asserts that "the doubling of the beer tax in January 1991, from $9 to $18 per barrel" displaced 31,000 workers. Official data from the U.S. Department of Labor flatly contradict this claim.

Between 1990 and 2000, beer industry wholesale trade employment rose by more than 8,000 jobs, including increases between 1990 and 1992 (a year before and after the tax increase).



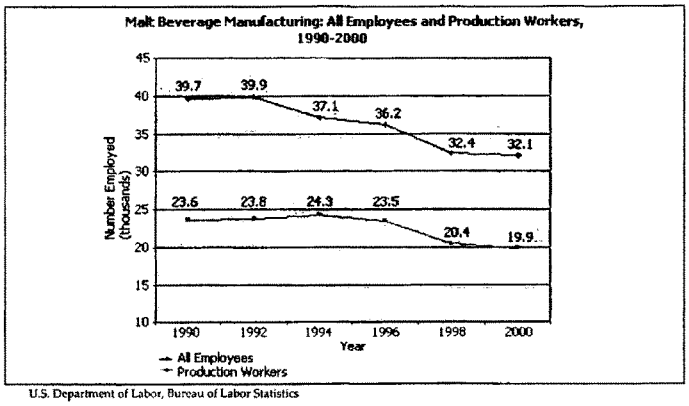
U.S. Department of Labor, Bureau of Labor Statistics

Employment at the manufacturing level declined by 7,600 between 1990 and 2000. However, that decline clearly represents a steady reduction in jobs that began before 1960. Since then, those jobs have been cut in half (from some 70,000 in 1960 to 32,100 in 2000). According to the Bureau of Labor Statistics, manufacturing jobs held steady between 1990 and 1992 at close to 40,000, then fell again between 1992 and 1998. These job reductions have resulted from increased mechanization and other efficiencies, as well as the dramatic consolidation within the beer industry during the past decades; not from beer tax increases! The graph below shows a steady decline in beer-industry manufacturing jobs since 1960.



U.S. Department of Labor, Bureau of Labor Statistics

The graph below illustrates that jobs in the manufacturing sector of the beer industry declined from 39,700 to 32,100 between 1990 and 2000. The number of production workers held steady between 1990 and 1995.



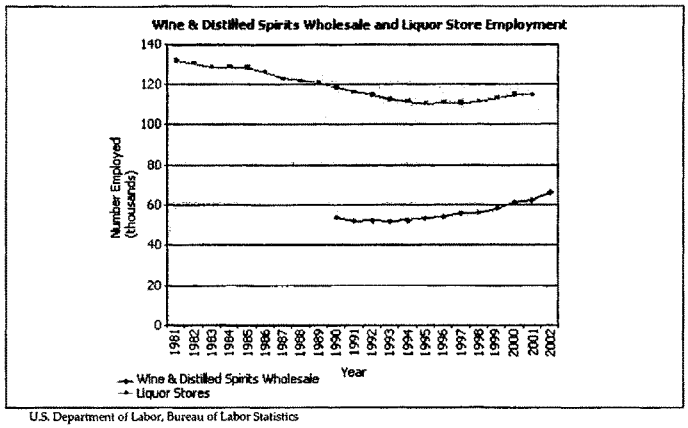
U.S. Department of Labor, Bureau of Labor Statistics

We calculate a net gain in beer-industry jobs following the 1991 federal beer-tax increase. However, even if jobs had been lost, other factors may have contributed strongly to the losses in the beer sector. For example, national unemployment went from 5.6% in 1990 to 7.5% in 1992 (hardly the result of the beer-tax increase). A recessionary economy helped depress sales of beer; and growing concern about health and safety concerns related to drinking may have moderated consumption. In any case, jobs lost to the beer industry would likely have been created elsewhere in the economy, as money not spent on beer flowed to other goods and services. In fact, as beer consumption decreased between 1990 and 1992 (from 27.5 to 25.9 gallons per capita – USDA/Economic Research Service), per capita consumption of bottled water rose from 8.0 to 8.2 gallons, carbonated soft drinks rose from 46.2 to 48.2 gallons, fruit juices from 7.9 to 8.4 gallons, fruit drinks from 6.3 to 6.5 gallons, and canned and bottled iced tea from 0.1 to 0.2 gallons. Arguably, retail employees at groceries and convenience stores, who had previously been handling more beer, then began handling more non-alcoholic beverages instead.

Other Employment Facts

According to the U.S. Department of Labor, grocery store employment declined by approximately 33,000 jobs between 1990 and 1992 (consistent with overall job loss in the economy), but rebounded in 1993. Those jobs have increased steadily since then.

Liquor store employment also decreased between 1990 and 1992 (from 118,400 to 114,800), but employment declines in this sector of the economy began in 1982, long before federal tax increases on liquor in 1986 and on liquor, wine, and beer in 1991 (U.S. Department of Labor, Bureau of Labor Statistics). These data clearly challenge the liquor industry's exaggerated claims of job losses. The Distilled Spirits Council of the United States' website [**http://www.discus.org/taxes**] asserts that 98,000 jobs, directly or indirectly generated by the liquor industry, were lost after the tax increases on liquor in 1986 and 1991.



U.S. Department of Labor, Bureau of Labor Statistics

Statement on
Health Care Coverage
THE SENATE FINANCE COMMITTEE
on behalf of the
U.S. CHAMBER OF COMMERCE (the "Chamber")
by
R. Bruce Josten
Executive Vice President, Government Affairs
U.S. Chamber of Commerce
May 5, 2009

The U.S. Chamber of Commerce would like to thank Chairman Baucus, Ranking Member Grassley, and members of the Committee for the opportunity to participate in today's roundtable and to submit this statement for the record. The Chamber supports your efforts to achieve access to affordable coverage for all Americans. The U.S. Chamber of Commerce is the world's largest business federation, representing more than three million businesses and organizations of every size, sector, and region.

The employer-based system voluntarily provides health benefits to over 130 million Americans. Overwhelmingly, employees are satisfied with these benefits and want their employers to continue providing it to them. Further, employers are currently spending over $500 billion on health benefits each year.

According to the U.S. Census Bureau, nearly 46 million Americans lack health insurance. The Chamber believes that this number is misleading, and that we must acknowledge the difference between those that cannot afford to purchase coverage, and those that can afford coverage, but choose not to do so. Undoubtedly this Committee will develop proposals to get both of these groups into the system.

Covering those who cannot afford coverage will necessitate a myriad of approaches. The Chamber believes it is paramount to begin with a greater focus on enrolling those who are already eligible for government-subsidized or free insurance. An estimated 11 million people are currently eligible, but federal and state agencies have not done an adequate job of streamlining procedures, putting boots on the ground, and signing them up. Nearly another 10 (9.7) million of these individuals are non-citizens; a solution for them will necessitate reopening the question of immigration reform.

About 15 million of the 46 million uninsured have high enough incomes that they likely could afford insurance, if they chose to purchase it. Their reasons for going without could range from feeling young and invincible, lacking appealing insurance options (they're often uninterested in gold-plated PPO plans), being boxed in by state insurance mandates that limit their purchasing options, or lacking an understanding of the necessity of obtaining coverage. There will be many proposals designed to prevent these individuals from opting out of the system and to force them to shoulder their "fair share" of the expenses of providing medical care to the nation. However, policymakers have a

responsibility to address their concerns if these individuals are to be obligated to purchase coverage.

If Congress creates an individual obligation to purchase coverage, we must first ensure that individuals will be able to obtain affordable coverage. This will require significant market reforms, new pooling options, removing state benefit mandates, and making available a full range of insurance options that will appeal to the young and healthy. Key to this function will be both the creation of a national insurance connector, and definition of a minimum standard of benefits. All potential coverage solutions for the uninsured will be unsustainable unless Congress enacts meaningful delivery system, payment, financing, and entitlement reform. The federal government may have a role in reinsurance as well to help make coverage expansion sustainable. Further, some proposals to cover the uninsured, like creating a government-run health plan or allowing Washington bureaucrats to dictate the operation of employee benefits, are alarming and may well make the system worse, not better.

The small group and individual insurance markets are in serious need of significant reform. Currently regulated at the state level, the costly and burdensome benefit mandates coupled with the lack of competition have led to the need for federal reform of the individual and small group markets. The Chamber has long supported granting small businesses the ability to pool risk and to offer uniform benefits across state lines to address these problems, to no avail. Large businesses have been successful in offering comprehensive benefits primarily because federal law (ERISA) protects them from the patchwork of inconsistent state laws and regulations, and the vast majority of individuals enrolled in ERISA plans report a high level of satisfaction with their plans. These plans must not be weakened in the process of health reform.

A national insurance connector should serve as a marketplace where individuals and small businesses can go to obtain coverage that meets the new standards. This connector must facilitate meaningful pooling options for these individuals so that their risks can be shared, their premiums can be predictable, and their costs lower. Further, having learned from the lack of competition and problems encountered at the state level, the connector must allow for a high amount of plan flexibility, greater risk pooling, and a range of options.

The plans sold in the connector will have to meet some minimum benefit standard, and the Chamber feels the best course of action for designing this standard would be to look at existing high-deductible health plan products that offer first-dollar coverage of preventative services. It is absolutely essential that individuals have both access to and incentive to use preventative services, but also that the remaining parts of the plan be up to consumers – make the minimum a catastrophic plan, allow individuals and purchasers to determine how much richer of a plan they would like to select. This will provide appropriate safeguards against financial difficulties and ensure access to appropriate care.

If Congress manages to maneuver these challenges in a way that successfully encourages individuals who can afford coverage to opt in, and also successfully enrolls those who are already eligible for free or subsidized care, there would still be about 10 million uninsured. This group is comprised of individuals who cannot afford coverage, the people who are driving the need for coverage reform in the health care system. Covering them will entail many challenges.

For some of these individuals and families, the best solution will be to create an expanded floor for Medicaid and other government programs so that they can enroll. For others, it will include offering government subsidies so that they can purchase private insurance, perhaps employer-sponsored insurance. In some cases, it may be appropriate to route this subsidy directly through an employer – subsidies and individual obligations must not encourage opting out of employer plans, and must be conscious of the adverse risks employer pools will face unless these policies are harmonized properly with the existing structure.

The Chamber does not believe that a mandate on employers to sponsor health insurance will make serious headway to cover the uninsured, but rather could lead to a loss of jobs. Employers who can afford to sponsor health insurance typically provide generous benefits – and most large employers do. Employers who cannot currently afford to offer health insurance benefits will not be able to do so simply because they are mandated to do so – small employers, seasonal employers and businesses that operate on very small profit margins will still be unable to afford to provide benefits. The Massachusetts employer mandate failed to have a meaningful effect on the uninsured, and actually exempted most of the businesses that didn't offer insurance – but it was disruptive to existing plans. In fact, reliance on that employer mandate in part contributed to serious funding problems in the Massachusetts plan.

Employers have been great innovators in health care, and many reforms we have led the way on have kept the unsustainable rising costs of health insurance from reaching the breaking point. A mandate on employers is sure to reduce flexibility and choice, while raising costs and providing little benefit. Existing mandates have proven inadequate in determining the scope of plans, helping to cover the uninsured, or properly distinguishing the good players from so-called free-riders. The push for a coverage mandate on employers is an ideological one, not a pragmatic one, and should not be viewed as a way to cover the uninsured.

Employers support the notion of "shared responsibility," when viewed through the lens of realism. Any objective observer would conclude that employers, who currently cover more than 130 million Americans and pay over $500 billion per year, are indeed being responsible. Mandating further "responsibility" on their part would exhibit confusion about the economic realities employers face. An employer mandate or maintenance of effort requirement would be a job-killer, because it would force struggling employers to spend money they don't have.

Another concerning proposal is the creation of a new government-run health plan, euphemistically referred to as the "public option." Proponents say that this is necessary to "keep private insurers honest," yet proposed market reforms should accomplish this goal without the creation of a new entitlement plan. Proponents claim that a government-run plan can compete on an equal playing field with private plans, but this would put the government in the position of being both a team owner and the referee; inevitably the government would move to give unfair advantages to the "public option," just as they are considering doing now with the public financing of student loans.

Even the op-ed page of the Washington Post has cited the "public option" as a backdoor way to bring the nation to single-payer, socialized medicine. The President's promise that Americans will be able to keep the health insurance they have cannot be kept if we move to such a system – which inevitably we would if, as the Lewin Group estimates, 130 million people would shift from the private sector to this public plan.

Employers are especially concerned with the prospect of a new government-run plan because of the bad experience we have had with current government-run plans. According to a recent study by Milliman, employer plans' costs are increased by an estimated 20 to 30 percent due to cost-shifting from Medicare and Medicaid. "Public option" proponents will say that this is denied by MedPAC, or that the new plan will not engage in this cost-shifting, but these assurances ring hollow – especially when we consider the incredible unfunded liabilities currently shrugged off by current government-run plans.

The Chamber is eager to work with you to enact reform, but urges your consideration and caution when crafting proposals that could prove harmful to U.S. companies and the private insurance marketplace. If structured properly, a connector could be a boon to small business. Subsidies could realign federal dollars in a way that seriously reduces the uninsured. Entitlement programs could be reformed, revamped, and improved. Even better, the coverage currently enjoyed by more than 250 million Americans could be secure and sustainable, have better quality, and be more affordable.

The Chamber looks forward to working with Congress on this and other initiatives that will help more individuals, small businesses, the self-employed, and others gain access to the highest quality, most affordable, and most accessible health care possible.

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[SUBMITTED BY SENATOR JOHN KERRY]

Iowa

We support any movement toward single payer health care as we believe our society is stronger when there is justice for all. .Martha Schut and Doug Peters

Martha Schut
iowa city, IA

It is the fairest, cheapest, and most efficient way to insure those private insurance companies don't want to cover or can't cover at a competitive cost.

Susan Franzen
Ames, IA

My sister was canceled from her privately purchased insurance after she developed cancer. She had paid premiums for years but once she was no longer profitable for the insurance company they pushed into a high risk insurance pool with high premiums and little coverage. This is not fair. I have friends who live in Ireland. They have a public insurance option. Their medication and health care is much cheaper than is ours. One of my friends in Ireland was recently laid off from her job. She does not have to worry about being forced into bankrupcy because Ireland offers public health care for everyone. With rising health care costs and rising unemployment we now more than every need a public health care option. I urge you to vote to include the option of public health insurance in your reform of health care.

Ervin Corcoran
Fairbank, IA

Having a viable public option, available to all, is a game changer. It gives everyone the expectation of good basic health care, which will bring unimaginable benefits to this country as people begin to understand that with health care as a right goes the responsibility of taking care of themselves to preserve that care for themselves and others; in other words, it gives everyone a stake in developing a sustainable health care future. It also gives people real health care security instead of the insecurity and fear that are sapping the energy of many people in this country. Finally, it will give Americans a country to be proud of, one that uses some of its riches to take care of all of us. A public plan option will embody the humane values of our nation.

Karen Metcalf
Bettendorf, IA

Public health care option is key to a society that cares for all people. Those in other countries have health care for all that need it while we who are to be the most educated and rich have millions who go without necessary care. The young, the old, and those who through no fault of their own lost jobs and in turn lost health care are all affected So much wasteful spending we as a nation have done to fund a needless war while millions go without care at home. We must have good options and not fighting along party lines. Senators and those in office have the finest health care available so all Americans should be able to get that same care. Support the option for health care!!

R.E. Corcoran
Fairbank, IA

The private sector health insurance industry has, with their huge annual premium increases, has created a drag on the American economy. This has caused American employers to pay more to provide less insurance coverage to their employees, if they can maintain it at all. The public option that is a central part of President Obama's proposal for health care reform, is the first step to making American manufacturer's and business more competitive in this global economy. This issue is one of the most important on the American agenda, and fixing it right will go a long way in improving the overall economy.

Don Ruby
St Charles, IA

We've proved that we can control the cost. Medicare operates on 4% overhead costs but Medicare D with involvement of private insurance companies operates at an extravagant 10 to 30% with the right to refuse coverage. Public option is hugely important in reversing the economic downturn.

Lora Swanson
Glenwood, IA

Health care must be accessible to all, everyone, no one left behind. There are too many people losing their health insurance when they lose their job. Too many bankruptcies due to just being sick. It is shameful in this country for this to happen. Please support Obama's plan. Please support a public option.

Trish Nelson
iowa city, IA

U.S. companies saddled with ever increasing health insurance costs cannot compete fairly with foreign companies whose governments subsidize their healthcare. We need to lift this burden off small business and provide an alternative for employees of large companies. Stop enriching insurance companies amd HMO's by providing a CHOICE. A public option will reduce emergency room use and provide healthy competition with private insurers that will lower all health care costs!

Alan Kamphuis
Ankeny, IA

We need health care availability for all. A public health care option similar to Medicare would be cheaper and more efficient than private insurance. It would relieve Americans of the fear of loss of health care.

Mary Kathryn Cowles
Coralville, IA

I think every American sould have access to health care. If we take care of our own people we are much better to work and maintain our own way of life. We would be able to not depend on other countries for food, clothing and other things.I think it should be within our budget to have what we need

Edna K. Angove
Onawa, IA

Having a public option in health insurance is a first step in health care reform. It will provide for those who don't have health insurance and reduce administrative cost. After we get government-sponsored health insurance, we have to address the ever-rising costs of delivery of services: physicians, hospitals, allied health care providers (PT, OT, radiology, etc.), medical supplies, and pharmaceuticals.

David Sands, Md
Fairfield, IA

I worked this afternoon at our Community Health Free Clinic. Two of the young nurses I worked with are going to school, have families and are working in hospitals.I cared for patients who have been laid off work and have families to support. You have heard these stories over and over again. The Public Health Option would help people in these situations have affordable, excellent health care.Please, let us put our differences aside and do what is equitable for each and every American.

Maryann Stewart
Cedar Rapids, IA

My sister recently had a beautiful baby girl. She has no medical insurance and is now afraid to check her mail. What should be an amazing memory is now marred by collection letters and dollar signs. In almost all other civilized society this would not be something she would need to worry about. It is time that we, as Americans, demand that the basic needs of every citizen is met.

Amie Buckley-Hauskins
amana, IA

I lost my private insurance, years ago. Without the public option, I have no chance of getting coverage of any kind.

William Doan
Fort Dodge, IA -

I am over 65 Medicare is, and has been, a good health care insurance plan. A similar plan should be optionally available to Americans of all ages. Please support it

Leroy W. Moore
Indianola, IA -

The public option for health care is very important in making sure that all people have access to health care regardless of preexisting conditions and economic status. It is time for the Congress to give the people the same type of health care thatthey have and their health care is paid for by the tax payers. I am tired of Congress giving in to lobbyists and not taking care of the people who sent them there.

Priscilla Payne
Windham, ME

Why are we even having this debate? Health care in this nation is so critical on so many fronts it is a no brainer. We need to have a public care option.

Gary Guisinger
Perry, ME

This is the modern world; we need health care to be accessible to everyone!

Langley Willauer
Hope, ME

I'm 77 and have been on Medicare for 12 years. It works. It's much less expensive than private coverage. There are problems, but they're the kind that can be solved.

Chris Pottle
Oxford, ME

Too many people do not have access to good health care and health insurance. My sister has a brain tumor similar to Edward Kennedy's. Part of the tumor was removed 3 years ago. She has to have periodic MRIs, but her health insurance at her job has changed dramatically with very high deductibles (more than $10000) and then she still will have to pay for a lot of her health care. The MRIs are essential for her well being, but she does not have access to proper care. She will have to choose health care, her daughter's college education, or paying her every day expenses. (Death, Bankruptcy, or her daughter being unable to go back to college are all in her future without access to quality health care. Thank you

Valerie Peterson
Woodland, ME

Having a public option in our health care system helps ensure that all Americans can access health care, that they will not go bankrupt when treating an chronic or acute illness. It is the single most civil service that a government can assist it's people with. Being healthy should not be a matter of how much money you can afford to part with to a private enterprise.

Eliza Richmond
Scarborough, ME

The public option is vital to health care for my children. My twenty six year old son, and my 38 year old step son are uninsured or under-insured. Their employers are very small business. They have no realistic prospect of employer provided coverage. Their lives will be markedly less secure, and their health increasingly at risk, if the current health insurance model is continued. A viable public option, or single payer insurance, simply must be added to the reform package Congress is considering

Eric Root
Fryeburg, ME

For a nation, as wealthy as ours, it is absolutely shameful that there are people in this nation with no health insurance. Having a public health care option can only help to reduce costs of medical insurance in this country. Preventative medicine is much cheaper than reactive emergency medical care. Health care reform can only help make us a stronger and healthier nation. When small businesses no longer have to worry about the costs of medical insurance for their employees, then they can begin to be more competitive and grow their businesses. I ask that you do not bend to the pressure from the Insurance and Pharmaceutical Companies as they lobby you to vote against the wishes (and health) of all American citizens. The time has come for us to improve the quality of life in this country. Sincerely, Erik & Katherine Missal

Erik & Katherine Missal
Woolwich, ME

Help We are a small, two employee business with no other choice but to purchase catastrophic private health insurance. Over the past 15 years we have been forced to raise our deductible again and again in response to Anthem's double digit annual increase. We now have a deductible of $15,000 each for a total liability of $30,000. This coverage costs us over $4,000 a year and takes a very painful bite out of our annual income. We are "under-insured" now and dread the very real possibility that we may have to join the ranks of the rapidly expanding number of "uninsured". It seems unconscionable that a private enterprise can profit so handsomely at our expense with so little benefit to us. We are in a health care crisis. We beg you to listen to the ever more numerous health care horror stories you no doubt have been hearing a great deal of. Lives are being destroyed. Should we have to delay or forgo health care to avoid inflated medical bills? How much more must we be burdened with to subsidize for-profit health insurance companies with multi-layered, overly complex and grossly inefficient administrative systems? Unlike much of the economy, the health care insurance business is thriving. If you want to help us weather the current unprecedented economic crisis, then give the American people a public option for health insurance and give us a much needed break. By doing so, we will finally be getting the quality, affordable and equitable health care that every citizen deserves

Jennifer Angelone
Portland, ME

Because I trust Medicare for All, and I don't trust the insurance companies. Who would be crazy enough to do that?

Sam Hunting
Orono, ME

My Dear Senators, If I want to send a letter or a package I go to the U.S Post Office and for 41 cents they will send a letter anywhere in the U.S. For about $8.00 I can send a package anywhere. Federal Express would send that same package over-night for $15.00. Now here is the beauty of living in a country that is at once capitalistic and democratic. How long would it take the postal service to deliver if Fed Ex did not do it overnight? and How much would Fed Ex or UPS charge if there were no Post Office willing to do it a much smaller fee? The public option could play the role of the postal service in my analogy by offering a quality inexpensive service that would lower the premiums of the private insurance companies not by mandate but through competition. The private companies would much like Fed Ex stay in business the old fashion way by providing a more luxurious service to those who can afford it.

Charles Hicks
Manchester, ME

The public health care option is critical because for many people it is the only way they are assured of coverage. The insurance companies are in business to make profits, not to make payouts to benefit the sick. The current system is broken. The public health care option means guaranteed coverage, paid for by a huge pool of insured people. If we don't get this, you will see people demonstrating in the streets for a single payer program. Who are we taking care of, the insurance companies or the nation's families and individuals?

Barbara Michael
Scarborough, ME

For many years I had health insurance through my employers, and really had no "choose your own doctor" except for doctors in the plan. I had a botched breast cancer surgery performed by a doctor in the plan. The insurance company wouldn't pay a penny if I used the doctor of my choice (who wasn't in their plan). This is why the Public Option is so important. I have been on Medicare now for 3 years and have been receiving far better care with absolutely no hassles. Please make sure the public option is included in health care reform.

Margaret M. Reiss
Brunswick, ME

The public health care option is so very important to me because I am a self-employed artist. I don't have insurance coverage with an employer since I work for myself. I can't afford to buy private insurance because the cost is much more than I can afford, and I don't qualify for Medicaid since I am above the income limits. I am one of those people who fall through the cracks, who hasn't had health coverage for the last 16 years. Thankfully I am in relatively good health, but since I'm in my late fifties, I don't know how much longer that will last. Please help people like me get health coverage; our lives depend on it.

Tamara Richel
rangeley, ME

As a small business owner, I have seen my policy increase from anywhere from 14-24% a year. Over the past 20 years I have had to increase our deductibles and give up on prescription drug benefits to keep our policy affordable. We have had very few real health care needs but our policy continues to increase as our group ages. We have had employees drop our group to join a spouse's policy that cost less and had better coverage. As a small business owner, I couldn't get the same coverage for the same premiums because I lacked the

number of people. It would cost me $300 MORE per person for the same coverage a company with 50+ people could get. I find this discriminating and unfair. And this hurts my business! It makes me very nervous that if one of my employees gets sick so they can not work, we are contracted to drop their coverage. If they aren't working, then none of them have the ability to pay for health coverage so this doesn't make an sense. This makes us all vulnerable to loosing all that we have worked so hard to achieve. Private health care also traps people in jobs that they may not want to stay in because they have coverage Please pass a public option. This is what government is suppose to do. Provide for things we can't do individually. Thank you.

Anne Callender
Portland, ME

We can no-longer wait for the current system to evolve into what it already should be. We need to bring the power of our collective voice hrough our government to ensure that all citizens have access to affordable high quality health care. This is not a plasma television or some other luxury item we are referring-to. It is also not "nose-jobs" for everyone. Notwithstanding, I am quite concerned that we may become distracted-enough by the legitimate fight to secure a public option that we forget/compromise-away that we are already over-paying the bill for high quality health care for all and not getting it. Might I humbly suggest that you discern the meaning of the four particular terms: "affordable", "high quality", "health care", and "for all"...before you spend one minute longer debating "how to get there" and "when we'll arrive".

David A. White
Bar Harbor, ME

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40 million uninsured people are waiting to maximize their productivity as healthy citizens, and private corporate greed has stood in their way long enough. Be bold. Do the right thing Make humanity proud. Pass the public option. :)

John Girard, Md
South Portland, ME

The Democrat majority in both houses owe the American people the dignity and respect of creating a a public health care option. Public health insurance costs less to administer and offers access and dignity to all. Public health insurance offers social and economic benefits at a critical time. Finally, with the passage of legislation for Public Health Insurance option, Americans can join the community of Western, industrialized countries with Public Health care system. Democrats, please get this right!

Rosalie Dert
Farmington, ME

It is the responsible choice. It allows those without wealth to live in dignity. It is beneficial to the welfare and health of our nation.

Alan Liska
Portland, ME

It is time that we begin to shape a viable health care reform plan for every one. Please support the public health care option that Sen. Kerry will enter on Tuesday May 5th. thank you- Emily Ecker, Woodstock, Maine

Emily Ecker
Woodstock, ME

If the United States won't take care of its citizens who are most in need, then we have no right to call our nation a Republic.

Tim Kutz
Bath, ME

Dear Senators, The only truly affordable, accessible, quality and comprehensive real health care reform is HR 676 single payer, medicare for all from birth to end of life If it does not pass then Americans like us and our families will not only have our financial health ruined, as has happened to so many already, but we will continually become more and more unhealthy with more and more of us dying from lack of adequate medical care or no medical care at all. Nothing will have changed except, with the for-profit private health insurance companies still in the equation, their profits will increase and skyrocket even more and more, as unbelievably high as they are and have been, including profits from insuring the nearly 50 million uninsured Americans with mandatory individual health insurance. HR 676 single payer is the only option for the biggest stakeholders of all...you, us, our families, your families, our friends, your friends, our coworkers...all Americans...! Our health depends on it. It really is a matter of life and death. Thank you. Tania Erickson Vanessa Erickson

Tania Erickson
Bangor, ME

When Managed Care came in years ago it was supposed to provide optimum care, but has been a disaster for many people with serious illness. There has to be a better way than "for profit" plans that are determined not to provide important care based on cost.

Lois Taitague
Limerick, ME

Please vote that All Americans have access to some sort of affordable healthcare.

Glenda Wright
Kittery, ME

It allows a full range of choices, offers the chance for reduced costs, and provides a safety net for all Americans to be able to pursue "life, liberty and happiness."

Patricia Kenny
Old Town, ME

Private insurance is not an option for so many people. I had to buy it when I went into self-employment, and it was terribly expensive for moderate coverage.

Judith Mabel
Brookline, MA

We need a single payer to reduce our costs and get more people insured!

Rebekah Richardson
Nahant, MA -

The single highest bill that I pay every month is for health insurance. Although I have a fairly good plan I am paying far too much for it. I do not understand why the US, out of all of the industrialized nations in the world, is the only country that does not have a national health system where all of the citizens are guaranteed good health care as a right, not as a privilege. If a health care reform bill passes that does not include, at minimum, a Public Option, then all it does is make the insurance companies that much richer and more powerful.

Paul Lind
Amherst, MA

I think that having a public health care option is extremely important because: 1. It will offer everyone the option to choose health care at a lower cost. 2. This is fair: people who like the private insurance that they have now can keep it, and those who actively want a Medicare-like coverage can choose that. 3. It would help our economy so much! Small businesses of under 25 employees create 80% of new jobs in our country, but small businesses are crippled by excessively high health insurance costs. 4. The number of people who are forced into filing for bankruptcy by health insurance costs is a tragedy for our nation. It is intolerable that we are doing this to our own people. 5. It is also a tragedy that 50 million Americans have no health insurance at all, and allowing a public health care option would do a lot to ameliorate the situation.

Darien Gardner
Northampton, MA

Dear Senators, It is time for a public health care option for EVERY American. The private insurance situation in this country has served the insurance companies and the large corporations. Self employed workers and small businesses have been paying far too much for too little coverage It's time to make good coverage available for all Americans.

Regina Touhey Serkin
Richmond, MA

Because my wife and I both work full time and can't afford the options we currently have available to us. We are both healthy, young and hard working Americans who deserve better.

Josh Lynn
Holyoke, MA

I'm retired now and bask in the knowledge that I need not worry about health care, thanks to Medicare. But oh so many years ago I recall going without any insurance after I had my babies and worried constantly until I could re-enter the work market and get medical insurance coverage! Stressful years!!!!!!!! How much happier it could have been to have had a public option to spell those times!!!!

Annarae Hunter
Oak Bluffs, MA

As a former pediatrician and pediatric physiatrist specializing in the care of handicapped children, I am well aware that they and their families are burdened by the enormous costs of health care. We need affordable public financed health care for all as a matter or right, not employment status.

P Saturen, Md
Westboro, MA

I am a physician.I support HR 767 which calls for single payer healthcare. It is vitally important that there be one risk pool financed by a single payer to make universal access more cost ef fective.

Peter Cohen, Md
Newton, MA

As a social worker, I see every day the suffering that American citizens face due to lack of coverage. This number is increasing as when people loose their jobs, they loose their health insurance. We are the only developed country in the world without guaranteed coverage.A way to see how this works would be to offer a public option at this time - Canada, Sweden, France, Germany and numerous other countries have greatly reduced costs and are able to provide needed care for their citizens - we should be able to do no less.

Norma Wassel
Cambridge, MA

Too many people in the U.S. confuse "healthcare insurance" with "healthcare." In one, the money is paid to a middleman; in the other, it's paid for services. I would gladly pay for a national-government-run healthcare delivery system as efficient as Medicare (the U.S. government's current healthcare delivery system for those over 65 years of age and which is 95% efficient) rather than the $14,800 annually that I, as a small business owner, pay to a private insurer in Massachusetts for my wife and I to have mediocre insurance coverage. Mandatory healthcare INSURANCE coverage is NOT the answer. It merely guarantees that insurers will be paid. Handsomely. Rather, guaranteed HEALTH CARE, paid by every American through taxes, is the answer The society that does not care for the health of its citizens is barbaric; for this to be happening in a country with the wealth of the U.S. is nothing short of shameful!

John Hebert
Brookline, MA

A public option would provide health care coverage to all regardless of job, pre-existing condition or chronic illness. It would control costs by eliminating waste in the for-profit insurance industry.

Rosemary Kofler
Amherst, MA

As a cancer survivor, I appreciate the importance of good insurance. Please support the Public Option as part of health care reform

Sheila Loayza
Wayland, MA -

Too much money is being spent on for-profit private insurance that could be spent on direct care for our citizens. Other countries are able to provide better insurance at lower rates for the majority of its citizens, and we should be able to also. It is a disgrace that the richest country in the world does not offer a public option for health care to its citizens putting them at financial risk due to illness and keeping them locked into jobs that they would leave for something better if not for the employer-based private insurance offered that they cannot afford to do without.

Katherine Byrne
Sharon, MA

The United States is the richest country in the world but stands number 33 in life expectancy ranking. All 32 countries ahead of the United States have universal healthcare services. We kindly ask you to pass a bill that includes a public and private option.

Enku Kebede-Francis
Boston, MA

Individuals need to have alternatives to the private health insurance market. The private health insurance market operates under imperatives (e.g. selective acceptance) which are not always in the best interests of the individual or arguably society as a whole.

Margaret E Rolph
E Walpole, MA -

I got involved in community organizing when I was 20 years old because I was alarmed by inequities in our health care system. Now thirty years later the problems are far worse. I have spend years hearing heart-breaking stories for individuals who are not getting the care they need or are ending up bankrupt to get care. This must stop. We need a public health insurance option that provides an alternative for lower costs and innovation delivering service – and most importantly to guarantee coverage that everyone living in America can afford.

Cynthia Ward
Boston , MA

Health care is essential for everybody, regardless of their wealth.

Carole Roy
Taunton, MA

Without a public health care option, there will be no real reform As we know, competition in business breeds success. Insurance companies need to be held accountable by a checks and balances of sorts, which a public option would provide.

Kristi Vrooman
Arlington, MA

I think it is vital for the U.S. to offer a public option for health care similar to Medicare and the health care options for members of Congress. No one should have to live without medical care and no one should have to go into debt or claim bankrupty in order pay their insurance premiums or medical bills. When changing jobs, people often have to change insurance carriers and sometimes doctors We shouldn't be dependent on our

employers for health care access or choice of physicans. I appreciate your support for a public health care option. Thank you for your work on this important issue.

Sarah Ciriello
Quincy, MA

Health care should be a right of every citizen in America, not just something that is provided to those lucky enough to work for corporations capable of affording good coverage or the wealthy for whom finances are no issue. Our health care system is broken– too many have no coverage or insufficient coverage, small and even large businesses cannot afford to offer coverage, and we have profit takers in the middle standing between patients and their doctors. I feel strongly that it is time that the US allow its citizens the choice of a public insurance option. Here in MA, my husband is unemployed and we're on his COBRA plan that is not affordable, and the small non-profit where I work offers an even less afforable option. We're concerned about keeping our insurance as we have a daughter with lupus. My adult son has better coverage at a very reasonable price through a state plan. I'd love to have a choice to participate in such an option. Please let each citizen make a health insurance choice that is best for them. Please give us a public insurance option and make the promise of health care reform a reality. Thank you!

Wynne Treanor-Kvenvold
Harvard, MA

I believe it is because I have a chronic illness with no sure, and need an expensive drug to keep it stable, have already been taking it at 20K+ year for 12 years. My insurance no longer wants to cover the cost and I could get very progressive without it, if it becomes non-affordable

Robin Montesano
Winthrop, MA

The only way to bring down health care costs is to move away from private insurers. If this country is not ready to endorse single-payer all the way, then including a public option for those who want or need it is the next best thing. Perhaps there is something to be said for providing both choices. I believe private insurers will fight hard against a public option because they know it threatens their existence. We must not let them win. Private insurers are in the business of excluding people who are sick and limiting care to those they agree to cover. They also waste large sums on marketing and administrative costs, money better spent on providing care. I don't see how lawmakers can in good conscience object to a public option, since they themselves benefit from one.

Mary Wyse
Amherst, MA

The Medicare and Medicare systems are less expensive to operate than for profit private payors. It's time the American people became the special interest group not the well funded lobby of private insurers. If we are given the choice between public and private coverage, the costs by private insurers would have to come down as well. Everyone deserves affordable healthcare coverage.

Joanne O'Connor
Weymouth, MA

It is the only way to make sure that everyone gets health care. Insurance companies want to make money primarily, they have an economic interest in not providing quality health care.

William Codington
Needham, MA

For-profit private insurance misdirects money that should be spent on health care towards administrative costs, fighting consumers so that insurance companies don't have to pay, and profit. A public health care option will reduce or eliminate these unnecessary expenditures, thus lower health care costs for everyone (due to competition). Furthermore, a public option will provide the possibility of true universal coverage–something which most other industrialized nations provide for their citizens but the US does not.

Jim Hammerman
Brookline, MA

Our current system of health care delivery is not sustainable. It leaves too many people without care, it is bad for businesses that need to compete in the global economy, and it is bankrupting the country People in ALL the industrialized countries pay much less, have longer life expectancy and generally have a higher opinion of the process than do Americans. We have to get to universal healthcare and the public option is an essential step. Sincerely, Peter R. Root

Peter Root
Hadley, MA

Throw out the word 'fair' and focus on the word 'care.' We need to care for all of our citizens and make health care affordable. Medicine and health is not a luxury, but a human right. Thank you.

Jordan Bray
Brookline, MA

It's time to guarantee every American healthcare they need, through a single-payer system, as in an improved and expanded Medicare for All. . A single payer system is the most effective reform to assure universal coverage, choice of doctor, and real cost controls that will end the financial and healthcare insecurity faced by American families and American businesses.

Mira Bishop
Marblehead, MA

Right now health insurance is tied to the workplace. If you lose your job, or become ill or injured and cannot work, you lose your health insurance and the only option is a short term Cobra policy which is extremely expensive. We must have an option that people can buy into that is high quality, without high out of pocket expenses, that allows people to maintain health insurance if they cannot work, are laid off, change jobs to one that does not have good health insurance.

Robin Kutner
Lexington, MA -

With the Obama Administration, this country has finally begun to dig itself out of the disaster of the bush years The world has begun to respect us once again as an ally and leader. Isn't it time we join the rest of the world in proffering the option of a public healthcare system to the people, the majority, who are not of the wealthy elite? Everyone: young, old, chronically sick, poor, wealthy, those who see a doctor for a checkup and those who need lifelong aid, everyone stands to benefit from a public healthcare system; the only people who don't are those multi-millionaires in the current healthcare system who make their profit off of the suffering of others. This nation is long overdue for healthcare reform, and we no longer have the neo-conservatives who stole the last administration standing in the way. You have been voted in to Congress to make a change; please don't let us down.

Clarissa J. Markiewicz
Cambridge, MA

We must have a public option that is not subject to the year end profit making issues. An option where the real goals are the health of the people and not how much money will be made in the quarter. An option where the delivery of health care is before the paperwork and bureaucracy and double digit MM salaries. An option where doctors again start to figure out in which way they can render a real focus on health and curing people and not in supporting the Health care industry goals, not just quantity but quality of health care. David

David Lovece
Burlington, MA

We've had many years of experience with our current healthcare options: private companies selecting the categories of people they'll insure and rejecting the many others. It is unconscionable that in this country so many people have to file for bankruptcy due to healthcare costs and/or lack of healthcare insurance. It's a fact that public options are less expensive than private healthcare insurance. Demand for public healthcare options are one of the reasons we have changes in the presidency and congress.

Norman Daoust
Cambridge, MA -

We elected President Obama to bring change to our great nation. Part of the agenda for change includes healthcare reform and the option of choosing between a public plan or a private plan. Choice is fundamental to our democracy. I urge you to pass President Obama's healthcare plan. Thank You.

John Zarvis
Lanesborough, MA

A public health care option is key so that citizens have choice, a choice not tied to their job situation and a choice not tied to a for-profit insurance company. It's also important to provide competition in the healthcare sector between the private and public. Medicare has been around for 40 years - a public health care option is viable - it just needs to be available to everyone! Please don't leave it by the wayside!

Sharon Germana
Boston, MA

We need to have health care coverage which cannot be denied for preexisting conditions of any kind, which cannot be lost when you change jobs, and which provides 100% of costs above a few thousand a year so that medical expenses no longer drive people into bankruptcy and poverty. Beyond this, we must find ways to control costs so

that health care does not grow to consume our entire GNP. That means people in the medical field– pharmaceutical companies, medical device manufacturers, hospitals, and, yes, doctors are going to have to accept lower profits and lower incomes. Expanded competition and shortened patents will be important means to achieve these cost reductions. This is a health care crisis. We need to act now.

Ken Thomson
Cambridge, MA

MEDICARE works for me (I'm 78), so why shouldn't EVERYONE have that choice??? Joan Kimball

Joan Kimball
Concord, MA

If no public option, it will be no reform. Only more insurance fo more of the same system would be much more money but not much more care.

Sterling Alam
Attleboro, MA

Senator the private health insurance really is not in the interest of the public. If you think it is so good why dont you ask your colleagues to purchase private health insurance plans. The insurance is linked to you job.When you really fall sick you loose your job that is when you need insurance the most. That is when you loose insurance coverage. Lets stick to single payer system with an option for individuals to choose private insurance plans. If it good enough to cover you why not me if I can pay the premium

Dhruv Mahajan
haverhill, MA

The public option will create competition for private health care plans, which I believe is good.

David Holbrook
Boston, MA

A public system provides a standard of care with ongoing improvements in quality of care.

Kathleen Holbrook
Boston, MA

Some things, for the public good, should not be for profit, health care being one of them. Why should my health care be refused for someone elses profit. IF we do not have a healty well educated society we are on our way out as the leaders of the world.

Eileen Mcgowan
Florence, MA

Having a public health care option is key to health care reform in America because it gives people a choice. My son, brother, sister-in-law, nephew and family have no health insurance because they can't afford it. Living in fear of catastrophic illness, or any illness, is not acceptable in the greatest country in the world. We need a system which includes all the people. Please include the public health care option. We have been talking health care reform for years, let's make this the year it finally happens. Thank you, Senator Kerry for your leadership on this issue.

Hollie Bagley
Hingham, MA

People need a choice.A public option is the better choice for me.All Americanns deserve health coverage. I believe in a government that cares about its citizens, Cost control in a public option is much easier. Medicare is such a system.We should all have this option. No one should be uncovered because of pre existing conditions or have to endure bankruptcy because ofhealth care expenses.PUBLIC OPTION PLEASE!!

Carol Genovese
Brookline, MA

It will make health care available to everyone and will save our country money.

Margaret Benefiel
Dorchester, MA

It will help keep premiums and health care costs down, and keep private insurance companies from overcharging.

Carl Schlaikjer
Middleboro, MA

The public health care option is absolutely necessary. Private insurance companies' purpose is to make a profit, which they do by denying care to as many as possible. The public option's purpose is to be sure people actually get the health care they need.

Marian Ferro
Watertown, MA

I know people who would like to change jobs or careers, but are worried about losing their health insurance.

Paul Kaplan
Tewksbury, MA

It is absolutely imperative that a public health care option be available to Americans. It is the only way to stop the travesty of uninsured and underinsured Americans, of sick Americans losing their homes and savings. The losses that people face in America due to lack or costs of healthcare are disgraceful, and it simply amazes me that anyone in Congress could think otherwise. All we are expecting from our public representatives is to make a real change by giving people an option, a choice; public or private This is utterly reasonable and any member of Congress who votes against it is clearly either more concerned about the insurance industry than their constituents, or totally out of touch with reality.

Kathryn Butler
Conway, MA

I became disabled 10 years ago as a result of a medical error. I am a retired hospital administrator having worked in a Florida hospital with over 60% Medicare patients. I have managed to maintain health insurance these past 10 years and for several years have received coverage under the Medicare program. Our monthly premium costs were over $2,000 per month for my wife and myself. Now that we are both covered by Medicare our monthly costs are less than $700 for a level of protection with no co-pays and deductibles. This public option has given me a better level of service at lower cost and retains my personal choice and individual decision making with my physician. The public option does not give my decision-making to the government. Additonally, my public option cvoverage provides care without expensive co-pays and co-insurance fees as are present in most private insurance plans Anyone who thinks that most Americans with their current insurance plans have adequate,low-cost health insurance are fooling themselves-private insurance for healthcare today is causing people to not receive healthcare they require to maintian good health. The public option like the current original Medicare coverage is superior coverage. I know this as a recipient and as a former hospital administrator. Work has to be done in dealing with end of life care for those people receiving Medicare today. Additonalwork has to done with part D coverage to control costs of pharmaceuticals and to fixthe donut hole procedures. finally a comprehensive health insurance plan should include provisions for dental care as well,which is being shown to closely impact an individual's health.

Don Freeman
Belchertown, MA

It's imperative that all Americans can obtain health coverage. Private insurance companies aren't willing to cover everyone, and their plans are unaffordable for many. If you don't care that millions of Americans find themselves without health care coverage through no fault of their own, imagine how you will feel when a serious swine flu epidemic spreads uncontrollably through the population because the uninsured don't have doctors to provide them with treatment.

Deborah Fogel
Newton, MA

A public option is VITAL for people who can't afford private insurance (like me for several years before I went on Medicare). I used to live in fear of going broke from my prescription costs, or in case of an illness or injury. I still can't afford any supplement to Medicare. No one should have to live that way'

Cathleen Groves
Savoy, MA -

It is important that every citizen be able to live without fear of what will happen if they take ill or an accident happens.

Geoffrey Lerner
Medford, MA

Health care is a right! I trust the government to provide good health care for all US citizens at a reasonable cost but not private companies, whose primary interest is maximizing profits.

Kaspar Kasparian
Arlington, MA

I think the american people need to be able to choose whether they want to participate in a government run health care system or not. I think it is crucial and just - to have an option for people who are currently not able to get health insurance. It is our job to take care of and protect each other when things go wrong. Especially when things happen through no fault of an individual.

Richard C Carter
Arlington, MA

My husband has a small business where I work. We need an affordable health care option that is truly affordable. The patchwork system we have in Massachusetts is NOT working. There are many doctors who will not accept those insured with MassHealth. We do not make enough money to afford decent health care without high deductibles and co-payments, yet we make a bit too much

to qualify for MassHealth. We, like many others, have fallen between the cracks. Because we own the business we have to pay the full premium and it is beyond our means. Business is not good because many of our customers are not paying their bills and if either one of us becomes ill, we will most likely lose our business. Please work hard to insure that any bill that is passed includes a government-run option. If enough of us sign on, we will be able to lower rates and costs because we will have the purchase power to do so. Thanks for listening. Now go do the right thing. Any bill that does not offer a public health insuruance option is a fraud. The insurance companies have too much administrative costs and make way too much money to make me believe they would be more efficient.

Janet Alfieri
Plymouth, MA

The public health care option will put all subscribers, regardless of health or age, into one risk pool and, theoretically, should provide the lowest cost high quality health care solution. By having both this option, as well as the private insurance companies, free market competition will force all providers to compete driving costs down as low as possible and forcing public health care to operate at optimum quality/efficiency.

Maurice Carey
Billerica, MA

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private plans want to maximize profit, a public option gives us real choice, can bring us the innovation we need in our brocken system and keep down the unsustainable increase in cost Senator keep up your efforts on our behalf

Philippe And Kate Villers
Concord, MA

As a nurse who has worked for 40 years primarily with patients over age 60, I have seen how valuable Medicare and Medicaid are to middle class and working people. These are the health plans that offer the most comprehensive care and with far lower administrative costs than private plans. People over 65 have had single payer for over 40 years and benefitted greatly. I urge you to keep the public option.

Rosemary Kean
Dorchester Center, MA

I am in process of retiring from a major corporation after 30 years The health care options I have had in the last ten years and the ones provided me as I retire are unintelligible and loaded with obscure "traps" which hit someone on fixed income with special cruelty. Friends who have Medicare (which I will now be able to enroll in) are unanimous in finding it intelligible, fair, and generous without "traps" Having such health coverage for my wife and myself, both close to 70, is a significant factor in our being able to free ourselves from worry and to free energy for giving back to the community from which we have received so much. Thanks! . . . and take care. Peter Castaldi

Peter Castaldi
Shrewsbury, MA

As a country, we can not afford to continue on this health care spiral downward. It is imperative that we have a public health care option now! If we are to have learned anything from the past, it is that we must put health care as a right and not as a luxury affordable by few.

Cheryl Hirshman
Lincoln, MA

Public health care is the least expensive route to universal health care, so let's take it.

Sidney Cholmar
Becket, MA

In these extremely difficult economic times, it's even more important to make affordable health care insurance available to all Americans. Having the option of public or private insurance is essential. Mike Ferriter

Mike Ferriter
Westborough, MA

Without a public health care option, I will never be able to afford health insurance. I can't even afford heat and food, let alone insurance. We need the kind of reform that reaches absolutely all members of our American society. We need a public option. Give us that choice.

Karen Kane
Williamstown, MA

I have seen patients as a health professional for more then 30 years. During this time I have worked for a number of health care companies, and I have witnessed, too often, how these for profit companies have pressured me to deny patients medical services that they were contracted to pay for or pressured me to push patients to seek out unnecessary services so that they could gouge medicare. These practices served not to promote health and efficiency but to generate positive numbers to optimize company profits. As a health care provider I believe these practices are unethical and have done what I could thru the years to challenge these practices without jeopardizing my employment in the future. I trust the US government to provide an ethical option that that truly serves the interest of public health. Health care is a right that all in our country should have - not a way to profit by using and abusing patients and healthcare worked, and not a way to profit by stealing taxpayer-money. Our government must provide a public option and change the unethical for-profit system that exists.

Linda H. Kasparian
Arlington, MA

I'm a freelance commercial artist and private health care is very difficult for me because I don't have an employer to help out. Please pass public health reform.

Luke Radl
Stow, MA

The public health care option is one of the leading alternatives proposed to save our present unsustainable health care system.

Don Schaefer
MA

Medicare has been good for me, at age 78. We need something similar for everyone in this country – for the sake of fairness, to cover everyone in this democratic, richcountry, andto save administrative costs!

Suzanne Vogel
Cambridge, MA

The United States of America is the undisputed world power with the largest economy. Will she continue to fail her citizens? The United States is spending about 40% more per capita on health care than any other industrialized country with universal health care. Our ranking by the World Health Organization (WHO) is atrocious given the above mentioned facts. When will the 90% of the population who need universal health care get what they are deprived of. These include small businesses who want healthy employees but can not afford to give them coverage, plus large corporations will not be burdened by escalating health cost or retirement benefits related to health care. What we the people want is our legislators to stand up against the tyranny of multi-nationals who are benefiting from the existing and failing system. We want a universally available public health-care option like Medicare for all Americans to be able to choose.

Wilfredo E Cespedes
Lynn, MA

A public option is an absolutely necessary component because it provides the moral conscience that the private sector will never have. Our current system, which forces those who are sick into bankruptcy, is inhumane and does not represent the values of the American people.

Rose Anderson
Melrose, MA -

I think that the public option is critical to give allAmericans an affordable option if they can't afford private health care or if they can't get goverment health care such as medicad or medicare.

Cynthia Salamanis
Waltham , MA

I think it is extremely important that we have a public option for health insurance because it means guaranteeing that everyone is insured. It also means that denying someone to keep high profits for the company will not happen. Too many people are denied coverage. Healthcare is a right, not a privilege. It is necessary to cover preventive care which will save costs in the future for problems that go undiagnosed until it is too late. The private insurance industries have proven that they cannot take responsibility for keeping our nation healthy; It is time for an affordable public alternative. Thank you.

Katherine Person
Templeton, MA

Senator Kerry, I'm from Massachusetts and sent a letter to your office in January telling you i had lost my health insurance in the middle of testing for ovarian cancer After fighting MassHealth and MSP for five months, I'm finally having surgery (still for diagnosis) on Thursday, May 7th, after selling my soul to get health insurance I can't possibly afford. My family has fallen through the cracks and I may die because of the uncaring way insurance is rationed in Massachusetts. I want access to the same insurance as you and Teddy Kennedy have,since I help pay for it. I had a story done on me on ABCTV40 of Springfield, MA in February. I have been in pain, unable to eat and losing weight for five months, all the while trying to figure out why I'm being punished for going to work everyday, voting, volunteering in my community, and raising my 15 year old daughter, who looks at me like I'm going to die ! If you don't pass

universal healthcare this time..... shame on you ! Donna-Lee De Prille 413 568-3544

Donna-Lee De Prille
Westfield, MA -

I am a healthcare provider and a small business owner.It is essential to healthcare reform that a public option be included. Having a public option is a way of allowing people to vote on whether they want more of their premiums directed toward their actual healthcare or toward overhead and profits. Let the people choose.

Marjorie Leary
Brookline, MA

We need affordable health coverage for everyone. I have insulin-dependent diabetes, and if I were to lose my job, I would have to choose between death and death without health insurance. It's a matter of life and death for me and millions of Americans who have pre-existing conditions. Diabetes is not a moral issue, but not providing basic health care to every American citizen is. Make it available to everyone via the public health care option. Thank you.

Lissy Friedman
Boston, MA

It is crucial to this country's health–financial, economic, educational, and creative, that public health care be an option. For the moment, there IS no option for millions of people, for private health care is tied to employment and often outrageously expensive, to both employer and employee. It is shameful for a "leading" country to have such Byzantine health care options as exist now. Give the American people the choice to stay with their private provider or have a single-payer public option.

Anne Levy
Belmont, MA

Private insurance has been a failure for large numbers of Americans. We can and must do better for all citizens. A public program works for seniors, it works for Congress, it will work for all Americans who wish to participate. Without it, individuals and small businesses, the essence of our country, will continue to be disadvantaged and their personal and economic health threatened. The public health option will give our citizens and small businesses an invigorating dose of well deserved and needed assistance.

David Croll
Sudbury, MA

I have three issues: 1. The existence of and requirement to use health insurance companies 2. The requirement of the Commonwealth of MA that I pay for (useless) health insurance and the 3. The impact of litigation on medical decision-making, 4 Useless and unnecessary procedures extending life but not quality of life. The first is the health insurance companies. As one insurance company salesperson remarked to me recently, insurance companies ALWAYS make money. I DO NOT want to pay my money to a go-between. Please, please give us a single payer alternative within the federal government. Healthcare is more than a 5-minute visit, tests and a prescription, but insurance companies, in attempting to streamline and reduce costs have impacted the amount of time a doctor can spend with the patient. Efficient operation is one thing; lack of doctor-patient relationship is quite another. Second is the requirement that MA residents must have health insurance. I do not have health insurance and am violating the law. I am going to be fined for this. I have no money but the bare minimum cost of insurance is around $200 a month and for what? You get almost no coverage. Who is benefiting from this? Third is our litigious society. Lawyers are almost like the mafia, threatening some sectors of our life with great financial harm on the basis of legal technical minutia. Not all countries operate this way. Removing the endless possibilities of lawsuits and very large compensation to both lawyers and the harmed would allow doctors to make better decisions. Fourth is the cost of unnecessary and useless procedures as well as medications. WBUR's recent series on palliative care highlights our misunderstanding of the dying process, almost as if we think we will live forever. We listen for and opt for every possible procedure that extends life. These procedures provide revenue to the hospitals and ALSO reduce the likelihood that a lawyer might be summoned. What is not addressed or understood is the quality of life that is (not) offered by such procedures. We also expect to get something from a doctor's visit. "Go home and rest, drink lots of hot liquids. You'll be better in a couple days." We want our symptoms to go away, we want an instant cure and we are willing to take any number of OTC's to get there. This may not be how our bodies were intended to recover. ———————— Simplify, simplify, simplify. I am NOT asking for a return to a time that no one can remember (the 50's for example). I am asking us to return to a simpler, almost village-centered way of life. When I was a child and got sick, my dad called the doctor and he came to our house. We got a shot and got better. If that same doctor now has to maintain an office, a staff and lots of test equipment, the price goes up significantly. That the the doctor will give us a prescription is assumed, even if it does little to promote a cure (reduces symptoms only). Who benefits from this? More profit oriented companies. There are home remedies, much less expensive, that also reduce symptoms. The doctors have never heard of these and most modern people have not either. Imagine that we as humans have evolved (been created??) to be viable whole systems that can sustain life. I recommend an approach to health care, the purpose of which is to sustain a healthy life, not to make it worse (OTC poisons). The H1N1 virus is called a shift because it represents a new (something or other), not just a variation on the current flu virus. It has been suggested that viruses of this sort can come into existence so much more readily because of the way in which livestock are held in tight and unsanitary quarters - more agribusiness. Something is wrong with this picture. I challenge Howard Dean and President Obama to imagine a completely different world. (I would be happy to help out.) There is no need to criticize or condemn as I have in this message, thereby causing the special interest lobbyists to multiply like flies. It suffices to depict a new and different world (some countries are already moving there ...) that promotes sanity, health and at the same time sustains our planet. President Obama has committed to returning science to its rightful place. Perhaps we could get scientists to certify the "new world" and set up a plan to move towards it. The rightful edict would simply put the ball in motion. All the others would then have to figure out how to respond. (as in car industry)

Nancy Conrad
Dorchester , MA

The public option is critical to health reform. The public option would increase competition within the health insurance market and thus would lower costs. Health insurance costs too much and is hurting American businesses and consumers. If we succeed in giving Americans the choice between public and private plans, and bring down costs at least 30%, that will be more money in the pockets of American consumers in businesses which will get our economy moving again and help to create new jobs. More businesses will invest in America if the healthcare costs are lowered to the level they are in the rest of the industrialized world. Please support a public plan, I don't care what it takes, this country needs it to begin a period of sustainable economic growth again. Healthcare needs to be portable from job to job, affordable, and universal, every American should have a right to healthcare. It is an enormous injustice that our nations prisoners receive healthcare, yet 47 million hardworking Americans do not simply because they cannot afford it. To me a public health insurance option is the most important issue, and I will be sure to vote and organize my community against any politician who doesn't support the public option. Please pass public option health reform. Do what's right for America. Thank You, Jeremy Kasparian

Jeremy Kasparian
Arlington, MA

To Whom It May Concern, As a small business owner, I would like to offer my perspective on the healthcare issue. Healthcare is a very big problem these days for small business owners. The current employer-based health insurance system run by corporate insurance companies impairs the ability of small businesses, such as mine, to compete with big corporations and government employment opportunities. The government and large companies can more easily afford to subsidize the health insurance plans of their employees. In many cases, the cost of health insurance is way too high even for many business owners themselves. The premiums that I pay for my family coverage are are truly crippling to my personal financial situation. I believe that we should have the right to freely choose between single-payer and for-profit health insurance If there was a single payer option for us to join along with millions of other Americans, we would certainly be able to save money. For-profit health care, among other things, results in overtreatment for some and no treatment for way too many. It is high time that America joined the rest of the civilized world and realized that health care is a social responsibility. Profit should take a back seat to providing affordable health care for all Americans. Thank you so much, Greg Bishop Marblehead, MA

Greg Bishop
Marblehead, MA

Senator Kerry, as one of your constituents, I can't thank you enough for taking these comments to the hearing. I am an employer, and I know the private market has failed to deliver good options

to small nonprofits like the one where I work – the plans are too costly, and lack quality. As a result, the high cost of healthcare means we try not to hire people. That's wrong. That's why we need a public option – if the private sector can beat it, fine. If not, well, my co-workers and I will sign up.

Avi Green
Cambridge, MA

A public option is key because the insurance companies have a lock on policy and rules of coverage. A public option would compete on cost and provide portable coverage and other options in the public interest.

Roy Pertchik
lexington, MA

I strongly support the public option in health care because we need a reliable, low-cost, not-for-profit alternative to private insurance. Why shouldn't people under 65 have the same care as those over 65?

Justin West
MA

I was diagnosed with bilateral breast cancer in August, 2007 and have, in the most difficult way, come to understand the inadequacies of our current health system. After having 2 lumpectomies and beginning intensive chemotherapy, it became very clear that my current insurance carrier would not cover many of my cancer-related claims. They went out of their way to deny as many claims as they thought they could. Keep in mind that this insurance carrier had been approved and recommended by the Commonwealth of Massachusetts Division of Insurance. Luckily, my husband and I had the sense to quickly change our coverage midstream despite my pre-existing condition. By comparison, my mother just had a stroke in Connecticut and I would be unable to move to become her caregiver because Connecticut insurance doesn't cover preexisting conditions. Unfortunately, with my Massachusetts health plan, we just received notice that our annual premium is increasing by 34% over that of last year to $1,176 per month (more than our mortgage) which we can no longer afford. Meanwhile, our Congressmen, through our taxes, are receiving unlimited free health care. For the reasons stated above, we need a public insurance option similar to Medicare that is also portable, truly affordable, and without loopholes that allow for the denial of claims. Health care coverage in this country should be a right and not a privilege for ALL AMERICANS, not just the wealthy few or our elected representatives!!!!!

Mary Ellen Kempton
Dedham, MA

Public health care is important because it is inherently more efficient than private health care. This is because the need for profit is removed. Those on private health care should not have to pay for public health care, and vice versa.

Erik S-N
Lexington, MA

I believe a public health care option is crucial for lowering administrative costs. If the government can promote health care for people under 65, then we will have healthier elderly and less to pay through Medicare. This is a direct investment in our future, and the health of our children. As I am fifteen, I see that this will affect me quite directly very shortly, and I believe strongly that a public heath care option is the right thing to do.

Peter Schmidt-Nielsen
Lexington, MA

Health care should be a right, not a privilege. A single-payer public option is critical to making universal coverage an affordable reality – especially during the current economic crisis.

Margie Pertchik
Lexington, MA

To get cost down and get everyone covered we need to get profit taking out of health care. I support full choice which means a public option for all who want it.

Judy Smith
Missoula, MT

The public health care option is a key part of health care reform because it brings health care to everyone.

Kate Montressor
Florence, MT

People need a choice. It has been demonstrated by medicare that the public health option has less overhead and it is clear that people can then truly choose who they want for insurance. Now, insurance companies choose who they will insure, so a public option will increase competition and give people a real choice. It is not acceptable to have so many uninsured due to cost, or refusal of insurance companies to cover people with existing conditions or at a certain age.

Barbara Summer
Bigfork, MT

Dear Senators Baucus and Tester, Private, corporate insurance companies, by definition, will ALWAYS prioritize Wall Street profit over the health and wellness of citizens. Thus, any true reform MUST, at a minimum, include a public insurance option. We as a society have decided that our veterans and the elderly should have public health insurance– the rest of us should also be given that choice. Thank you.

Derek Goldman
Missoula, MT

For Senator Max Baucus, Currently I have decent health care. What frightens me is, if for any reason, I have to go to the ER. The first stop for everyone without Health Care Insurance is the ER. We've had friends who had to go to the ER and have waited many hours to even get seen. And YES they did have health insurance. But there were so many in the ER, they had to lie in the hallway for many hours, because there were so many people ahead of them. You get the picture. With a public option health plan, people will not need to use the ER as a first provider. I am a huge proponent of Single Payer, but it does not appear to be a nationwide option at this time, so please, please support this public option as a part of Obama's Health Care Plan. Thanks so much!! Evelyn K. Fizell Note: We currently live in CA, but plan to move to our property in Frenchtown, MT in 2010.

Evelyn K. Fizell
Frenchtown, MT

We need to have a say in what type of healthcare is available and affordable. To only have a private option puts too much power in the hands of folks who prioritize profit instead of healthy constructive citizens. Healthcare is a right–not a privilege– and to not have access to healthcare is a sentence for a life of needless suffering and/or early death.

Niraja Golightly
Missoula, MT -

health care should be available to every citizen in this country. Most every other advanced countries in the world are able to provide this...as so should we! Our current model of privatized health insurance has not been able to do this. We need a public health option.

Rob Reynolds
MT

I believe the public health care option is important so that we are not captives to the private insurance business and their whims about for example pre-existing conditions, not paying for preventive healthcare and increase premiums anytime they feel like it. Healthcare should not be a for profit business! It should be a right for every American.

Sacha Draine
Hammond, MT

I was self employed in the state of Montana from 1980 till I turned 65. It took many years for my business to even afford major medicical insurance and then I was forced to change companies every year because they raised my rates so high. After I turned 55 I found it very difficult to buy any insurance because the state did not require them to insure me. The year before I turned 65 I spent $3000.00 on insurance premiums and $2500.00 out of pocket for the deductable, so I basically paid for my own healthcare. We are the only industriallized nation on earth where someone can go bankrupt because of illness—-we need healthcare not health insurance.

Harry D Annear
Belgrade, MT

I am the only member of my immediate family who has insurance coverage. There are eleven others who are uninsured because they can not afford coverage and are not covered at work. Public health insurance modeled after Medicare or that provided to Government employees is of paramount importance to me and my family. I urge you to see that it is provided for our citizens this year.

Kristi L Tolliver
Billings, MT

Having a public health care option is vital because the overseers of such an entity–the government– would have its constituents' best interests in mind and not the profits of corporations, CEOs and their shareholders. Each year, my health insurance premiums rise by at least $30 a month, and each year, I have scaled back my deductibles and/or changed plans to keep at least some health insurance. This ever-increasing system of rates and diminishment of services must be checked by a viable single-payer option. Further, three years ago, I lost a sister to breast cancer at the age of 39. Had she not had to worry so much about the affordability of health care and had access to quality health care–like our representatives and senators have– she would still be here today I urge Sen. Baucus, who does not have to run for re-election for five years and will probably have 60 votes in the Senate come June–to do the right thing and move the public health care option through the Senate and into law.

Mike O'Connell
Bozeman, MT

As a student and soon-to-be-member of the work force, one of my biggest concerns is finding a job that gives me health care. I have found that I have had to overlook perfectly good job options because they don't supply health care. There is absolutely no reason why the richest nation in the world can't supply affordable health care for all its citizens. A single-payer health care program would cut out the wasteful bureaucracy of private insurance companies, would put our nation's health interests above corporate profits, and is long overdue. As a fellow Montanan, I urge Senator Baucus to move the public health care option through the Senate and into law.

Emily Almberg
Bozeman, MT

From my own personal experience, having private health insurance is like having none at all. We need a program (such as our congressmen have) that is inclusive and available to all, particularly those who need it and often can't afford it. I have to believe that in the long run it will save money. . and lives.

Cookie Agnew
Big Timber, MT

Baucus is a wolf in the sheep skin; he has sold out the interests of American people often; he is doing it again by sabotaging the President's healthcare reform with the public option. But he and those who go against the people's interests will not get away with it... "Mr. Bush worked with Republican Chuck Grassley to cut a deal with Democrat Max Baucus to win bipartisan passage of a big tax cut in a Senate split 50-50 after the 2000 election." - Karl Rove, WSJ 4/09

Joe Plum
MT

Joe King
MT

It's key because so many of us Americans have spent years in dept to insurance companies and hospitals. I'm a seasonal firefighter in Montana. I work hard and help contribute to this community as well as many others across the U.S. and even though the money is good, it provides to health care benefits or options. I'm currently paying of medical dept for the next six years because i couldn't afford issurance, and i still can't afford it now. There are people across this country with a lot less than I, and it disgusts me to know how bad they have it when I think I've got it bad. If Baucus wants to help the lives of us Montanans, he needs to support this reform!

Catalin Corrigan
Bozeman, MT

Health care should be available to everybody.

Joy Quick
Volga, WV

Private insurers are in business to make money, not to insure good health. They deny insurance to those who are not a 'good risk', waste money on advertising, and are not meeting the needs of the American public. A public option is needed for those who cannot afford private insurance, cannot obtain coverage, or simply who trust the government to do what is right for the American people. Now I call on you, as our representatives, to do what is right for us, and lift the burden of fear of bankruptcy because of rising health care costs from our shoulders.

Paul Epstein
Charleston, WV

I work in Health Care, and I see people suffer every day from the current system. A Public Option would be a just and viable choice for our country, and I hope you will vote for it.

Elizabeth Jean Kent
Charleston, WV

This health care reform is far to important to let obstructionist defeat it by playing politics by the minority. The American people elected the majority to pass it.

Leroy E. Hunter
Morgantown, WV

Having a public health care option is essential for people like us. We are young, professional artists who depend upon this legislation to realize our goals. Self-employed people and small businesses would benefit tremendously from this option. Access to good health care is a right to every person.

Derek Overfield & Lauren Adams
WV

People should have the choice to have health-care coverage provided by an entity whose primary purpose is to provide health-care coverage and not provide profit for their share-holders. A non-profit entity open to all is the only hope for the millions with pre-existing conditions, and particularly for those who lose jobs. By removing the responsibility for employee health-care coverage our companies will be on a level playing field with those abroad.

Kenton And Susan Miller
mathias, WV

Especially during these hard times with so many folks unemployed, we have the resources to provide health care to all we need to do it. I am so impressed with my own medicare coverage gained through my retirement.

Marilyn Witbeck
Charleston, WV

My name is David A Whitaker, I am a disable veteran. I support the health care bill.

David A Whitaker
Martinsburg, WV

Lack of universal health is unacceptable in a wealthy and civilized country. We can and must do better to provide for the basic needs of our citizens.

Martin Broadhurst
Shepherdstown, WV

AMERICAN BENEFITS COUNCIL

STATEMENT OF JAMES A. KLEIN

ON BEHALF

OF THE

AMERICAN BENEFITS COUNCIL

SUBMITTED TO THE

COMMITTEE ON FINANCE

OF THE

UNITED STATES SENATE

FOR THE ROUNDTABLE DISCUSSION

ON

FINANCING HEALTH CARE REFORM

MAY 12, 2009

STATEMENT OF JAMES A. KLEIN ON BEHALF OF THE AMERICAN BENEFITS COUNCIL

ON

FINANCING HEALTH CARE REFORM

Chairman Baucus, Ranking Member Grassley, and Members of the Committee, thank you for the opportunity to participate in this roundtable discussion on financing health care reform. My name is James A. Klein, and I am President of the American Benefits Council (the "Council"). The Council is a public policy organization representing plan sponsors, principally Fortune 500 companies, and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly or provide services to retirement and health plans that cover more than 100 million Americans.

Mr. Chairman, I commend you and the other Members of the Committee for holding today's roundtable to focus on the important issue of health care reform financing. Your leadership is critical to ensuring that we as a country continue to take the necessary steps to ensure that all Americans have affordable and comprehensive health care coverage, while also ensuring that these steps are undertaken in a sustainable and fiscally sound manner.

In considering the financing of health care reform, we urge that Congress adhere to four foundational principles:

(1) In conjunction with ensuring health coverage for all Americans, enact systemic changes that will mitigate cost increases and, thereby, restrain the need for greater revenue;

(2) Proceed conservatively in estimating costs, savings and revenue – it is better to err on the side of overestimating the cost of expanding health coverage and underestimating the savings or revenue from various financing proposals;

(3) Reforming the health care system is a societal imperative, and the responsibilities associated with doing so should be shared equitably by the stakeholders in the system; and

(4) Ensure that Americans can keep the coverage they enjoy, which for most people is employer-sponsored coverage. Financing and other policies should protect and build upon employer-based health coverage.

As a country, we spent approximately $2.4 trillion on health care in 2007, according to the most recent available data from the U.S. Department of Health and Human Services.[1] This amount is almost twice as much as we spent in 1996, and total national health care spending is projected to double yet again by 2017.[2] That level of increase is not sustainable. We already spend far more per capita on health care than any other developed nation, yet we rank well below other countries on many vital indicators of health status. However, perhaps even more troubling is the well-documented evidence that patients receive appropriate care for their conditions only about 55 percent of the time,[3] and medical errors may account for as many as 98,000 fatalities each year.[4]

It all adds up to an annual rate of increase in health care spending that exceeds by three or more times projected increases in the gross domestic product or the future growth in employee wages and far outpaces the expected growth in federal or state revenues.[5] Taken together, these projections make it abundantly clear that no matter who ultimately pays the bill, health care must be made more affordable, or it cannot be made more available. In addition, our health care system is marked by wide and unexplained variations in both the overuse and underuse of health services and all too frequently subjects patients to preventable medical errors. Moreover, despite widespread agreement on the importance of extending health coverage for all Americans, too many people are left without coverage entirely, including an estimated nine million children.[6]

There is now a broad consensus that we need to begin the process of taking well-reasoned steps to reform the current health care system. However, while doing so will be costly, spending more money is not the only solution to the system's challenges. Indeed, among the most compelling reforms required are those that, if designed properly, will help reduce costs and obviate, to some extent, the need to raise revenue. The Council believes that a significant amount of financing for health reform can be found from reforms made to, and within, the health care system – through, for example, increased efficiencies, continuous improvements in quality of care, better transparency in the pricing and quality of providers and their services, and through the use of standard health information technologies among providers and related institutions.

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[1] NAT'L COAL. ON HEALTH CARE, HEALTH INSURANCE COSTS 1 (2008), *available at* http://www nchc.org/documents/Cost%20Fact%20Sheet-2009 pdf

[2] *See id.*

[3] *See* Elizabeth A. McGlynn et al , *The Quality of Health Care Delivered to Adults in the United States*, 348;26 NEW ENG. J. MED. 2635, 2635 (June 26, 2003), *available at* http://content.nejm.org/cgi/content/full/348/26/2635

[4] INST. OF MED., TO ERR IS HUMAN BUILDING A SAFER HEALTH SYSTEM 26 (Linda T Kohn, Janet M Corrigan & Molla S. Donaldson eds., 2000), *available at* http //www.nap.edu/openbook.php?isbn=0309068371.

[5] NAT'L COAL. ON HEALTH CARE, HEALTH INSURANCE COSTS (2008), *available at* http://www.nchc org/documents/Cost%20Fact%20Sheet-2009 pdf

[6] COVER THE UNINSURED, QUICK FACTS ON THE UNINSURED, *available at* http://covertheuninsured.org/content/quick-facts-uninsured.

Moreover, the current income and payroll tax exclusion for employer-paid health coverage ("employee exclusion") represents a comparatively small portion of our current annual health expenditures – and it works! It helps deliver comprehensive and affordable health coverage to a significant majority of American families. Thus, although the employee exclusion is perhaps more easily identified and quantified than other aspects of health financing – because we are able to put our metaphorical hands on it – the Council believes, for reasons more fully described below, that any reform measures should build upon, rather than replace, the current employer-based system and preserve the employee exclusion. The key components of any proposed health reform initiative should be carefully assessed to determine if they will strengthen, impede or reduce participation in the employer-based health system.

PRINCIPLE #1 – In conjunction with ensuring health coverage for all Americans, enact systemic changes that will mitigate cost increases and, thereby, restrain the need for greater revenue.

As we discuss in our recent report, *Condition Critical: Ten Prescriptions for Reforming Health Care Quality, Cost and Coverage*, the Council's members strongly believe that "we can, and must, achieve a more affordable, more inclusive and higher quality health care system," and that we must "close the coverage gap and bring all Americans into the health care system."[7]

As we consider next steps for moving toward this important goal, we must be mindful of not only the current economic climate and of already sky-high levels of health care spending, but also of the need to build a long-term sustainable reformed health system. Accordingly, the Council believes that we need to look for cost savings from within the system as one important way to help finance any reform measures.

Reduced Costs Through Increased Quality of Care

Health care may be the one service or product in the United States where many purchasers routinely and willingly pay as much, or more, for poor quality as for good quality. Notably, some of the largest contributing – and most controllable – factors fueling the rapid rise in health care costs are the uneven quality of care and a system that too often provides unnecessary, ineffective or insufficient treatment.

The Council believes there are a host of reforms that can be undertaken to increase the quality of care that will also result in significant cost savings system-wide. They include the following:

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[7] AMERICAN BENEFITS COUNCIL, CRITICAL CONDITION: TEN PRESCRIPTIONS FOR REFORMING HEALTH CARE QUALITY, COST AND COVERAGE 1 (2009), *available at* www.americanbenefitscouncil.com/documents/condition_critical2009 pdf.

- *Implement nationwide interoperable health information technology.* Providers and other stakeholders must be linked to ensure that patient records and other information are readily available. Overall, the health care system lags far behind other industries in the use of information technology to advance efficiency, consistency and safety.

- *Provide safe harbor protections for health care providers and payers for decisions and practices that are evidence-based.* Determinations that are consistent with consensus-based quality measures or comparative effectiveness research should be protected by liability safe harbors.

- *Establish a national review process to rigorously examine existing and proposed state and federal benefit mandates.* This review process should aim to sunset existing benefit mandates that are not evidence-based, consistent with best practices in benefits design and clinical care, or are contributing unnecessarily to increases in health care costs.

- *Promote personal wellness and ownership for maintaining a healthy lifestyle.* Incentives should be strengthened for the expansion of benefit plans, workplace wellness programs and educational programs that promote wellness and encourage greater personal responsibility for adopting a healthy and safe lifestyle.

- *Increase participation in chronic disease management programs.* The availability of, and participation in, focused care management initiatives to address chronic diseases and other health care priorities should be significantly expanded.

- *Expand the understanding and availability of appropriate end-of-life care options.* Best practices research should be expanded to assist patients, families, health care providers and other caregivers in considering therapeutically appropriate end-of-life care options.

Increased Savings Through Transparency in Pricing and Quality

Another area where system-based reforms can deliver significant cost savings is by making price and performance information more easily accessible, so consumers can identify providers with a proven record of delivering high-quality care. A more transparent system also gives health care providers needed tools to evaluate their performance and encourages continuous quality improvement. A transparent health care system provides incentives to move consumers and health care providers in the direction of evidence-based care by relying on clear, objective information on treatment options and costs. Finally, transparency also protects patients from unsafe or unproven care. While consumers should certainly be armed with information to identify high performance health care providers, they should also be able to steer clear of those with high rates of medical errors or who fail to deliver evidence-based care.

Employers play a unique role in making the health care system more transparent by working with health care providers, insurers, consumer groups and government officials to help identify and disseminate the type and amount of information needed for better health care decision-making. Many employers have developed effective incentives to encourage broad employee participation in a wide range of health improvement initiatives. This experience will be essential in creating a critical mass of users of cost and quality information in order to establish a consumer-centric health care system.

The following changes can help increase transparency, thus leading to better, more informed health care purchasing decisions and significant cost savings for the system as a whole:

- *Design and implement consensus-based quality and cost measures.* Public-private partnerships representing major health care system stakeholders have proven to be effective in developing initial sets of quality measures. Cost measures should also be developed based on episodes of care rather than unit prices for components of health care services.

- *Transform the current payment structure from a procedure-based, fee-for-service system to a value-based system.* Health care providers should be rewarded by a payment system that initially provides financial incentives for routine reporting of quality and cost information based on nationally-adopted consensus measures. Ultimately, health care providers should be rewarded for their demonstrated performance in the delivery of quality care, rather than simply the volume of services provided.

- *Foster continuous improvement by health care providers.* Health care providers should be equipped with comparative clinical performance information to support continuous improvement in patient care.

- *Expand the use of consumer incentives in a broader range of health plan options.* Health plans should provide incentives for plan participants to choose services from health care providers who deliver care consistent with consensus-based quality measures and demonstrate a commitment to quality improvement. Greater use of "consumer-directed" plans is one such strategy to achieve this objective.

- *Expand the practice of nonpayment for serious preventable medical errors.* All payers for health care services should adopt the practice, used by Medicare, where no payments are made for certain serious preventable medical errors, also known as "never events." A consistent response by all public and private payers to end such payments will lead to more effective internal controls to improve patient care and safety. Health care providers also should be required to report all medical errors as a condition of payment by Medicare.

- *Establish a national entity with a broad-based governance body to significantly increase the capacity for independent, valid comparative research on clinical and cost effectiveness of medical technology and services.* Rigorous comparative effectiveness research is needed to examine clinical and cost evidence to support decisions on medical technology, treatment options and services to help ensure that more patients receive the right care for their conditions.

In addition to the above, the following must also be part of comprehensive reform:

- *Reform the individual insurance market.* Many current rules foster adverse selection within the individual insurance market and limit the pooling of risk for pricing and selling insurance. A more efficient individual insurance market reduces the cost of insurance for individual purchasers.

- *Reform medical liability rules.* Reasoned reform of unwarranted attorney's fees and excessive damages awards is an important cost savings initiative.

All of the above-mentioned proposals are systemic improvements that should generate cost savings that can be used as part of a fiscally sound approach to overall health system reform.

PRINCIPLE #2 – Proceed conservatively in estimating costs, savings and revenue – it is better to err on the side of overestimating the cost of expanding health coverage and underestimating the savings or revenue from financing proposals.

The Council urges the Committee and Congress as a whole to proceed in a careful and deliberate manner in considering the nature and cost of any reforms. As part of this process, the Council urges the Committee not to underestimate the costs of health reform and to be conservative in determining the savings or revenue that is likely to be raised from any financing proposals, especially those where accurate valuations may be particularly difficult to obtain.

We likely can all agree that the cost of expanding health coverage to millions of currently uninsured Americans will not be an inexpensive venture and will require significant and sustained financial investment. We cannot, however, begin to have a meaningful discussion regarding health reform financing unless and until we better understand the expected costs associated with expanding coverage. Accordingly, the Council urges the Committee to use the myriad of resources at its disposal to understand as fully as possible the expected costs of health reform.

On a related note, it is important for all of us to keep in mind that there likely will be times when we might otherwise want to avoid confronting head-on the cost and financing realities. There is little doubt that the process of accurately estimating the projected costs of

health reform is no easy task. As quoted by the *The Wall Street Journal* on May 5, 2009, Douglas Elmendorf, director of the Congressional Budget Office, acknowledged that, with respect to the process of accurately estimating the cost of health reform, "[t]his is as complicated as all get out."[8] The American people are not well served by failure to fully account for the expected costs of health reform. The long-term result of doing so could be unexpected tax increases on the American public and/or a system – albeit well-intentioned – that is not sustainable in the long-term.

We must be equally vigilant that we do not undertake processes that unintentionally or otherwise give undue value to potential financing vehicles. For example, this statement addresses how meaningful savings can be realized from system-based changes, including those designed to increase the quality and efficiency of health care and transparency in pricing. The Council strongly believes that real and significant cost savings can be achieved through implementation of these changes and that these savings can be used to help finance broader health reform measures. Nonetheless, we are not unaware of the complexities inherent in trying to quantify the expected revenue that could be raised for health reform through these systemic changes. Accordingly, we urge all parties involved to be conservative in valuing those savings. As a country, we will be best served by being measured in calculating the financial aspects of health reform.

PRINCIPLE #3 – Reforming the health care system is a societal imperative, and the responsibilities associated with doing so should be shared equitably by the stakeholders in the system.

There is broad national consensus that we need health reform. The Council strongly shares that view. We do, however, believe that the costs associated with health reform should be shared equitably by all stakeholders within the system.

Significantly, employers and employees already expend a significant amount of financial resources to ensure that employees and their families have health coverage. In 2007, employers as a group paid an astounding $530+ billion for group health plan coverage for their workers and their families.[9] On average, this amounted to $9,325 per employee for family coverage in 2008.[10] Notably, employees have also been working hard to pay their share of our nation's health care burden. In 2008, in addition to the employer premium contributions noted above, employees paid on average $3,354 towards the premium costs associated with their employment-based health coverage.[11] Accordingly, to the extent that

[8] Janet Adamy, *Need For Cost Data Slows Health-Care Overhaul*, WALL ST. J., May 5, 2009, at A2

[9] EMPLOYEE BENEFIT RESEARCH INST., EBRI DATABOOK ON EMPLOYEE BENEFITS tbl 2.2f (2009), *available at* http://www.ebri.org/pdf/publications/books/databook/DB Chapter%2002.pdf.

[10] THE KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS 2008 ANNUAL SURVEY 1ex.A (2008), *available at* http://ehbs.kff.org/pdf/7790.pdf. This amount reflects the portion of the premium paid by an employer for coverage for a family of four.

[11] *Id.* This amount reflects the portion of the premium paid by an employee for coverage for a family of four.

additional revenue sources are needed, after taking into account those generated from system-based changes, Congress should acknowledge that employers and employees already – as the saying goes – generously "give at the office."

On a related note, given that the costs associated with health reform will not be insignificant, Congress should ensure that any reforms are both desirable and effective. History has shown that where the American taxpayer is asked to "foot the bill," reforms enacted without deliberate consideration can result in taxpayer disapproval, unanticipated additional costs and even wholesale repeal of the reform. Perhaps the best example of this is the enactment and prompt repeal of the Medicare Catastrophic Coverage Act in the late 1980s.[12] The reform was intended to help our aging population enhance Medicare coverage and was to be paid for by Medicare-eligible individuals in the form of higher Medicare premiums. Once enacted, however, many of these individuals were soon confronted with higher premium costs for a benefit they were already receiving from other sources or did not desire. With widespread and growing dissatisfaction among seniors over the change, Congress eventually repealed the measure.[13]

Undoubtedly, the Committee recalls the lessons learned by this experience. Even where reforms are based on lawmakers' best intentions, if the reform is not one valued or desired by the American public, especially where we are asking them to pay for the reforms in the form of higher taxes or reduced employer-based benefits, this can lead to an unsustainable system of changes.

Notably, in the Medicare catastrophic coverage example, many of the benefit improvements were lost when the financing mechanism proved unsustainable, and the law was repealed. With comprehensive health care reform, if we fail to move in a reasoned and fiscally sound manner, it is likely to be very difficult, if not impossible, to undo any unintended negative consequences. Accordingly, the Council urges the Committee and Congress as a whole to carefully consider any and all legislative changes only if economically and politically sustainable sources of financing are available.

PRINCIPLE #4 – Ensure that Americans can keep the coverage they need and value, which for most people is employer-sponsored coverage. Financing and other policies should protect and build upon employer-based health coverage.

The current employer-based model for health care has been, and continues to be, very successful in delivering comprehensive health coverage to a majority of American families.

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[12] Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360.

[13] Medicare Catastrophic Coverage Repeal Act of 1989, Pub. L. No. 101-234.

In fact, in 2007, 61% of non-elderly Americans were covered by employer-based health insurance.[14]

All available data indicates that, by and large, those 160 million Americans who receive health care coverage through the employment setting are exceedingly satisfied. A 2007 study by the National Business Group on Health reported that over 67% considered their employer-provided coverage to be either "excellent" or "very good." Thus, the Council urges the Committee to recognize the inherent value of the current employer-provided system (including the existing tax treatment) in delivering comprehensive coverage to American families. The Council believes that any reform measures should be designed to build upon the current employer-based model.

Notably, there has been discussion as to whether the employee exclusion should be modified. Some have suggested that the value of the current employee exclusion should be limited or otherwise "capped," either by limiting the amount of the exclusion to some specific amount – thereby taxing employer-paid coverage in excess of such amount – or by allowing the availability of the employee exclusion only to persons with incomes below a certain threshold.

It would be a mistake to limit or otherwise undermine the exclusion. Equating to less than 10 percent of our annual health expenditures, there can be little doubt that the employee exclusion makes possible essential coverage for a significant majority of American families. Raising taxes on those who participate in health plans is not the way to solve the health care system's ills. Limiting the exclusion based upon the cost of some level of coverage raises a number of issues:

- *Geographical differences in cost.* Any limit on the current employee exclusion would operate as nothing more than a tax increase for individuals who live in higher-cost areas given the very real variations in health care costs depending on geographic location. But even those in lower-cost areas might not be protected. For example, if an individual works for a large multi-state employer, with most of its employees in high-cost areas, such individual might be subject to tax because the insurance cost for the group as a whole is generally higher.

- *Differences in age among employees.* Any limit on the employee exclusion could penalize workers based on age. Most notably, older workers likely would be subject to a higher tax than younger workers because their coverage generally costs more. Additionally, younger workers who are employed by a company with a comparatively older, more expensive workforce likely would be taxed more than their counterparts at another company with an overall younger workforce.

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[14] KAISER FAMILY FOUNDATION, THE UNINSURED: A PRIMER, KEY FACTS ABOUT AMERICANS WITHOUT HEALTH INSURANCE 1 (2007), *available at* www.kff org/uninsured/upload/7451-03.pdf.

- *Treatment of multi-state plans.* A limit on the employee exclusion would necessitate an extraordinarily complex set of rules to specify if, and how, multi-state employers can combine worksite employee groups for purposes of valuing and pricing health insurance. Without such rules, workers whose employers combine their workforces from high-cost areas would be more likely to run afoul of any limit on the employee exclusion than workers whose employer combines workforces from high- and low-cost areas for purposes of valuing and pricing health coverage. Complexity and inequity would result.

- *Indexing.* Unless any limit on the current employee exclusion is indexed using an appropriate measure that reflects real cost increases, any such limit is unlikely to keep pace with increasing health costs. The end result would be that the tax benefits delivered vis-à-vis the employee exclusion in Year 1 would be less in each subsequent year. Notably, this is, in part, how the Bush Administration's health reform proposal was scored as revenue-neutral over 10 years, by indexing the proposed standard above-the-line deduction based on the overall Consumer Price Index (CPI), not the health factor of the CPI, which is a much more reliable indicator of annual health cost increases.

  Some have suggested that a "cap" on the amount of the exclusion and/or the absence of any meaningful indexing would help contain health costs. It is true that changes in the employee exclusion would likely make health care more expensive for employees and that generally when you make something more expensive people tend to use less of it. If only it were that simple when it comes to health coverage! It is hard to imagine that employers or employees need any additional incentives to try and reduce health care costs. It is unclear whether such cost containment would in fact be realized. We doubt that the nation would want to experience diminished health care coverage based on such an untested theory.

As the above discussion is intended to demonstrate, it would be very difficult, if not impossible, to design a limit to the current employee exclusion that did not result in tax inequities and/or require a burdensome and costly set of valuation rules for employers and workers. Notably, this was tried once before with the enactment of Internal Revenue Code Section 89[15] and it was famously unsuccessful. Despite best intentions, the statutory and regulatory regime established by Congress and the Treasury Department for purposes of valuing employer-provided health coverage proved completely unworkable.

One reason the valuation rules were so complex under Section 89 is because there is great diversity among employer plans. This diversity is driven in large part by employer innovations in plan design fashioned to provide the coverage that best meets a workforce's

[15] I.R.C § 89.

specific coverage needs. So quite apart from the cost and complexity that Section 89 imposed on employers, had it gone into effect, it would have stifled innovation and inexorably led to coverage that was less responsive to workers' needs. Congress was left with no choice but to repeal Section 89 just as the law was going into effect after employers had wasted countless millions of dollars in a futile effort to comply with a set of ill-advised requirements.

A limit on the exclusion based not upon the extent of coverage, but rather on the income of the family receiving such coverage, has its own set of complexities and inequities. It is essentially nothing more than a tax increase on individuals with income above whatever threshold is set – simply a less straightforward and explicit one. This is because the value of any employer-paid coverage would be taxable to such individuals as additional W-2 wages. One can only begin to imagine the complexities and inequities that would result from imposing a tax on families who incomes are above the specified threshold, but whose members have differing levels of health coverage from multiple sources. Limits on the employee exclusion undoubtedly would have a destabilizing effect on the employer-sponsored health coverage system. An even more obvious and greater destabilization of the system would result if limits were imposed on employers' ability to deduct health care expenditures.

Conclusion

The Council believes that adherence to the four principles set forth in this testimony will provide a logical and equitable basis for evaluating the costs of health reform and a sustainable and equitable framework for financing those reforms. Thank you for the opportunity to share the Council's perspectives. We look forward to working with the Committee on the important efforts upon which it has embarked.

[SUBMITTED BY EDWARD KLEINBARD]

BACKGROUND MATERIALS FOR SENATE COMMITTEE ON FINANCE ROUNDTABLE ON HEALTH CARE FINANCING

Before the
SENATE COMMITTEE ON FINANCE
on May 12, 2009

Prepared by the Staff
of the
JOINT COMMITTEE ON TAXATION

May 8, 2009
JCX-27-09

CONTENTS

I. OVERVIEW

The Senate Committee on Finance has scheduled a roundtable on health care financing for May 12, 2009. As background for this roundtable, at the request of Chairman Baucus, the staff of the Joint Committee on Taxation has prepared background material relating to present-law tax expenditures related to health care and the Administration's fiscal year 2010 budget proposal to reduce the value of itemized deductions claimed by certain taxpayers. [1] The Administration's proposal is intended to offset the cost of health care reforms.

The Internal Revenue Code[2] includes a number of significant tax expenditures for health expenses.[3] The availability of these different benefits depends in part on the answers to the following questions:

1. Is the individual covered under an employer-provided health plan?

2. Does the individual have self-employment income?

3. Does the individual itemize deductions and have medical expenses that exceed a certain threshold?

4. Is the individual covered by a high-deductible health plan?

Table 1 shows estimates of the tax expenditures for the health care sector in 2008. The largest tax expenditure is for employer-provided health care benefits. The remaining tax expenditures, such as the self-employment exclusion and the deduction for medical expenses greater than 7.5 percent of adjusted gross income, were each less than $11 billion, while the estimated tax expenditure for health savings accounts was less than $1 billion.

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[1] This document may be cited as follows: Joint Committee on Taxation, *Background Materials for Senate Committee on Finance Roundtable on Health Care Financing*, (JCX-27-09), May 7, 2009. This document is available at www.jct.gov.

[2] Unless otherwise indicated, all section references are to the Internal Revenue Code of 1986, as amended (the "Code").

[3] Appendix A compares in tabular form the various tax provisions that mitigate the costs of health care under present law.

Table 1.–Selected Tax Expenditures for Health, 2008

Value of Tax Expenditures	Billions of Dollars
Exclusion of employer sponsored health care	226.2
Income	132.7
FICA	93.5
Exclusion of Medicare benefits from income	41.8
Hospital Insurance (Part A)	21.3
Supplemental Medical Insurance (Part B)	14.9
Prescription Drug Insurance (Part D)	4.4
Exclusion of subsidies to employers who maintain prescription drug plans	1.1
Deduction for medical expenses above 7.5% of adjusted gross income	10.7
Self-employed health insurance deduction	5.2
Exclusion of medical care and TRICARE insurance for military dependents and retirees not enrolled in Medicare	2.1
Exclusion of health insurance benefits for military retirees enrolled in Medicare	1.2
Health savings accounts	0.5
Health Coverage tax credit	0.1

Source: JCT Staff calculations.

The presentation in Table 1 differs from conventional estimates of tax expenditures in two respects. First, these estimates do not include the effects of "tax form behavior." In particular, conventional expenditure estimates prepared by the Staff of the Joint Committee on Taxation (the "JCT Staff") assume that when taxpayers are denied an exclusion for employer sponsored insurance, they can deduct premiums under section 213 to the extent that their expenses exceed 7.5 percent of adjusted gross income. By contrast, the estimates in Table 1 assume that, if the exclusion for employer sponsored health insurance were repealed, employees would not be permitted to take into account the insurance premiums towards the section 213 medical expense deduction. In addition, conventional tax expenditure estimates are calculated only with respect to their effect on income taxes, and thus do not include payroll tax under the Federal Insurance Contribution Act ("FICA") effects. The estimate for the FICA effects of the employer exclusion in Table 1 does not reflect the effects of changes in current FICA liability on the present value of taxpayers' future social security benefits. Finally, unlike revenue estimates, neither the estimates in Table 1 nor conventional tax expenditure estimates assume other behavioral responses by taxpayers. The expenditure for Health Coverage Tax Credit ("HCTC") is expected to increase in 2009 due to the enactment of the TAA Health Coverage Improvement Act of 2009 (Pub. L. No. 111-5) that increased the coverage per eligible individual and the number of individuals eligible for the credit.[4]

[4] Joint Committee on Taxation, *Tax Expenditures for Health Care* (JCX-66-08), July 31, 2008.

The exclusion of employer sponsored health care had a value of $226 billion with $133 billion coming from exclusion from the income tax and $93 billion from excluding the value of health insurance from both the employer and employee portions of the Federal Insurance Contribution Act FICA tax.

The most favorable tax treatment under present law generally is provided to individuals who are in an employer plan where the employer pays the premium.[5] Such individuals may exclude from income and wages employer-provided health insurance. Depending on the employer's plan, they may also exclude from income some amounts expended for medical care not covered by insurance. Self-employed individuals receive the next most favorable treatment. They may deduct 100 percent of the cost of their health insurance from their income tax, but they may not deduct their health insurance premiums from their payroll tax base.[6] In the case of the employer-provided exclusion and the self-employed deduction, there is no cap on the tax benefit that would limit the generosity of health plans that can be purchased with pre-tax dollars. The tax benefit is only subject to the limitation that the health benefits covered must fall under the definition of medical care in section 213(d). Present law also provides additional, less significant, tax expenditures for other health care benefits.

There are significant non-tax advantages to operating through the employer-provided system. Providing health insurance coverage through a large group provides significant savings because of risk mitigation and lower administrative costs. Employers typically have superior negotiating power, compared to individual consumers, in negotiating the terms of insurance coverage with insurers. In addition, a group system mitigates the problems of adverse selection because the formation of employer groups is not highly correlated with health status. This results in a relatively even distribution of individuals who are high-risk and may have trouble finding affordable health insurance in the individual market. The combination of tax and economic advantages of employer-provided health care has resulted in the employer-provided system providing the vast majority of health care coverage, resulting in the large tax expenditure seen in Table 1 for employer-provided health care.

Nevertheless, the current system of providing a tax subsidy for employer-provided health care with no or little subsidy in the case of insurance purchased outside of the employer market distorts taxpayer and market behavior. The existence of the subsidy reduces the price of the consumption of health care, leading to overconsumption of health care relative to other goods

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[5] The refundable HCTC provides a greater tax benefit than the exclusion. Fewer than one-half million taxpayers per year, however, are estimated to be eligible for the credit. Similarly, certain individuals are temporarily able to purchase health insurance at a reduced premium due to an employer tax credit for a portion of their COBRA eligibility period under the provision of the Consolidated Omnibus Reconciliation Act of 1985.

[6] In addition, where applicable, the deduction for self-employed individuals is taken after eligibility for the Earned Income Tax Credit ("EITC") has been calculated. In contrast, an employee's earned income for purposes of the EITC is determined after the exclusion of the value of employer provided health insurance.

and services for those taxpayers with qualifying plans, and a comparative disadvantage for those purchasing health insurance in the individual market.

II. EMPLOYMENT RELATED TAX EXPENDITURES

A. Employer-Provided Health Care

In general

The Code generally provides that an employee may exclude from his or her gross income the value of employer-provided health care. Income generally is defined to include compensation paid to a service provider in any form, whether in cash or in kind. The value of health insurance that an employer purchases for its employees constitutes compensation to each covered employee in this general sense. The exclusion therefore represents a departure from the Code's general tax principle that compensation should be included in income; the exclusion for employer-provided health care is the largest tax expenditure under the current tax system. The tax expenditure for the exclusion for employer-provided health care is estimated to be $226.2 billion for 2008, using the methodology described in connection with Table 1. This represents by far the largest portion of the total tax expenditures for health and is the third largest health expenditure if measured against direct Federal spending, exceeded only by direct expenditures for Medicare and Medicaid.

Table 2.–Calendar Year Tax Benefit from Employer Exclusion by AGI,* 2008

Adjusted Gross Income	Total Savings (millions)	Income Tax Savings (millions)	FICA Tax Savings (millions)	Total Tax Returns (thousands)	Average Savings Per Return (dollars)
< 10,000	3,620	(269**)	3,889	5,698	635
10,000 – 29,999	34,423	17,779	16,644	17,631	1,952
30,000 – 49,999	42,667	22,697	19,970	17,369	2,457
50,000 – 74,999	46,052	24,716	21,336	14,879	3,095
75,000 – 99,999	37,055	22,110	14,945	9,502	3,900
100,000 – 199,999	48,060	33,962	14,098	10,726	4,481
200,000 – 499,999	11,645	9,549	2,096	2,463	4,728
> 500,000	2,680	2,182	498	600	4,467
Total	**226,202**	**132,726**	**93,476**	**78,868**	**2,868**

* See discussion immediately following Table 1 for the methodologies applied in calculating the value of this exclusion. Table 2 reflects both income and FICA tax distributional consequences.

** Negative amounts reflect the fact that the exclusion reduces earned income for purposes of the earned income credit, resulting in a decrease in refundable credits for some recipients.

Source: JCT Staff calculations.

Table 2 shows the total savings from the employer exclusion for eight income brackets. This table shows that taxpayers with adjusted gross income ("AGI") less than $50,000 obtain cash savings from the exclusion for employer-provided health care valued at between $600 and $2,500, while those earning more than $100,000 per year have average cash savings worth between $4,000 and $5,000.

As with other compensation, the amount paid by an employer for employer-provided health care of employees is deductible. Unlike other forms of compensation, however, if an employer contributes to a plan providing health coverage for an employee (and his or her spouse and dependents), the contribution and all benefits (including reimbursements) for medical care under the plan are excludable from the employee's income for both income and payroll tax purposes.[7] The exclusion applies both in the case in which employers absorb the cost of their employees' medical expenses not covered by insurance (i.e., a self-insured plan) as well as employer payments to purchase health insurance. There is no limit on the amount of employer-provided health coverage that is excludable.

Active employees participating in a cafeteria plan[8] may pay their share of premiums on a pre-tax basis through salary reduction. Such salary reduction contributions are treated as employer contributions and thus also are excluded from gross income and wages for payroll taxes.

The Employee Retirement Income Security Act of 1974 ("ERISA") preempts State law relating to certain employee benefit plans, including employer-sponsored health plans.[9] While ERISA specifically provides that its preemption rule does not exempt or relieve any person from any State law which regulates insurance, ERISA also provides that an employee benefit plan is not deemed to be engaged in the business of insurance for purposes of any State law regulating insurance companies or insurance contracts. As a result of this ERISA preemption, self-insured employer-sponsored health plans need not provide benefits that are mandated under State

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[7] Secs. 104, 105, 106, 125, and 3121(a)(4). Health coverage provided to active members of the uniformed services, military retirees, and their dependents are excludable under section 134. That section provides an exclusion for "qualified military benefits," defined as benefits received by reason of status or service as a member of the uniformed services and which was excludable from gross income on September 9, 1986, under any provision of law, regulation, or administrative practice then in effect.

[8] If an employer offers employees a choice between taxable benefits (which include cash compensation) and qualified benefits (which include employer-provided accident and health coverage), the choice must generally be provided under a cafeteria plan that satisfies the requirements of section 125. Otherwise providing this choice may result in income inclusion even if the employee chooses an excludable benefit. *See* sec. 125 and proposed Treas. Reg. secs. 1.125-1 through -7 published in the Federal Register on August 6, 2007, 72 FR 43938.

A cafeteria plan must be in writing and must not provide for deferred compensation except as specifically provided in section 125(d). Certain excludable benefits are not permitted to be provided in a cafeteria plan, including long-term care benefits, contributions to Archer MSAs, qualified scholarships under section 117, benefits under educational assistance programs under section 127, and certain fringe benefits under section 132. HSA contributions are allowed through a cafeteria plan. If benefits provided under a cafeteria plan discriminate in favor of highly compensated participants, any exclusion from income for benefits under the plan may not apply to such highly compensated participants. Any qualified benefit must also satisfy any specific requirements under the section that allows its exclusion.

[9] ERISA sec. 514.

insurance law. Further, self-insured employer plans are not subject to State insurance taxes or regulation, such as premium taxes imposed on insurance companies under State law.

Unlike tax-qualified pension plans, present law includes few requirements or limitations on the design of employer-provided health care plans. In particular, and in contrast to most other Federal tax benefits, there is no limitation on the amount of health benefits that an employer can provide on a tax-free basis. This effectively allows taxpayers to control the amount of their tax benefit. Employer-provided health plans are not required to cover all employees or to provide the same benefits to all employees.[10] In addition, the tax exclusion is not predicated on coverage of certain illnesses or conditions.

While there are certain restrictions with which group health plans must abide, the Code imposes an excise tax on group health plans that fail to meet these requirements.[11] The excise tax is generally equal to $100 per day during the period of noncompliance and is imposed on the employer sponsoring the plan if the plan fails to meet the requirements.

In addition to offering health insurance (or self-insurance), employers often agree to allow employees to fund (or fund themselves) employer sponsored accounts to reimburse some of the remaining medical expenses of their employees (and their spouses and dependents). These arrangements are commonly used by employers to pay or reimburse employees for medical expenses that are not covered by health insurance. These arrangements include health flexible spending arrangements ("FSAs") and health reimbursement arrangements ("HRAs").

Health FSAs typically are funded on a salary reduction basis under a cafeteria plan, meaning that employees are given the option to reduce their current cash compensation and instead have the amount made available for use in reimbursing the employee for his or her medical expenses. Health FSAs that are funded on a salary reduction basis are subject to the Code's requirements for cafeteria plans, including a requirement that amounts remaining in a health FSA under a cafeteria plan as of the end of a plan year must be forfeited by the employee (referred to as the "use-it-or-lose-it-rule").[12] If the health FSA under a cafeteria plan meets certain requirements, the compensation that is forgone is not includible in gross income or wages. Health reimbursement arrangements ("HRAs") operate in a manner similar to health FSAs, in that they are an employer-maintained arrangement that reimburses employees for

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[10] An exception to this general rule applies in the case of self-insured group health plans, which must satisfy certain nondiscrimination rules in order for the benefits of highly compensated individuals to be excludable. Sec. 105(h). As previously discussed, benefits provided under a cafeteria plan are subject to certain nondiscrimination requirements.

[11] Secs. 4980B; 4980D.

[12] Sec. 125(d)(2). See proposed Treas. Reg. secs. 1.125-1 through -7. However, if a plan chooses, a grace period not to exceed two and one-half months immediately following the end of the plan year during which unused amounts may be used is allowed. Notice 2005-42, 2005-1 C.B. 1204. Health FSAs are subject to certain other requirements, including rules that require that the FSA have certain characteristics similar to insurance.

medical expenses. Some of the rules applicable to HRAs and health FSAs are similar (e.g., the amounts in the arrangements can only be used to reimburse medical expenses and not for other purposes), but the rules are not identical. In particular, HRAs cannot be funded on a salary reduction basis and the use-it-or-lose-it rule does not apply. Thus, amounts remaining at the end of the year may be carried forward to be used to reimburse medical expenses in the next year.[13] Unlike a health FSA, an HRA is permitted to reimburse an employee for health insurance premiums.

Unlike the section 213 itemized deduction for medical expenses which (as discussed below), in the case of drugs, is limited to prescribed drugs,[14] tax-free reimbursement for non-prescription drugs is permitted in the case of an employer-provided health plan. Thus, for example, amounts paid from an FSA, HRA, or health savings account (described later in the pamphlet) to reimburse the employee for nonprescription medicines, such as sunscreen, nonprescription aspirin, allergy medicine, antacids, or pain relievers, are excludable from income. This creates an even greater tax preference for employer-provided health care arrangements.

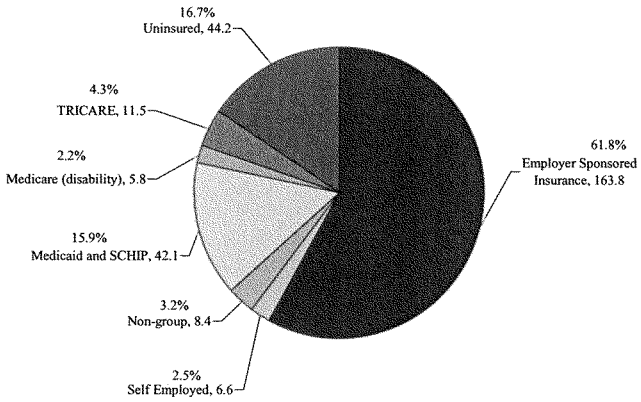
[13] Guidance with respect to HRAs, including the interaction of FSAs and HRAs in the case of an individual covered under both, is provided in Notice 2002-45, 2002-2 C.B. 93.

[14] Under section 213(b), in the case of medicine or drugs, an expenditure is taken into account only if it is incurred for a prescribed drug or insulin.

Coverage under employer-sponsored health care

The vast majority of Americans finance health care through employment-based insurance coverage.

Figure 1.–Health Insurance Coverage Source for the Nonelderly Population, 2008
[millions of persons]



* Total exceeds 100% because individuals may have multiple sources of health insurance coverage.

Source: JCT Staff calculations based on Medical Expenditure Panel Surveys (2001-3), and Internal Revenue Service Statistics of Income 2005 data; Congressional Budget Office March 2008 baseline.

All employers do not provide equal access to health insurance. Historically, small businesses are far less likely than large businesses to offer health insurance.[15] Small businesses are more sensitive to price than are large businesses when considering offering health insurance. Therefore, if the price of health insurance changes due to a change in the tax treatment of health

[15] Forty-nine percent of workers in firms with fewer than 10 employees held employment-based health insurance while more than 77 percent of employees in firms with more than 100 employees held employment-based coverage. Based on Employee Benefit Research Institute analysis of Current Population Survey, March, 2008; Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2008 Current Population Survey," Vol. 321; September, 2008. Subsidies for Employment-Related Health Insurance: Estimates for 2006," *Health Affairs* Vol. 25 Issue 6, November/December, 2006 pp. 1568-1579.

insurance, the greatest impact will be seen in the rates at which health insurance is offered by small businesses.

Employer involvement in the purchase of health insurance has both advantages and disadvantages in the market. The primary advantage is that health insurance costs less when purchased through an employer as compared with the non-group market; non-group insurance is more expensive.

The principal reason for the price advantage of group over individual health insurance is that insuring a group has less per capita risk than insuring an individual; therefore, the risk premium paid to the insurance company is lower. Employer-sponsored health plans provide a pooling mechanism that is unrelated to the health status of the insured, which minimizes problems with adverse selection into health plans. (Adverse selection refers to the fact that those who are most likely to use health care services are the most likely to purchase health insurance.) Economies of scale also reduce the administrative costs for group plans, and therefore health insurance premiums are lower to this extent for employer plans relative to premiums in the non-group market.[16] As a result, insurance purchased through the group market is less expensive, because it is less costly to sell to and maintain one group of several hundred people than to sell and maintain hundreds of groups of one to two people.

Finally, employers generally have superior negotiating power with an insurance company than does an individual consumer. Employers may have more experience and sophistication in evaluating insurance proposals, can offer much larger blocks of business by virtue of the group nature of employer-provided insurance, and may have other business relationships with the insurer.

There is some recent evidence from the financial services sector that shifting people into the individual market would increase the time and effort required to purchase health insurance. This may lead to procrastination in obtaining insurance and a temporary or even a permanent rise in the rate of uninsurance. Complexity of choice, paired with the absence of a deadline for acquiring insurance, will likely lead to delays in the purchase of insurance.[17] These complexity problems were seen by some American seniors after the release of the Medicare Part D plans in 2004, which required many seniors to choose a prescription drug plan in order to optimize

[16] A Congressional Research Service Report from 1988 found that insurance in small groups (fewer than five members) cost 40 percent more than in large groups (more than 10,000 members). Congressional Research Service, *Costs and Effects of Extending Health Insurance Coverage*, 1988.

[17] Research on retirement plans finds that as the number of investment options increased by 10, participation declined by 1.5 to 2 percentage points. S.S. Iyengar, G. Huberman, and W. Jiang. "How Much Choice Is Too Much?: Contributions to 401(k) Retirement Plans," in Olivia Mitchell and Stephen Utkus, eds., *Pension Design and Structure: New Lessons from Behavioral Finance* (Oxford, UK: Oxford University Press, 2004): pp. 83-96.

prescription drug benefits. There were reports that, with so many complicated options, many seniors had difficulty choosing a plan.[18]

Some have argued that employers are good agents for their employees and provide invaluable research into the appropriate health plans to offer. The employer acts as an agent to limit and guide choice. The open enrollment period, which is a limited time window when insurance can be chosen, prevents excessive procrastination before purchase.

Although the individual market is at a cost disadvantage relative to the employer market for health insurance, it provides greater choice for health insurance coverage. This said, only one percent of those offered employer insurance decline it and purchase insurance in the individual market.[19]

Some employees may feel locked into their current jobs because switching to a different employer could result in a loss of their current health coverage. Despite the protection provided by the Health Insurance Portability and Accountability Act ("HIPAA") for pre-existing conditions,[20] an employee who has insurance with a certain level of coverage for a specific condition through his or her current employer may nevertheless lose that level of coverage if the employee were to move to a new job because the new employer's health plan does not cover that condition or does not provide the same level of coverage for the condition. Even if the health plan is substantially identical, the employee might be concerned that the new job might not work out, and the employee might become unemployed resulting in a loss of coverage or the potential for significantly higher premium costs. The resulting labor market inefficiency is commonly referred to as "job lock," where individuals remain with employers to maintain their current health insurance when their preference is to leave the workforce or find new work.[21] There are other examples of job lock. Job lock may prevent an individual from leaving a large employer

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[18] John Leland, "73 Options for Medicare Plan Fuel Chaos, Not Prescriptions," *New York Times*, May 14, 2004. Jack Hoadley, "Medicare Part D: Simplifying the Program and Improving the Value of Information for Beneficiaries," The Commonwealth Fund: May, 2008.

[19] Congressional Budget Office, "CBO's Health Insurance Simulation Model: A Technical Description," October 2007.

[20] Although a group health plan sponsored by an employer is limited by HIPAA in its ability to impose a pre-existing condition exclusion on a plan participant, a plan is permitted to exclude conditions diagnosed within the six-month period ending on enrollment in the plan, provided that the exclusion generally may not extend for longer than 12 months (18 months in the case of certain late enrollees in the plan) and the maximum exclusion period must be reduced by the participant's aggregate periods of "creditable coverage." Creditable coverage includes a participant's coverage under a group health of a prior employer provided that there is no more than a 63 day gap in coverage between the new plan and the old plan. Sec. 9801.

[21] Evidence of job lock in the literature is mixed, with some papers finding health insurance decreasing mobility, some papers finding no effect and some papers finding an effect only under certain specifications. Brigitte C. Madrian, "The U.S. Health Care System and Labor Markets," National Bureau of Economic Research, Working Paper # 11980, January 2006.

that offers insurance and starting a new independent business due to increased health insurance premiums that may be charged with respect to an individual health insurance policy.[22] Job lock also may prevent an employee who is sick or has a sick dependent from switching to an employer with another health plan for fear of disrupting the patient-physician relationship.

Market distortions from employer-provided health care

The tax treatment of health care affects the health care market and can distort consumer choices. Reduced taxation of income spent on health insurance is an implicit subsidy by the Federal government to eligible consumers. This "discount" on the employer purchase of health insurance provides an incentive for the purchase of more generous health insurance benefits than would otherwise be purchased without the discount. Increased health insurance benefits generally include some combination of reduced copayments, lower deductibles and expanded benefits. Because consumers are responsive to changes in the cost of health care,[23] increased health insurance benefits lead to an increase in the use of health care services. Therefore, the tax exclusion for health insurance and other medical services increases the demand for health care services.

The distortion in the market caused by the tax preference afforded health insurance arises from a two-part market response: 1) demand for medical care increases, increasing the price of health care services; and 2) increased prices draw additional resources into the medical services sector, and away from other less tax-favored sectors. These market mechanisms affect the price for all health care services. The market inefficiency arising from the tax-induced spending on health care versus other goods generates a loss to the economy referred to as "dead weight loss,"[24] because it results in a net loss of consumer welfare. Therefore, the impact on the economy materially exceeds the loss of tax revenues from subsidizing health care expenditures. The elimination of this distortion could lead the economy to function more efficiently and increase overall societal welfare.

There is substantial evidence that the tax preference for health care does indeed increase demand; however, estimates of the size of the increase span an extremely wide range, indicating

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[22] While HIPAA contains rules that generally require that an individual who loses employer-provided health coverage have access to an individual health insurance policy without being subject to pre-existing condition exclusions, such rules are subject to a number of exceptions (including rules that permit a State to implement alternative individual health insurance protections) and the rules do not provide protections with respect to the premium that may be charged for the policy. See 42 U.S.C. 300gg-41, 44.

[23] Joseph P. Newhouse, *Free For All?: Lessons From the RAND Health Insurance Experiment,* Harvard University Press, 1996.

[24] Martin S. Feldstein, "The Welfare Loss of Excess Health Insurance," *Journal of Political Economy* Vol. 81 Issue 2, (Mar-April 1973): pp. 251-280.

considerable uncertainty among economists on the true size of the increase in the volume and price of health care due to the tax exclusion.[25]

On the other hand, some observers argue that tax subsidies for health insurance and other medical expenditures may correct an existing market failure where people have the tendency to spend below the optimal level of health insurance and health services due to underestimation of their likelihood of needing medical care in the future. Under this view, the tax subsidy might make the health care market more efficient and may improve welfare.[26]

Equity issues relating to employer-provided health care

The current tax treatment of health care expenditures is criticized as inequitable because it provides an inconsistent tax benefit based on how health coverage is provided.[27] Generally, those who obtain their health insurance through their employer are afforded the most favorable tax treatment. Those who must obtain health insurance in the individual market receive the worst tax treatment. Many observers believe that this inequity combined with the lack of group rates in the individual market may lead to some persons remaining uninsured.

Some critics assert that the tax exclusion for employer-provided health care is inherently regressive, and thus unfair – those with the greatest income are in the highest tax brackets, and therefore receive the greatest tax benefit from the exclusion from income. For example, a single individual with no dependents and $100,000 of taxable income per year has a marginal income tax rate of 28 percent, excluding the effects of Social Security and Medicare taxes. If that person purchases a health plan through an employer that costs $5,000, the Federal income tax value of the tax exclusion (the income tax not paid) is $1,400. A single individual with no dependents and taxable income of $30,000 is in the 15 percent bracket and would therefore receive a 15 percent, or $750, subsidy for the same health plan.

The argument that the exclusion (or a similar deduction) for employer-provided health care is unfair because it is regressive is somewhat incomplete, in that the asserted unfairness of the exclusion follows directly from the tax rate structure being progressive. For example, under a single tax rate system (a flat tax), the tax benefit in the example above would be identical for the $100,000 earner and the $30,000 earner.

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[25] Joseph P. Newhouse, *Free For All?: Lessons From the RAND Health Insurance Experiment,* Harvard University Press, 1996.

[26] For example, one study found that 25 percent of patients took zero or one drug after a heart attack rather than two or more drugs due to the drugs' copayment costs even though the extra drugs cost only $1,855 per year, while they provided $35,000 in health care benefits (not including savings from decreases in future medical costs). This study indicated that costs greatly impact the purchase of these drugs and they are often underutilized. Niteesh K. Choudhry, et. al., "Cost-Effectiveness of Providing Full Drug Coverage to Increase Medication Adherence in Post Myocardial Infarction Medicare Beneficiaries," *Circulation* Vol. 117 (2008) pp. 1261-1268.

[27] See Appendix B and Appendix C for illustrations of the tax benefits for an individual depending on the source and type of coverage.

Any exclusion from income or deduction will be regressive given a progressive rate structure, but the appropriateness of a deduction in defining the tax base arguably should be determined independently of the rate structure.[28] If the tax base is intended to reflect ability to pay, then a deduction for an expenditure that reduces ability to pay may be appropriate, notwithstanding that the decision to have a progressive rate structure means that a given deduction will have more value the greater is the taxpayer's marginal tax rate.

Additionally, it must be recognized that policies with respect to permitted deductions and the marginal rate structure are set concomitantly to achieve the desired level of progressivity of the tax code overall. If a deduction were not permitted, the rate structure, including the bracket widths, might have evolved differently. That is, the same overall degree of progressivity of the tax code can be achieved with or without a given deduction, through the alteration of the rate structure. In the example above, it would be possible to permit the exclusions for employer-provided health care but alter the rate structure to raise taxes on the employee with $100,000 of income by $1,400, and the employee with $30,000 of income by $750, thus negating the tax advantage of the exclusion and preserving the progressivity of the tax code in the absence of the tax exclusion.

Geographic Variation In Health Spending

Markets for medical care are largely local and health spending varies greatly across regions even after controlling for both a health plan's benefits and the risk of the local population (a measure called actuarial value).[29] The higher costs are rooted in a combination of greater use of health care services and higher cost per service with little explicit evidence of greater resultant health outcomes in these regions. Because health insurance premiums are largely made up of health spending, health insurance premiums vary greatly by local markets. The person living in the low premium region pays a lower total cost (premium) for the same quality health care as the person in the high premium region.

Currently, both individuals may exclude their entire premium from all taxation regardless of premium cost because the tax exclusion for employer sponsored premiums is unlimited; every dollar of insurance purchased is subsidized through the tax code. Therefore, the greater the premium, the greater the tax subsidy. Currently, if two people purchase the same health plan benefits and one lives in a high premium region and one lives in a low premium region, the individual in the high premium region receives a greater tax benefit than a person living in the low premium region.

A uniform dollar cap on the tax exclusion would impact a greater portion of the population in regions with high premiums than in regions with low premiums. In regions with low premiums, a family could purchase a plan with greater actuarial value tax free than could the

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[28] For related discussion, see William D. Andrews, "Personal Deductions in an Ideal Income Tax," 86 *Harvard Law Reveiw* 309, 1972.

[29] Peter Orszag, "Health Care and Behavioral Economics," Presentation to the National Academy of Social Insurance, May 28, 2008.

same family living in a high premium region. If there were no behavioral response to a cap on the exclusion, much of the incidence of the tax would be felt in high premium regions.

Generally, the tax code does not adjust for variation in cost of living between regions and some types of variation may be considered unconstitutional. In 2009 the marginal tax rate for a married couple filing jointly increases from 15 percent to 25 percent at $67,900 across the entire United States, even though $67,900 can purchase many more goods and services in a low cost region than it can in a high cost region. Economic theory holds that wages adjust in regions to account for these variations. In other words, even though cost of living is higher, pay is higher to appropriately compensate workers.

Although the tax code typically does not adjust for regional variation, the federal government often takes regional variation into account in other situations, particularly in health care. Most broadly, the Department of Labor calculates the Consumer Price Index by launching surveys in dozens of regions across the country to estimate cost of living in different regions. The Department of Health and Human Services uses Geographic Practice Cost Index ("GPCI") to vary Medicare payments to physicians by local practice conditions including wages of individuals who would make comparable earnings to physicians, as well as practice expenses, such as office rents and other labor costs of running a physicians' office. The Department of Health and Human Services also creates separate Federal poverty lines for Alaska and Hawaii due to a higher cost of living than in the contiguous states. The Federal Poverty Level for a family of four in the continental U.S. is $22,050, while it is $27,570 in Alaska and $25,360 in Hawaii.[30] This measure is often used to determine eligibility for Medicaid which although state run, is largely funded by the Federal government. Lastly, the Federal Medical Assistance Percentage legislation varies its funding of state Medicaid programs by state largely using an average measure of per capita income from the Bureau of Economic Analysis at the Department of Commerce. The share of Medicaid expenses paid for by the Federal government ranges from 50 percent in the states that have the highest per capita incomes to 75 percent in states with the lowest per capita incomes.[31]

Alternative tax policies subsidizing insurance coverage

Because of the efficiency and equity concerns associated with subsidizing health insurance through the exclusion for employer-sponsored health care, those considering options for financing health reform often consider capping the employer exclusion as a potential source of funding. On the other hand, removal or reduction of the exclusion of employer-provided health care from an employee's taxable income and wages could reduce the number of firms offering health insurance, possibly increasing the number of uninsured.

For example, one study estimated that the total number of employees offered health insurance would drop by 15.5 percent if all of the exclusions were repealed and by 9.7 percent if

[30] Notice, 74 Fed. Reg. 4199, 4200 (Jan. 23, 2009).

[31] Christie Provost Peters, National Health Policy Forum, Issue Brief No. 828, Medicaid Financing: How the FMAP Formula Works and Why It Falls Short 4-5 (2008).

the income tax exclusion were repealed, but the payroll and State tax exclusions remained.[32] Proposals to eliminate the tax exclusion for health insurance would need to consider any increase in the total number of uninsured.

However, the unlimited exposure of the Federal budget created by the exclusion could be reduced by capping the dollar amount of the exclusion per person or per tax return. A cap would also reduce the incentive for individuals to over-consume health insurance. To the extent that the cap is lower than the total cost of a policy the marginal cost of the policy would be paid with after-tax dollars. If the cap is not indexed, or is indexed to a measure that grows more slowly than medical costs, the subsidy for employer-provided health care would decline relative to the cost of care over time. In this event, the economic distortion effects of the exclusion would be reduced gradually over time.

One alternative to a tax exclusion for health insurance is a tax deduction available contingent on the purchase of health insurance. A set deduction would maintain the Federal subsidy for employer-sponsored health insurance, but would reduce the marginal incentive to purchase more expensive insurance because the deduction's value does not increase with the cost of insurance.[33] Under this approach, the tax subsidy would be large enough to enable people to continue insurance coverage, but there would be no tax advantage to purchase insurance that costs more than the cap. A tax credit would behave in much the same way, except its value would not vary with the marginal tax rate of the individual.

If such a deduction were provided for the purchase of insurance in the individual market in addition to employer-sponsored insurance, individuals who do not have the option of obtaining employer-sponsored health insurance would be able to use the deduction to help purchase insurance in the individual market, thus reducing the number of uninsured. However, the advantage of obtaining insurance through one's employer would also be reduced, possibly leading to a reduction in the number of firms offering health insurance benefits and therefore, the total number of individuals eligible to receive employer sponsored health insurance coverage.

The net effect of this policy on the number of uninsured individuals would depend on the size of the fixed deduction relative to the cost of a typical insurance policy.[34] The amount of the deduction could be chosen to limit Federal budget exposure, and, like the cap, it could be

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[32] Jonathan Gruber and Michael Lettau, "How elastic is the firm's demand for health insurance?" *Journal of Public Economics*, Vol. 88 (2004), pp. 1273-1293.

[33] See, for example, the proposal included in the Administration's Fiscal Year 2009 Revenue Proposals.

[34] For example, the Congressional Budget Office finds that removing the exclusion and replacing it with flat deductions of $7,000 for single policies and $15,000 for family policies would reduce the number of uninsured people by about five million in the first several years after enactment. Congressional Budget Office, "An Analysis of the Presidents Budgetary Proposals for Fiscal Year 2009," March 2008, p.10.

indexed to grow more slowly than medical expenditures, thus reducing the Federal budget impact and the tax subsidy for health insurance over time.

An additional consideration in the setting of subsidy levels for employer and non-group insurance is the interaction of these changing subsidies with adverse selection. Non-group insurance is generally more attractive to individuals with low medical costs. To the extent that there is a substantial re-alignment between the attractiveness of employer-sponsored insurance and non-group insurance, younger, healthier individuals may decline employer coverage to such an extent that the advantages of risk pooling by employers are lost, resulting in significant declines in the offer of employer-sponsored insurance. To the extent that this occurs without some alternate risk pooling mechanism being made available, this could result in a significant increase in the number of uninsured individuals and/or the cost of employer-sponsored insurance.

None of the approaches described above addresses the limitations of the exclusion or deduction in providing subsidies for the purchase of health insurance to those who are least able to afford it: to people who have little income and thus little or no tax liability. To address this problem, the exclusion or deduction could be converted to a refundable credit.[35] In contrast to an exclusion or deduction (even a deduction of a fixed amount), a refundable credit will provide the same benefit or subsidy to all taxpayers regardless of their income levels. While a non-refundable credit for an expenditure would generally be as easy to administer as a deduction for the same expenditure. A refundable tax credit poses significant difficulties in administration for several reasons.[36] It brings into the income tax system people who otherwise would not be part of the tax system, and thus the IRS may not have easily verifiable information about their income and other information necessary to monitor compliance with the credit. Additionally, some have proposed that refundable tax credits be made available on an advance basis, so that they could be used directly to purchase health insurance. Such a system could require timely verification of insurance status and credit eligibility by the IRS. Some believe refundable credits, particularly advanceable refundable credits, may encourage fraud. Existing refundable credits in the Code that have been paid in error have proven difficult for the IRS to recoup.[37]

Exclusion from income, in contrast to either deductions or credits, has the administrative advantage of not requiring valuation or verification of the excluded item, at least when the

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[35] Lily L. Batchelder, Fred T. Goldberg Jr., Peter R. Orszag, "Efficiency and Tax Incentives: The Case for Refundable Tax Credits," 59 *Stanford. Law Review* Vol. 23 (2006).

[36] See, for example, the following papers regarding the administration of the earned income tax credit: Janet McCubbin, "Non-compliance with the Earned Income Tax Credit" pp. 237-273; and Jennifer Romich and Thomas Weisner, "How Families View and Use the Earned Income Tax Credit: Advance Payments Versus Lump-Sum Delivery," pp. 366-391, in *Making Work Pay*, Bruce Meyr and Douglas Holtz-Eakin, eds, New York: Russell Sage Foundation, 2001.

[37] Government Accountability Office, "Advanced Earned Income Tax Credit: Low Use and Small Dollars Paid Impede IRS's Efforts to Reduce High Noncompliance," Report to the Joint Committee on Taxation, GAO-07-1110, August 2007.

exclusion is not capped. Providing a tax benefit through an exclusion has limited application, however, as it requires that the subsidized item be provided to the taxpayer in the form of compensation, or other form of income.

B. Deduction for Health Insurance Premiums of Self-Employed Individuals

Under present law, self-employed individuals may deduct from self-employment the cost of health insurance for themselves and their spouses and dependents.[38] The tax expenditure for the deduction for health insurance premiums for self-employed individuals was $5.2 billion for 2008.

The deduction is not available for any month in which the self-employed individual is eligible to participate in an employer-subsidized health plan. Moreover, the deduction may not exceed the individual's self-employment income and is taken from earned income after the Earned Income Tax Credit "EITC" has been calculated. The deduction applies only to the cost of insurance, i.e., it does not apply to out-of-pocket expenses that are not reimbursed by insurance.[39] The deduction does not apply for self-employment tax purposes. For purposes of the deduction, a more than two percent shareholder-employee of an S corporation is treated the same as a self-employed individual.[40] Thus, the exclusion for employer-provided health care does not apply to such individuals, but they are entitled to the deduction for health insurance costs as if they were self-employed.

This deduction has the effect of putting a self-employed individual in a similar position to an employee by allowing the self-employed individual to receive the equivalent of an income tax exclusion for health insurance coverage provided by the business for which the self-employed individual performs services. In fact, however, the two regimes differ in several important respects. First, as described above, a deduction from income for self-employment tax purposes is not provided in the case of a self-employed individual. For this reason, a self-employed individual receives less favorable tax treatment than does an employee with the same coverage provided by their employer. The employer-provided exclusion retains another significant advantage because the exclusion for self-employed individuals does not apply in the case of non-insurance arrangements, such as an HRA.

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[38] Sec. 162(l).

[39] Premiums for a self-insured plan are eligible for the deduction if the self-insured plan actually constitutes an insurance arrangement, which generally means that the arrangement must result in adequate risk-shifting and not merely reimburse the individual for health expenses. For example, the IRS has ruled that a self-insured health plan of a law firm covering 200 self-employed partners and 800 employees demonstrated adequate risk shifting where the plan charged premiums that were determined on the basis of the actuarial costs of the plan and each partner was liable for a pro-rata share of plan experience losses. Pvt. L. Rul. 200007025. Self-employed individuals are not eligible to participate in HRAs. See Notice 2002-45, 2002-2 C.B. 93. In addition, self-employed individuals are not eligible to participate in a cafeteria plan, including a health FSA funded by elective contributions, because cafeteria plan participation is limited to employees. *See* sec. 125(d)(1)(A).

[40] Sec. 1372.

On the other hand, a self-employed individual, particularly a partner or a self-employed individual with a minority interest in a business, may be at an advantage over an employee because the self-employed individual may unilaterally decide to purchase health insurance regardless of whether the business offers health coverage to its employees. A significant cost differential may exist, however, because the self-employed individual may have to purchase coverage on the individual market because only some states will count self-employed individuals as an employer for health insurance purposes and thus not have the benefit of administrative savings and risk pooling from the group market unless the business has other self-employed individuals or common-law employees under the same plan.[41]

Table 3 shows the tax savings by self-employed health deduction by income bracket for 2008.

Table 3.–Self Employed Deduction Tax Savings, 2008

Adjusted Gross Income	Total Income Tax Savings (millions)	Self Employed Deduction Number of Returns (thousands)	Average Savings Per Return (Dollars)
< 10,000	13	485	27
10,000 – 29,999	306	863	355
30,000 – 49,999	428	612	699
50,000 – 74,999	529	579	914
75,000 – 99,999	496	425	1,167
100,000 – 199,999	1,427	735	1,941
200,000 – 499,999	1,267	410	3,090
> 500,000	691	189	3,656
Total	5,157	4,298	1,200

Source: JCT Staff calculations.

[41] Even if a self-employed individual's business does not employ and cover enough employees to generate the advantage of risk pooling, state law may provide assistance. Under HIPAA, an employer with two to fifty employees is generally guaranteed access to insurance in the small group market, and States are permitted to allow sole proprietors with no employees to purchase health insurance on the small group market rather than being limited to the individual market. 42 U.S.C. sec. 300gg-11, 91(e). While HIPAA does not require the States to provide protections as to the amount of premiums charged in the small group market, many States do provide for premium protection rules for this market.

III. OTHER PRESENT LAW HEALTH CARE TAX EXPENDITURES

A. Itemized Deduction for Medical Expenses

Individuals may claim an itemized deduction for unreimbursed medical expenses, but only to the extent that such expenses exceed 7.5 percent of AGI.[42] As a result, the deduction is beneficial only if two conditions are met: the taxpayer's medical expenses must exceed the 7.5-percent of AGI threshold, and the taxpayer must have sufficient personal deductions in general to claim an itemized deduction. The tax expenditure for the itemized deduction for medical expenses was $10.7 billion for 2008.

Table 4 shows the medical expense deduction by income bracket for 2008. The greatest total tax expenditure is in the middle of the income distribution.

Table 4.–Calendar Year Medical Expense Deduction, 2008

Adjusted Gross Income	Total Income Tax Savings (millions)	Medical Expense Deduction Number of Returns (thousands)	Average Savings Per Return (Dollars)
< 10,000	7	987	7
10,000 – 29,999	754	3,272	230
30,000 – 49,999	1,853	3,135	591
50,000 – 74,999	2,612	2,606	1,002
75,000 – 99,999	1,958	1,340	1,461
100,000 – 199,999	2,658	1,022	2,601
200,000 – 499,999	680	86	7,907
> 500,000	162	7	23,143
Total	10,684	12,455	858

Source: JCT Staff calculations.

This deduction is available both to insured and uninsured individuals, thus, an individual with employer-provided health insurance (or another form of tax-subsidized health benefits, as summarized in this section) may also claim the itemized deduction for the individual's medical expenses not covered by that insurance if the 7.5-percent AGI threshold is met. Moreover, an individual's nonsubsidized health insurance premiums can be counted towards the 7.5-percent threshold. In practice, however, it is very unusual for an individual who purchases insurance with after-tax dollars to meet the income threshold solely through the premiums that the individual has paid.

There are a few common ways that individuals use this deduction. For those who are insured, it mainly consists of payments for expensive medical items that are not covered by an

[42] For alternative minimum tax purposes, the itemized deduction is calculated using a floor of 10 percent of adjusted gross income. Sec. 56(b)(1)(B).

individual's insurance, often including mental health care, dental care, and long-term care. Mental health care can consist of either frequent use of outpatient services, such as psychotherapy, or the use of inpatient services such as an inpatient rehabilitation facility for substance abuse or other mental illness. Dental care is only insured in a subset of those who have health insurance and frequently dental insurance is insufficient to cover expenses. People may reach the 7.5-percent limitation due to use of acute dental services such as root canal surgery. Lastly, the need for nursing home care, particularly in the elderly population, is another reason for the use of the medical deduction. While Medicare covers up to 100 days of nursing home care, Medicaid coverage is only available once an individual can show he or she is impoverished, and long-term care insurance is rare and frequently insufficient to cover the cost of nursing home care. Therefore, the cost of a nursing home frequently is paid directly by the taxpayers. In addition, someone in a nursing home is likely to be too sick to work and therefore, may have sufficiently limited income to more easily qualify for the deduction for medical expenses in excess of 7.5 percent of income.

Health insurance is designed to spread the risk of expensive health care over time and across people through the payment of insurance premiums. The 7.5-percent of AGI threshold, however, arguably distorts the decision whether to buy insurance or to self insure. Thus, if an individual without access to any tax-advantaged health insurance has a major medical event costing 50 percent of income every 10 years, that person can pay for 42.5 percent (50 - 7.5) of that event tax-free through the section 213 medical expense deduction if they self insure. If, however, that person pays an actuarially fair premium in the individual market every year, his or her annual medical expenses are below the threshold and therefore, he or she cannot deduct any of it. (In practice, however, it is unlikely that those individuals who do not purchase health insurance will have the liquidity to pay medical expenses that are such a large portion of their annual income.)

The deduction for medical expenses above 7.5 percent of AGI, like other deductions for expenses not directly incurred to earn income, might be criticized on the grounds that the deduction is inconsistent with the Code's general measure of taxable income, and (more importantly) might at the margin distort taxpayer behavior by encouraging taxpayers to view the U.S. Treasury as a partial co-insurer of major medical expenses (through the tax benefits of the deduction), thereby crowding out the private insurance market.[43] On the other hand, there is a longstanding consensus that a personal income tax should account for an individual's ability to pay tax, and that large medical expenses are generally involuntary nature, have a direct impact

[43] Moreover, not all medical expenses are involuntary. To this extent the deduction for medical expenses creates additional efficiency costs in that it encourages excessive consumption of some medical services since the government subsidizes the cost of these discretionary services. Thus, while the deduction is not likely to encourage excess consumption of some services, such as critical need surgeries, it could cause excessive consumption of ancillary services, such as private hospital rooms, etc. Similarly, other medical expenditures have a strong personal consumption component, such as the quality or variety of one's eye glass frames, and a deduction or exclusion that includes these types of medical expenses is more likely to create economic distortions in consumption.

on the taxpayer's ability to pay tax.[44] It therefore is argued that, for the income tax to be horizontally equitable— that is, to tax equally those with equal ability to pay— a deduction for medical expenses should be provided.

However, a floor on such a deduction may be justified on economic grounds. Small health expenditures are predictable and part of consumption, however, very large medical expenditures are unpredictable and more likely impact the ability to pay taxes.

A floor on the deductibility of medical expenses can be argued to be appropriate for administrative reasons, to eliminate the need for the Internal Revenue Service to audit millions of returns each claiming deductions for minor medical expenses.

Medical expenses that qualify for deduction are narrower than medical expenses for which an FSA or HSA can be used. For example, non-prescription medicines such as aspirin are not deductible under the medical deduction, but could be purchased using dollars set aside in an HSA, HRA or an FSA.

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[44] See William D. Andrews, "Personal Deductions in an Ideal Income Tax," 86 *Harvard Law Review*, 309, 1972; William J. Turnier, "Personal Tax Deductions and Tax Reform: The High Road and the Low Road," 31 *Villanova Law Review*, 1703, 1986. Andrews argues that the main point of the Haig-Simons definition of income (Income = Consumption + Change in Wealth) is to focus on the uses of income and not its sources, and that an ideal income tax would not treat income differently based on its source. He argues that an ideal income tax should focus on elaborating the notion of taxable consumption embodied in the Haig-Simons definition of income in order to arrive at a fairer definition of taxable income. He concludes that a medical expense deduction is necessary in an ideal income tax, i.e., that consumption of medical care should not be taxable consumption. Turnier rejects some of Andrews' reasoning, but ultimately arrives at the same conclusion that a deduction for medical expenses is necessary for an income tax to accurately base tax on ability to pay.

B. HSAs and Archer MSAs

Present law provides that individuals with a high deductible health plan (and no other health plan except for a plan that provides permitted coverage)[45] may establish and make tax-deductible contributions to a health savings account ("HSA"). The tax expenditure for HSAs was $0.5 billion for 2008. HSAs are one of the lowest cost tax expenditure in the health care sector.

Like opening an individual retirement account ("IRA"), the decision to create and fund an HSA is made on an individual-by-individual basis, but unlike the case of an IRA, an HSA is subject to the condition that the individual is covered under a high deductible health plan (purchased either through the individual market or through an employer). Subject to certain limitations, contributions made to an HSA by an individual are deductible for income tax purposes, regardless of whether the individual itemizes personal deductions. Moreover, the individual can exclude from income (and from taxable wages) contributions that the individual's employer (including contributions made through a cafeteria plan through salary reduction) makes to the individual's HSA.

A high deductible health plan is a health plan that has an annual deductible that is at least $1,150 for self-only coverage or $2,300 for family coverage (for 2009) and that limits the sum of the annual deductible and other payments that the individual must make in respect of covered benefits to no more than $5,800 in the case of self-only coverage and $11,600 in the case of family coverage (for 2009).[46]

Earnings on amounts in an HSA accumulate on a tax-free basis. Distributions from an HSA that are used for qualified medical expenses are excludable from gross income regardless of the taxpayer's age and regardless of whether treated as paid out of the account's contributions or its earnings.

Distributions from an HSA that are not used for qualified medical expenses are includible in gross income and are subject to an additional tax of 10 percent. The additional 10-percent tax does not apply, however, if the distribution is made after death, disability, or the individual attains the age of Medicare eligibility (i.e., age 65).

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[45] An individual with other coverage in addition to a high deductible health plan is still eligible for an HSA if such other coverage is "permitted insurance" or "permitted coverage." Permitted insurance is: (1) insurance if substantially all of the coverage provided under such insurance relates to (a) liabilities incurred under worker's compensation law, (b) tort liabilities, (c) liabilities relating to ownership or use of property (e.g., auto insurance), or (d) such other similar liabilities as the Secretary may prescribe by regulations; (2) insurance for a specified disease or illness; and (3) insurance that provides a fixed payment for hospitalization. Permitted coverage is coverage (whether provided through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care. Effective after December 20, 2006, with respect to coverage for years beginning after December 31, 2006, certain coverage under a health FSA is disregarded in determining eligibility for an HSA.

[46] These amounts are indexed for inflation.

In sum, HSAs provide the opportunity to pay for current out-of-pocket medical expenses on a tax-favored basis, as well as the ability to save for future medical (and after age 65, nonmedical) on a tax-favored basis. To the extent that amounts in an HSA are not used for qualified expenses, an HSA provides tax benefits similar to an IRA,[47] including the same tax deferral of contributions and earnings ultimately used to fund general living expenses after age 64 and the same 10-percent additional tax for nonqualified distributions before age 65.

In contrast to an FSA or HRA, both of which require substantiation for tax-free reimbursement of a medical expense, an individual is not required to provide substantiation to the trustee or custodian of an HSA that a distribution is for a qualified expense to be entitled to the exclusion.[48] Instead, the individual simply maintains his or her own books and records with respect to the expense and claims the exclusion for a distribution from the HSA on his or her return if it is used for a qualified expense. This may result in certain nonqualified distributions not being reported as subject to tax, including the 10-percent additional tax.

For 2009, the maximum aggregate annual contribution that can be made to an HSA is $3,000 in the case of self-only coverage and $5,950 in the case of family coverage.[49] The annual contribution limits are increased for individuals who have attained age 55 by the end of the taxable year (referred to as "catch-up contributions"). In the case of policyholders and covered spouses who are age 55 or older, the HSA annual contribution limit is greater than the otherwise applicable limit by $1,000 in 2009 and thereafter. Contributions, including catch-up contributions, cannot be made once an individual is enrolled in Medicare.

If an employer makes contributions to employees' HSAs, the employer must make available comparable contributions on behalf of all employees who have comparable coverage

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[47] Other tax-favored vehicles may also be used to save for future medical expenses, but they are not specific to use for medical expenses and they do not provide the same tax benefits. For example, funds in a traditional IRA may be used to pay medical expenses, but distributions for medical expenses are includible in gross income in the same manner as are other traditional IRA distributions.

[48] Qualified medical expenses include expenses for diagnosis, cure, mitigation, treatment, or prevention of disease, including prescription drugs, transportation primarily for and essential to such care, and qualified long-term care expenses. Qualified medical expenses do not include expenses for insurance other than for (1) long-term care insurance, (2) premiums for health coverage during any period of continuation coverage required by Federal law, (3) premiums for health care coverage while an individual is receiving unemployment compensation under Federal or State law, and (4) premiums for individuals who have attained the age of Medicare eligibility, other than premiums for policies that provide supplemental coverage for individuals whose primary insurance is Medicare.

[49] These amounts are the same as the maximum deductible amounts permitted under a high deductible plan for purposes of Archer Medical Savings Accounts ("MSAs") and are indexed for inflation. In the case of individuals who are married to each other, if either spouse has family coverage, both spouses are treated as only having the family coverage with the lowest deductible and the contribution limit is divided equally between them unless they agree on a different division. Limitations exist based on the amount of the deductible under the high deductible health plan apply to years beginning before January 1, 2007.

during the same period. Employer contributions are not includable in employees' incomes or taxable wages. Contributions are considered comparable if they are either of the same amount or the same percentage of the deductible under the plan. If employer contributions do not satisfy the comparability rule during a period, then the employer is subject to an excise tax equal to 35 percent of the aggregate amount contributed by the employer to HSAs for that period. The comparability rule does not apply to contributions made through a cafeteria plan.

A taxpayer may not combine the benefits of an HSA with those of an Archer MSA. Amounts can be rolled over, however, into an HSA from another HSA or from an Archer MSA. One-time rollovers are permitted from IRAs to HSAs.

Like an HSA, an Archer MSA is a tax-exempt trust or custodial account to which tax-deductible contributions may be made by individuals with a high deductible health plan.[50] Archer MSAs provide tax benefits similar to, but generally not as favorable as, those provided by HSAs for individuals covered by high deductible health plans. The main differences include: (1) only self-employed individuals and employees of small employers are eligible to have an Archer MSA; (2) for Archer MSA purposes, a high deductible health plan is a health plan with (for 2009) (a) an annual deductible of at least $2,000 and no more than $3,000 in the case of self-only coverage and at least $4,000 and no more than $6,500 in the case of family coverage and (b) maximum out-of pocket expenses of no more than $4,000 in the case of self-only coverage and no more than $7,350 in the case of family coverage;[51] and (3) the additional tax on distributions not used for medical expenses is 15 percent rather than 10 percent.

After 2007, no new contributions can be made to Archer MSAs except by or on behalf of individuals who previously had made Archer MSA contributions and employees who are employed by a participating employer. In light of this fact, the fact that HSAs are more generous than Archer MSAs, and the fact that an individual can roll over an Archer MSA into an HSA, one can expect Archer MSA to soon be replaced by HSAs.

Proponents of high deductible health plans believe that such plans help to alleviate the distortion in the health insurance market caused by the exclusion for employer-sponsored health insurance. Some proponents of HSAs believe that many current health insurance policies cover routine medical expenses and that the tax laws should provide a subsidy only for insurance for substantial and unpredictable medical expenses.

The creation of HSAs was intended to encourage high deductible health plans and to control the growth of health care spending. Proponents of HSAs believe that if consumers personally pay for a greater portion of their health care purchases (because of the large deductible) out of a fund that can be used for savings (and therefore ultimately is the consumer's money to use as they wish), they will be more prudent in their health spending. In theory, this

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[50] Sec. 220.

[51] These deductible and out-of-pocket expenses dollar amounts are for 2009. These amounts are indexed for inflation.

would result in lower volume of services and potentially consumer pressure to drive down prices of health care services.[52]

Prior to the introduction of HSAs, there was a clear tax advantage to structuring employer-sponsored health insurance to have a low deductible. The tax exclusion for premiums meant that purchasing a more generous plan with no deductible, essentially paying the deductible through the increased premium, was tax-advantaged because any deductible had to be paid out of after-tax dollars, but the premium could be paid with pre-tax dollars. HSAs were meant to equalize health spending through premiums and through out of pocket spending while creating a financial incentive for individuals to be economical in their health expenditures. Concerns exist that HSAs and high deductible health plans are likely to be more attractive to healthier individuals, with the result that adverse selection will occur. If correct, this could erode the group market and result in higher premiums for individuals with greater health risks. When insurance is priced on a group basis, individuals with lower health risks in effect subsidize higher risk individuals. If the healthy, low risk individuals leave the pool to seek cheaper, high deductible insurance, the average cost will increase for those remaining. This in turn may cause the next-lowest risk individuals to leave the pool, with a concomitant rise in cost for those still remaining, resulting in a spiral that could drive a plan with generous benefits to price itself out of the market.

To the extent that amounts in HSAs are not used for current medical expenses, HSAs provide a tax benefit similar to that of a deductible IRA, in that HSAs allow tax-free compounding of earnings. HSA proponents argue that this feature may help contribute to lowering medical costs by in effect rewarding lower spending on medical care. Because HSAs operate similarly to deductible IRAs, there is concern that they will be used as an additional tax shelter for retirement income for wealthy individuals. Critics argue that HSAs are primarily attractive to higher income individuals who can afford to self insure on a current basis for the higher deductible under the high deductible plan and who are primarily interested in a long-term tax-favored savings vehicle. In this regard, critics observe that a taxpayer can fund both an HSA and a deductible IRA, thereby substantially increasing the individual's annual contributions for tax-preferred savings. In response, proponents of HSAs argue that the additional tax of 10 percent for uses other than health care before age 65 (the age of Medicare eligibility) may mitigate this issue.

[52] Evidence from the RAND Health Insurance experiment indicates that health expenditures are elastic; those who can access health care for free used 20 percent more hospital visits than those who paid a 25 percent coinsurance payment or higher for medical care. See Robert H. Brook, et. al. "The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Reform Debate," RAND Corporation. 2006. http://www.rand.org/pubs/research_briefs/2006/RAND_RB9174.pdf Accessed 24 July 2008.

C. Refundable Credit for Health Insurance Expenses of Certain Classes of Individuals

1. Health insurance tax credit

Under the Trade Adjustment Assistance Reform Act of 2002,[53] certain individuals are eligible for the Health Coverage Tax Credit ("HCTC").[54] The HCTC is a refundable tax credit equal to 80 percent of the cost of qualified health coverage paid by an eligible individual. [55]

In general, eligible individuals are individuals who receive a trade adjustment allowance (and individuals who would be eligible to receive such an allowance but for the fact that they had not exhausted their regular unemployment benefits), individuals eligible for the alternative trade adjustment assistance program, and individuals over age 55 who receive pension benefits from the Pension Benefit Guaranty Corporation. The credit is available for "qualified health insurance," which includes certain employer-based insurance, certain State-based insurance, and in some cases, insurance purchased in the individual market. The credit is available on an advance basis through a program established and administered by the Treasury Department. Persons entitled to Medicare and certain other governmental health programs, covered under certain employer-subsidized plans, or with certain other specified coverage are not eligible for the credit.[56]

The HCTC is often cited as an example of how a broad-based refundable tax credit for health insurance (or health expenses) could operate. However, the size of the population eligible for the HCTC is not representative of the population at large. In addition, the costs of administering the credit were significant in the first several years of implementation. The credit generally is delivered as follows: the eligible individual sends his or her portion of the premium to the Treasury. The Treasury pays the full premium (the individual's portion and the amount of the refundable tax credit) to the insurer. Alternatively, an eligible individual is also permitted to pay the entire premium during the year and claim the credit on his or her income tax return.[57]

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[53] Pub. L. No. 107-210, secs. 201(a), 202 and 203 (2002).

[54] Sec. 35.

[55] The amount of the credit was increased from 65 percent to 80 percent by the TAA Health Coverage Improvement Act of 2009, Pub. L. No. 111-5, effective May 2009. The credit returns to 65 percent for months after December 31, 2010.

[56] Sec. 35(f).

[57] See Internal Revenue Service Publication 4181.

2. COBRA continuation coverage premium reduction

The Consolidated Omnibus Reconciliation Act of 1985 ("COBRA") requires that a group health plan[58] must offer continuation coverage to qualified beneficiaries with respect to a covered employee[59] in the case of a qualifying event (such as a loss of employment). A plan may require payment of a premium for any period of continuation coverage. The amount of such premium generally may not exceed 102 percent[60] of the "applicable premium" [61] for such period and the premium must be payable, at the election of the payor, in monthly installments.

Section 3001 of the American Recovery and Investment Act of 2009[62] provides that, for a period not exceeding nine months, an assistance eligible individual is treated as having paid any premium required for COBRA continuation coverage under a group health plan if the individual pays 35 percent of the premium. Thus, if the assistance eligible individual pays 35 percent of the premium, the group health plan must treat the individual as having paid the full premium required for COBRA continuation coverage, and the individual is entitled to a subsidy for 65 percent of the premium. An assistance eligible individual generally is any qualified beneficiary who elects COBRA continuation coverage and the qualifying event with respect to the covered employee for that qualified beneficiary is a loss of group health plan coverage on account of an involuntary termination of the covered employee's employment (for other than gross misconduct). In addition, the qualifying event must occur during the period beginning September 1, 2008 and ending with December 31, 2009.

The premium subsidy also applies to temporary continuation coverage elected under the Federal Employees Health Benefits Program ("FEHBP") and to continuation health coverage

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[58] A group health plan is defined as a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

[59] A "covered employee" is an individual who is (or was) provided coverage under the group health plan on account of the performance of services by the individual for one or more persons maintaining the plan and includes a self-employed individual. A "qualified beneficiary" means, with respect to a covered employee, any individual who on the day before the qualifying event for the employee is a beneficiary under the group health plan as the spouse or dependent child of the employee. The term qualified beneficiary also includes the covered employee in the case of a qualifying event that is a termination of employment or reduction in hours.

[60] In the case of a qualified beneficiary whose minimum coverage period is extended to 29 months on account of a disability determination, the premium for the period of the disability extension may not exceed 150 percent of the applicable premium for the period.

[61] The applicable premium for any period of continuation coverage means the cost to the plan for such period of coverage for similarly situated non-COBRA beneficiaries with respect to whom a qualifying event has not occurred, and is determined without regard to whether the cost is paid by the employer or employee.

[62] Pub. L. No. 111-5.

under State programs that provide coverage comparable to continuation coverage. The subsidy is generally delivered by requiring employers to pay the subsidized portion of the premium for assistance eligible individuals. The employer then treats the payment of the subsidized portion as a payment of employment taxes and offsets its employment tax liability by the amount of the premium subsidy.[63] To the extent that the aggregate amount of subsidy for all assistance eligible individuals for which the employer is entitled to a credit for a quarter exceeds the employer's employment tax liability for the quarter, the employer can request a tax refund or can claim the credit against future employment tax liability.

There is an income limit on entitlement to the premium reduction and subsidy, and it is conditioned on the individual not being eligible for certain other health coverage. To the extent that an eligible individual receives a subsidy during a taxable year to which the individual was not entitled due to income or being eligible for other health coverage, the subsidy overpayment is repaid on the individual's income tax return as additional tax. However, in contrast to the HCTC, the subsidy for COBRA continuation coverage may only be claimed through the employer and cannot be claimed on an individual's tax return.

[63] In the case of a multiemployer group health maintained by a multiemployer or a plan subject to a State program, the person to whom the reimbursement is payable is either the multiemployer group health plan or the insurer providing coverage under an insured plan.

IV. PRESIDENT'S FISCAL YEAR 2010 BUDGET PROPOSAL TO LIMIT THE RATES AT WHICH TAXPAYERS MAY BENEFIT FROM ITEMIZED DEDUCTIONS

As described in greater detail below, the President's Fiscal Year 2010 budget proposals contain a proposal to limit the tax rates at which taxpayers may benefit from itemized deductions, such as the charitable contribution deduction, the mortgage interest deduction, and the deduction for State and local income taxes. The proposal is designed in part to fund a new reserve fund for health care reform.

Present Law

General structure of the individual income tax

Under the Code, gross income means "income from whatever source derived" except for certain items specifically exempt or excluded by statute. An individual's AGI is determined by subtracting certain "above-the-line" deductions from gross income. These deductions include, among other things, contributions to a tax-qualified retirement plan by a self-employed individual, contributions to certain IRAs, one-half of self-employment taxes, certain moving expenses, and alimony payments.

In order to determine taxable income, an individual reduces AGI by any personal exemption deductions and either the applicable standard deduction or his or her itemized deductions. Personal exemptions generally are allowed for the taxpayer, his or her spouse, and any dependents. For 2009, the amount deductible for each personal exemption is $3,650. This amount is indexed annually for inflation. The deduction for personal exemptions is reduced or eliminated for taxpayers with incomes over certain thresholds, which are indexed annually for inflation. The applicable thresholds for 2009 are $166,800 for single individuals, $250,200 for married individuals filing a joint return and surviving spouses, $199,950 for heads of households, and $125,100 for married individuals filing separate returns.

Standard and itemized deductions

A taxpayer also may reduce AGI by the amount of the applicable standard deduction. The basic standard deduction varies depending upon a taxpayer's filing status. For 2009, the amount of the standard deduction is $5,700 for single individuals and married individuals filing separate returns, $8,350 for heads of households, and $11,400 for married individuals filing a joint return and surviving spouses. An additional standard deduction is allowed with respect to any individual who is elderly or blind.[64] The amounts of the basic standard deduction and the additional standard deductions are indexed annually for inflation. Finally, a taxpayer may reduce

[64] For 2009, the additional amount is $1,100 for married taxpayers (for each spouse meeting the applicable criterion) and surviving spouses. The additional amount for single individuals and heads of households is $1,400. If an individual is both blind and aged, the individual is entitled to two additional standard deductions, for a total additional amount (for 2009) of $2,200 or $2,800, as applicable.

AGI by an additional standard deduction for State and local property taxes paid of $500 ($1,000 for joint filers) and for qualified motor vehicle taxes.

In lieu of taking the applicable standard deductions, an individual may elect to itemize deductions. The deductions that may be itemized include State and local income taxes (or, in lieu of income, sales taxes), real property and certain personal property taxes, home mortgage interest, charitable contributions, certain investment interest, medical expenses (in excess of 7.5 percent of AGI), casualty and theft losses (in excess of $500 per loss and in excess of 10 percent of AGI), and certain miscellaneous expenses (in excess of two percent of AGI).

Under present law, the total amount of otherwise allowable itemized deductions (other than medical expenses, investment interest, and casualty, theft, or wagering losses) is reduced by three percent of the amount of the taxpayer's 2009 adjusted gross income in excess of $166,800 ($83,400 for married couples filing separate returns). These amounts are adjusted annually for inflation. In computing this reduction of total itemized deductions, all present law limitations applicable to such deductions (such as the separate floors) are first applied and, then, the otherwise allowable total amount of itemized deductions is reduced in accordance with this provision. Under present law, the otherwise allowable itemized deductions may not be reduced by more than 80 percent.

Individual income tax rates

A taxpayer's net income tax liability is the greater of (1) regular individual income tax liability reduced by credits allowed against the regular tax, or (2) tentative minimum tax reduced by credits allowed against the minimum tax. The amount of income subject to tax is determined differently under the regular tax and the alternative minimum tax, and separate rate schedules apply. Lower rates apply for long-term capital gains; those rates apply for both the regular tax and the alternative minimum tax.

To determine regular tax liability, a taxpayer generally must apply the tax rate schedules (or the tax tables) to his or her regular taxable income. The rate schedules are broken into several ranges of income, known as income brackets, and the marginal tax rate increases as a taxpayer's income increases. Separate rate schedules apply based on an individual's filing status. For 2009, the regular individual income tax rate schedules are as follows in Table 5:

Table 5.–Federal Individual Income Tax Rates for 2009

If taxable income is:	Then income tax equals:
	Single Individuals
Not over $8,350	10% of the taxable income
Over $8,350 but not over $33,950	$835 plus 15% of the excess over $8,350
Over $33,950 but not over $82,250	$4,675 plus 25% of the excess over $33,950
Over $82,250 but not over $171,550	$16,750 plus 28% of the excess over $82,250
Over $171,550 but not over $372,950	$41,754 plus 33% of the excess over $171,550
Over $372,950	$108,216 plus 35% of the excess over $372,950
	Heads of Households
Not over $11,950	10% of the taxable income
Over $11,950 but not over $45,500	$1,195 plus 15% of the excess over $11,950
Over $45,500 but not over $117,450	$6,227.50 plus 25% of the excess over $45,500
Over $117,450 but not over $190,200	$24,215 plus 28% of the excess over $117,450
Over $190,200 but not over $372,950	$44,585 plus 33% of the excess over $190,200
Over $372,950	$104,892.5 plus 35% of the excess over $372,950
	Married Individuals Filing Joint Returns and Surviving Spouses
Not over $16,700	10% of the taxable income
Over $16,700 but not over $67,900	$1,670 plus 15% of the excess over $67,900
Over $67,900 but not over $137,050	$9,350 plus 25% of the excess over $67,900
Over $137,050 but not over $208,850	$26,637.50 plus 28% of the excess over $137,050
Over $208,850 but not over $372,950	$46,741.50 plus 33% of the excess over $208,850
Over $372,950	$100,894.50 plus 35% of the excess over $372,950
	Married Individuals Filing Separate Returns
Not over $8,350	10% of the taxable income
Over $8,350 but not over $33,950	$835 plus 15% of the excess over $8,350
Over $33,950 but not over $68,525	$4,675 plus 25% of the excess over $33,950
Over $68,525 but not over $104,425	$13,318.75 plus 28% of the excess over $68,525
Over $104,425 but not over $186,475	$23,310.75 plus 33% of the excess over $104,425
Over $186,475	$50,447.25 plus 35% of the excess over $186,475

Alternative minimum tax liability

An alternative minimum tax is imposed on an individual, estate, or trust in an amount by which the tentative minimum tax exceeds the regular income tax for the taxable year. The tentative minimum tax is the sum of (1) 26 percent of so much of the taxable excess as does not exceed $175,000 ($87,500 in the case of a married individual filing a separate return) and (2) 28 percent of the remaining taxable excess. The taxable excess is so much of the alternative minimum taxable income ("AMTI") as exceeds the exemption amount. The maximum tax rates on net capital gain and dividends used in computing the regular tax are also used in computing

the tentative minimum tax. AMTI is the taxpayer's taxable income increased by the taxpayer's "tax preference items" and adjusted by redetermining the tax treatment of certain items in a manner that negates the deferral of income resulting from the regular tax treatment of those items.

The exemption amounts for 2009 are: (1) $70,950 in the case of married individuals filing a joint return and surviving spouses; (2) $46,700 in the case of other unmarried individuals; (3) $35,475 in the case of married individuals filing separate returns; and (4) $22,500 in the case of an estate or trust. The exemption amounts are phased out by an amount equal to 25 percent of the amount by which the individual's AMTI exceeds (1) $150,000 in the case of married individuals filing a joint return and surviving spouses, (2) $112,500 in the case of other unmarried individuals, and (3) $75,000 in the case of married individuals filing separate returns or an estate or a trust. These amounts are not indexed for inflation.

Among the preferences and adjustments applicable to the individual alternative minimum tax are accelerated depreciation on certain property used in a trade or business, circulation expenditures, research and experimental expenditures, certain expenses and allowances related to oil and gas and mining exploration and development, certain tax-exempt interest income, and a portion of the amount of gain excluded with respect to the sale or disposition of certain small business stock. In addition, personal exemptions, the standard deduction, and certain itemized deductions, such as State and local taxes and miscellaneous deductions items, are not allowed to reduce alternative minimum taxable income.

Description of President's Budget Proposal

The proposal limits the rate at which taxpayers with taxable income in excess of a threshold amount benefit from itemized deductions. In general, the proposal limits the benefit of itemized deductions for individuals with taxable income in excess of $200,000 and married couples with taxable income in excess of $250,000 to 28 percent.

For example, assume that a taxpayer in the 35-percent income tax bracket makes a $1,000 charitable contribution. Under present law, the $1,000 contribution would result in a $350 tax savings, or 35 percent of $1,000 (disregarding any other limitations that may apply to reduce the taxpayer's itemized deductions). Under the proposal, the same $1,000 contribution by the same 35-percent[65] bracket taxpayer would result in a tax savings of only $280 (28 percent of $1,000).

Effective date.–The proposal is effective for tax years beginning after December 31, 2010.

[65] Under a separate budget proposal, the President would increase the top marginal tax rates for higher-bracket taxpayers. For the sake of simplicity, however, the examples in this section assume a top marginal income tax rate of 35 percent, as under present law.

Analysis

The proposal has been the subject of considerable debate, much of which centers on the likely effect of the proposal on charitable giving and housing (discussed below), although the proposal applies more broadly to all itemized deductions. Some proponents have argued that limiting the benefit of itemized deductions in this manner will reduce the incentive to undertake certain activities. Some opponents have argued that such a limitation is inappropriate to the extent that the deductions, such as those for medical expenses, casualty or theft losses, or local taxes, are designed to reflect more accurately a taxpayer's ability to pay. If this is the case, then no adjustment should be made to the deductions, and any concern about fairness or progressivity should be addressed through the marginal tax rate structure. Furthermore the extent to which the proposal impacts progressivity is unclear given the interaction with other budget proposals such as the so-called Pease limitation on itemized deductions and provisions of the alternative minimum tax.

Charitable deduction

Some argue, for example, that the proposed limit on itemized deductions diminishes a taxpayer's incentive to make charitable contributions by increasing the cost of charitable giving[66]; such commentators argue that the proposal therefore will result in a decrease in charitable giving.[67] For example, disregarding any other limitations that may apply to limit itemized deductions, under present law a 35-percent bracket taxpayer who makes a $1,000 charitable contribution will save $350 (35 percent of $1,000). In other words, the after tax cost to the taxpayer is only $650 to give $1,000 to charity ($1,000 - $350 savings). Under the proposal, the same $1,000 charitable contribution would cost the same taxpayer $720 ($1,000 - (28 percent of $1,000)). This represents a cost increase of more than 10 percent.

Others, however, argue that the proposed limit will result in little if any reduction in overall charitable giving.[68] Some argue, for example, that charitable giving is motivated in

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[66] For a recent literature review of the responsiveness of charitable giving to its price, see John Peloza and Piers Steele, "The Price Elasticities of Charitable Contributions: A Meta Analysis," Journal of Public Policy & Marketing 24(2): 260-272, 2005. See also Charles T. Clotfelter, *Federal Tax Policy and Charitable Giving* (Chicago: University of Chicago Press), 1985; and Jon Bakija and Bradley Heim "How Does Charitable Giving Respond To Incentives And Income? Dynamic Panel Estimates Accounting For Predictable Changes In Taxation," National Bureau of Economic Research Working Paper 14237, August 2008.

[67] *See* Independent Sector, Statement on Changes to Tax Incentives for Charitable Giving and Health Care Reform, *http://www.independentsector.org/media/20090326_giving_healthcare_statement.html* (March 26, 2009) (arguing that changing in tax benefits affect charitable giving levels and that the President's budget proposal will result in a decrease in charitable giving).

[68] For example, the Center on Philanthropy at Indiana University performed a study to determine how the President's proposal would affect charitable giving. *See* The Center on Philanthropy at Indiana University, white paper, "How Changes in Tax Rates Might Affect Itemized Charitable Deductions," *available at* http://www.philanthropy.iupui.edu/docs/2009/2009_TaxChangeProposal_WhitePaper.pdf

significant part by factors other than tax rules, such as altruism and the overall state of the economy;[69] most taxpayers, therefore would not eliminate or significantly reduce charitable giving under the proposal. Indeed, under the proposal, each additional dollar given to charity by a taxpayer subject to the proposal will continue to result in a tax savings, although at a rate of 28 percent rather than the higher 33- or 35-percent rates.

Furthermore, some argue that the proposal improves fairness and equity to the tax treatment of itemized deductions by partially leveling the tax benefit to higher- and lower-income taxpayers resulting from identical gifts. For example, assume that a taxpayer in the 35-percent bracket and a taxpayer in the 25-percent bracket each make identical $1,000 contributions to charity. As a result of the $1,000 contribution, the higher-income taxpayer will have a tax savings of $350 (35 percent of $1,000), such that his cost of making the $1,000 contribution is $650 ($1,000 - $650). The taxpayer in the 25-percent bracket, however, will achieve a tax savings of only $250 (25 percent of $1,000), such that his cost of making the $1,000 contribution is $750 ($1,000 - $250). In other words, under present law, an identical charitable contribution results in a greater benefit (in this example, $100) to the higher-bracket taxpayer, even though the lower-bracket taxpayer arguably has been more generous by contributing a higher percentage of his taxable income to charity. The proposal limits (but does not eliminate) this disparate treatment by limiting the rate at which the higher-bracket taxpayer may benefit from itemized deductions to 28 percent.

On the other hand, such a fairness argument rests on an implicit assumption that, when a taxpayer makes a charitable contribution, he or she is buying something. If, however, one's initial view is that a gift to charity reduces a taxpayer's resources available for private consumption, then the proposed modification to the marginal rates at which taxpayers may benefit from deductions should not be undertaken, else taxpayers similarly situated with respect to resources available for private consumption would face differential tax burdens.

Mortgage interest and property tax deductions

The deductions for home mortgage interest and property taxes reduce the after-tax cost of financing and maintaining a home. The benefit generally rises as the marginal tax rate of the taxpayer rises. However, research suggests that the benefits of the home mortgage interest deduction, and thus the costs of any limitation, are distributed heterogeneously among taxpayers,

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(March 2009) (hereafter "Indiana University White Paper). Using a simplified model and 2006 itemized deduction data, the Center estimated that, if the budget proposal had been in effect in 2006, "the impact on itemized giving would have been a relatively small reduction when measured as a percentage of total itemized charitable giving by individuals (a decrease of 2.1 percent)." Looking only at the highest income households, the Center estimated a slightly larger drop (approximately 4.8 percent). The Center concluded that "[t]he larger economy plays a more important role in changes in giving than do tax rate changes."

[69] *See, e.g.*, Indiana University White Paper, *supra*.

even among those with more than $250,000 in income.[70] Within this group, the largest benefits accrue to younger homeowners, who tend to have higher loan-to-value ratios, and to those taxpayers purchasing more expensive homes.

Limiting itemized deductions would raise the after-tax cost of financing and maintaining a home for affected taxpayers. One study estimates that completely repealing the mortgage interest deduction would raise the cost of capital for owner-occupied housing by seven percent.[71] Smaller cost increases would be associated with limiting the deduction. However, if taxpayers adjusted their portfolios to reduce their loan-to-value ratios, changing the tax treatment of mortgage interest might have little impact on the user cost.[72] As with the benefits of the deduction, the largest increases in the cost of housing would occur for younger, high-income homeowners with relatively higher loan-to-value ratios and relatively fewer non-housing assets with which to reduce those ratios. Demand for housing by affected taxpayers would be expected to decline in response to the increased cost.

Some argue that the proposal would have a detrimental effect on the U.S. economy, because it would lead to a decline in home prices at a time when many homeowners have seen the value of their residences decline to an amount below their mortgage balances. Areas with relatively large numbers of affected taxpayers and relatively inelastic housing supply would be expected to face the greatest price declines. This, they argue, could lead to deterioration in bank balance sheets as the value of their mortgage loans and mortgage-backed securities also decline.

Others argue that limiting the home mortgage interest deduction is unlikely to have a detrimental effect on the U.S. economy. They argue that the limitation will affect too few taxpayers to reduce incentives for the marginal homebuyer. Still others question whether the mortgage interest deduction does much to encourage homeownership and thus the positive spillover benefits that might entail.[73] On the contrary, to the extent that the mortgage interest deduction creates economic distortions–increasing the size and cost of housing, increasing the allocation of capital to owner-occupied housing away from potentially higher pre-tax return

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[70] James Poterba and Todd Sinai, "Tax Expenditures for Owner-Occupied Housing: Deductions for Property Taxes and Mortgage Interest and the Exclusion of Imputed Rental Income" *American Economic Review Papers and Proceedings*, vol. 96, number 2 (May 2008).

[71] *Id.*

[72] *See* Martin Gervais and Manish Pandey, "Who Cares about Mortgage Interest Deductibility?" *Canadian Public Policy,* University of Toronto Press, vol. 34, number 1 (March 2008). Wealthier households are more likely to alter their balance sheets to reduce their loan-to-value ratios. To the extent that non-housing assets generate income derived subject to tax, such portfolio shifting will reduce taxable income for these households, partially offsetting the increase in tax due to limitation of the deduction. Indeed, the benefits of deductibility do not increase with income as fast as taxes paid. Accordingly, Gervais and Pandey (2008) find "mortgage interest deductibility makes the tax code less progressive at relatively low levels of income and more progressive for relatively high levels of income."

[73] Edward L. Glaeser and Jesse M. Shapiro, "The Benefits of the Home Mortgage Interest Deduction" Harvard Institute of Economic Research, Discussion Paper Number 1979, (October 2002).

investments in other sectors, increasing the amount of leverage used to purchase homes--limiting the deduction could be beneficial to the economy as a whole.

V. THE VALUE OF TAX EXEMPTION FOR TAX-EXEMPT HOSPITALS

Present Law

Tax exemption

Charitable organizations, i.e., organizations described in section 501(c)(3), generally are exempt from Federal income tax, are eligible to receive tax deductible contributions,[74] have access to tax-exempt financing through State and local governments (described in more detail below),[75] and generally are exempt from State and local taxes. A charitable organization must operate primarily in pursuance of one or more tax-exempt purposes constituting the basis of its tax exemption.[76] The Code specifies such purposes as religious, charitable, scientific, educational, literary, testing for public safety, or to foster international amateur sports competition, or for the prevention of cruelty to children or animals. In general, an organization is organized and operated for charitable purposes if it provides relief for the poor and distressed or the underprivileged.[77]

The Code does not provide a per se exemption for hospitals. Rather, a hospital qualifies for exemption if it is organized and operated for a charitable purpose and meets additional requirements of section 501(c)(3).[78] The promotion of health has been recognized by the IRS as a charitable purpose that is beneficial to the community as a whole.[79] It includes not only the establishment or maintenance of charitable hospitals, but clinics, homes for the aged, and other providers of health care.

Although section 501(c)(3) hospitals generally are exempt from Federal tax on their net income, such organizations are subject to the unrelated business income tax on income derived from a trade or business regularly carried on by the organization that is not substantially related to the performance of the organization's tax-exempt functions.[80] In general, interest, rents,

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[74] Sec. 170.

[75] Sec. 145.

[76] Treas. Reg. sec. 1.501(c)(3)-1(c)(1).

[77] Treas. Reg. sec. 1.501(c)(3)-1(d)(2).

[78] Although nonprofit hospitals generally are recognized as tax-exempt by virtue of being "charitable" organizations, some may qualify for exemption as educational or scientific organizations because they are organized and operated primarily for medical education and research purposes.

[79] Rev. Rul. 69-545, 1969-2 C.B. 117; see also Restatement (Second) of Trusts secs. 368, 372 (1959); see Bruce R. Hopkins, *The Law of Tax-Exempt Organizations*, sec. 6.3 (8th ed. 2003) (discussing various forms of health-care providers that may qualify for exemption under section 501(c)(3)).

[80] Secs. 511-514.

royalties, and annuities are excluded from the unrelated business income of tax-exempt organizations.[81]

Charitable contributions

In general, a deduction is permitted for charitable contributions, including charitable contributions to tax-exempt hospitals, subject to certain limitations that depend on the type of taxpayer, the property contributed, and the donee organization. The amount of deduction generally equals the fair market value of the contributed property on the date of the contribution. Charitable deductions are provided for income, estate, and gift tax purposes.[82]

Tax-exempt financing

In addition to issuing tax-exempt bonds for government operations and services, State and local governments may issue tax-exempt bonds to finance the activities of charitable organizations described in section 501(c)(3). Because interest income on tax-exempt bonds is excluded from gross income, investors generally are willing to accept a lower rate on such bonds than they might otherwise accept on a taxable investment. This, in turn, lowers the cost of capital for the users of such financing. Both capital expenditures and limited working capital expenditures of charitable organizations described in section 501(c)(3) of the Code generally may be financed with tax-exempt bonds. Private, nonprofit hospitals frequently are the beneficiaries of this type of financing.

Bonds issued by State and local governments may be classified as either governmental bonds or private activity bonds. Governmental bonds are bonds the proceeds of which are primarily used to finance governmental functions or which are repaid with governmental funds. Private activity bonds are bonds in which the State or local government serves as a conduit providing financing to nongovernmental persons[83] (e.g., private businesses or individuals). For these purposes, section 501(c)(3) organizations are treated as nongovernmental persons. The exclusion from income for interest on State and local bonds does not apply to private activity bonds, unless the bonds are issued for certain permitted purposes ("qualified private activity bonds") and other Code requirements are met.

Analysis of Value of Tax Exemption for Section 501(c)(3) Hospitals

In 2006, the Joint Committee on Taxation analyzed the Federal cost associated with tax-exempt status for private nonprofit hospitals.[84] The analysis was not an estimate of the revenue

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[81] Sec. 512(b).

[82] Secs. 170, 2055, and 2522, respectively.

[83] For these purposes, the term "nongovernmental person" generally includes the Federal Government and all other individuals and entities other than States or local governments.

[84] The analysis was performed at the request of the Congressional Budget Office ("CBO") and was incorporated into a CBO report regarding the community benefits provided by tax-exempt hospitals

effects of removing tax-exempt status from hospitals, but was an evaluation of the amount of tax savings generated by tax-exempt status, considering the then-current level of activity of such hospitals. The analysis was based on data from IRS Forms 990 ("Return of Organization Exempt from Income Tax") filed for 2002.

The total Federal tax cost associated with the tax exemption for section 501(c)(3) hospitals and their supporting organizations for calendar year 2002 was estimated to be approximately $6.1 billion, as follows in Table 6.

Table 6.–Federal Tax Cost Estimate for Tax Exempt Hospitals, 2002[85]

Tax Type	2002 Value (Billions of Dollars)
Corporate income tax (Federal)	2.5
Tax-exempt bond financing (Federal)	1.8
Charitable contributions (Federal)	1.8
Total	**6.1***

* Details do not add to total due to rounding.

The value of tax exempt status for nonprofit hospitals is extremely difficult to quantify. The Form 990 that hospitals file with the IRS does not include all information that would be required to compute hypothetical Federal tax liability. The Form 990, for example: (1) does not provide information on State or local tax liability, which typically would be deductible by a business; (2) records book depreciation rather than tax depreciation; (3) does not reflect tax-exempt debt that has been issued by another entity on behalf of the filer; and (4) provides only limited information from which to determine possible relationships between the hospital and other tax-exempt and taxable filers. Because of these inherent limitations in the data and for various other reasons, the estimate carries substantial uncertainty.

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that was published in December 2006. *See* Congressional Budget Office, "Nonprofit Hospitals and the Provision of Community Benefits" (December 2006), at pp. 5-6.

[85] In 2008, the staff of the Joint Committee on Taxation published a tax expenditure estimate for the exclusion of interest on State and local government qualified private activity bonds for private nonprofit hospital facilities of $12.1 billion for the five-year period 2008 through 2012. *See* Joint Committee on Taxation, *Estimates of Federal Tax Expenditures for Fiscal Years 2008-2012* (JCS-02-08), October 31, 2008, at p. 56. As with the estimates derived from the above-described analysis, tax expenditure estimates are not revenue estimates and do not consider the behavioral effects of changes in tax laws. The 2008 tax expenditures publication also includes a tax expenditures estimate for health-related charitable contributions of $23.2 billion over the period 2008 through 2012; that figure, however, includes deductions for contributions not only to hospitals, but also to other health-related charitable organizations. The 2008 tax expenditure estimates are not directly comparable to the estimates from the 2006 study.

Also, as indicated above, the estimates are not revenue estimates, because they do not consider likely behavioral responses to proposed changes in tax laws. For example, such behavioral responses might include, corporate reorganizations, shifting of revenues between entities, changes in patterns of investment, or changes in charitable contributions.[86]

[86] In 2008, the staff of the Joint Committee on Taxation described certain tax subsidies intended to subsidize or induce behavior directly related to the production of business or investment income. *See* Joint Committee on Taxation, *Estimates of Federal Tax Expenditures for Fiscal Years 2008-2012* (JCS-02-08), October 31, 2008, at pp. 21-23. This description included tax-exempt status for certain organizations exempt from tax under section 501(a) that arguably have a direct business analog or compete with for-profit entities, such as small insurance companies, mutual or cooperative electric companies, State credit unions, and Federal credit unions. Along these lines, some argue that tax-exempt hospitals similarly operate much like for-profit hospitals and compete directly with such entities.

APPENDIX A
COMPARISON OF PRESENT-LAW TAX BENEFITS FOR HEALTH EXPENSES[1]

Provision	Tax Benefit	Class Eligible	Maximum Dollar Limit on Tax Benefit	Qualified Costs/Expenses
1. Employer contributions to an accident or health plan (sec. 106)	Exclusion from gross income and wages.	Employees (including former employees).	No limit on amount excludable.	Contributions to health plan for the taxpayer, spouse and dependents.
2. Employer reimbursement of medical expenses (sec. 105)	Exclusion from gross income and wages.	Employees (including former employees).	No limit on amount excludable.	Medical care expenses (as defined under section 213(d)) of the taxpayer, spouse and dependents.
3. Employer-provided health benefits offered under a cafeteria plan (sec. 125)	Exclusion from gross income and wages (for salary reduction contributions).	Employees.	No limit on amount excludable.	Coverage under an accident or health plan (secs. 105 and 106).
4. Health reimbursement arrangements (secs. 105 and 106)	Employer-maintained arrangement providing exclusion from gross income and wages for amounts used to reimburse employees for medical expenses. Amounts remaining at the end of the year can be carried forward to reimburse medical expenses in later years. There is no tax-free accumulation of earnings.	Employees (including former employees).	No limit on amount excludable.	Medical care expenses (as defined under section 213(d)) of the taxpayer, spouse and dependents.
5. Health flexible spending arrangements (secs. 105, 106, and 125)	Typically employee salary-reduction arrangement providing exclusion from gross income and wages for amounts used to reimburse employees for medical expenses.	Employees.	No limit on amount excludable.	Medical care expenses (as defined under section 213(d)) of the taxpayer, spouse and dependents (but not premium payments for other health coverage).

[1] The table describes the legal limits that apply under present law. Employers may establish rules and limitations consistent with those under present law. For example, it is common for employers to place a limit on the amount of expenses that may be reimbursed through an FSA or HRA.

Provision	Tax Benefit	Class Eligible	Maximum Dollar Limit on Tax Benefit	Qualified Costs/Expenses
6. Deduction for health insurance expenses of self-employed individuals (sec. 162(l))	Income tax deduction for cost of health insurance expenses of self-employed individuals. Deduction does not apply for self-employment tax purposes.	Self-employed individuals.	No specific dollar limit; deduction limited by amount of taxpayer's earned income from the trade or business.	Insurance which constitutes medical care for the taxpayer, spouse and dependents.
7. Itemized deduction for medical expenses (sec. 213)	Itemized deduction for unreimbursed medical expenses to extent expenses exceed 7.5 percent of adjusted gross income (10 percent for alternative minimum tax purposes).	Any individual who itemizes deductions and had unreimbursed medical expenses in excess of 7.5 percent of adjusted gross income.	No maximum limit.	Expenses for medical care (as defined under section 213(d)) of the taxpayer, spouse and dependents. Medicine or drugs must be prescribed or insulin.
8. Health Savings Accounts ("HSAs") (sec. 223)	Contributions are deductible if made by an eligible individual and excluded from gross income and wages if made by an employer (including contributions made through a cafeteria plan through salary reduction). Distributions used for qualified medical expenses excludable from gross income. Earnings on amounts in the HSA accumulate on a tax-free basis.	Individuals with a high deductible health plan and no other health plan other than a plan that provides certain permitted coverage. High deductible health plan is a plan with a deductible of at least $1,150 for self-only coverage and $2,300 for family coverage (for 2009). Out-of-pocket expense limit must be no more than $5,800 for self-only coverage and $11,600 for family coverage (for 2009).	Maximum annual contribution is $3,000 for self-only coverage or $5,950 for family coverage (for 2009). Additional contributions permitted for individuals age 55 or older. No limit on the amount that can be accumulated in the HSA.	Qualified medical expenses include those for medical care (as defined under section 213(d)), but do not include expenses for insurance other than certain limited exceptions.
9. Archer Medical Savings Accounts ("Archer MSAs") (sec. 220)	Contributions are deductible if made by an eligible individual and excluded from gross income and wages if made by an employer. Distributions used for qualified medical expenses	Employees of small employers who are covered under an employer-sponsored high-deductible health plan (and no other health plan other than a plan that provides certain	Maximum annual contribution is 65 percent of the annual deductible under the high-deductible health plan in the case of self-only coverage, and 75 percent of the annual deductible in the	Qualified medical expenses include those for medical care as defined under section 213(d), but do not include expenses for insurance other than certain limited exceptions.

Provision	Tax Benefit	Class Eligible	Maximum Dollar Limit on Tax Benefit	Qualified Costs/Expenses
	are excludable from gross income. Earnings on amounts in the Archer MSA accumulate on a tax-free basis.	permitted coverage) and self-employed individuals covered under a high-deductible health plan. Definition of high-deductible health plan differs from that for HSAs. No new contributions may be made after 2007 except for individuals who previously had an MSA or work for an employer that made MSA contributions.	case of family coverage. No limit on the amount that can be accumulated in the MSA.	
10. Health Coverage Tax Credit (sec. 35)	Refundable tax credit of 80 percent of the cost of qualified health insurance coverage.	Individuals receiving trade adjustment assistance and certain individuals receiving benefits from the PBGC.	Limited to 80 percent of the cost of qualified health insurance for months of coverage beginning April 2009. Limited to 65 percent of the same cost for months of coverage beginning after December 31, 2010. No specific dollar limit.	Qualified health insurance as defined in section 35(e).

APPENDIX B
COMPARISON OF VALUE OF HEALTH TAX BENEFITS: NON-HIGH-DEDUCTIBLE HEALTH PLAN

Assume that husband (H) has a health insurance plan that provides coverage for his wife (W) and dependents. The policy's premium is $850 per month ($10,200 annually) and has a $700 deductible. The family's out-of-pocket expenses are approximately $1,400 for the year. Thus, H's annual medical costs are $11,600. H and W file a joint income tax return and their annual adjusted gross income is $80,000.

Situation	Tax-Subsidized Employer Premiums	Tax-Subsidized Employee Premiums	Tax-Subsidized Out-of-Pocket Expenses	Value of Employment Tax[1] (E) and Income Tax[2] (I) Subsidy	Value of Total Tax Subsidy as a Percentage of Total Health Costs
(a) H's health insurance is provided through his employer. The employer pays 75 percent of the premium for such coverage.	$7,650	$0	$0	$1,086 (E) $1,913 (I) $3,000 total	26%
(b) The employer also allows the employee's share of the annual premium to be paid on a tax-free basis (i.e., through a cafeteria plan).	$7,650	$2,550	$0	$1,448 (E) $2,550 (I) $3,998 total	34%
(c) The employer also offers a reimbursement account (i.e., either a health flexible spending arrangement or a health reimbursement arrangement).	$7,650	$2,550	$1,400	$1,647 (E) $2,900 (I) $4,547 total	39%
(d) H is self-employed.[3]	NA	$10,200	$0	$0 (E) $2,550 (I)	22%
(e) H does not have employer-provided coverage and is not self-employed.[3]	NA	Taken into account in determining itemized deduction of $5,600[4]	Taken into account in determining itemized deduction of $5,600[4]	$0 (E) $1,400 (I)	12%

[1] The employment tax subsidy includes both the employer and employee portions of old-age, survivors, and disability insurance ("OASDI") and hospital insurance ("HI"). The effective employment tax subsidy rate is the combined employer and employee tax rate divided by gross-of-tax compensation. The effective subsidy is thus 0.153 / (1 + .0765) = 14.2%. The subsidy rate drops substantially for taxpayers with earnings above the Social Security earnings cap.
[2] This example assumes an effective marginal income tax rate of 25 percent. Subsidies to state and local income taxes are ignored here.
[3] This example ignores the fact that this policy in an individual market would either be more expensive or provide less comprehensive coverage.
[4] Medical expenses are deductible to the extent they exceed 7.5 percent of adjusted gross income ($80,000 X 7.5% = $6,000. $11,600 - $6,000 = $5,600). In addition, the taxpayer must claim itemized deductions on Schedule A. For most taxpayers, this means that total itemized deductions exceed the standard deduction. For alternative minimum tax purposes, medical expenses are deductible to the extent they exceed 10 percent of adjusted gross income.

APPENDIX C
COMPARISON OF VALUE OF HEALTH TAX BENEFITS: HIGH-DEDUCTIBLE HEALTH PLAN

Assume that H has a high-deductible health insurance plan that provides coverage for his wife (W) and dependents. The policy's premium is $765 per month ($9,180 annually) and has a $2,000 deductible. H makes contributions of $2,000 to a health savings account ("HSA"). The family's out-of-pocket expenses are approximately $2,420 for the year. Thus, H's annual medical costs are $11,600. H and W file a joint income tax return and their annual adjusted gross income is $80,000.

Situation	Tax-Subsidized Employer Premiums	Tax Subsidized Employee Premiums	Tax-Subsidized Out-of-Pocket Expenses	Tax-Deductible HSA Contribution[1]	Value of Employment Tax[2] (E) and Income Tax[3] (I) Subsidy	Value of Total Tax Subsidy as a Percentage of Total Health Costs
(a) H's health insurance is provided through his employer. The employer pays 75 percent of the premium for such coverage.	$6,885	$0	$0	$2,000	$ 978 (E) $2,221 (I) $3,199 total	28%
(b) The employer also allows the employee's share of the annual premium to be paid on a tax-free basis (i.e., through a cafeteria plan).	$6,885	$2,295	$0	$2,000	$1,304 (E) $2,795 (I) $4,099 total	35%
(c) The employer also offers a reimbursement account (i.e., either a health flexible spending arrangement or a health reimbursement arrangement).	$6,885	$2,295	$2,420[4]	$2,000	$1,647 (E) $3,400 (I) $5,047 total	44%
(d) H is self-employed.[5]	NA	$9,180	$0	$2,000	$0 (E) $2,795 (I)	24%
(e) H does not have employer-provided coverage and is not self-employed.[5]	NA	Taken into account in determining itemized deduction of $5,600[6]	Taken into account in determining itemized deduction of $5,600[6]	$2,000	$0 (E) $1,900 (I)	16%

[1] Amounts contributed to a HSA can be used to pay qualified out-of-pocket expenses on a tax-free basis.

[2] The employment tax subsidy includes both the employer and employee portions of old-age, survivors, and disability insurance ("OASDI") and hospital insurance ("HI"). This example assumes that HSA contributions are made by the taxpayer. HSA contributions made by the employer would also be excluded from wages for employment tax purposes. See footnote 1 to Appendix B for calculation of employment tax subsidy.

[3] This example assumes an effective marginal income tax rate of 25 percent. Subsidies to state and local income taxes are ignored here.

[4] Individuals eligible to make contributions to an HSA must have a high deductible health plan and no other health plan, other than certain permitted coverage. The reimbursement account is permitted if it allows reimbursements only for certain limited purposes (e.g., vision or dental) or in certain other limited situations.

[5] This example ignores the fact that this policy in an individual market would either be more expensive or provide less comprehensive coverage.

[6] Medical expenses are deductible to the extent they exceed 7.5 percent of adjusted gross income ($80,000 X 7.5% = $6,000. $11,600 - $6,000 = $5,600). For alternative minimum tax purposes, medical expenses are deductible to the extent they exceed 10 percent of adjusted gross income. Distributions from an HSA are not taken into account in determining the itemized deduction. If H used distributions of $2,000 from his HSA to pay qualified medical expenses, the itemized deduction would be limited to $3,600.

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STATEMENT

Before the

**UNITED STATES SENATE FINANCE COMMITTEE
ROUNDTABLE**

On

Delivery System Reform

**Allan Korn, M.D.
Senior Vice President and Chief Medical Officer
Blue Cross and Blue Shield Association**

April 21, 2009

INTRODUCTION

The Blue Cross and Blue Shield Association (BCBSA) commends Chairman Baucus's and Ranking Member Grassley's leadership in holding this important series of roundtable discussions to bring stakeholders together to work toward solutions for improving today's healthcare system.

BCBSA is pleased Congress and the Administration have made healthcare reform a national priority, and we share the commitment to enacting healthcare reform legislation this year that expands coverage to all Americans, reins in costs, and improves the quality and safety of care delivered to patients.

BCBSA strongly believes everyone in our country should be insured. It is unacceptable that 46 million people are uninsured, and we look forward to working with Congress, the Administration and all stakeholders to ensure everyone has coverage.

To attain the goal of having everyone covered, we must address the underlying problems of our current delivery system. Escalating costs are the main reason people are unable to obtain health insurance, and rising health care costs must be addressed through delivery system reforms that increase quality and enhance value. Such a reformed delivery system would ensure patients get the right care at the right time and should focus on four priorities outlined in our comprehensive health care reform proposal, *The Pathway to Covering America*:

- *Providing information on what works best* by comparing the relative clinical effectiveness of new and existing medical procedures, drugs, devices, and biologics – this is a vital first step in addressing the approximately 30 percent of all healthcare spending that goes toward ineffective, redundant, or inappropriate care. (Wennberg, 2003)

- *Changing incentives to advance the best possible care,* instead of paying for more services that may be ineffective, redundant, or even harmful – because providers are generally paid based on the number of services they provide, regardless of quality or outcomes.

- *Empowering consumers and providers* with the information and tools they need to make informed decisions – because too often consumers and providers do not have what they need to encourage the right care done right at the right time for each and every patient.

- *Promoting healthy lifestyles* to prevent chronic illness and work aggressively to help patients with chronic illnesses manage their own health – because one of the greatest challenges facing the healthcare system is managing the care for the growing number of people with chronic illnesses.

A robust private insurance system is critical to reforming the delivery system so that all patients have access to safe, affordable quality care. Private plans in general and Blue Plans in particular have been active innovating in these priority areas. Private health plans' efforts, which depend on thoughtful, coordinated contributions from patients, hospitals, physicians, and policymakers, are already helping to reform the delivery system by changing incentives to advance the best possible care, not just drive the use of more services.

Creating a new government plan that would compete with the private sector would undermine the ability of the health care sector to implement meaningful delivery system reforms. The private sector has led the way in developing innovative programs (e.g., chronic care management, wellness programs, and Centers of Excellence) that would not be possible under a government plan due to enormous political pressure. Private health plans lead innovations to improve quality of care that the government has been historically slow to adopt.

To help the Committee develop its delivery system reform proposals, our statement covers:

(1) The Blue delivery system reforms that we have successfully put into practice to-date; and

(2) Recommendations for what the government should do to reform the delivery system, including recommendations to move Medicare away from a system based on fee-for-service design to one that pays based on quality, coordinated, and outcome-driven care.

PRIVATE SECTOR INNOVATIONS

Today's private insurance companies have been the driver behind numerous innovations in the four priority areas we identified for delivery system reform.

I. Information on what works best

Today, only about half of patients get a full recommended course of evidence-based care. BCBSA and Blue Plans have been working to help doctors and other caregivers deliver better and more consistent clinical care to their patients – the right care done right at the right time for each and every patient – through two leading efforts: (1) BCBSA's Technology Evaluation Center; and (2) Blue Health Intelligence. We also recommend that the government encourage research on what works best and put it into practice – the bedrock of encouraging the right care at the right time for every patient is comparative information on the clinical effectiveness of different treatment approaches.

Technology Evaluation Center

Since it was founded by BCBSA more than 20 years ago, the Technology Evaluation Center (TEC) has helped physicians and other caregivers across the country improve quality. TEC has led the development of scientific criteria for assessing the effectiveness of medical technologies through comprehensive reviews of clinical and scientific evidence. TEC is one of only 14 evidence-based practice centers for the Agency for Healthcare Research and Quality, publishing an average of 15-20 clinical assessments annually. Recently, for example, TEC assessed whether computer-assisted navigation improved alignment of the implant during knee replacement surgery. TEC's study found that there was little existing evidence that computer-assisted navigation technology helped improve patient outcomes compared to conventional knee replacements.

Blue Health Intelligence

To further support evidence-based medicine, we created Blue Health Intelligence (BHI) – the nation's largest, most comprehensive healthcare data repository – which has patient-protected health claims information on more than 54 million BCBS subscribers. BHI will be a powerful research tool that can inform decisions that will ultimately improve care. It can benefit employers

by providing them with information on trends and utilization that they can use to develop state-of-the-art wellness programs. It can also provide information on breakthrough treatments and potential problems in care delivery. For example, if BHI had existed a few years ago, we would have known sooner about Vioxx's link to increased heart attack and stroke risk.

Comparative Effectiveness Research

We applaud the comparative effectiveness provisions included in the American Recovery and Reinvestment Act of 2009, but urge further steps to strengthen delivery system reform:

- Create an independent, federally chartered, not-for-profit Institute to prioritize and fund a variety of research – including clinical trials, cohort studies, literature reviews, and other studies – evaluating the comparative clinical effectiveness of different procedures, drugs, devices, and biologics.

- The Institute should ensure that new comparative information is disseminated timely to providers, patients, and others in easy-to-use formats. Electronic medical records should be required to incorporate these guidelines into their clinical decision support systems.

- Finally, the resulting evidence-based standards should inform medical malpractice, for example by creating rebuttable presumptions and safe harbors concerning the standards of care that providers are expected to meet in medical malpractice cases.

II. Changing Incentives

Most physicians and hospital staff are well-trained and well-intentioned, but need to spend more time improving the processes by which care is delivered, and using systems to support decision-making that adheres to the scientific evidence that is available. This requires realigning financial incentives, as well as training in process improvement techniques. We must change processes and incentives in our current health care system to advance the best possible care, not just drive the use of more services. We believe that by helping providers implement best patient care practices, health plans can deliver better value and efficiency to members, ensuring access to affordable and high quality health coverage.

Blue Distinction

One major way that BCBSA has been realigning incentives and helping providers is our national program of nearly 800 Blue Distinction Centers (BDC) across 43 states. This program designates facilities that have demonstrated expertise in delivering quality healthcare in the challenging specialty areas of Transplantation, Bariatric Surgery, Cardiac Care, and Complex and Rare Cancers.

To receive this designation, facilities must meet stringent quality criteria, as established by experts in the specialty field. Centers must demonstrate better outcomes and consistency of care, which provide greater value for Blue Plan members. Facilities that have the BDC designation are subject to periodic evaluations as criteria continue to evolve; facilities that do not receive the BDC designation receive assessments and advice on doing better the next time.

The early results for the Cardiac Care BDCs are especially encouraging. Currently there are more than 410 Blue Distinction Centers for Cardiac Care. The stringent clinical criteria that designated

facilities met were developed in collaboration with the American College of Cardiology (ACC), the Society of Thoracic Surgeons (STS), and with the input from a panel of leading clinicians.

A study by HealthCore, Inc., found that readmission rates for certain procedures performed at Blue Distinction Centers for Cardiac Care® were lower than at other hospitals. The study found:

- 26 percent lower readmission rates for bypass surgery and 37 percent lower for outpatient angioplasty, based on 30-day cardiac-related readmission rates.
- 21 percent lower readmission rates for bypass surgery and 32 percent lower for outpatient angioplasty based on 90-day cardiac-related readmission rates.
- Lower costs, five percent less for bypass procedures and 12 percent less for outpatient angioplasty, with a 90-day episode of care.

Similarly, there is a significant difference in the inpatient mortality of patients admitted to BDC facilities as opposed to those facilities that were denied the designation. And in a striking confirmation that improved quality leads to better affordability, allowed charges for bypass surgeries were $45,215 in BDCs – $2,260 less than in non-BDC hospitals. Economic criteria were not used to designate facilities as BDCs; it just turned out that facilities that offered better care were associated with better clinical outcomes and generated more affordable care, an important insight for national policy.

Pay-for-Quality

A critical strategy for BCBS Plans to drive delivery system reform is to continue to raise the bar on quality through the use of pay-for-quality or pay-for-performance (P4P) programs that begin to align incentives – improving quality and affordability by facilitating the adoption of best patient care practices for hospitals, physicians, and members. Plans focus on measuring quality indicators that have been identified by national quality improvement organizations as areas of opportunity, and tie significant financial incentives to improvements in these quality measures.

For example, Highmark BCBS's hospital P4P program has focused on reducing the incidence of central line bloodstream infections in ICUs. During 2008, hospitals in the program reported a significantly lower rate of central line infections compared to the national average, (1 infection per 1000 line days compared to 2.7 infections per 1000 line days), translating to an imputed savings of more than $21 million and between 69 and 142 lives saved compared to the national norm. Highmark's P4P program for primary care physicians has greatly increased the rate of generic prescribing, resulting not only in financial savings to members and employers, but also increasing the likelihood that patients will adhere to treatment plans.

III. Empowering Consumers and Providers

With timely information and well-designed electronic tools, BCBS Plans have been working to encourage the right care done right at the right time for each and every patient. Blue Plans across the U.S. are leading efforts to promote widespread adoption of electronic medical records, e-prescribing, personal health records, and consumer decision-support tools. We are very pleased the American Recovery and Reinvestment Act will play a decisive role in furthering adoption of health information technology.

- *Claims-based Electronic Records:* Many Blue Plans are giving providers access to comprehensive information on a patient's health and medical history through payer-based electronic health records. These records are populated with pertinent claims data such as recent health encounters, diagnoses, medication histories, prescription refill status from pharmacies, and test results from laboratories. This information enables providers to better coordinate care.

- *Personal Health Records:* Blue Plans are providing personal health records (PHRs) for their members, which are auto-populated with key claims data, including medications, immunizations, and provider information, and can be self populated with other important information such as family history and over-the-counter drugs. A PHR can help consumers be better informed and more actively involved in their healthcare -- and lead to better coordination among caregivers.

- *Electronic Prescribing:* Blue Plans have been leaders in facilitating e-prescribing. For example, in 2006 BCBS of North Carolina launched an e-prescribing program that provided more than 1,000 high-volume prescribing physicians with a handheld personal digital assistant (PDA), software licenses, and wireless network hardware free-of-charge. Since the program's launch, the improvements to patient safety have been impressive: more than four million electronic prescriptions have been submitted, 59 percent received drug-to-drug interaction warnings, 32 percent of the orders were flagged as formulary warnings, and 2 percent were halted altogether because of patient allergy alerts.

IV. Promoting Healthy Lifestyles

Chronic illnesses such as heart disease, hypertension, diabetes, and stroke account for 70 percent of deaths and 75 percent of total healthcare costs. Delivery system reforms that encourage patients and caregivers to aggressively tackle these diseases can go a long way to improving patient care.

Disease Management

One such reform is the aggressive use of disease management programs. BCBS Plans nationwide have led the way in implementing disease management programs for members with complex chronic conditions. For example, BC of Idaho launched a disease management program in 2001 designed to reduce hospital admissions and improve medication compliance for members with congestive heart failure (CHF). The program used educational materials and one-on-one physician coaching and outreach to improve self-management techniques, as well as offered biometric monitoring equipment to high-risk CHF members that allowed them to report on their conditions from home. The coordinated efforts led to a five percent reduction in hospital readmission rates among members with CHF.

Horizon BCBS of New Jersey is using critical health IT tools while also offering primary care physicians financial incentives to provide comprehensive, coordinated patient care and management of chronic diseases. Under this pilot, Horizon shares pertinent claims data with providers that can tell the physician which of his or her patients have diabetes and which have not had important tests or screenings as part of their recommended care, such as a blood glucose test within the last year. With this information now readily available, physicians are able to reach out to the patient to make sure they are getting the care they need. This program is yielding impressive results: in just one year, compliance rates for HbA1c blood tests (a key health status indicator for patients with diabetes) jumped from 40 percent to over 90 percent.

INNOVATIONS TO REFORM MEDICARE

We urge Congress to follow the lead of the private sector and, instead of creating a new government plan, begin moving Medicare away from a system based on fee-for-service design to one that pays based on quality, coordinated, and outcome-driven care.

We recommend Congress enact a three-tiered strategy for Medicare that phases in a range of innovative reforms:

- Tier I – Reforms that could be started immediately and would lay the groundwork for major changes in the structure of the healthcare delivery system by moving away from fee-for-service care to reward quality and outcomes. This includes expanding successful pay-for-performance programs based on Plan experience to all of Medicare.
- Tier II – Reforms that could be planned now and implemented within the next two years to build on Tier I reforms and further advance quality and outcomes. These include promoting wellness through benefit design changes, and creating an environment of professional accountability for providers.
- Tier III – Major reforms in the structure of the healthcare delivery system that could be planned now, tested through public-private demonstrations over the next couple years, and implemented thereafter. This includes piloting approaches that move the entire system away from fee-for-service and into new payment models that will more closely align outcomes with reimbursement.

Tier I Reforms

We recommend that Medicare start these reforms now, but phase them into completion at different rates.

1) Pay-for-quality

Medicare should follow the lead of the private sector by expanding its pay-for-quality incentive programs and eventually require participation by all Medicare providers. Medicare should start with primary care physicians and hospitals in 2010 because extensive performance measures are available, and accelerate efforts to develop performance measures for specialists in order to expand to specialists by 2011.

We urge incorporating lessons learned from successful Blue program: for example, incentives must be in the range of 10 percent to 15 percent to motivate practice changes. CMS should also:

- Explore the potential for incorporating med-mal insurance discounts for high-performers into incentive programs.

- Streamline quality reporting requirements to reduce providers' administrative burden.

We note that BCBS of Massachusetts has launched a major new program in collaboration with all provider communities in the state, basing reimbursement on clinical outcomes and efficiency. Although recently launched, such innovation is only possible in an environment within which decisions can be made and revisited by all participants without political or social pressure from myriad interested parties.

2) Increase reporting and transparency

We urge CMS to continue to partner with the private sector to provide quality information on individual physicians and hospitals.

3) Build up the Primary Care Workforce

Increasing payments to primary care physicians, while at the same time strengthening the foundation of the overall primary care workforce, are critical delivery system reforms to ensure a high performing health care system.

- To increase payments, we recommend adjusting payments through the Resource Based Relative Value Scale (RBRVS) to give primary care providers a 5 percent relative increase in 2010; 10 percent in 2011; and 15 percent thereafter. Paying for this could be done primarily by reducing payments for imaging services to providers who rely heavily on costly imaging machines. At the same time, we would change the membership of the RVS Update Committee – which is sponsored by the AMA and makes recommendations that CMS uses to set payment rates. Currently only five of the Committee's 29 members represent primary care specialties as defined by the AAFP. We would increase the proportion of primary care physicians to at least 35 percent of the medical professionals on the Committee, and add private payers as non-voting members.

- To strengthen the overall primary care workforce, we would recommend increasing educational subsidies for primary care providers (not only physicians, but also physician assistants and nurse practitioners). This could involve (1) modifying current Graduate Medical Education (GME) payments to provide greater subsidies for primary care training (hospitals currently receive only slightly higher payments for training primary care residents versus specialists); (2) Augmenting current loan forgiveness programs by forgiving loans for primary care providers who work in medically underserved areas and who are not part of the National Health Service Corps; (3) For primary care positions only, lifting the cap introduced under the Balanced Budget Act of 1997 so that additional primary care residency programs could be funded; and (4) Removing the Medicare limitation on supporting allied (non-physician) health practitioner clinical training not directly operated by a hospital so that more professionals can receive training.

4) Create clinical pathways to help physicians provide compassionate and cost-effective end-of-life care.

Medicare spends more than a quarter of its annual budget on care for those in their last year of life. Among patients who died of cancer, a major contributor to cost and quality-of-life issues is the

widespread use of chemotherapy in the last three months of life. Studies show that 15 to 20 percent of patients with incurable, end-stage cancer receive chemotherapy within 14 days of their death, a time when chemotherapy has no benefit.

- Therefore, we recommend funding a pilot starting in 2009 to identify the extent of overuse errors in treatment of cancer patients, for example by measuring non-palliative chemotherapy use in the last two weeks of life, and to establish best use of palliative care. CMS would develop pathways based on the pilot and incorporate those pathways into future pay-for-quality programs for specialists treating cancer patients.

Tier II Reforms

We recommend that Medicare start planning for these reforms now, and implement them within the next two years.

1) Create an environment of "professional accountability" that empowers provider organizations to drive quality care.

In order to empower providers to take a role in ensuring quality care, we recommend that CMS engage and fund medical specialty boards to determine standards for appropriateness of care that would be used by all practicing providers. To ensure full representation, and to ensure that reforms also affect rural or underserved communities, mechanisms to reach out to non-board-certified physicians also must be funded and developed. The standards for appropriateness that are developed and then used by Medicare should be vetted and endorsed by the National Quality Forum or another nationally-recognized, consensus organization.

2) Modernize benefit design to promote prevention, wellness, and management of chronic conditions.

Medicare beneficiaries should be incentivized to participate in wellness activities, such as through programs that provide financial incentives for participating in a personalized online health promotion program and meeting targeted health goals. As one example of how to do this, BS of California offers its members a program called Healthy Lifestyle Rewards. The customized, online program attacks the root causes of chronic illness by offering financial incentives to motivate individual efforts to reduce modifiable risk factors. Cash rewards are offered, and the amount is determined based on the member's duration of participation completion of online modules that drive behavioral change and provide practical support.

Medicare should also identify and test relevant value-based insurance designs – where the more clinically beneficial the service is to a beneficiary, the lower that beneficiary's cost sharing for the service. Demonstration programs could begin in 2010, with full implementation in 2011.

3) Advance administrative efficiencies that can lower costs and free up provider time for patient care.

Medicare should require providers (with rare exceptions) to use the standard HIPAA electronic transactions for submitting claims, getting eligibility and benefits information, etc. Currently, while close to 70% of overall claims in general are submitted by providers electronically, the rates for other electronic transactions are much lower – most eligibility and benefits checks are done by phone calls or paper.

Tier III Reforms

We recommend that Medicare start planning for these fundamental delivery system reforms now, test them in demonstrations in 2010, and implement lessons learned thereafter.

These recommendations would fundamentally change the delivery system to pay for quality, integration, and coordination of care (among primary care practitioners, specialists, and hospitals). Since they would largely be entirely new approaches, we recommend each first be pilot tested to fully understand their impact before broader implementation. Medicare could partner with the private sector on these pilots to ensure that eventual implementation is sustainable in an all-payer environment.

1) Expand the scope of care coordination in the medical home model.

Medicare should establish public-private pilots that integrate specialists and hospitals into the medical home model. The current medical home model incentivizes the primary care provider to better coordinate care, but lacks a mechanism to encourage hospitals and specialists to respond to, or participate in, these coordination efforts. Therefore, we recommend that the pilots establish and include incentives (such as expanded fee schedules or other additional payments) for specialists and hospitals to share information and improve coordination.

2) Encourage greater integration of providers through "virtual" arrangements.

Medicare should establish public-private pilot programs that give providers incentives to participate in what are known as "Accountable Care Organizations" (ACOs), which emulate fully-integrated delivery systems. These models are expected to greatly improve care coordination, as well as lower costs, by allowing participating providers a share of savings gained through efficiency.

Coordination by providers should be incentivized through group-level quality reporting and payments that tie a provider's performance rating to that of all other providers involved in the patient's care. Medicare should also:

- Set spending targets for care with opportunities for providers to receive a share of any savings, as long as quality benchmarks also are met.
- Pilots should be structured to determine who best to serve as the primary recipient of shared savings (e.g. hospitals or individual providers) and under what method those savings should be allocated to the other providers involved in the patient's care. This would address a key challenge in such delivery system reforms: how to equitably distribute resources [shared savings] across physicians, hospitals, and other providers – and, ultimately, taxpayers.[1]

3) Encourage greater integration of providers through bundled episodic payments for a targeted patient population.

[1] Mechanic, RE, and Altman, SH. (2009). Payment reform options: Episode payment is a good place to start. *Health Affairs, 28, no. 2.*

We also recommend that CMS establish public-private pilot programs where Medicare and private payers use bundled payment arrangements for certain conditions. Rather than separate payments for the hospital, post-acute providers, and physicians involved in treatment of a patient hospitalized for a procedure, only a single payment would be made by the payer for a defined episode of care.

Because the predetermined payment will be split among the hospital, post-acute providers, and physicians, it is hoped they will collaborate more closely to avoid complications and unnecessary procedures and re-admissions, thus preserving more of the payment for them. We recommend initially focusing on congestive heart failure/coronary disease, since this condition results in some of the highest rates of hospital readmissions under our current system, and would likely benefit most from the improved care coordination that episodic payments are expected to produce.

- As in the recommendation above, pilots should be structured to determine who best to serve as primary recipient of the payment, and under what method it should be allocated to the rest of the providers involved in the patient's care.

- Reduced hospital readmission rates should be established as one overall performance objective to which payments are tied, to encourage better care and follow-up of patients after discharge from acute care.

CONCLUSION

BCBSA appreciates this opportunity to share our recommendations for delivery system reforms to increase quality and enhance the value of our healthcare system. Delivery system reforms are critical as we work toward the goal of assuring all Americans have access to affordable, high quality care. The Blue System has several successful initiatives already underway that are making a difference in advancing the best possible care for patients. Our vision for a reformed delivery system would ensure patients get the right care at the right time by focusing on four priorities:

- *Providing information on what works best* by comparing the relative clinical effectiveness of new and existing medical procedures, drugs, devices, and biologics.

- *Changing incentives to advance the best possible care,* instead of paying for more services that may be ineffective, redundant, or even harmful.

- *Empowering consumers and providers* with the information and tools they need to make informed decisions.

- *Promoting healthy lifestyles* to prevent chronic illness and work aggressively to help patients with chronic illnesses manage their own health.

We believe a robust private insurance system is critical to achieving these needed delivery system reforms. Creating a new government plan would undermine the ability of the healthcare sector to implement the meaningful delivery system reforms needed to improve our healthcare system. Instead, Congress should follow the lead of the private sector and begin moving Medicare away from a system based on fee-for-service design to one that pays based on quality, coordinated and outcome-driven care. We look forward to continuing to work closely with Congress, the Administration and all stakeholders to enact comprehensive healthcare reform legislation this year.

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Policy Options to Promote Delivery System Reform

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April 21, 2009
Senate Finance Committee

This statement on policy options to promote delivery system reform comes with the sincere thanks and appreciation from the business community for the leadership shown by Senators Baucus and Grassley, and all of the members of the Senate Finance Committee. We are pleased that you are asking the right questions, including how to rein in the out of control health care costs while simultaneously fostering higher quality care. We also appreciate your understanding that reform cannot be just about expanding coverage. If we do not reform how we deliver and pay for care, the health care system will be an ever increasing weight dragging down the economy, America's business community and individual patients across the country.

The Pacific Business Group on Health is a nonprofit association of many of the nation's largest purchasers of health care, based in California. PBGH represents both public and private purchasers who cover over 3 million Americans, seeking to improve the quality of health care while moderating costs. Research tells us that quality varies, is often unsafe, and that we are providing far too much inappropriate and unnecessary care. Americans believe in value – most shop to get the best quality possible for their money. Yet, no one is getting good value for their health care dollar. Our health care system is broken:

- Quality of care varies dramatically between doctors and hospitals, but those differences are invisible to patients.
- Payments reward quantity over quality and fixing problems over prevention.
- Lack of standardized performance measures makes it impossible to know which providers are doing a good job, and those who are not.
- Consumers lack information to make the choices that are right for them.

Purchasers are not interested in dictating the form of health care delivery, but they do want better results. We live in a large and complex society, and one that expects continuous increases in knowledge and continuous innovation in how to apply that knowledge to achieve value. In most of our members' industries, they have seen dramatic and valuable innovations in how services are delivered and products are made. Now they want to see a health care environment where similar innovation and efficiency is facilitated and rewarded. They want a delivery system that succeeds when it achieves improved health through health promotion, prevention of illness, and effective treatment of disease and injury. The primary tests of delivery system reform should be

demonstrable improvements in health outcomes and efficient use of societal and personal resources. If we create the right incentives and metrics, the many thousands of highly trained and passionate professionals will be encouraged and enabled to deliver more effective, efficient care.

I would like to highlight five policy approaches that can help create the kind of environment that will encourage effective delivery system reform:

1. Transparency in provider performance and the comparative effectiveness of treatments, drugs and devices
2. An infrastructure to support the efficient collection and sharing of information
3. Payments that reward higher value and provide consistent incentives across both public and private sector payors
4. Effective ways to engage patients with information and incentives to make the best decisions
5. Policy and governance processes that incorporate the perspectives of those who receive and pay for care, as well as those who provide it

1. We need to know who's doing a better job and what works – promoting policies that foster transparency in provider performance and the comparative effectiveness of treatments, drugs and devices.

We know there is huge variation in the quality of health care, but we don't know who is or isn't delivering the right care at the right time. All too often we don't know which drugs, devices or treatments are the right ones. Without better information, providers cannot improve their performance, consumers cannot make better choices and payers cannot know who or what to reward. Continuous improvement will not occur based on top-down orders from Washington to "do the right thing." Health care professionals in every community in America want to provide the best quality care and to improve their performance – but can't get far if they don't know how they're doing. And, consumers and purchasers cannot identify and reward high quality efficient care without measures of what works and who's providing the right care. As part of charting out our gaps in performance, we know that people of color, limited English speakers and poor people often receive lower quality health care, even when they have the same health care coverage as other populations.

Improving quality requires sharing information about what is happening inside our health care system with everyone who gets, gives or pays for care. There are a range of concrete policy options that can foster better measurement – which is the foundation for all efforts to improve the value of our health care system:

- The recommendations of over 170 groups under the name "Stand for Quality" – representing an array of consumers, employers, clinicians and other providers, hospitals, health plans and more – called for dramatically increased federal leadership in aligning priorities, developing performance measures to fill gaps, and engaging stakeholders in how those measures are used by the public sector (information available at www.standforquality.org). These recommendations call for the development of robust, independent systems for collecting and reporting performance results on patients' outcomes, cost and patients' views of care, and whether the right processes of care are being delivered by doctors, medical groups, hospitals, nursing homes, and other providers. The breadth of support for doing measurement right – expanding our measurement of outcomes, patient-experience, disparities in care and resource use – is historic and charts a path for action.
- The American Reinvestment and Recovery Act's (ARRA) support for comparative effectiveness research is an important step, but we need to dramatically expand comparative effectiveness research so patients can have better information that they can use with their doctors to understand what's the right treatment for them. We need more than the studies being funded under ARRA, but an ongoing independent and robust comparative effectiveness process that will assure that decisions about care are driven by the evidence and what is in the patient's interest.
- CMS should routinely make available the Medicare claims database to qualified "Quality Reporting Organizations" via HIPAA-compliant agreements. This would enable employer-sponsored and individually sponsored health benefits plans to use aggregated public and private claims data to generate provider-specific health care performance results and ultimately lower premiums and raise quality of care.

2. There needs to be an infrastructure to support the efficient collection and sharing of information.

Health care is an information-dependent industry that has failed to keep up with the revolution in knowledge and information processing that has transformed the global economy. Patients, clinicians, and policymakers need reliable, real-time information to make sound decisions – whether about individual patient care or the allocation of societal resources. It is intolerable that we continue to "manage" a $2+ trillion industry that affects the well-being of every American with paper documentation and crude billing codes. As we enter the second decade of Google - with instant access to much of the world's knowledge - it is time to extend the network information model to US health care. We encourage you to consider several key principles:

1. The goals of health IT investments are to improve health care quality and affordability, stimulate innovation, and protect privacy – not the mere installation of software or hardware.

2. These goals can be achieved only through the effective use of information to support better decision-making and more effective processes that improve health outcomes and reduce unnecessary costs.
3. The definition of "meaningful use" should hinge on whether information is being used to deliver care and support processes that improve patient health status and outcomes.
4. It would be a strategic mistake to assume that only a highly integrated EHR system can achieve the goals of meaningful use. Public policy and incentive programs must allow for innovation in the architecture and technologies used to deliver information to clinicians and patients.
5. Consumers, patients, and their families should benefit from health IT through improved access to personal health information without sacrificing their privacy.

We also encourage you to recognize that every American is a user of the emerging health information network – it is not the preserve of researchers or doctors or institutions. Massive databases of valuable health information are already in digital form – medication histories, laboratory results, claims and billing data, imaging studies and, now, electronic health records – but we have not addressed the policy issues and the transport standards that would allow these data to be exchanged and aggregated under proper controls. To stimulate greater consumer engagement in their own care, and to encourage innovation in health care delivery, we need to establish the technical and policy framework that would open up the data networks to wider use.

3. Payments must be reformed to reward higher value and we need to be sure that these efforts align public and private sector efforts.

Our health care system pays providers for the number of treatments and procedures they provide and pays more for using expensive technology or surgical interventions. It is neither designed to reward better quality, care coordination or prevention nor to encourage patients to get the right care at the right time. While there are literally hundreds of efforts across the country to reform payments, without Medicare's leadership these efforts will be too small and run the risk of distracting instead of focusing health care providers on delivering better care. Recently a coalition of consumers, employers, labor and providers have come together because of their agreement on the need to transform the payment system. This group – the Center for Payment Reform – has established six core principles that should guide both public and private payment policies:

1. Reward the delivery of quality, cost-effective and affordable care
2. Encourage and reward patient-centered care that coordinates services across the spectrum of health care providers and care settings
3. Foster alignment between public and private health care sectors
4. Make decisions about payment using independent processes

5. Reduce expenditures on administrative and other processes
6. Balance urgency to implement changes against the need to have realistic goals and timelines

Using these principles as guidance, we must design payment systems to reward providers for giving the right care at the right time and encourage patients to be actively engaged in their care. Some policy options that should be taken include:

- Reward those who provide truly needed care – not care that is of unlikely benefit to patients. More health care is not always better care. In fact, too much care can harm people by subjecting them to unnecessary dangers and treatments. We need to stop giving and paying for care people do not need. In both the measurement arena and in payment, there is far too little discussion of overuse and whether care is appropriate. The fact that overuse is one of the priority areas identified by the National Priority Partnership effort being facilitated by the National Quality Forum is good news. We need to build on that identification to design payments that foster the right care and not overuse.
- Providers who deliver high-quality, cost effective care or who improve significantly should be rewarded. Medicare's efforts on both the clinician and facility fronts should be dramatically expanded.
- Fee-for-service payments should be modified to promote primary care, better coordination and more efficient care. We need to rebalance the payment equation to better compensate providers engaged in preventive care, time spent coaching patients and coordinating care for those with chronic conditions; and relatively decrease payments for procedures and testing. Not only does the current payment "get what we pay for" – large amounts of procedures, and consultations with uncertain benefit – we are generating a pipeline of specialist physicians who will see every patient as the "nail" for whom their "hammer" is the appropriate instrument. We need to begin signaling now for today's and tomorrow's physicians that we will reward primary care.
- Medicare, along with private payers, must embark on rapid cycle demonstrations to move away for the quality-blind fee-for-service "pay for quantity" approach. Substantial piloting of medical homes and bundled payments are examples of such efforts. We need to move to paying for episodes of care rather than discrete services. This means paying once for the total package of treatments necessary for a medical condition, rather than paying separately for each treatment. Congress, however, must balance the need for rapid cycle testing with the urgency which cries out for change. Launching demonstrations and pilots that allow for expansion are needed, but Congress should call on Medicare to move payments to reward coordination, quality and efficiency. Changing payments to promote quality cannot and should not happen overnight – but it can and must happen. Congress can foster this movement by requiring CMS to report on how Medicare spending is indeed patient-

centered and rewarding better performance. Potential reporting elements include:
    - Percentage of total Medicare payments that reward better care, participation in reporting programs or improvements in delivery (such as e-prescribing);
    - Percentage of total Medicare payments that specifically foster and reward care coordination;
    - Percentage of Medicare payments for care that is either of uncertain value because of gaps in evidence or for which there is no demonstration that the patients' values and preferences were incorporated in the decision process.
- Medicare should consider the circumstances it can and should reimburse providers for electronic consultations with patients.
- Allow providers such as physician assistants, nurses, pharmacists, nutritionists and dietitians to provide more care for which they are appropriately trained, such as working in settings like retail clinics.

4. There must be effective ways to engage patients with information and incentives to make the best decisions.

Health care consumers cannot compare the quality or efficiency of care offered by medical practitioners, clinics and hospitals or the various treatment options available to them to make good choices. Americans need tools to help them make good health care decisions. Some policy options that will foster better engagement of patients:

- The federal role must be first and foremost make sure that there is valid information consumers can use to compare quality and cost-efficiency of medical treatments and providers. Creating that information should allow for any users – public and private – to build on that information as long as patient privacy is protected.
- Medicare should explore providing information and incentives for wellness and the selection of higher value providers. Private health plans are increasingly offering not just tools, but incentives for their enrollees to improve their health and make better choices among providers. Medicare should follow the same path to investigate how beneficiaries can be given tools and incentives to make better choices. This could take the form of restructuring the standard Medicare Supplement plans to require that they offer information and tools to facilitate patient choice.
- Medicare should support shared decision making processes. This support can take the form of both providing incentives to patients to get coaching and reducing payments to providers in cases where preference sensitive care (i.e., care for which there is more than one medically reasonable choice, with choices that differ in risks and benefits – such as treating chest pain from coronary artery disease or early-stage prostate cancer) was delivered in the absence of patient participation in decision-making.

- Medicare should support information technology through which all of a patient's health records can be centrally stored electronically, allowing easy access to a patient's complete medical history by both providers and patients.

5. Policies must be made and revised in ways the incorporate the perspectives of those who receive and pay for care, as well as those who provide care.

Congress should assure that patient-centeredness and value are at the core of all the decisions made on an ongoing basis. There are many elements in health reform that will not mark the "end" of the discussion, but rather the beginning – the beginning of ongoing considerations on how to assess comparative effectiveness, determining what "meaningful use" is for health information technologies, assessing how payments should be adjusted to reflect higher value. Common to all of these areas is the fact that those who provide services or make products will always be "at the table" making sure their voices are heard (whether that is in the halls of Congress or in federal agencies). At every step along the way, Congress should look to create processes that assure that the voice of consumers – those who receive care – and employers and public purchasers – those who pay for care – is not only at the table, but there are structures to assure the policy making is particularly guided by their perspectives.

One example of this is the case of how Medicare reviews the relative value of its payments. Currently CMS seeks input from a range of sources, including the AMA/Specialty Society Relative Value Scale Update Committee (the "RUC") – through which evidence from and voting by the medical specialties themselves is garnered. As the AMA notes – "the RUC has created the best possible advocate for physician payment, the physician." We need to re-boot Medicare's process to have the regular review of the relative value of health care services framed not primarily by those who receive the payments, but by those who receive the care and pay the bills. We need new decision processes, potentially inside or above CMS, that should be structured so that a majority of its members represent public and private payers, consumers and patient advocates, along with the critical involvement of physicians and other clinicians assured in a way that is balanced such that a substantial portion of them should be from primary care specialties. This new, patient-centered value review process should certainly still look to specialty societies to inform their deliberations, but should actively go beyond those societies as it seeks evidence to review and revise relative value adjustments framed by what patients need and improving value. We need similar structures to shape other major reform decisions to assure that "delivery reform" is guided by those who are the intended beneficiaries.

Conclusion

Far too many patients today are not receiving the care we know they should. Far too many doctors and other clinicians are being paid to do more, not to provide care coordination or better care. Most providers are paid the same whether they deliver high quality or low quality care, irrespective of their cost-efficiency. Wasted spending that buys no incremental health likely exceeds 30% of current spending. The trends and current reality call on you to act with the urgency felt by employers and by all Americans. **We must change these dynamics – consumers must have the performance information and incentives to make the best choices; and providers must be given the tools to improve and be rewarded for doing a better job.**

Private purchasers are looking to Medicare to be their partner – but without Medicare working in parallel and taking major steps forward the actions of the private sector are bound to lose to the concerted opposition from industry. The federal government needs to promote markets – both directly as a purchaser and by supporting the information every American needs to get better care. As noted, there are key leadership steps that Medicare and the federal government must take, including (1) creating comparative performance information not just on providers, but for treatments and using it in payment and incentives; (2) rebalance Medicare payments to reward primary care and care coordination; and (3) establish a new CMS payment review process that is physician-informed, but patient-centered. These three steps, along with many others, will move us toward a health care system that is patient-centered and sustainable. Thank you for the opportunity to be with you today.

Reforming Provider Payment
Moving Toward Accountability for Quality and Value

Statement of
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Senate Finance Committee
Roundtable on Health Care Reform
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About the Engelberg Center for Health Care Reform

The mission of the Engelberg Center for Health Care Reform, launched at the Brookings Institution in July 2007, is to develop data-driven, practical policy solutions that promote broad access to high-quality, affordable, and innovative care in the United States. Efforts currently underway at the Engelberg Center include making available better measures of quality and cost to drive higher-value health care and creating a policy framework for generating better evidence on what works, including medical treatments, provider practices, and care delivery models.

In addition, in collaboration with the Dartmouth Institute for Health Policy & Clinical Practice, the Engelberg Center is working toward implementation of reforms in health care financing that promote better care through feasible ways of linking provider payments to improved outcomes and lower costs. The Engelberg Center has also sponsored a series of public meetings on practical solutions to these and other issues. More information on these activities is available at www.brookings.edu/healthreform.

The following statement draws on the materials for one of these recent conferences, on accountability for quality and cost in health care payments, which were prepared jointly with the Dartmouth Institute for Health Policy & Clinical Practice.

Introduction

The debate about health care reform is increasingly about how to support needed changes in how health care is delivered. Concerns have expanded from targeted discussions about the millions of Americans without health insurance to broader consideration of gaps in quality, rising health care costs, and the structure of a system that is failing to address either problem. Dramatic variations in health care spending that bear little relation to health outcomes highlight the fact that simply trying to subsidize more affordable coverage in our existing health care system is not sustainable. Further, payments in Medicare and other health insurance programs are largely tied to the volume and intensity of medical services. As a result, many efforts by health care providers to prevent complications and implement innovative, lower-cost ways of delivering care – such as spending more time with patients to promote understanding of health risks and needed lifestyle changes or using allied health professionals to help with adherence to medications – actually reduce the

payments they receive. Similarly, patients with chronic diseases often get little support for taking steps to improve the quality and reduce the costs of their own care.

Feasible Principles for Reforming Health Care Payments

Increasing awareness of these problems has resulted in a growing array of public- and private-sector initiatives to promote efforts by providers to improve care and to foster greater accountability for both quality and cost. While there is ongoing debate over the specific form that such approaches should take and how to implement them around the country, these efforts are marked by growing consensus on several guiding principles for reform.

First, there is increasing agreement on the need for local accountability for quality and cost across the continuum of care. The consistent provision of high-quality care – particularly for those with serious and chronic conditions – will require the coordination and engagement of multiple health care professionals across different institutional settings and specialties. The health care system must not only facilitate, but also encourage such coordination.

Second, a successful approach to achieving greater accountability must be viable across the diverse practice types and organizational settings that characterize the U.S. health care system and should be sufficiently flexible to allow for variation in the strategies that local health systems use to improve care.

Third, successful reform will require a shift in the payment system from one that rewards volume and intensity to one that promotes value (improved care at lower cost), encourages collaboration and shared responsibility among providers, and ensures that payers – both public and private – offer a consistent set of incentives to providers.

Finally, with increased accountability on the part of providers must come greater transparency for consumers. Measures of overall quality, cost, and other aspects of performance relevant to consumers will facilitate informed choices of both providers and services and increase consumers' confidence in the care they are receiving as their providers face different incentives.

Many of the payment reforms that have been proposed or are already in use – for example, bundled payments, disease management, and pay for performance – represent meaningful steps toward greater accountability. The next step is accountability for care that leads to better outcomes and lower costs at the person level, with support for the infrastructure required to provide high-quality, coordinated care.

The Accountable Care Organization Model

The Accountable Care Organization (ACO) enables providers to receive more support for any steps they take to improve care, without big changes in their existing payments or big new financial risks. This model establishes benchmarks based on improvements in quality and spending. In addition to their usual payments, if providers in an ACO improve quality while slowing spending growth, they receive shared savings from the payers. ACO payment reforms can also be supported by other short-term steps to promote better quality care. For example, they are well-aligned with many existing reforms, such as the medical-home model and bundled payments, and also offer additional support (and accountability) to the provider organization to enable them to deliver more efficient, coordinated care. This approach has been implemented in programs like Medicare's Physician Group Practice (PGP) Demonstration, which has shown significant improvements in quality as well as savings for large group practices.

Because the groups receive a share of the savings beyond a threshold level, steps like care coordination services, wellness programs, and other approaches that achieve better outcomes with less overall resource use result in greater reimbursement to the providers. These steps thus "pay off" and are sustainable in a way that they are not under current reimbursement systems. In addition, the shared savings approach provides an incentive for ACOs to avoid expansions of health care capacity that are an important driver of both regional differences in spending and variations in spending growth, and that do not improve health.

The ACO approach also builds on current reform efforts that focus on one key group of providers, as in the medical-home model, or on a discrete episode of care, as in bundled payments. On their own, these initiatives may help strengthen primary care and improve care coordination, but they do not address the problem of supply-driven cost growth highlighted by the Dartmouth group. If adopted within a framework of overall accountability for cost and quality as is envisioned in the ACO model, both the medical home and bundled payment reforms would have added incentives to support not only better quality, but also lower overall spending growth (see Appendix).

By shifting the emphasis from volume and intensity of services to incentives for efficiency and quality, ACOs provide new support for higher-value care without radically disrupting existing payments and practices. The ACO model builds on current provider referral patterns and offers shared savings payments, or bonuses, to providers on the basis of quality and cost. A wide variety of provider collaborations can become ACOs assuming that they are willing to be held accountable for overall patient care and operate within a particular payment and performance measurement framework. Examples include existing integrated delivery systems, physician networks such as independent practice associations, physician-hospital organizations, hospitals that have their own primary-care physician networks, and multispecialty group practices. Alternatively, primary-care groups or other organizations that provide basic care could contract with specialized groups that provide high-quality referral services with fewer costly complications.

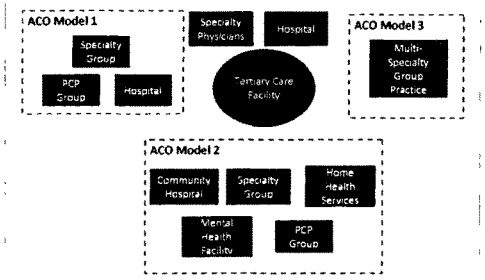
Regardless of specific organizational form, the ACO model has three key features:

1. **Local Accountability.** ACO entities will be comprised of local delivery collaborations that can effectively manage the full continuum of patients' care, from preventive services to hospital-based and nursing-home care. Their patient populations are comprised of those who receive most of their primary care from the primary-care physicians associated with the ACO (see Figure 1). (As noted above, ACOs may include a range of specialists, hospitals, and other providers, or may contract or collaborate with them in other ways.)

Figure 1

ACOs Can Be Configured in Different Ways

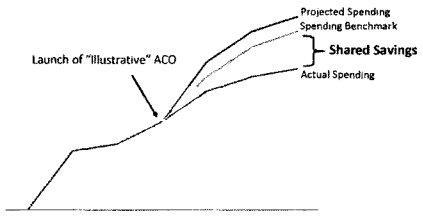
(Some care will likely be delivered outside of the ACO)



2. **Shared Savings.** ACO-specific expenditure benchmarks will be based on historical trends and adjusted for patient mix. Contingent on meeting designated quality thresholds, ACOs with expenditures below their particular benchmark will be eligible for shared savings payments, which can be distributed among the providers within the ACO. These shared savings allow for investments – in health IT or medical homes, for example – that can in turn improve care and slow cost growth (see Figure 2).

Figure 2

Shared Savings Derived from Spending Below Benchmarks That Are Based on Historical Spending Patterns



3. **Performance Measurement.** Valid measurement of the quality of care provided through ACOs will be essential to both ensuring that cost savings are not the result of limiting necessary care and promoting higher-quality care. Such measurement should include meaningful outcome and patient-experience data.

Laying the Foundation for Successful Implementation

While the ACO framework holds promise for improving quality, cost, and overall efficiency, it does create some important implementation issues. It is worth highlighting some factors that can improve the likelihood of success.

Engagement of a broad range of key local stakeholders, such as payers, purchasers, providers, and patients alike, can provide momentum for ACOs. A demonstrated history of successful

innovation and reform with respect to health IT adoption and clinical innovations, for example, may also be a good foundation for further ACO reforms.

Having a structural foundation in place at the outset will also facilitate the transition to an ACO. Key factors include patient populations that are sufficient in size to permit reliable assessment of expenditures and quality performance relative to benchmarks, in order to calculate shared savings. Additional key elements include some degree of integration – either formal or virtual (i.e., for the purposes of the ACO) – within the delivery system and the capacity for collecting and reporting on the performance of participating providers.

Finally, having an agreement and process in place for distributing shared savings will be critical in terms of presenting an attractive proposition to providers – that is, a real opportunity to generate additional payments in return for improved care – and rewards genuine improvements in efficiency.

Key Design Components

While consideration of the more technical aspects of implementation are beyond the scope of this overview, a brief description of several key design questions highlights the decisions that will need to be made at the ACO level through negotiations with participating payers:

- **Organization of the ACO.** The form and management of the ACO need to be well-defined. ACO "leaders" who will drive improvements in care and efficiency must be identified from the start.

- **Scope of the ACO.** The specific providers involved in ACOs are likely to include primary-care physicians and may also include selected specialists as well as hospitals and other providers. Such decisions about the scope of providers to be included will clearly shape many of the technical aspects of the ACO, referral patterns, and other behavioral changes induced by the ACO itself.

- **Spending and quality benchmarks.** Spending benchmarks must be projected with sufficient accuracy based on historical data (or other comparison groups) and savings thresholds to provide confidence that overall savings will be achieved. Sufficient measures of quality to provide evidence of improvement are also essential.

- **Distribution of shared savings.** Elements of the distribution of savings that will be subject to negotiation include the percentage split between providers and payers, for example 80/20 or 50/50, and the specific agreement governing how the savings will be distributed among the ACO providers.

Looking Ahead: The Promise of ACOs

The ACO model is receiving significant attention among policymakers and leaders in the health care community, not only because of the unsustainable path on which the country now finds itself, but also because it directly focuses on what must be a key goal of the health care system: higher value. The model offers a promising approach for achieving this goal without requiring radical change in either the payment system or current referral patterns. Rather, fee-for-service remains in place, and most physicians already practice within natural referral networks around one or a few hospitals.

In addition, as provider organizations become more comfortable with payments that are based on value, further reforms can increase the "weight" on shared savings while reducing the "weight" on

traditional fee-for-service payments. By promoting more strategic and effective integration and care coordination, and by doing so without requiring disruptive short-term changes in payment, accountable care can provide a feasible path to meaningful improvements in health care.

For a more technical discussion of health care reform and the ACO model, see:

- "Real Health Care Reform in 2009: Getting to Better Quality. Higher Value, and Sustainable Coverage." The Engelberg Center for Health Care Reform, November 2008.
- CBO, *Budget Options, Volume I: Health Care* (December 2008), pp. 72-74 (Option 37, "Bonus Eligible Organizations").
- Fisher, Elliott, Mark McClellan, John Bertko, Steven Lieberman, Julie Lee, Julie Lewis, and Jonathan Skinner. "Fostering Accountable Health Care: Moving Forward in Medicare." *Health Affairs* Web Exclusive, January 27, 2009: w219-w231.

Appendix

Comparison of Payment Reform Models

	Accountable Care Organization (Shared Savings)	Primary Care Medical Home	Bundled Payments	Partial Capitation	Full Capitation
General strengths and weaknesses	Makes providers accountable for total per-capita costs and does not require patient "lock-in." Reinforced by other reforms that promote coordinated, lower-cost care	Supports new efforts by primary-care physicians to coordinate care, but does not provide accountability for total per-capita costs	Promotes efficiency and care coordination within an episode, but does not provide accountability for total per-capita costs	Provides "upfront" payments that can be used to improve infrastructure and process, but provides accountability only for services/providers that fall under partial capitation, and may be viewed as too risky by many providers/patients	Provides "upfront" payments for infrastructure and process improvement and makes providers accountable for per-capita costs, but requires patient "lock-in" and may be viewed as too risky by many providers/ patients
Strengthens primary care directly or indirectly	Yes – Provides incentive to focus on disease management within primary care. Can be strengthened by medical home or partial capitation to primary-care physicians	Yes – Changes care delivery model for primary-care physicians allowing for better care coordination and disease management	Yes/No – Only for bundled payments that result in greater support for primary-care physicians	Yes – Assuming that primary care services are included in the partial capitation model allows for infrastructure, process improvement, and a new model for care delivery	Yes – Gives providers "upfront" payments and changes the care delivery model for primary-care physicians
Fosters coordination among all participating providers	Yes – Significant incentive to coordinate among participating providers	No – Specialists, hospitals and other providers are not incentivized to participate in care coordination	Yes (for those within the bundle) – Depending on how the payment is structured, can improve care coordination	Yes– Strong incentive to coordinate and take other steps to reduce overall costs	Yes– Strong incentive to coordinate and take other steps to reduce overall costs
Removes payment incentives to increase volume	Yes – Adds an incentive based on value, not volume	No – There is no incentive in the medical home to decrease volume	No, outside the bundle – There are strong incentives to increase the number of bundles and to shift costs outside	Yes/No – Strong efficiency incentive for services that fall within the partial capitation model	Yes – Very strong efficiency incentive
Fosters accountability for total per-capita costs	Yes – In the form of shared savings based on total per-capita costs	No – Incentives are not aligned across provider, no global accountability	No, outside the bundle, no accountability for total per-capita cost	Yes/No – Strong efficiency incentive for services that fall within partial capitation	Yes – Very strong accountability for per-capita cost.
Requires providers to bear risk for excess costs	No – While there might be risk-sharing in some models, the model does not have to include provider risk	No – No risk for providers continuing to increase volume and intensity	Yes, within episode – Providers are given a fixed payment per episode and bear the risk of costs within the episode being higher than the payment	Yes – Only for services inside the partial capitation model	Yes – Providers are responsible for costs that are greater than the payment
Requires "lock-in" of patients to specific providers	No – Patients can be assigned based on previous care patterns, but includes incentives to provide services within participating providers	Yes – To give providers a PMPM payment, patients must be assigned	No – Bundled payments are for a specific duration or procedure and do not require patient "lock-in" outside of the episode	Yes (for some) – Depending on the model, patients might need to be assigned to a primary-care physician	Yes – To calculate appropriate payments, patients must be assigned

Statement of Lewis Morris
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CURBING FRAUD, WASTE, AND ABUSE MUST BE AN ESSENTIAL COMPONENT OF ANY HEALTH CARE REFORM STRATEGY

Introduction

On behalf of Inspector General Levinson and the Office of Inspector General (OIG), I thank you for the opportunity to discuss why combating waste, fraud, and abuse must be an essential component of any strategy to reform the health care system. OIG is an independent, non-partisan agency committed to protecting the integrity of the 300 agencies and programs administered by the Department of Health and Human Services (HHS). Approximately 80 percent of OIG's resources are dedicated to promoting the efficiency and effectiveness of the Medicare and Medicaid programs and protecting these programs and their beneficiaries from fraud and abuse. Thanks to the hard work of our 1,500 employees and our law enforcement partners, from FY 2006 through FY 2008, OIG's investigative receivables averaged $2.04 billion and its audit disallowances resulting from Medicare and Medicaid oversight averaged $1.22 billion per year. The result was a Medicare- and Medicaid-specific return on investment for OIG oversight of $17:$1. In addition, in FY 2008, implemented OIG recommendations resulted in $16.72 billion in savings and funds put to better use.

The history of Federal health care programs shows us that the way the health care system reimburses for items and services dictates how the unethical and dishonest will exploit it. For example, when Medicare pays on a fee-for-service basis, providers have an incentive to increase the number and complexity of the services, even if those services are not medically necessary. When the program pays on a capitated basis, the incentive is reversed. Patients may not receive the necessary services for which the program has paid the health care provider. In short, the specific anti-fraud measures and program safeguards that must be integrated into a reformed health care system depend on the way that system and its payments are structured. Enacting appropriate anti-fraud measures simultaneously with any health care reform is essential to protect the integrity of the health care system.

Fraud in the U.S. Health Care System

Regardless of the structure of health care reform, detecting and preventing waste, fraud, and abuse in the health care system is critical. The United States spends more than $2 trillion on health care every year. The National Health Care Anti-Fraud Association estimates conservatively that of that amount, at least 3 percent—or more than $60 billion each year—is lost to fraud. Funds wasted on medically unnecessary services and other improper payments also deplete needed resources from the health care system. Although Centers for Medicare and Medicaid Services (CMS) has made progress in addressing improper payments, it continues to pay for services that were not properly documented or

medically necessary. For example, CMS reports that the improper payments rate for Medicare fee-for-service payments was 3.6 percent, or $10.4 billion in 2008.

Sophisticated health care fraud schemes rely on falsified records, elaborate business structures, and the participation of health care providers and even patients to create the false impression that the Government is paying for legitimate health care services. Although we cannot measure the full extent of health care fraud in Medicare and Medicaid, everywhere we look we continue to find fraud in these programs.

For example, in FY 2008:

- The Federal Government won or negotiated approximately $2.35 billion in investigative receivables, including criminal, civil, and administrative settlements or civil judgments. The Government's enforcement efforts resulted in 455 criminal actions and 337 civil actions against individuals or entities that engaged in health-care-related offenses.

- OIG opened 1,750 new health care fraud investigations and had over 2,500 health care investigations open at the end of FY 2008.

- OIG excluded 3,129 individuals and entities from participation in Medicare, Medicaid, and other Federal health care programs. Most OIG exclusions result from convictions for crimes concerning Medicare or Medicaid, for patient abuse or neglect, or as a result of license revocation.

Five Principles for Combating Health Care Fraud, Waste, and Abuse

For the U.S. health care system to adequately serve the medical needs of current patients and remain solvent for future generations, we must pursue an effective strategy to combat fraud, waste, and abuse. We believe that this strategy must embrace five principles:

1. Scrutinize individuals and entities that want to participate as providers and suppliers, prior to their enrollment in health care programs.

2. Establish payment methodologies that are reasonable and responsive to changes in the marketplace.

3. Assist health care providers and suppliers in adopting practices that promote compliance with program requirements, including quality and safety standards.

4. Vigilantly monitor the programs for evidence of fraud, waste, and abuse.

5. Respond swiftly to detected frauds, impose sufficient punishment to deter others, and promptly remedy program vulnerabilities.

I will briefly elaborate on each of these principles.

Scrutinize individuals and entities that want to participate as providers and suppliers prior to their enrollment in health care programs.

Screening measures should include requiring providers to meet accreditation standards, requiring proof of business integrity or surety bonds, periodic recertification and onsite verification that conditions of participation have been met, and full disclosure of ownership and control interests. A lack of effective screening measures gives dishonest and unethical individuals access to a system that they can easily exploit. For example, in January of 2005, an individual arrived in Miami-Dade County from Cuba and soon thereafter enrolled as a Medicare provider. From April until June of 2005, his new company billed over $4.1 million in fraudulent claims for which the Government paid $1.65 million. He has since disappeared. In our experience, it is too easy for organized crime to recruit "front men" as the nominal owners of fraudulent medical supply companies and replace them when the scheme is detected.

It also is important to increase the structural transparency of the companies that participate in the health care system. For example, many nursing home chains adopt elaborate corporate structures designed to obscure ownership of facilities and defuse accountability. Under this scenario, when a nursing home fails to provide adequate care to its residents, it can be impossible to identify who is actually operating the facility and should be held accountable for the neglect of the residents.

Establish payment methodologies that are reasonable and responsive to changes in the marketplace.

Health care programs should have mechanisms to ensure that payments remain reasonable and reflect market conditions. OIG has conducted extensive reviews of Medicare payment and pricing methodologies, which have determined that the program pays too much for certain items and services. When reimbursement methodologies do not effectively respond to changes in the marketplace, the system and its beneficiaries bear the cost.

OIG recently found that Medicare reimburses suppliers for negative pressure wound therapy pumps based on a purchase price of more than $17,000, but suppliers paid an average of $3,600 for new models of these pumps. Negative pressure wound therapy pumps are a type of durable medical equipment (DME) used to treat ulcers and other serious wounds. When Medicare first started covering wound pumps in 2001, it covered only one model, which was manufactured and supplied by one company. Medicare paid for this pump based on the purchase price as identified by that company. In 2005, Medicare expanded its coverage to include several new pump models manufactured by other companies. However, Medicare reimburses suppliers for these new pumps based on the original pump's purchase price, which is more than four times the average price paid by suppliers.

In another study of DME reimbursement, OIG found that in 2006, Medicare allowed on average of $7,215 for rental of an oxygen concentrator that costs about $600 to purchase new. Additionally, beneficiaries incurred $1,443 in coinsurance charges for these

equipment rentals. We determined that if home oxygen payments were limited to 13 months rather than the current 36 months, Medicare and its beneficiaries would save $3.2 billion over 5 years. Because Medicare's reimbursement methodologies do not respond promptly to changes in the marketplace, Medicare and beneficiaries are paying too much.

In addition, the health care system must anticipate that providers may alter their practices in response to program integrity efforts. Proactively establishing program safeguards helps to ensure that changes to payment methods result in savings and not merely to modify an abusive practice. For example, prior Medicare policy precluded separate payment for preadmission diagnostic tests performed within 24 hours before the beneficiary's admission to a hospital. OIG found that hospitals were performing the tests shortly beyond the 24-hour period to maximize reimbursement. In response, CMS changed the policy to preclude payments for tests performed within the 72-hours prior to admission. Subsequent OIG work found that hospitals responded by changing preadmission procedures and conducting these tests as far as 2 weeks before the admission date. In considering any payment system, it is important to consider the incentives that it creates and seek to maximize the positive behavior (i.e., high-quality, cost-effective care) and implement necessary safeguards to reduce the negative incentives.

Assist health care providers and suppliers in adopting practices that promote compliance with program requirements.

Health care providers must be our partners in ensuring the integrity of health care programs and should adopt internal controls and other measures that promote compliance and prevent, detect, and respond to health care fraud, waste, and abuse. Compliance programs are an essential component of a comprehensive anti-fraud strategy, and policymakers should consider how to motivate health care providers to incorporate integrity safeguards and tools into their organizations. Recognizing the importance of compliance systems, the New York Medicaid program requires its health care providers to implement an effective compliance program as a condition of participation in Medicaid.

The Government also must play a leadership role in promoting the health care industry's commitment to integrity. As part of its collaboration with the health care industry, for example, OIG publishes voluntary compliance program guidances, fraud alerts, and advisory opinions on the fraud and abuse laws. We also offer a way for providers that uncover fraudulent billings or other misconduct within their organizations to self-disclose the problem and to work with OIG to the resolve the issue, including return of the inappropriate payments.

Vigilantly monitor the programs for evidence of fraud, waste, and abuse.

The health care system compiles an enormous amount of data on patients, providers, and the delivery of health care items and services. However, the Federal health care programs often fail effectively to use claim-processing edits and other information technology to identify improper claims before they are paid. For example, our review of hospital compliance with Medicare's postacute care transfer policy identified over $200 million in improper payments made for claims that misrepresented that the patients were discharged

to home when the patients were actually discharged to postacute care settings. Although CMS implemented OIG's recommendation and installed an edit to detect transfers improperly coded as discharges, CMS continues to make some erroneous payments.

For over a decade, OIG has reported on integrity vulnerabilities related to how Medicare identifies the physicians who order medical items and services. We found that in 1999, Medicare paid $91 million for DME claims with invalid or inactive identifiers for the prescribing physicians. Of this amount, almost $8 million was paid for DME claims that identified deceased physicians as the prescribers. Medicare's claims-processing systems verified that the identifiers listed on claims met certain data format requirements but did not verify that the identifiers were valid and active. In 2005, Medicare began implementing a new system of provider identifiers. OIG analyzed DME claims from 2007 to determine whether the new system addressed the vulnerabilities of the former system. We found that Medicare allowed $34 million in payments for DME claims with invalid or inactive prescriber identifiers, including $5 million for claims that identified deceased prescribers. Although the amount of waste has declined since 1999, the failure to detect invalid and inactive provider identifiers may continue to be a problem under the new system.

Respond swiftly to detected fraud, impose sufficient punishment to deter others, and promptly remedy program vulnerabilities.

Our investigations have shown that there is an increase in organized crime elements within the health care fraud arena. Health care fraud is attractive to organized crime because the penalties are lower than those for other organized-crime-related offenses (e.g., offenses related to illegal drugs); there are low barriers to entry (e.g., a criminal can obtain a supplier number, gather some beneficiary numbers and bill the program); schemes are easily replicated; and there is a perception of a low risk of detection. Because they target health care items and services that produce excessive reimbursement, these criminals can reinvest some of their profit in kickbacks for additional referrals, thus using the program's funds to perpetuate the fraud scheme. To combat health care fraud successfully, we need to alter the cost-benefit analysis for those considering heath care fraud by increasing the risk of swift detection and the certainty of punishment.

As part of this strategy, law enforcement must accelerate the Government's response to fraud schemes. By way of example, Florida's Miami-Dade County is plagued by fraudulent DME companies, infusion clinics, and other dishonest Medicare providers and suppliers. In May 2007, the Department of Justice (DOJ) and HHS created a strike force whose primary goal was to attack the fraud problem in South Florida by decreasing the amount of time between the Government's detection of a fraud scheme and the arrest and prosecution of the offenders. To date, the strike force has opened 106 cases, convicted 141 of its targets, and secured $189 million in criminal fines and civil recoveries. Building on the success of the South Florida strike force, in March 2008, DOJ and OIG created a second strike force in another fraud hotspot—Los Angeles.

The health care system must continually upgrade procedures for identifying and preventing payments to abusive providers. Criminals will test a system's payment edits and program integrity algorithms by "pinging" the system with small batches of test claims and will then

submit fraudulent claims that are below those thresholds. Dishonest billing companies are rewarded financially by the fraudsters for their ability to circumvent payment edits and identify billing codes for exploitation. To protect itself from fraud schemes, which evolve in response to program safeguards, the health care system must continually update its payment edits and other integrity measures.

The health care system also must respond more quickly once a vulnerability is identified. For example, once identity theft is uncovered, the program must make it more difficult for scam artists to misuse a beneficiary's or legitimate provider's Medicare number. When a consumer discovers his or her credit card has been stolen, it is a simple matter to cancel the card and stop its potential abuse. Medicare also needs to be able quickly to void compromised Medicare beneficiary or provider numbers and to sanction those who traffic in this type of information.

Conclusion

In the health care system, how you pay determines how you will be cheated. A comprehensive health care integrity strategy should be an integral element of any systemic health care reforms. OIG and its law enforcement partners will need new tools and sufficient resources if we are to succeed in our ongoing fight against health care fraud, waste, and abuse.

United States Senate Committee on Finance
Roundtable on Delivery System Reform
Statement of Mary D. Naylor, RN, PhD, FAAN

Health Care Needs of Chronically Ill Older Americans: The Challenge.

Elder's Perspective: More than 20% of older Americans suffer from five or more chronic conditions.[1] Age related changes, complicated by multiple, progressive physical, cognitive and emotional health problems contribute to accelerated functional decline, poorer quality of life, and decreased survival rates among these elders.[2] The chronic illness trajectory among this group is characterized by frequent changes in health status. As a result, these elders typically require health care services from numerous providers across several care settings each year.[3] Yet, multiple studies reveal that the health care needs of these older adults are poorly managed, often with devastating consequences.[3] Insufficient communication among older adults, family caregivers and health care providers about critical aspects of elders' care, poor continuity of care, and inadequate preparation of these elders to manage their changing health care needs are the norm, contributing to high rates of medical errors and preventable hospital readmissions.[1,3] Researchers estimate that one-quarter to one-third of hospitalizations among these elders are avoidable.[4]

Family Caregiver's Perspective: Family caregivers, the spouses, children and friends who are the primary providers of services to these elders, also face tremendous challenges.[5] Available research suggests that family caregivers lack the knowledge, skills and resources to effectively address the complex needs of elders coping with multiple coexisting conditions. Studies also reveal that the stress and burden associated with the care giving experience contribute to substantially higher rates of chronic illness among family caregivers.[6,7]

Societal Perspective: In addition to the human burden, societal costs associated with caring for this group of older adults are enormous. In 2005, health care services for Medicare beneficiaries with five or more chronic conditions accounted for 75% of total Medicare spending.[8] The vast majority of these costs were due to high rates of hospital admission and readmission. In 2007, the Medicare Payment Advisory Commission (MedPAC) estimated that nearly one in five Medicare beneficiaries admitted to a hospital were readmitted within 30 days of discharge, with an even higher rate among beneficiaries with multiple chronic conditions.[9] These findings were reinforced by a recent study reported in the *New England Journal of*

Medicine.[10] MedPAC calculated that this "churning" of patients accounts for an estimated $15 billion annually in Medicare spending.[11] In addition to the impact of caring for older adults with multiple chronic conditions on health care spending, American businesses lose an estimated $34 billion each year due to employees' need to care for loved ones.[12]

Given the expected growth of older adults coping with multiple chronic conditions, and increasing evidence of significant lapses in quality and rapidly rising costs, improving the health care and outcomes of this patient group is considered a national priority by the Institute of Medicine (IOM) and leaders of other national health care groups.[3,13,14] Health care leaders agree that a core strategy in response to this challenge is the identification of the most cost-effective interventions to enhance the care management of these elders and reduce their rates of avoidable hospitalizations.

The Transitional Care Model: An Evidence-Based Solution

Until recently, few rigorous studies of interventions designed to improve the care and outcomes of chronically ill older adults have included those with multiple coexisting conditions. For the past 20 years, this group of elders has been the exclusive focus of a multidisciplinary team at the University of Pennsylvania and the architects of the Transitional Care Model (TCM). The TCM is among the very few care management interventions that have been associated in multiple randomized clinical trials (RCTs) with significant improvements in health outcomes and reductions in health care costs among at risk, chronically ill elders.

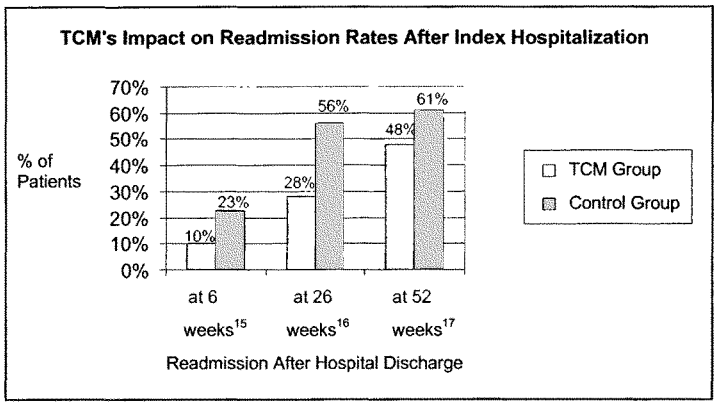
For the millions of older Americans who suffer from multiple chronic conditions, the TCM emphasizes identification of patients' health goals, coordination and continuity of care throughout acute episodes of illness, development of a streamlined plan of care to prevent future hospitalizations, and preparation of the older adult and family caregivers to implement this care plan—all accomplished with the active engagement of patients and their family caregivers and in collaboration with the patient's physicians and other health care providers. Unlike other interventions that focus on addressing gaps in care, the major goal of the TCM is to interrupt cycles of avoidable hospitalizations among these elders and promote longer-term positive health outcomes.

The TCM targets older adults with two or more risk factors, including a history of recent hospitalizations, multiple chronic conditions and poor self-health ratings. The essential elements of the model are as follows:

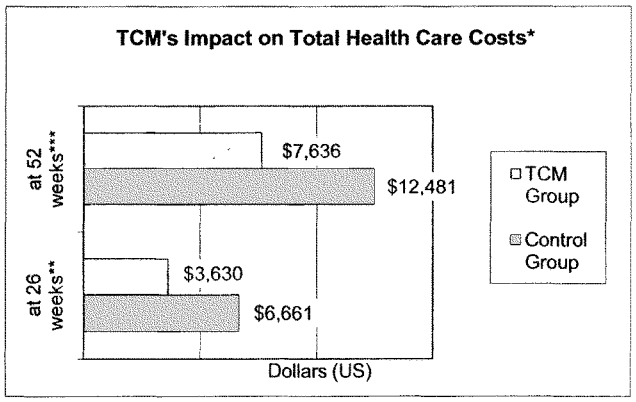
1. Identification of each elder's and family caregiver's health goals;
2. The transitional care nurse (TCN), a master's prepared nurse with advanced knowledge and skills in the care of this population, as the primary coordinator of care to assure continuity throughout acute episodes of care;
3. In-hospital assessment, collaboration with team members to reduce adverse events and prevent functional decline while hospitalized, and preparation and development of a streamlined, evidenced-based plan of care;
4. Regular home visits by the TCN with available, ongoing telephone support (seven days per week) through an average of two months post-discharge to implement the care plan;
5. Continuity of medical care between hospital and primary care providers facilitated by the TCN accompanying patients to the first follow-up visit;
6. Comprehensive, holistic focus on each patient's goals and needs including the reason for the primary hospitalization as well as other complicating or coexisting health problems and risks;
7. Active engagement of patients and family caregivers with focus on meeting their goals;
8. Emphasis on patients' early identification and response to health care risks and symptoms to achieve longer term positive outcomes and avoid adverse and untoward events that lead to readmissions;
9. Multidisciplinary approach that includes the patient, family caregivers and health care team;
10. Ongoing communication among the patient, family caregivers, and health care providers.

Effects on Healthcare Quality and Costs. Across three National Institute of Nursing Research (NINR)-funded RCTs completed to date,[15,16,17] the TCM has demonstrated improved quality and cost outcomes for at risk, older adults when compared to standard care.

- ✓ *Reductions in preventable hospital readmissions for both primary and co-existing health conditions.* Additionally, among those patients who are rehospitalized, the time between their index hospital discharge and readmission has been increased and the total number of inpatient days decreased.



- ✓ *Improvements in health outcomes.* In the most recently reported RCT,[17] for improvements in physical health and quality of life were reported by patients who received TCM.
- ✓ *Enhancement in patient satisfaction.* Overall patient satisfaction has increased among patients receiving TCM.
- ✓ *Reductions in total health care costs.* After accounting for the cost of TCM, mean per patient savings in total health care costs have been consistently demonstrated.[16,17]



** Total costs were calculated using average Medicare reimbursements for hospital readmissions, ED visits, physician visits, and care provided by visiting nurses and other healthcare personnel. Costs for TCM care are included in the intervention group total.*
*** Naylor et al., JAMA, 1999.*
**** Naylor et al., JAGS, 2004.*

Translating Research Into Practice

Despite the evidence establishing the linkage between TCM and enhanced value, a number of organizational, regulatory, and financial barriers have prevented widespread adoption of the model. In response to these challenges and with the support of a number of foundations,[18] the Penn team formed partnerships with leaders of the Aetna Corporation (Aetna) and Kaiser Permanente Health Plan (KP) to translate and integrate the TCM for use in everyday practice and assess its effectiveness among at risk, chronically ill older adults. The findings of this translational research effort have resulted in TCM being identified as a "high value" proposition by Aetna leaders. The project with KP is ongoing. Based on the improvements in health outcomes, member and physician satisfaction and the reductions in rehospitalizations and total health care costs observed in the Aetna project, the University of Pennsylvania Health System (UPHS) has adopted TCM as a service and local insurers will begin to reimburse UPHS for delivery of TCM to their members later this month.

Principles for Delivery System Reform

The research findings on the TCM, combined with the growing body of evidence from related studies, yield the following principles to inform the redesign of the health care system for older Americans coping with multiple chronic conditions.

Principle 1: High quality health care ensures "the right care at the right time" for each chronically ill elder and their family caregivers but "one size does not fit all." The Penn team's work has shown the TCM to be cost-effective among at risk, chronically ill older adults. A recently published study underscored the value of multidisciplinary teams and in-person contact as core elements in the success of care management interventions targeting at risk chronically ill elders.[19] However, the 80% of older Americans coping with at least one chronic condition represent a wide range of health care needs and risks.[20,21] Alternative models of care are more appropriate for lower risk groups experiencing fewer, less severe chronic conditions and health risks. Findings from a 2009 evaluation study of the Centers for Medicare and Medicaid (CMS) Coordinated Care Demonstration sites[22] suggests that, with appropriate screening and risk adjustment, chronically ill elders could be stratified and matched with a set of services aligned with individual needs and risks. Authors of this report also concluded that higher risk groups will need evidence-based transitional care to achieve substantial Medicare savings.

Principle 2: The right skill set and support is essential to build person-and family-centered, team-based programs of transitional care for the chronically ill older adults. Both family caregivers and health care professionals lack the knowledge, skills and resources to address the complex needs of elders with multiple chronic conditions.[23]. AARP and the United Hospital Fund are among a number of advocacy organizations that have highlighted the family caregivers' need for information and support, especially as their loved ones experience critical health care transitions.[1,5] The IOM's recent report on the geriatric workforce, acknowledged the need to build the capacity and competence of all individuals involved in the delivery of care to elders, including family caregivers and community workers.[24] Health professionals, especially nurses who have been demonstrated over multiple rigorous studies to play a leadership role in transitional care, need increased preparation to deliver person- and family-centered, longitudinal, team-based care.

Principle 3: Existing performance measurement and reporting systems do not capture the quality and costs of an episode of care for chronically ill older adults. Significant progress has been made in measuring and reporting processes of care and outcomes for a number of high-prevalence and high-cost chronic conditions. Ongoing investments should be made to enable transparency of both quality and cost information for older adults coping with *multiple* chronic conditions across an entire episode of care. An acute episode of chronic illness for this patient group spans hospital, post-acute and primary care settings and interactions with multiple providers. Measures are needed that reflect the complexity of health needs among these elders and are more closely aligned with their health care experience throughout such an episode. The National Quality Forum has provided a measurement framework for assessing value associated with the care of people over the course of a chronic episode of illness.[25] Ongoing efforts to design and implement robust measures consistent with this framework must resolve issues related to shared accountability for clinical and economic outcomes. Additionally, standard metrics are needed that assess care delivered to vulnerable populations including older adults representing diverse racial and ethnic minorities, living in rural settings, and those with low socioeconomic status, language barriers, poor health literacy and inadequate social support. Systems that publicly report performance data also must be designed to produce minimal

provider burden. To achieve these goals, fully accessible, electronic health records from which data elements are automatically drawn to generate the measures are essential.

Principle 4: Investments in comparative effectiveness research are needed to identify high value practices with proven results. Although a growing body of evidence exists that supports specific models of care for the chronically ill older population, including models of transitional care, comparative effectiveness research is needed to identify the most effective and efficient core elements of these multifaceted interventions, and to compare their benefits and costs. A federally sponsored, independent review body should be established to critically evaluate evidence, compare scientific results, and convey the relative value of specific models of care to payers, providers, and the public.

Principle 5: Translational tools that enable swift application of evidence-based transitional care are a high priority. Tools that enable the rapid dissemination and implementation of best practices at a national-level are needed. Clinical information systems that house evidence-based assessment tools and intervention protocols, foster information exchange, provide just-in time data for quality monitoring and improvement among all providers and across all settings throughout episodes of care are important. Web-based modules that prepare providers to deliver evidence-base care also are needed.

Principle 6: Regulatory barriers, including payment policies that prevent the delivery of transitional care, must be eliminated. The delivery of high quality transitional care is contingent on a workforce of skilled multidisciplinary providers, in partnership with older adults and their family caregivers, delivering a range of comprehensive services across episodes of care. Currently, health care is oriented to the delivery, monitoring, and payment of acute care services within separate and distinct settings including hospitals, home health care agencies and skilled nursing facilities. Little attention has been paid to care that crosses settings or involves multidisciplinary teams of providers. State and federal laws, financing models, eligibility rules, and quality monitoring systems are not uniform and often create confusion and conflict for providers and consumers. Furthermore, existing payment systems impede the delivery of

transitional care. Adoption of innovations in chronic care management and transitional care, in particular, is dependent on greater flexibility in regulation and payment policies.

Policy Recommendations to Assure High-Value Transitional Care

Policy recommendations that hold great promise for improving the care and outcomes of at risk, chronically ill older Americans and decreasing health care costs are described below.

Transitional Care Benefit

A program of transitional care should be available for all at-risk, chronically ill Medicare beneficiaries as a covered service during a beneficiary's first hospitalization each year. CMS would define criteria specifying the eligible population. Required program components would include:

- A transitional care nurse (TCN) who is prepared to deliver and coordinate services for at risk chronically ill elders throughout acute episodes of illness (substituting for traditional visiting nurse services):
- A comprehensive assessment of each elder's goals and needs within 24 hours of hospital admission;
- A transitional plan of care developed by the TCN in collaboration with each elder, family caregiver (if available), physicians and other health team members within 48 hours of hospital admission;
- A home visit by the TCN within 24 hours of hospital discharge;
- The TCN accompanying the elder to the first visit to the primary care provider following the hospital discharge;
- At least weekly home visits by the TCN during the first month after hospital discharge to implement the plan of care (e.g., monitoring and managing symptoms, teaching elders and family caregivers to promote self-management; offering counseling and support to assure elders' adherence to medications and other therapies; promoting elders' access to primary care and community-based services; coordinating the care provided by others; and, if appropriate, facilitating transitions to palliative or hospice care);

- Seven day per week telephone availability during daytime hours of TCN for elders' or family caregivers' questions or concerns with plan for emergency backup during evening and night hours; and,
- A written summary of each elder's progress in meeting goals distributed to the elder, physicians and other relevant team members within 36 hours of completion of intervention.

Payment for Transitional Care

Payment for transitional care services will require significant reform of current models. Payment made to any designated entity providing transitional care services would be structured to explicitly recognize transitional care as an episode of services that crosses multiple settings and providers. The payment would cover transitional care services for the first index hospitalization each year and include services throughout the index hospitalization and post-discharge period for an average of 60 days following the index hospitalization discharge (range 30- 90 days).

Accountability for Outcomes

Entities providing transitional care services would be held accountable for process and outcome performance measures that have been endorsed by the National Quality Forum and specified by the CMS. Payment would be linked to performance on these measures. CMS would establish a mechanism to publicly report such measures, benchmarking high performers to identify practices that contribute to lower hospital readmission rates. Best practices would be disseminated through existing federal structures and programs including, but not limited to, Medicare's Conditions of Participation, the Quality Improvement Organization (QIO) Program, and public-private quality alliances (e.g., Hospital Quality Alliance).

Conclusion

A rigorous body of evidence has consistently demonstrated the capacity of the TCM to improve the quality of care and outcomes for the growing population of older adults coping with multiple chronic conditions and to decrease total health care costs. Additionally, this approach to care has been successfully translated in the "real world" of clinical practice and, based on findings with a major insurance organization, has been identified as a 'high value' proposition. The proposed

transitional care benefit would accelerate the adoption of evidence-based models of care such as the TCM that would enhance the health care experience for millions of older Americans and their family caregivers, improve their health outcomes and achieve substantial health care savings for the Medicare program

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Statement of Debra L. Ness
President, National Partnership for Women & Families
Senate Finance Committee
Roundtable on Delivery System Reform
April 21, 2009

Chairman Baucus, Ranking Member Grassley, and members of the Committee, thank you for the opportunity to participate in this Roundtable on how to reform our health care delivery system.

The National Partnership for Women & Families is a non-profit, non-partisan advocacy organization with over three and a half decades of experience promoting access to quality health care, fairness in the workplace, and policies that help women and men meet the dual demands of work and family. Over the past 15 years, the National Partnership has brought together a wide range of consumer and patient groups to push for meaningful reforms of our health care system -- focusing on improving quality, getting costs under control and expanding affordable coverage.

I applaud the Committee for recognizing that these issues -- quality, cost, and coverage -- are inextricably linked, and for beginning these Roundtable discussions in the essential first place, with this discussion of delivery system reform.

The American people know that our health care system is broken and needs transformational change. They see a delivery system that is centered on the provider, rather than the patient. They see a payment system that rewards volume over value, promotes fragmentation over coordination, and rewards specialty care at the expense of primary care. Ours is a system that is largely blind to quality, outcomes, or appropriateness of the care delivered and received.

The American people want you to fix the delivery system in a way that will accomplish three things:

- Improve the quality of the care they receive.
- Make care more affordable - for individuals, families, businesses, and taxpayers.
- Get better value for the health care dollars we spend out of our own pockets, through our employers, and through public programs.

We can accomplish all three of these objectives if we recognize that changing the way we pay for health care can transform the way that health care is delivered. However, we must do so in a way that makes patient-centered care our guiding principle for system reform. Patient-centeredness should be the beacon that guides our efforts, and the ultimate test of our success.

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Putting Patients First—Meeting the Needs of the Most Vulnerable Patients

Delivery system reform must put patients first. There are none for whom this is more important than the most vulnerable among us -- those with multiple serious chronic conditions, especially those whose medical conditions are complicated by physical or cognitive impairment or whose access to health care is already limited by their low income, race, or ethnicity.

These are the people who make heaviest use of the current system, at the highest cost, but with the poorest outcomes. While these complex patients exist in every age group, they are heavily concentrated among older adults. It is not surprising that, although they represent only 20% of all Medicare beneficiaries, they account for 68% of Medicare spending. Yet in spite of all that spending, the system is not serving them well because it is oriented toward acute care, not to their chronic care needs. Consider the following:

- They make 37 visits to 14 different doctors who prescribe 50 separate prescriptions in the course of a year. *But that does not mean they get the care they want or need.*
- Because their doctors do not talk to each other or coordinate all of this care, the majority of these patients receive duplicate tests and procedures, different diagnoses from different physicians, and contradictory information on how to manage their conditions. *And they do not get better.*
- Because no one is responsible for managing their care, they experience complications from inappropriately prescribed medications, suffer from preventable medical errors, and are frequently hospitalized for conditions that could be treated in ambulatory settings. *Their lives are put at risk.*
- When they are discharged from the hospital, they go home without the information, support and follow up they need to take care of themselves or recognize symptoms that require attention. As a result, one in 10 is readmitted within 15 days and one in five is back in the hospital within 30 days. *They are getting sicker.*
- They are left on their own to find and arrange the non-medical services they need to live at home and stay out of the hospital or nursing home. *They feel abandoned and overwhelmed.*

If we can make the delivery system work for these most vulnerable and complex patients, we can make it work for everyone. If we fail them, we will never get health care spending under control.

Defining Patient-Centered Care

Patient-centered care is a straightforward concept. It is care that meets the patient's needs and preferences – at the right time, in the right setting, for the right reason, at the right cost. When patients and their families are asked what they want out of the health care system, their answers are just as clear.

- They want to be able to choose their own doctors.
- They want their doctors to talk to each other.

- They want their doctors to have the time, the information, and the support to do the best job they can.
- They want to better understand their conditions, how to take care of themselves or their loved ones, and how to recognize symptoms that should be cause for concern.
- They want someone who knows them and recommends care that makes sense based on their needs, wants and life circumstances.

We have good models of patient-centered care from research and clinical practice, which show that it is possible to deliver better care and reduce health care costs. Some of the best of these are represented at this Roundtable this morning.

These models have within them common elements on which we can build to reshape the delivery system and to pay for the care that patients want and need. The National Partnership for Women & Families has developed a yardstick for defining and evaluating patient-centered care, based on these successful models and our own work with patients and caregivers across the country. These are the elements we will use to measure our success in transforming the delivery system.

- ***Care is comprehensive, coordinated, personalized and planned, based on an assessment of the total needs of the patient and, where applicable, his or her caregiver.***

- ***Patients' experience of care is routinely assessed and improved.***

- ***Patients and their caregivers are full partners in their care, assisted with management of chronic illnesses and health care decision-making.***

- ***Transitions between settings of care are smooth, safe, effective and efficient.***

- ***Patients can get care when and where they want and need it.***

- ***Care is connected to and integrates the community resources patients and caregivers need to maintain their health and well-being.***

- ***Continuous quality improvement and the elimination of disparities are a top priority.***

Achieving a patient-centered delivery system will require significant change in *what* we provide and *how* we provide it. Toward that end, we must pursue two key strategies: a payment system that rewards and encourages better coordinated, integrated and accountable care, and a health care infrastructure that supports the delivery of this care.

Shift Payment Incentives to Reward and Encourage Better Coordinated, Integrated and Accountable Care

Twenty-first century medicine requires team-based coordinated care that is anchored in primary care. This will require a fundamental shift in payment systems that will foster – perhaps force –

redesign of physician practice and the management of transitions among settings of care. We have four specific recommendations:

- ***First, immediately revalue primary care.*** This means increasing payment to primary care physicians and eliminating the distortions in physician fee schedules that have produced an over-supply of procedure-based specialist services at the expense of the chronic care management, coordination, and support that patients desperately want and need.

- ***Second, we need to change the way CMS makes decisions about payment under the physician fee schedule.*** We can no longer justify a process for deciding payment values that is solely driven by the providers of care. Those who receive and pay for care must have a voice in shaping the payment decisions that ultimately define what and how care gets delivered.

- ***Third, provide adequate risk-adjusted payment to primary care practices for care coordination and management services*** that are not currently reimbursed, for patients who need such services.

- ***Fourth, provide payment incentives to specifically encourage safe and effective transitions*** among settings of care, coordinated with primary care providers.

Delivery system reform must, at a minimum, address the needs of a Medicare population that is living longer with multiple chronic illnesses. Old models that reward acute care interventions at the expense of chronic care management must be replaced by new models that support high-quality, coordinated, comprehensive care, particularly for the highest risk and most vulnerable patients.

I commend this Committee for its foresight in authorizing the Medicare Medical Home Demonstration. This is a step in the right direction. The National Partnership has convened consumer organizations representing a broad and diverse array of patients and families, who want to ensure that this new model of care genuinely transforms practice and moves us to truly patient and family-centered care. Toward that end, we have adopted a set of core consumer principles for patient-centered care in the medical home. These principles are available at www.nationalpartnership.org/medicalhome.

We need to recognize, however, that as currently conceived, the Medicare Medical Home Demonstration will not adequately meet the needs of the most vulnerable and complex patients without further evolution. Other models, including those incorporated in Senator Wyden's Independence at Home proposal and Senator Lincoln's Geriatric Assessment and Chronic Care coordination approach, should be considered alongside the current demonstration.

Ultimately, the issue is not which of the several successful models is in place, but whether you have provided the payment incentives that encourage redesign of practice and whether you have linked payment to patient-centered criteria and outcomes. Toward that end, we encourage the following:

- ***Risk-adjusted payment for team-based primary care*** that is tied to the severity and complexity of the patient's needs, including the number and nature of chronic conditions, physical and cognitive limitations, mental health needs, and social and environmental factors.

- ***Payment for an appropriate range of multi-disciplinary care management and coordination services***, based on the patient's level of needs. This would include a full geriatric assessment including a caregiver assessment, a total plan of care developed with the patient and caregiver, education and training of the patient and caregiver in ongoing management of their conditions, regular consultation with the patient and caregiver, coordination with all health care providers treating the patient across all settings, and proactive linkages to community services and supports for patients who need them.

- ***Adequate payment and incentives to support effective transitions of care*** as patients and caregivers move between hospital, home, and nursing facilities. Such payments must compensate for effective management of their medications and ongoing needs and appropriate follow-up care. Payment should be sufficiently flexible to support successful models that are based in a hospital, primary care practice, or community setting.

- ***Provide a range of pathways for primary care practices to achieve practice transformation***. As we move towards payment models that reward better and more coordinated primary care, the enhanced payment needs to be tied to increased accountability and commitment to achieving truly patient-centered outcomes. However, we need to also recognize that there is great diversity among primary care practitioners in their ability to engage in the transformative practice re-design.

- ***Create incentives and pathways for primary care practices to engage as part of larger integrated systems of care***. To best serve the diverse and complex needs of patients with chronic and acute care issues, our payment models need to promote integrated delivery systems. Most of you are familiar with the best of these – such as the Permanente Medical Group, the Mayo Clinic, Intermountain Healthcare, and the Geisinger Health System. Integrated systems can promote collaborative team-based care to better serve patients' complex needs, share accountability, and generate savings from better management of patients' conditions.

- ***Better integrate Medicare and Medicaid services for dual eligible individuals***. We have built a system of care that splits responsibility for services between states and the federal government, with our frailest citizens caught in the tug-of-war between Medicare and Medicaid. I congratulate Senator Baucus for recognizing this problem in *Call to Action*, the white paper on health care reform. It is imperative that we implement strategies to facilitate coordination of Medicare and Medicaid services for these vulnerable individuals.

Transformed Health Care Delivery Requires New Infrastructure

As we adopt new models of care and move towards a transformed delivery system, it will require a set of critical infrastructure elements:

- A strong foundation of ***measurement, reporting and ongoing quality improvement.***
- Widespread adoption of ***health information technology (HIT)*** that helps us improve quality, coordination, and safety, engages patients and caregivers, reduces costs, and allows assessment of quality and improvement.
- ***Comparative effectiveness research*** that gives clinicians and patients better information about what works and what doesn't, and enables them to make good decisions about treatments and services.
- The right tools and strategies to ***engage patients and caregivers*** in managing their health and making health care decisions.
- An ***adequate workforce,*** appropriately trained, in sufficient numbers, and effectively deployed to meet the needs of our population – particularly those who have been traditionally underserved, and the rapidly growing number of individuals with multiple chronic conditions and geriatric syndromes.

Measurement, Reporting and Quality Improvement

We spend billions of dollars on health care services that do not improve patient outcomes while millions of Americans are uninsured or underinsured. Racial and ethnic minorities, the poor, those with less education or language barriers, and those with chronic and multiple chronic conditions are disproportionately affected. Effective measurement and reporting, linked to ongoing quality improvement, are essential for improving quality, making sure care is patient-centered, eliminating disparities, and reducing costs.

There are a number of key elements to ensuring that measurement and reporting yields these results:

- ***First, we need the right measures***. We are currently lacking measures in critical areas, such as: outcomes and functional status, care coordination and transitions, measures of care for patients with multiple conditions, measures of "patient-centeredness," measures that help us address disparities, and measures of efficiency and resource use. We therefore need clear national priorities for measure development, and adequate resources to develop, test, endorse, and keep measures up to date. We also need effective strategies for collecting, analyzing and reporting this data, as well as translating this information into effective tools to help clinicians improve the quality of care they deliver.

- ***Second, we need an effective process*** for ensuring that all stakeholders – including those who provide the care, receive the care, and pay for care have input in building this foundation for measurement and quality improvement *and* determining how measurement is used for reporting and payment.

- ***Third, we need the federal government to invest in building this foundation.*** To that end, more than 170 organizations, representing consumers, clinicians and other health care professionals, hospitals, employers, and health plans have recently come together to support such an investment in an initiative called *Stand for Quality*. They are united in their belief that building this foundation of measurement, reporting, and quality improvement is essential to transforming our delivery system, improving quality, and reducing costs.[1]

Widespread Adoption of Health Information Technology

We know that good health care is possible without HIT. But we also know that the best health care – and the patient-centered system of care people want and deserve – is not. The provisions in the American Recovery and Reinvestment Act of 2009 – particularly those related to incentives, meaningful use and privacy – were a terrific step forward, and I applaud Congress for the strength of this effort.

Creating a system that is patient-centered and reduces costs requires that we demand and reward the effective use of electronic clinical information to improve patient status and health outcomes. HIT is a key tool that can support each of the elements of patient-centered care defined above – including delivering better quality, more coordinated care, facilitating transitions of care, enabling the collection of quality and performance information, supporting patient and clinician decision-making, and connecting patients and families with health care providers and giving them better tools to manage their own health.

As the federal government prepares to provide financial incentives for the adoption and use of HIT, we must ensure that those incentives are linked to meaningful use of information to provide better quality, more patient-centered care that improves health outcomes.

Comparative Effectiveness Research

Patients and clinicians need access to the latest research comparing the effectiveness of different treatments and which drugs have the best results. And this research needs to be expanded in scope to take into account the critical needs of subpopulations, such as children, people of color, women, and the older adults with multiple chronic conditions. Armed with better information, patients and their doctors can choose the wisest course of action that is right for them and their situation and not waste time or money on unnecessary tests and less effective treatments or drugs. To achieve this we need a robust federal commitment to comparative effectiveness research. I want to thank Chairman Baucus and other members of this Committee that supported the $1.1 billion in the American Recovery and Reinvestment Act for comparative effectiveness research. It was a tremendous start. Now we need to establish a long-term framework, such as that proposed by Chairman Baucus and Senator Conrad, so that the research is driven by a open and transparent priority-setting process that reflects the views of all stakeholders – most especially consumers.

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[1] *See* Stand for Quality at www.standforquality.org (Apr. 16, 2009).

Tools and Strategies to Engage Patients and Caregivers

We need a health care delivery system that helps empower patients and caregivers to recognize and demand high quality care, make sound health care decisions, and become true partners – with their clinicians – in managing their own care.

- ***First, performance measurement needs to be coupled with consumer-friendly public reporting***, so that patients and their caregivers can make informed decisions about where to seek their care. Today, despite the fact we live in an information age, consumers are left in the dark about the quality of care provided by the pediatrician who treats their child, or the cardiologist caring for their aging parent. Consumers have a right to information about the quality, cost, and relative effectiveness of the providers and treatments they choose. We simply cannot expect consumers to make wise decisions about how to spend their health care dollars without the right information.

- ***Second, patients and caregivers need to be asked for feedback on their experience of care***, and that feedback should be used to improve care and reduce disparities. All health care organizations and settings, including individual and group physician practices, hospitals, nursing homes, assisted living facilities, community health centers, ambulatory settings, and hospice, home health, end stage renal disease, and behavioral health providers should administer and publicly report on patient experience surveys. Those results should then be made available to help providers improve the care they provide, and help patients and caregivers make informed choices about where they seek treatment and services. We simply cannot make claims about achieving a patient-centered health care system unless asking patients about their experience of care is a routine practice in every care setting.

- ***Third, "shared decision-making" must become an integral component of the patient-clinician relationship***. A patient's treatment choices should be based on clear understanding of their options and their trade-offs and should be consistent with the patient's values, preferences, and life situation. Truly informed patients can play a more active role in decisions about their care, working with their health care providers to pursue treatment that matches their needs and preferences. Numerous studies have documented that patient's use of shared decision aids results in reduced rates of elective surgery in favor of more conservative options.[2] The Foundation for Informed Medical Decision Making found that for 70 percent of people who have a heart bypass operation, the result would have been the same if they had chosen medication alone.[3] Many of those patients were probably unaware that they had more than one treatment option, and would likely have chosen differently.

- ***Fourth, we need to re-design public and private insurance benefits*** to give consumers incentives to make truly value-based decisions. Benefit design can support consumers in their ability to take actions to prevent and manage disease, select quality care at the best

[2] MedPAC Public Meeting Transcript, p. 9, Apr. 8, 2009.
[3] Foundation for Informed Medical Decision Making, "Did You Know", http://www.informedmedicaldecisions.org/ (Apr. 16, 2009).

price, and use clinicians or settings that deliver better quality more affordably. Benefit re-design based on value can dramatically achieve both better health outcomes and lower costs. For example, in 2001, Pitney Bowes lowered co-payments for asthma and diabetes medications for their employees. They reported a $1 million savings from reduced complications in the first year, and $2.5 million in savings in the second year.[4]

Building an Adequate Workforce

The demographic shift occurring in our population as the first of the baby boomers reach age 65 calls into sharp relief the fact that we have a health care workforce largely untrained in caring for an aging generation. As Americans live longer with multiple and more complex conditions, we face a tsunami that will overwhelm our ability to deliver care, regardless of how well designed and organized the delivery system is. Without "boots on the ground" to directly care for patients and their families, we cannot achieve our goal of providing patient-centered high quality care to all Americans.

The health care workforce is suffering from problems related to both size and training – we need a larger primary care workforce and a workforce that is trained in effective ways of caring for the high-risk, high-cost patients with multiple chronic conditions that are increasingly becoming our "typical" patients. But the pipeline for training physicians in geriatrics is long and dry; very few medical school students take a course in geriatrics, and less than 300 physicians completed geriatrics training in 2007.[5]

Addressing these workforce challenges requires providing better compensation and incentives. Redesigning our payment system to reward and encourage primary care will help. Other incentives like loan forgiveness and scholarships can make a difference, as will improved working conditions and benefits so we can retain our current practitioners. As a pragmatic first step, we urge that every primary care clinician gets trained in the principles of high quality geriatric care.

Conclusion

We have an extraordinary opportunity for transformational change of our health care delivery system. The magnitude and urgency of the crisis we face in today's health care system demands that we act boldly. To do anything else is morally and fiscally irresponsible.

Yet the process for transforming our system is also extraordinarily complex. Each change is fraught with consequences, intended and otherwise, and at every turn there is much we will learn only by taking action.

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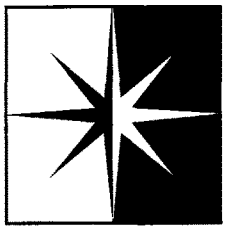
[4] Fuhrmans, V., "A Radical Prescription," Wall Street Journal, May 10, 2004, and "Value Based Benefits Designs," Presentation by Horn, D., Pitney Bowes, Inc., Inaugural University of Michigan VBID Conference, December 15, 2005.

[5] Gawande, Atul. *The Way We Age Now*, New Yorker Magazine. April 30, 2007.

We must take into account the tremendous variation in our current system. Providers and payers will have different capacities to respond to change, and patients vary tremendously in their needs and preferences. We must therefore avoid a "one size fits all" approach.

This calls for a mix of vision and pragmatism. We must set our sights high. Be clear about direction. But also chart a course that creates multiple pathways for providers to reach our goals. We must establish mechanisms for rapidly testing, assessing, and implementing what we learn. And most importantly, we must hold ourselves to our commitment to forge an effective system that delivers high quality, patient-centered care for everyone. Patients and their families are counting on us.



NEW AMERICA
FOUNDATION

STATEMENT OF LEN M. NICHOLS, PH.D.
DIRECTOR, HEALTH POLICY PROGRAM
NEW AMERICA FOUNDATION

SENATE COMMITTEE ON FINANCE
COVERAGE ROUNDTABLE

MAY 5, 2009

NEW AMERICA FOUNDATION
1899 L STREET, NW SUITE 400
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Chairman Baucus, Ranking Member Grassley, other distinguished members of the Committee, thank you for inviting me to participate in this roundtable discussion today. My name is Len M. Nichols. I am a health economist and I direct the Health Policy Program at the New America Foundation, a non-profit, non-partisan public policy research institute based in Washington, D.C., with offices in Sacramento, California. Our program seeks to nurture, advance, and protect an evidence-based conversation about comprehensive health care reform. We remain open minded about the means, but not the goals: all Americans should have affordable health insurance and access to high quality health care that is delivered within a politically and economically sustainable system. I continue to believe the best way to accomplish these goals is to work toward bipartisan agreement about specific reforms and pathways. Your committee has long been a beacon of bipartisanship in a city that is too often devoid of it, so I am doubly proud to be before you today. I am happy to share ideas for your consideration today and hereafter with you, other members of the Committee, and staff.

Your letter of invitation indicated your focus today would be on three primary questions:

- How to make the market more affordable and workable for individuals and small businesses?
- What is the role and responsibility of individuals, employers and government in achieving health coverage for all Americans?
- What role should public programs play?

I will address each of these questions in turn in this written testimony, after a prefatory paragraph about coverage in general.

Our goal should be to make sure our insurance markets work for *all* Americans (and for legal immigrants, as well). We fail to live up to our own standards of a Just and strong society, standards which are derived from the roots of our Judeo-Christian heritage, when we accept as inevitable that tens of millions of our fellow citizens will remain without health insurance. There is nothing inevitable about it. We weaken ourselves, our communities, and our very sense of community when we leave so many without a seat at our health care table of plenty. Unlike when we stopped debating health system reform in August of 1994, we now know (from the Institute of Medicine) that roughly 20,000 Americans die every year from lack of access to timely care they would have had if they had garden variety health insurance. We also know now, again thanks to the IOM, that the yearly economic loss from premature death and unnecessarily prolonged illnesses of the uninsured exceeds the likely public cost of covering the uninsured. We simply must find a solution that works for all of us. I know we can, if we but will, and this committee is the right leadership group to show us the way.

MAKING AN INSURANCE MARKET WORK FOR INDIVIDUALS AND SMALL BUSINESSES

The technical goal of health insurance reform is to extend the advantages of large group purchasing – large, balanced risk pools and administrative economies of scale – to all. The fundamental idea is to make our most problematic insurance markets more efficient *and* more fair. The following structural changes are necessary conditions for success:

A new insurance marketplace to pool risk and reduce administrative burden. Our current individual and small-group markets work far better for insurers than for the people who try to purchase insurance within them. Every small business survey in the past 20 years reports that purchasing health insurance for their workers is one of the greatest headaches of small business owners. Recent polling has shown that health insurance is one of the major impediments to new business formation, a particularly ominous sign for an economy that depends on innovation and small businesses in particular to nurture that innovation. There are few surveys of individual market recipients per se, but we know from representative household survey data that the vast majority of people who have any other insurance option – be it a public program, large group insurance, or even small group insurance – take it rather than purchase in the non-group market. Reform that does not fix these markets is not worthy of the name.

Rather than tweak around the edges, these marketplaces need fundamental reorganization. The cleanest way to do so is make a new market (hereafter insurance "exchange") that replaces the current individual and small group markets. After a reasonable transition period, total replacement with new rules is strongly preferred to leaving existing markets alongside a new one with different rules. It will be safer and more efficient to have one marketplace with one set of rules rather than risk the inevitable risk-selection activity if old market rules and behaviors are permitted to coexist.

Let there be no doubt: health insurance reform is about changing the business model of insurers, *from* risk segmentation, aggressive underwriting and profiting from dividing us, *to* thriving by helping all of us find value and pathways to better health among the best providers and most effective health-enhancing strategies and behaviors. Many insurers are capable of making this shift. Indeed, the larger, national firms are largely there and many local non-profits have always preferred the search for value within the delivery system to aggressive underwriting. But as long as risk segmentation and underwriting are possible, some traditional insurers will continue to pursue those strategies, for they are highly profitable. As a result, we will be left with many Americans as badly served by these underwritten markets as they are today.

Do note, however, these new exchanges could be organized at the state or even sub-state levels. It is not necessary (or wise) to have one national exchange, as explained below.

Within the new exchanges, one immediate question must be answered: how small is "small?"

The answer to this question depends upon your vision of reform. If you want the exchange to work for individuals and *all* small groups, and you expect large groups (i.e., all non-small groups) to be able to self-insure on their own (as the happiest large firms do today), then the dividing line between small and large should be the firm size at which an employer can safely and efficiently self-insure. Actuarial experts tell me this is around 500 or 1000 workers, not the typical 50 that defines the upper bound of the small group market in the vast majority of states (some go as low as 25). Over time, larger self-insured firms might be allowed to enter this marketplace if they so choose.

But if you want to minimize the number of small employers the new arrangements will help (and correspondingly preserve today's very high profit margins for insurers in this market segment), then you could cutoff eligibility for the exchange near current law levels, at 50 or even 25 workers (or go as low as 10 if you value insurers welfare far, far more than small employers'). This will leave employers of 11, 26 or 51 at the mercy of what the commercial market currently offers up to them today, and in many states, that is highly unsatisfactory. This poor performance is of course why the National Federation of Independent Business (NFIB) and other employer groups have tried so hard for so long to create association health plans and other options for this market segment and why Senators Lincoln and Snowe have worked so hard for so long to fashion their bipartisan compromise legislation that would improve small group markets' performance for small employers, the customer, not the sellers.

Insurance market rules governing the new marketplaces should be uniform across the country, but the exchanges themselves could be organized on a national, state, or sub-state level. It is important to remember that all health markets (like politics) are local. Competing against Kaiser in San Francisco or Group Health in Seattle is different than competing against Blue Cross of Arkansas in Little Rock. Exchange managers and oversight boards can and should bring local expertise and flexibility to the overall federal superstructure.

New insurance market rules to make quality health coverage accessible to all. No American should be denied coverage or charged differential premiums because of their health status or family history. The market rules that must govern exchanges include: guaranteed issue and renewal (sell to all); modified community rating (limited age and geographic variation, no health status discrimination); no pre-existing

condition exclusions (after a phase-in period); individual requirement to purchase or obtain health insurance. Age rating, while important to minimize aggregate subsidy cost, must be limited or it could become an effective proxy for health status rating.

Minimum benefit package to ensure that coverage is meaningful. All Americans should have coverage that enables access to effective, high-quality care as well as protects their financial health. Therefore, Congress or another authority should require a minimum level of benefits to guarantee the quality of coverage being offered in the marketplace and protect against adverse selection that could result from wide variations in product design. It is more complicated, but imaginable, that an actuarial value standard be set rather than a specific package of benefits. This would allow insurers with different approaches to quality and efficiency to compete without causing undue risk selection. Risk adjustment (distributing payments to insurers based on differential risk profiles) will be necessary to help reduce the incentive to and consequences of adverse selection. Insurers should also be permitted to sell supplemental products; however, these packages must be priced and described separately to allow consumers to easily compare different choices and create transparency regarding cost and value.

Subsidies to make sure quality coverage is affordable to all. Reform proposals should include sliding scale subsidies for individuals and families who need help affording coverage. Affordability has two dimensions – for households and for governments. Ultimately, the final definition of affordability will reflect political judgments about what households and governments can afford. This definition may evolve over time. Subsidies could be available for both premiums and cost-sharing requirements (depending on the design of the minimum package) and made available directly or through the tax code.

We should keep in mind that the federal government already spends more than $200 billion per year subsidizing insurance through the tax treatment of employer-provided health coverage. Economists, analysts, and courageous policy makers have argued for years that the income tax exclusion for employer premium payments is both regressive and inefficient relative to other ways to subsidize insurance coverage. The current employer tax exclusion is a poorly targeted subsidy that we could and should use to make our health system both more efficient and more fair. Therefore, as we think about how to finance coverage expansion and necessary subsidies, we should remember that some of the resources we have dedicated already could be targeted far more efficiently.

Requirement to purchase coverage to balance the risk pool and make sure everyone is paying their fair share for health care. When combined with the reforms described above, a requirement to purchase coverage is necessary to make the insurance market function efficiently and fairly. Without a purchase requirement, insurers will legitimately fear that mostly the sick will buy health insurance (adverse

selection). That fear will produce higher premium bids, which will cost people and governments more money. Purchase requirements will guarantee that the population seeking care represents the entire population. As a result, insurers will bid lower in a competitive context. In addition, once insurance is accessible (through the newly reformed marketplace) and affordable (through subsidies), all individuals should be required to purchase coverage to make sure everyone pays their fair share for health care.

Increased emphasis on insurer transparency to engender fair competition and give consumers the information they need to make informed choices about the insurance products that are right for them. Insurers should be required to report information on quality and patient satisfaction indicators. Also, the marketplace(s) or exchange(s) will want to help the public compare administrative efficiency by making available the ratio of premiums collected versus dollars spent on patient care. The risk profiles of enrollees will need to be reported for exchange-wide risk adjustment as well.

SHARED RESPONSIBILITY: ROLES AND RESPONSIBILITY FOR INDIVIDUALS, EMPLOYERS, AND GOVERNMENTS

Our nation can meet its goals for health reform if everyone shares in the responsibility.

Individuals. As a condition of living in a community that helps individuals afford insurance and care, everyone has a personal responsibility to maintain their own health. Value-based design features in the minimum benefit package that encourage healthy eating, exercise, and lifestyle behaviors will help give Americans some of the tools they need to achieve this goal. In addition, part of taking individual responsibility for one's our own health includes a requirement to access appropriate health care services when necessary. This is possible only if a person is insured. Therefore, a requirement to purchase or enroll in coverage represents one part of an individual's personal responsibility to the larger community.

Employers. Employers have played key roles for a long time in our health system, and will likely always be involved in various ways, for the economic case for healthy workers is increasingly clear. Certainly in the short run, we expect large employers who choose to, to continue offering health insurance to their workers on a largely self-insured basis. But when I think about the global nature of the 21st century economy, I must say I am increasingly skeptical that we can continue to rely on employer financing as much as we have in the past. Therefore, I would recommend designing purchasing arrangements that can function without explicit employer contributions over time, and yet offer the distinct advantages of large group purchasing. This is what exchanges do, with the right rules, as we have outlined.

I do not believe that it is necessary or even wise to have an employer requirement to finance a sustainable health system for all. But I also understand that this approach has political resonance because of the simple and profound logic of shared responsibility. Therefore, I would offer the following observations:

The vast majority of large firms offer coverage. Likewise, most small, high-wage firms also offer coverage to attract and retain workers. Therefore, in a pay or play framework, the only firms who will be required to "pay" the tax would be small and low-wage. Workers or owners in these firms do not have much ability to pay by definition. Too high a tax rate on small, low-wage firms risks forcing layoffs or even closings. Therefore, the tax rate on these firms would have to be relatively low. In my view, there is just not enough potential revenue in this scenario to justify the very high political cost of forcing employers to contribute to health costs against their will. One possible compromise approach could be to make the "pay" requirement a function of firm size and average wage or revenue per worker and exempt the smallest and lowest wage businesses.

However, let me be clear: employers should be allowed to continue to offer coverage and/or continue to contribute toward the coverage their workers choose in the exchange(s) if they would like.

This does raise a key point about choice of plan within the exchange. I am a strong proponent of individual choice. The exchange managers' job is to determine which insurers and which plans of those insurers meet the conditions of participation. Small employers (and large ones eventually) should be allowed to contribute toward their worker's choice, with a fixed payment or voucher, but individual workers, just like individuals with no employer offer (and individuals who work for governments or large firms in their own contexts) should determine which plan they want to enroll in. Individual choice will force insurers to satisfy individual customers, not benefits managers or heads of companies alone.

Governments. There are two main roles for government, rule maker and enforcer, and steward of the system as a whole. Good policy sets rules and enforcement mechanisms to channel self-interest to serve the public interest. This is what the insurance reform rules and new exchanges are all about.

But the government must also be a steward of our collective health care resources. Stewardship requires government to evaluate the performance of our system as a whole, and to use all available resources, including the Medicare program, to re-align incentives to improve the quality and efficiency of our health delivery system. Part of stewardship is also accountability to taxpayers, so that subsidy costs – absolutely necessary to make the purchase of insurance and access to care affordable for many – are nevertheless kept to the minimum necessary to accomplish our collective goals.

ROLE FOR PUBLIC PROGRAMS

As we create a sustainable system of coverage for all, public programs will play indispensable roles.

Medicare. Medicare has served some of our nation's most vulnerable citizens for generations. Yet, rising health care costs threaten the long-term sustainability of the program. Medicare can and must lead the way to broader health system transformation through reforms that add value and reduce cost growth over time. By changing Medicare's payment structure to align the incentives of providers across silos of care (hospitals, physicians, post-acute facilities, drugs, devices, labs, etc.), we can create powerful incentives for providers to adopt high-value care processes. In turn, this will make the delivery of care to the under-65 population more efficient (as did the move to diagnosis-related group payments to hospitals in the 1980s) and inspire private insurers to adopt similar, if not identical, incentive-based contracts. In many ways, Medicare reform is integral to health system reform and will have the triple benefit of making Medicare sustainable while delivering higher quality care to beneficiaries along with savings that can help finance coverage expansion subsidies in the intermediate and long runs.

Medicaid. The strengths and weaknesses of the Medicaid program are well known, and you have true Medicaid experts on this panel so I will be brief. Today, Medicaid provides essential services to some of our most vulnerable citizens. We must be mindful of its essential role today when thinking about system reform.

I am, however, haunted by this question: what other country with a commitment to coverage for all has a different health insurance program specifically for the poor? Provider payment rate and other variations across the nation lead me to believe that it would be preferable in the long run to transition non-elderly Medicaid enrollees into the insurance available in the exchanges, as long as they qualified for appropriate subsidies, perhaps some wrap around benefits for cost effective social support services that are not provided by traditional insurance, and special low-income cost sharing benefits. In the short run, however, I would recommend strengthening Medicaid payment rates to allay access problems and continuing current Medicaid programs at least for all those with incomes below poverty.

New Public Health Insurance Plan. No issue has been more contentious than this one so far, much to my surprise. Granting individuals the choice between public and private health plans serves two primary purposes. First, many Americans distrust private health insurers. A public health insurance plan would assure these individuals that their insurance company is accountable to them and not profits or boards of directors. Second, a public health insurance plan could serve as a valuable "benchmark" and provide a way for consumers to compare premiums, benefit

design, and the administrative efficiencies of different health plans. This benchmark role could be especially valuable in year one of a new exchange that some insurers (at least) will oppose and would like to erase. This benchmark role can be provided without inevitably leading to a government takeover of the health system, as some seem to fear.

Let me be crystal clear: if the playing field is level, it is possible for public and private health insurance plans to compete and deliver value for consumers without distorting the insurance market. This policy question should not create an impasse or stall reform efforts.[1]

Three conditions are absolutely necessary for public and private health plans to compete fairly:

- All insurance market rules must apply to all plans equally.
- The authority governing the insurance marketplace cannot also manage the public health insurance plan.
- The public health insurance plan cannot leverage Medicare or other public insurance products to administer prices or claim an unfair advantage.

Real-world experience is instructive. More than 30 states offer their employees a choice between privately insured products and a self-insured product for which the state bears the insurance risk. Under this scenario, the state picks the managers of the self-insured product, which then competes with traditional private insurers. In her recent testimony before the this committee, Secretary of Health and Human Services, Kathleen Sebelius, pointed to state employee benefit plans as examples wherein "public and private plans compete on the basis of benefits, innovation, and cost," without destroying the marketplace.

Yet, this type of public plan alone will not be sufficient to control costs. Therefore, cost growth control must be addressed through a systemic approach that includes a health information infrastructure, realigned provider and patient incentives, and best practice information. Medicare can and must lead the way for the private sector. But simply using Medicare's pricing power to control costs without addressing the underlying reasons health care costs are growing so rapidly will not fix our problem.

CONCLUSION

Coverage for all is an essential part of re-making our health system. Comprehensive health reform must also include efforts to improve quality and reduce cost growth.

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[1] For further information on my thoughts about a competing public plan, see: Len M. Nichols and John M. Bertko, "A Modest Proposal for a Competing Public Insurance Plan," *New America Foundation*, March 2009.

But the foundation of a *health* system must be coverage. Without coverage, tens of millions of Americans will never have access to appropriate, life-saving care.

There is a compelling collective interest in making sure coverage is a reality for all Americans: the economic loss we suffer as a result of the uninsured exceeds the cost of covering everyone.[2] Also, everyone must be in the system for it to work at its highest possible level. I hope this testimony is useful and I remain, as always, eager to answer any questions.

[2] Health Policy Program, "The Case for Health Reform," *New America Foundation*, 2009.

Statement
of the
American College of Surgeons

Presented by

Frank G. Opelka, MD, FACS

Committee on Finance
United States Senate

Roundtable to Discuss
Reforming America's Health Care Delivery System

April 21, 2009

Chairman Baucus, Ranking Member Grassley, and members of the Committee, on behalf of the American College of Surgeons (ACS) and the more than 74,000 ACS members, thank you for the opportunity to join you today in this roundtable discussion on "Reforming America's Health Care Delivery System."

I am Frank Opelka, and I am a colorectal surgeon from New Orleans, Louisiana. I am the Vice Chancellor of Clinical Affairs and Professor of Surgery at the Louisiana State University (LSU) Health Science Center. I am also the Chief Executive Officer, Chairman of the Board of Directors, and President of the LSU Healthcare Network. Within the ACS, I have served as Chair of the ACS Patient Safety and Quality Improvement Committee and am a member of the ACS Health Policy and Advocacy Committee. I also serve as Chair of the Surgical Quality Alliance, which is a collaborative effort of the ACS and 25 surgical specialty societies to promote and improve the quality of surgical care in the United States.

Today's roundtable covers one of the most important topics in the health reform discussion. Reform of our nation's health care system covers a range of important issues, from covering the uninsured to expanding patient access to care, from improving the quality of care to containing the growth of our nation's rising health care costs. A myriad of problems and challenges calls for not one but many steps and solutions to put us on the path to extending the possibility and promise of quality health care to all Americans. In addition, before adopting any proposed steps or solutions, we must carefully consider what unintended consequences may result. For example, a little over ten years ago, many were predicting a surplus of physicians, and as a result, Congress set limits on graduate medical education that have held the number of residencies static even as the American population continued to grow. Today, physician shortages are on the rise in both urban and rural areas, and surgery has not been immune from these trends. In fact, data from the Dartmouth Atlas show a 16.3 percent decline in the per capita number of general surgeons between 1996 and 2006 as well as per capita declines of 12 percent, 11.4 percent, and 7.1 percent in urology, ophthalmology, and orthopaedic surgery, respectively. So while our present situation calls for change and health system reform, we must proceed deliberately and thoughtfully to ensure that the policy changes we make today do not lead to unintended consequences that could undermine Americans' access to quality care.

Improving Surgical Quality—System-Wide Approach

Much of the discussion around health reform has been on how our nation can improve the value of care that patients receive while either limiting the growth of or, in some cases, even reducing the volume of services used by patients. From our perspective, this discussion must start with a discussion of how we improve the quality of care, which from the ACS perspective means surgical care.

The concept of delivery system reform starts from an important and appropriate premise that patients receive their care in a large system of care rather than from one physician or health care provider. It is this same premise that has been the foundation for our

own successful surgical quality improvement (QI) efforts. For example, the ACS National Surgical Quality Improvement Program (NSQIP) started with a successful effort within the Department of Veterans Affairs, which produced marked reductions in VA post-operative mortality and complications of 27 and 45 percent, respectively, between 1991 and 2001. ACS NSQIP is a prospective peer-controlled, validated database that quantifies 30-day risk-adjusted surgical outcomes and allows for comparisons among all participating hospitals. ACS NSQIP does not merely examine the care the surgeon provides in the operating room, but rather it captures data regarding the range of pre-operative, intra-operative, and post-operative care that the surgical patient receives over the 30 days following the surgery. After a pilot to test NSQIP in three non-federal hospitals in 1999, the ACS applied for a grant from the Agency for Healthcare Research Quality (AHRQ) in 2001 to expand the program to 14 hospitals. Based on its successful application in these hospitals, the ACS has spearheaded the effort to implement ACS NSQIP in private hospitals across the country, with ACS NSQIP currently in place in 235 hospitals nationwide. The program has received wide recognition as a successful model for surgical quality improvement and the Joint Commission recognizes the value of participation in ACS NSQIP by including a Merit Badge next to the profile of all ACS NSQIP hospitals.

In the field of cancer care, the American College of Surgeons Commission on Cancer (CoC) is a pioneer in measuring performance. The more than 1,400 hospitals and free-standing cancer treatment facilities approved by the CoC report clinical data to the National Cancer Data Base (NCDB) and receive evidence-based benchmark comparison reports based on accepted standards of care for all types of cancer. Since 1995, the NCDB has captured over 21 million cancer cases and includes data on about 70% of all newly diagnosed malignant cases of cancer nationwide annually. To provide better "real-time" feedback, the CoC has also developed a new reporting system that could link into an interoperable, nationwide health information technology (HIT) system, which received significant support in the recently enacted American Recovery and Reinvestment Act of 2009 (H.R. 1). This prospective electronic reporting system, which is called the Rapid Quality Reporting System (RQRS), monitors evidence-based performance measures in real-time, alerting providers when standards of care for select cancers are not being met. The ACS believes RQRS could ultimately play an important part in any new, outcomes-based payment models.

Another important area of health care delivery comes through the emergency and trauma care delivered in our nation's hospitals. Traumatic injury is the leading cause of death for Americans aged 1 through 44, and studies of conventional trauma care show that as many as 25 percent of trauma patient deaths could have been prevented if optimal acute care had been available. In addition to saving lives, restoring function, and preventing disabilities, ensuring appropriate trauma care also can serve an important role in the larger goal to contain the growth of health care costs. According to an AHRQ report, trauma injuries were the second most expensive health care condition in 2005, costing approximately $72 billion. This includes money spent for doctor visits, clinics, emergency room visits, hospital room stays, home health care, and prescription drugs. The cost of trauma-related emergency room visits alone was $7.8 billion. The

National Safety Council's 2005-2006 edition of *Injury Facts* found that the total cost of unintentional injuries for 2004 was $574.8 billion, with $298.4 billion in wage and productivity losses and $98.9 billion in medical expenses alone.

Trauma systems provide for effective and efficient use of scarce and costly community resources. Yet, only one in four Americans lives in an area served by a trauma care system. Both the Institute of Medicine (IOM) and the Emergency Medical Treatment and Labor Act (EMTALA) Technical Advisory Group have documented significant gaps in our trauma and emergency healthcare delivery systems, showing that hospital emergency departments and trauma centers across the country are severely overcrowded, emergency care is highly fractured, and critical surgical specialties are often unavailable to provide emergency and trauma care. The IOM has found that a coordinated, regionalized, accountable system based on the current trauma care system model should be created. Unfortunately, the most consistent element among the states is the lack of uniformity regarding system development. As a result, the quality of care a trauma patient receives largely depends on the quality of the regional and local system in place to respond emergency and trauma situations.

Since 1976, the ACS Committee on Trauma (COT) has developed criteria to categorize hospitals based on the level of trauma care available. These guidelines are now used by states to certify some hospitals as trauma centers and many hospitals seek certification to become a trauma center from the ACS COT. In addition, in 1989, the ACS COT collaborated with emergency medical organizations, governmental agencies, trauma registry vendors, and other interested parties to develop the National Trauma Data Bank (NTDB), which contains over 2 million cases from over 600 U.S. trauma centers and is the largest aggregation of trauma registry data ever assembled. The goal of the NTDB is to inform the medical community, the public, and decision makers about a wide variety of issues that characterize the current state of care for injured persons in our country. The information contained in the data bank has implications in many areas including epidemiology, injury control, research, education, acute care, and resource allocation. Finally, the ACS COT plans to develop a trauma QI program, paralleling the efforts with ACS NSQIP.

Through these efforts, the ACS has demonstrated a commitment to delivery reform that both includes and extends beyond the care that the surgeon provides to his or her patients. In addition, these efforts are based not simply on doing more for the patient but on doing what is most clinically appropriate for the patient. The ACS recognizes that surgical care is provided through a surgical team in the operating room and through a team of health care professionals, including the surgeon, who care for and monitor a patient's progress before and after an operation.

Achieving Better Quality and Better Value—A Collaborative Effort

The Physician Quality Reporting Initiative (PQRI) has sought to change the culture among physicians regarding QI efforts, and while this effort has not been without some value, the PQRI has also been limited in its effectiveness because it is focuses almost

solely on the physician's role in caring for a patient and because it is structured in such a way that supports a Medicare culture that bases how much a physician gets paid with how many services a physician provides. If we are to truly improve the value of care that patients are receiving, incentives need to be better aligned to ensure that the better value is what is being rewarded. Senator Baucus's and Senator Grassley's inclusion of provisions in the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) to allow physicians to meet the requirements of the PQRI through participating in an approved registry was a step in the right direction because registries focus not on providing more care but on clinically appropriate care. By building on such measures that reward participation in proven QI initiatives, incentives can be better aligned within Medicare to promote better quality and better value through collaboration and information sharing. It is this understanding of the importance of collaboration and information sharing between the surgeon and others caring for the surgical patient—a truly system-based approach—that has been the foundation of success for ACS's QI efforts.

Just as the ACS has approached surgical quality improvement as an effort that extends beyond the surgeon, the ACS likewise believes that efforts to improve the care in our hospitals must support and recognize the role of surgeons in caring for patients. Even though our members are paid separately from hospitals, surgeons are the critical component of the care delivered in hospitals, and delivery reform should support the collaborative efforts of surgeons and hospitals to serve patients facing a major illness, disease or injury. If hospitals do not have surgeons, hospitals cannot survive and patients in the surrounding community are forced to travel great distances to seek surgical care. Likewise, our members cannot serve patients if there is not a hospital with whom to partner in caring for patients. In this context, it is important to consider how best to build upon the current hospital quality improvement program. Last year, Chairman Baucus and Grassley released draft legislation that would expand the existing hospital QI effort to include surgical care. If the expanded program is to be a success, it will be essential that the hospital program and the PQRI be in harmony to improve and not impede quality surgical care. As a result, if surgical care is included in this effort, it is critical that the perspective of surgeons and others who are caring for these patients be considered and weighed in measure development. In addition, if surgical care is included, risk-adjustment to account for the wide-range of patient acuity, as is included ACS NSQIP for example, will bring not only accountability but also added respectability that will yield the buy-in from hospitals, surgeons, and other stakeholders needed to ensure the program's success.

If surgical care is included in the hospital QI program, it will be of vital importance to ensure that the public reporting of performance data regarding specific hospitals be accurate. As you know, the Centers for Medicare & Medicaid Services (CMS) already publicly reports certain hospital measures, but the addition of surgical care would require an added complexity and should be approached with a degree of caution. If surgical care is included, ensuring appropriate risk-adjustment becomes all the more important to ensure that hospitals and surgeons are not penalized for caring for high-risk and severely ill patients. The ACS is concerned that at present there are

considerable limitations with the public reporting of hospital quality information. These limitations were chronicled in the November/December 2008 issue of *Health Affairs*. In the article, some hospitals listed as top performers in one survey were listed toward the bottom of another and vice versa. Before reporting this type of data to the public, it will be necessary to ensure that the measures being used are recognized by clinicians as true measures of quality and not simply proxies for what a payer, private or public, or a consumer may interpret as quality care. One such proposed proxy has been to define "high quality" providers as those, who, on a review of Medicare claims, perform the highest number of certain procedures. Such proposals could have particular impact on rural and other underserved areas where general surgeons care for a wide range of patients with a wide range of conditions, diseases, and injuries. Many rural, frontier and even some urban communities already face an emergency and surgical workforce crisis, and, if not done carefully and accurately, public reporting could serve to threaten patients' ability to access care in these smaller communities. The public reporting of data that has not been appropriately aggregated and risk-adjusted could lead to incentives that eventually drive surgeons and patients away from these rural communities to hospitals in larger cities. Such a result would not only bring added inconvenience to patients as they seek acute health care services, but it would also threaten the future of hospitals in these smaller, rural communities. These rural hospitals not only serve an important economic function in smaller communities, but they also serve as a safety net when patients are in need of emergency surgical care. The distance a patient travels before receiving the necessary care can often be the difference between life and death. As a result, it is of the utmost importance that appropriate safeguards be developed to ensure that public reporting does not threaten access to care in rural and underserved communities and that any reported data be based on sound clinical information with thorough testing before being released to the public.

In raising these cautions and concerns, I want to stress that the ACS also sees these QI efforts as an opportunity to build on successful efforts already underway, such as those in ACS NSQIP and the NCDB. In fact, the Baucus-Grassley legislative draft provides such an opportunity by including the Surgical Care Improvement Project (SCIP) as part of future hospital QI payment reforms. It is important to note that ACS NSQIP also gathers data under SCIP, which could help facilitate hospitals' ability to meet these requirements should they become a part of the larger hospital QI program. As Congress has appropriately set incentives for physician participation in registries that satisfy the requirements of PQRI, the ACS believes that ACS NSQIP, a database already in existence, could similarly support efforts to design a meaningful hospital QI program for patients.

In addition to supporting the hospital QI expansion, the ACS NSQIP's use of 30-day risk-adjusted outcomes could also support the proposal, included in the President's budget, to bundle hospital payments to cover not just the hospitalization but to cover care from certain post-acute providers provided within 30 days after hospitalization. Just as a successful hospital QI expansion must have risk-adjustment so must any proposal that would penalize hospitals with higher readmission rates. To simply punish

hospitals with higher readmission rates, without accounting for the severity of patient's illness or other conditions that could lead to complications, could have adverse consequences for hospitals, surgeons and ultimately, the sickest of patients that they are seeking to serve.

Building a Foundation for Success—A New Approach to an Old Problem

As the Committee studies the important issue of delivery reform, it is important not to lose sight of the fact that no delivery system, no matter how ingenious, can survive if those who are caring for patients are not being appropriately reimbursed, and the most immediate challenge for patient access to surgical care is the precarious reimbursement situation confronting surgeons and surgical practices. As the Committee is well aware, Medicare payments to physicians will be cut 21.5 percent on January 1, 2010 if Congress does not act. The ACS calls on this Committee and Congress to take action to stop this cut, to provide an increase in Medicare payments for all physicians in 2010, and to initiate reform for Medicare's physician payment system this year. The ACS greatly appreciated the leadership of Chairman Baucus and the bipartisan support from this Committee to enact the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) last July that reversed the 10.6 percent cut in Medicare physician payments. In addition, MIPPA included the largest Medicare payment increase for physicians since 2005 by replacing a scheduled 5.4 percent cut in 2009 with a 1.1 percent increase this past January. MIPPA also made changes to how work was valued under Medicare fee schedule, increasing payments for some surgical services. In spite of these important measures, Medicare payments for many surgical procedures have been reduced significantly over the past twenty years and, in some cases, they have been cut by more than half from reimbursement levels in the late 1980's.

In discussing delivery system reform, many often discuss the importance of measures to promote primary care to both prevent illness and disease as well as to manage the conditions that a patient may already have. To this end, some, most notably the Medicare Payment Advisory Commission (MedPAC), have proposed financing increased reimbursement for primary care by simply cutting reimbursement for care provided by other physician specialties. Such proposals, while seeking to promote efforts to help Americans better manage their care, would only exacerbate the workforce challenges described earlier and establish a reimbursement structure that would ultimately undermine patients' ability to access the life-saving acute care services that only surgeons are qualified to provide. The ACS wholeheartedly supports efforts to prevent disease and to manage patient care not only because it is in the best interests of the patient and health care system but also because, when these patients need surgery, they are much less likely to encounter complications and much more likely to recover quickly from the operation. However, regardless of how well patients' care is managed, acute situations requiring prompt and definitive access to surgical care will continue to occur.

A better alternative would be reforms that recognize the important roles that different specialties play in caring for the whole patient. Unfortunately, Medicare's payment

model is not constructed in such a way. At present, physicians and hospitals are paid under separate Medicare silos, and even though, I have described that ACS's QI efforts are in collaboration with hospitals, Medicare's physician and hospital QI efforts are essentially separate from each other. In the discussion of health reform and Medicare physician payment reform in particular, considerable attention is being paid to ideas that would base payment on organizational arrangements such as accountable care organizations (ACOs) or through regional constructs such as hospital referral regions (HRRs). ACS sees great promise in models that seek to better coordinate the range of care from primary to acute services, but also believes that these models can only be successful if these relationships are entered into voluntarily. Not forcing physician involvement in these organizations and arrangements will help ensure that these relationships will be based on collaboration and mutual respect in improving the quality and, ultimately, the value of patient care. Likewise, ensuring a voluntary arrangement will also protect against the imposition of "one-size-fits-all" or "top-down" efforts that fail to recognize that the unique health delivery situations facing different practices, hospitals, populations and regions.

The hope for patients in these systems of care is that they will receive integrated, high quality care in more efficient way, and indeed there are examples of systems that do that now. In addition, there is also the hope that these systems will contain costs. While the ACS supports the goal of containing cost, it is critical that the goal of cost containment not be used as tool by ACOs, HRRs or any other organization or arrangement, public or private, to deny a patient access the best clinical care available—whether that care is provided by a surgeon or any other physician or health care professional. Likewise, when measuring the quality and cost of care delivered in these systems, it will always be critical to risk-adjust to account for possible complications and outcomes. Finally, in order to determine the value and practicality of different models, ACS believes that appropriate demonstration and pilot projects should be conducted before widespread implementation. It is likely that a variety of models will be needed to meet the various situations and needs facing patients, physicians and health care delivery around the country.

As Congress, CMS, and other policymakers test and study various payment models and systems of care, the ACS supports a transitional step that would replace the blunt tool of the sustainable growth rate for all physician services under Medicare with a reimbursement structure of multiple expenditure targets. As policymakers find more desirable payment models and arrangements to promote better value in care, this model could be phased out over the next three to five years or as Congress determines appropriate as it evaluates a variety of different models of care. Until that time, the ACS proposes replacing the single expenditure target of the SGR with multiple expenditure targets based on sub-sets or categories of services such as major surgical procedures, primary care, and other physician services. Such a structure would no longer subject low-volume growth services, such as major surgical procedures and primary care, to the across-the-board cuts of the SGR, and it would also enable Congress to focus additional dollars toward particular services, such as primary care, without necessarily cutting other services.

Thank you again for the opportunity to participate in this important discussion today. The ACS looks forward to working with this Committee in the days and weeks to come to reform our nation's health care system and to preserve and improve Americans' ability to access high quality surgical care and health care services.

Written Statement for the Record by
Ron Pollack, Executive Director, Families USA

For the Senate Finance Committee

Roundtable on Coverage Issues in Health Reform
May 5, 2009

Mr. Chairman, Members of the Committee:

Thank you for inviting Families USA to participate in today's roundtable about coverage issues in health care reform. We applaud Chairman Baucus's deep commitment to expanding quality, affordable health coverage and care to our nation's families. I want to take this opportunity to thank the Chairman for his leadership on the reauthorization of the Children's Health Insurance Program. I also would like to acknowledge the early, important contribution Senator Baucus and his staff made to the health care reform debate by issuing a very thoughtful "white paper" on health care reform in November of 2008. This paper has helped to focus the debate and encouraged diverse groups to coalesce around a common framework for expanding coverage.

For the American people, fundamentally reforming our nation's health care system is of utmost urgency. One out of three Americans under the age of 65, 86.7 million people, went without health insurance for some period of time during 2007 and 2008.[1] Of these uninsured, four out of five were from working families, and people from lower-income families were more likely to go without health insurance than their higher-income counterparts.[2] *And these data are for the time period before the worst of the current recession.* When you factor in the effects of the recession—job losses and the accompanying loss of job-based coverage, the tightening of family budgets, and pressure on the bottom lines of American businesses—you can expect the number of uninsured Americans to rise to record levels if nothing is done. Addressing the crisis of the uninsured is critical to the economic security of American families and to the goals of improving the quality and lowering the costs of health care for those lucky enough to have insurance today.

At the same time that the number of uninsured is rising, people who have insurance are struggling to afford rising premiums. And these two problems—uninsurance and high premiums—are interrelated. In fact, the presence of uninsured people in our nation's health care system adds to the cost of the health insurance premiums that American consumers and businesses must pay for coverage.

Premiums for both job-based and individually purchased health insurance have risen rapidly over the last few decades: Between 2000 and 2008 alone, the average annual premium for job-based family health coverage doubled, rising from $6,351 to $12,680.[3] During the same period, the average worker's share of average annual family premiums rose from $1,656 to $3,354, an increase of nearly 103 percent.[4] Although families are paying more and more for coverage, they are getting less and less: On average, deductibles and copayments are increasing, there are more limits on covered services, and other limits are being placed on benefits in an effort to hold down the cost of coverage.[5]

Obviously, making sure that all Americans have access to quality, affordable health coverage will increase access to medical care for millions of Americans and will save countless lives. Less obvious, however, is the fact that covering the uninsured will help contain rising health care costs for people with health coverage today and improve the quality and efficiency of our health care system—both primary goals for national health reform. This is true for several reasons.

First, the cost of care for people who don't have insurance doesn't just disappear. We all pay—in the form of higher medical bills and higher insurance premiums—for the care provided to the uninsured. When people who don't have insurance get sick, many delay or forgo care.[6] And when they can no longer ignore serious symptoms, they see doctors and go to hospitals. They struggle to pay as much as they can of their medical bills (nationally, more than one-third of the cost of care for the uninsured is paid by the uninsured themselves, out of their own pockets).[7] Much of the remaining cost is paid by doctors and hospitals charging higher rates for services covered by insurance. Insurance companies pass these increased costs on to purchasers of insurance through higher premiums. In 2005, on average, $922 of the cost of family health insurance coverage was attributed to the cost of caring for the uninsured[8]—an amount that can be

characterized as a "hidden health tax" that all of us with insurance now pay. Later this month, Families USA will issue a report that updates this "hidden health tax."

Second, if everyone is in the health care system, we can slow down the growth of health care spending. If everyone has quality, affordable health care—including preventive services, as well as early diagnosis and treatment of conditions—we can *manage chronic disease* rather than *manage the crises* that result from delayed care. When everyone has coverage, health conditions can be treated early, before they become expensive problems that drive up total health care spending. If we can slow the growth of health care spending as a share of our GDP, we'll be better able to invest in education, our national infrastructure, and other national priorities.

Third, when everyone has quality, affordable coverage, cost-saving public health goals are achievable. Doctors play a key role in motivating patients to reduce obesity, control high blood pressure, lower cholesterol, and reduce other risk factors. Efforts to improve our nation's overall health through public health initiatives cannot be successful if millions of people are left behind because they don't have insurance.

Fourth, public health threats and epidemics cannot be monitored and addressed when so many people in our nation are uninsured. In order to address health threats such as flu viruses, Lyme disease, West Nile virus, and tuberculosis, we need to be able to develop a complete picture of disease prevalence and patterns of transmission. When we leave millions of people outside the health care system, we hinder our efforts to identify patterns and deal with these threats early and effectively.

Families USA's Recommendations for Expanding Coverage

Families USA has two core goals for health care reform: 1) that everyone who currently has satisfactory health care coverage can keep that coverage, and 2) that those who do not currently have health care coverage can get it. The most effective way to achieve these goals and reform our health care system is to build on and improve what currently works in our system. Health care coverage for Americans under the age of 65 is built on a foundation of two pillars—job-

based health coverage and Medicaid. More than half of the population currently has health insurance through an employer, and Medicaid provides coverage for the low-income children, pregnant women, parents, seniors, and people with disabilities who often lack access to employer coverage and for whom coverage in the individual health insurance market is unaffordable. In our efforts to reform the health care system, it is imperative that we preserve, strengthen, and expand those two pillars as we move forward to cover all Americans.

Therefore, we recommend the following three-pronged framework for expanding coverage as part of health care reform:

- First, health care reform should build on and strengthen Medicaid for people who have low incomes or severe disabilities. Medicaid is a safety net that now covers approximately 60 million people who can't otherwise afford health insurance. But it is a safety net with holes, and it fails to protect many very vulnerable people. We recommend establishing a national eligibility floor for Medicaid for everyone, as well as improving and streamlining the enrollment process.
- Second, we believe that moderate-wage working families should receive significant subsidies to help make insurance premiums affordable. Sliding-scale subsidies are an integral part of the health reform initiative that was established in Massachusetts—an initiative that has enabled Massachusetts to become the state with the highest rate of health coverage in the nation.
- Third, we believe that working families should receive help with out-of-pocket health care costs, such as deductibles and copayments. These costs should be capped, and the cap should be set at a percentage of family income. This will help to ensure that health care is affordable and that medical-related bankruptcies are prevented.

These three recommendations are critical to making health coverage affordable for those who today lack coverage or who are at risk of losing their health coverage. This framework, which uses a hybrid public-private approach to expanding coverage, mirrors key concepts in an agreement that was endorsed by 18 very diverse stakeholders on March 27, 2009. The Health

Reform Dialogue participants included groups representing employers, physicians, nurses, consumers, insurers, public health professionals, and others.[9]

In addition to these three recommendations to address access to quality, affordable health care coverage, Families USA recommends that important improvements be made to the Medicare program especially for seniors and people with disabilities who are low-income. These low-income seniors and people with disabilities are in need of assistance with out-of-pocket health care costs that are increasingly unaffordable.

The following sections provide additional detail regarding Families USA's recommendations.

Expand and Improve Medicaid for Low-Income Individuals

For the lowest-income Americans, the most appropriate vehicle for expanding coverage is undoubtedly the Medicaid program. Health reform must expand and improve Medicaid to ensure that all Americans can have affordable, high-quality health coverage. Medicaid is specifically designed to meet the unique needs of low-income people with complex health care needs, while the private insurance market is not. With respect to coverage for low-income Americans, Families USA recommends: (1) that a national Medicaid eligibility floor be established, (2) that the Medicaid enrollment process be streamlined to facilitate easier enrollment for all eligible individuals, and (3) that provider reimbursement rates be increased to help broaden the provider network and improve access to care.

Why Medicaid?

Medicaid is already the backbone of the health care system for the most vulnerable Americans. It covers approximately 60 million low-income people: 29.4 million children, 15.2 million adults, 6.1 million seniors, and 8.3 million people with disabilities. What's more, it is specifically designed to meet the unique needs of these populations, who tend to be sicker and have more intensive health care needs than the general population.[10]

As with any coverage expansion, special attention will need to be paid to ensuring that the Medicaid delivery system is retooled to handle an increase in the number of Medicaid enrollees

without compromising access to care. However, Medicaid is the most efficient and effective way to cover more low-income Americans who cannot obtain coverage in the private market. Every state already has a Medicaid program with an existing provider network and administrative infrastructure. It makes sense to build on this foundation, particularly since it has a proven track record of effectively serving low-income individuals.

A little-known fact is that Medicaid is actually *more efficient* at covering low-income people than private coverage. After controlling for health status (since Medicaid enrollees tend to have greater health care needs), it costs more than 20 percent *less* to cover low-income people in Medicaid than it does to cover them in private health insurance.[11] In this cost-conscious climate, it only makes sense to expand coverage in the most cost-effective ways possible. The most cost-effective way to expand coverage for low-income uninsured people is Medicaid.

Cost-Sharing Protections

Medicaid includes very important protections against out-of-pocket costs to ensure that these costs do not prevent people from getting the health care services they need. Unlike private health insurance, Medicaid typically does not require premiums or enrollment fees, and there are limits on other forms of cost-sharing. Certain services (preventive care services for children, emergency services, pregnancy-related services, and family planning services) and certain populations (children of certain ages and incomes, foster children, hospice patients, institutionalized patients, and women in the Medicaid breast or cervical cancer programs) are exempt from any kind of cost-sharing, and copayments for individual services are limited to so-called "nominal" amounts of a few dollars or less.

These protections are absolutely imperative to the success of the Medicaid program for low-income people. Low-income adults with private insurance pay more than six times as much for out-of-pocket costs as do low-income adults with Medicaid.[12] There is extensive research that demonstrates the serious burden these out-of-pocket health care costs can pose for low-income people.[13] When people cannot afford these costs, they often delay or forgo care, which can result in more costly complications later on.[14] Because Medicaid incorporates such strong cost-sharing

protections, people enrolled in Medicaid are more likely to get the care they need, when they need it.

Comprehensive Benefits

Medicaid's comprehensive benefit package ensures that the program provides appropriate coverage to people with diverse health care needs. For example, Medicaid has specific protections that are designed to ensure that children get both preventive care and treatments for any health complications they may have (referred to as Early and Periodic Screening, Diagnostic, and Treatment, or EPSDT, services). Medicaid also covers services that low-income people need that are not usually covered in private health insurance. For example, Medicaid covers transportation to doctors' appointments, services that help people with disabilities live independently, and services provided at rural and community health centers. It is unlikely that a private health insurance plan would ever cover these services.

Medicaid is also a key source of coverage for people who are very sick or who have disabilities. While most private health plans have annual or lifetime maximums that people with intensive health care needs can quickly exceed, Medicaid has no such limits. It provides coverage to all those who need it, even people with serious health care problems, whom the private market is simply not interested in serving. Similarly, while private coverage often excludes coverage for pre-existing health conditions, people enrolled in Medicaid are guaranteed to receive the health care services they need, regardless of any past or current health care problems. The Medicaid benefits package is specifically designed to meet the health care needs of low-income individuals, and, as a result, Medicaid enrollees are less likely than both the uninsured *and* those with private coverage to lack a usual source of health care or to have an unmet health care need.[15]

Medicaid Appeal Rights and Protections

Because low-income people cannot afford health care services that are not covered by their insurance, Medicaid's appeal rights are particularly important. These rights ensure that low-income people who are sick can appeal coverage denials without jeopardizing any ongoing treatment. They can also appeal enrollment or eligibility decisions, and they have the right to a

fair hearing. Also, unlike the private health insurance market, there are no pre-existing condition exclusions in Medicaid, nor are there waiting periods before an otherwise eligible person can enroll. Medicaid is guaranteed to be available to all who are eligible; people cannot be turned away because they are sick or have experienced health problems in the past; and they can begin receiving services as soon as they are determined to be eligible. In addition to the cost-sharing protections and the comprehensive benefits package, these design features make Medicaid particularly well-suited to providing coverage to low-income people.

Create a National Medicaid Eligibility Floor

To be eligible for Medicaid under federal law, a person must not only have a low income; he or she must also belong to one of the following Medicaid eligibility categories: children, pregnant women, parents with dependent children, people with disabilities, and seniors. If a person does not fall into one of these categories, he or she can literally be penniless and still be ineligible for Medicaid. Also, because the Medicaid program is a state-federal partnership, states set their own eligibility levels. There are federal minimums, but eligibility levels vary widely from state to state. Only 16 states and the District of Columbia cover working parents with incomes at least up to the poverty level ($18,310 for a family of three), and the national median eligibility level for parents is a mere 67 percent of poverty ($12,268 for a family of three).[16] The picture is even grimmer for low-income adults who do not have dependent children: In 43 states, these individuals are ineligible for Medicaid no matter how low their income. (A table presenting the eligibility levels for these three groups in every state is attached to this testimony.) An estimated 45.1 percent of non-elderly Americans with income below the poverty level were uninsured in 2007.[17]

Health reform offers an opportunity to address these gaping holes in the health care safety net, and to ensure that, in addition to improving coverage for those with moderate incomes, the very lowest-income Americans are covered as well. Families USA recommends that Congress establish a national Medicaid income eligibility floor, below which any individual is guaranteed to be eligible for Medicaid, regardless of age, parental status, or health status. More than one in three uninsured Americans has an income below the poverty level.[18] Establishing a federal floor

for Medicaid—preferably at approximately 133 percent of the federal poverty level—would significantly reduce the rate and number of uninsured Americans.

If a new national eligibility floor is established, the federal government should provide substantial funding assistance rather than relying on the federal-state Medicaid matching formula that is currently in place. There are a number of approaches to how you might restructure the Medicaid federal-state financial partnership; any approach, however, should provide the federal help needed so that the new nationwide eligibility floor is fiscally achievable.

Establishing a national eligibility floor will also involve several important policy decisions with which Congress will have to grapple. These include the following: how a new national floor will affect states that have higher and lower eligibility levels for existing coverage; what funding will be available for coverage above the new floor; and how the new Medicaid coverage will intersect with any new subsidies for the purchase of private health coverage that may be provided to those with low and moderate incomes (see the following sections of this testimony). We urge that in addressing these issues, Congress follow a fundamental principle of "first, do no harm." No harm should come to those who currently rely on Medicaid coverage in the states, or to the fundamental characteristics of the Medicaid program that make it meaningful for low-income people and people with disabilities. Further, states should not be financially harmed by a coverage expansion. We look forward to the opportunity to help staff navigate the issues that may arise in crafting this new policy.

Streamline Medicaid Enrollment and Improve Access to Care

In order to ensure that the new Medicaid expansion enrolls as many eligible people as possible, Families USA recommends that Congress establish a new, simplified enrollment process for both currently and newly eligible people. Experience with the Children's Health Insurance Program (CHIP) has shown the importance of establishing simple, streamlined enrollment policies and procedures to help eligible people get and keep coverage.[19] Examples of these simplifications include allowing 12 months of continuous eligibility to individuals once they are enrolled in Medicaid, minimizing the amount of documentation people need to provide when they apply for

and renew their coverage, eliminating asset tests, allowing application by mail and online, and simplifying the application itself so that it is short and easy to understand.

It will also be crucial that there be coordination between the application process for Medicaid and the subsidy for purchasing private health insurance coverage. Experience tells us that low-income people have fluctuating incomes, and those with incomes "at the margins" may not know in advance for which program they are eligible. It is imperative that any Medicaid expansion and any new program that subsidizes private health coverage for moderate-income individuals require a process for screening applications that includes provisions to facilitate enrollment, such as a "screen and enroll" requirement similar to that in CHIP. Such a requirement would ensure that individuals who apply for the subsidy but who are actually eligible for Medicaid are enrolled in Medicaid, and vice versa. The enrollment process should ensure that the right people get into the right program, and it should not make people jump through unnecessary hoops to do so.

In addition, it will be important to make sure that there are enough providers participating in Medicaid to serve all the enrollees. There are already undeniable problems with provider participation in Medicaid, especially because of the generally lower payment levels to health care providers. This problem needs to be addressed so that Medicaid enrollment results in access to needed care.

Making Health Coverage Affordable in the Private Market

Moderate-income working American families are also struggling to afford health insurance coverage—whether they are offered coverage through a family member's job or are forced to seek coverage in the non-group private market. Even when employers pay a significant portion of the premiums, the share of the premium that working families must pay may be unmanageable. In 2008, the average annual premium contribution for job-based family coverage was $3,354.[20] That's approximately $280 per month in premiums alone. Once additional out-of-pocket costs such as deductibles, copayments, and fees for uncovered services are factored in, even those with high-quality job-based plans may face health care costs that are too great a burden to bear. In 2009, for example, we project that 14.3 million Americans *with insurance* are in families that will spend more than one-quarter of their pre-tax income on health care costs.[21]

Workers without an offer of job-based coverage—and those who cannot afford the out-of-pocket costs associated with their employer's plan—may seek coverage on their own in the individual health insurance market. However, finding an individual insurance plan that meets both their needs and their budget is likely to be extremely challenging. One recent survey found that nine out of 10 people who sought individual coverage never purchased a plan—either because they couldn't find an affordable plan, they were rejected for coverage, or they were offered a plan that excluded coverage for the very care they were most likely to need.

As these data show, hard-working, moderate-income families—both those with an offer of job-based coverage and those who must seek coverage on their own—are likely to have difficulty affording the high cost of quality coverage on their own. To help these families who are above Medicaid eligibility levels, Families USA recommends a system of private market subsidies.

Subsidies for the Purchase of Coverage

To help moderate-income families afford the high cost of premiums—either for insurance through the workplace or in the individual market—subsidies will be essential. Sliding-scale subsidies should be designed to deliver greater assistance to those with greater need, and these subsidies should cover the cost of premiums up-front so that lower-income families with tight budgets do not have to pay for premiums out-of-pocket and wait for reimbursement. In addition, subsidies should be used for coverage that includes comprehensive benefits and protections against high out-of-pocket costs. The subsidy should be large enough to ensure that no individual or family spends more than a specific percent of income on total health care costs, including premiums, cost-sharing (such as copayments and deductibles), and fees for uncovered services. Finally, in order to protect the existing foundation of job-based insurance coverage and help to contain costs, subsidies should be available for job-based coverage when an offer of quality coverage exists.

Assistance for Out-of-Pocket Costs

While the high cost of premiums is undoubtedly a barrier to securing coverage for many moderate-income families, providing insurance coverage alone is not enough to ensure sufficient financial protection. It will be necessary to provide additional assistance with out-of-pocket costs, such as deductibles and copayments, to ensure that these families can both receive and afford the care that they need. This assistance could be provided by in a number of ways. One approach would be to provide subsidized plans with differing cost-sharing protections based on income. Another approach would be to provide one plan and also provide an additional subsidy based on income to help lower-income families cover out-of-pocket costs. The additional out-of-pocket subsidy would be on a sliding scale and protect individuals and families from spending more than a certain percentage of income on the total of their share of premiums plus deductibles, copayments, and other out-of-pocket costs (a cap on out-of-pocket costs based on income). Empirical research shows that reducing cost-sharing helps to ensure that lower-income people are able to obtain necessary care.[22]

Creating a Fair Marketplace for the Subsidies

In order to ensure that each person with a subsidy can use this subsidy to purchase quality coverage at a fair, affordable price, some key insurance market reforms must be implemented. First and foremost, insurers must provide an offer of coverage to all applicants regardless of health status, age, or other factors. In addition, the coverage offered must meet certain standards to ensure that federal subsidies are purchasing quality, cost-effective coverage. The federal government, together with states, should oversee this system to be sure that public dollars actually go to health care and that companies do not make unreasonable profits. Plans must include comprehensive benefits, and premiums should not discriminate against people because of health status, age, or other factors. To facilitate the comparison and selection of plans, a health insurance "exchange" or "connector" would be invaluable. Creating an exchange would help to facilitate the presentation of basic information on different plans, such as benefits packages, out-of-pocket costs, and coverage limitations, in a clear, consumer-friendly way.

Improvements to the Medicare Program

Low-income seniors and people with disabilities also are in need of assistance with health care costs. Although these groups have coverage through Medicare, they must pay sizable Medicare premiums. Moreover, they can incur substantial out-of-pocket costs in the form of cost-sharing for in-patient and outpatient services when they develop serious illnesses.

Over the past two decades, Congress has created several programs to serve low-income Medicare beneficiaries. There are three Medicare Savings Programs (MSPs): Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualified Individual (QI). These programs, which are administered by state Medicaid programs, cover the Medicare Part B premium (currently $96.40/month) for people whose incomes are too high to qualify for Medicaid. The QMB program also covers beneficiaries' cost-sharing under Medicare Parts A and B, which can run into the thousands of dollars for people with substantial health care needs.

The Part D Low-Income Subsidy (LIS) was created in 2003 as part of the Medicare prescription drug benefit. The LIS pays for Part D premiums and other out-of-pocket costs and, perhaps most importantly, it protects low-income beneficiaries from falling into the infamous coverage gap (known colloquially as the "doughnut hole").

Both the Medicare Savings Programs and Low-Income Subsidy program have the potential to be of enormous help to low-income seniors. However, the programs have several flaws. First, the income eligibility standards for these programs are relatively low. Worse, these levels differ from each other, which causes confusion. The QMB program (the one that provides help with deductibles and copayments as well as with premiums) is available only to seniors and people with disabilities whose incomes are below the poverty line – $10,830 in annual income for an individual, $14,570 for couples. The SLMB program's income limit is 120 percent of the poverty line; QI extends eligibility to 135 percent of poverty; and the LIS limits eligibility at 150 percent of poverty.

Second, all of the programs have asset tests whose eligibility levels are so low that they disqualify Medicare beneficiaries who have even very modest savings. Although we applaud Congress for increasing and, at last, indexing asset limits for the MSPs as part of last year's Medicare Improvements for Patients and Providers Act (MIPPA), the level of qualifying assets is still quite low. Even taking the MIPPA improvements into account, asset limits for MSPs next year will be slightly above $8,100 for an individual and $12,910 for a couple.[23] In LIS, individuals with assets over $12,510 or couples with more than $25,010 are disqualified from even a partial subsidy. The assets eligibility test not only disqualifies many low-income Medicare beneficiaries from getting the subsidies they need. It also establishes a very cumbersome process requiring substantial documentation, thereby making it difficult for low-income seniors and people with disabilities to gain access to these important programs.

Finally, a substantial number of low-income seniors and people with disabilities who are eligible for the MSP and LIS programs are not participating in them. Simplification and alignment of the programs could substantially improve enrollment. In addition, cooperation among federal agencies and states could better target outreach and enrollment efforts.

Families USA urges Congress to include improvements to the programs serving low-income Medicare beneficiaries as part of health care reform. In particular, the following:

- Income eligibility levels should be increased for MSPs and the LIS and the levels should be aligned across the programs.
- The asset limits should be eliminated, or at a minimum, substantially increased, and should likewise be aligned across all programs.
- Include administrative simplifications and require inter-agency cooperation at both the federal and state levels to substantially increase enrollment.

In conclusion, health care reform presents a tremendous opportunity to move forward and provide quality, affordable health coverage to everyone in our country—and to do so within the framework of our uniquely American system. Families USA believes that we can build on the

best of what we have today by melding both public and private approaches so that the strengths of each are preserved and fostered.

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[1] Kim Bailey, *Americans at Risk: One in Three Uninsured* (Washington: Families USA, March 2009).
[2] Ibid.
[3] Families USA calculations based on Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2000 Annual Survey* (Washington: Kaiser Family Foundation, 2000) and Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2008 Annual Survey* (Washington: Kaiser Family Foundation, September 2008).
[4] Ibid.
[5] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2008 Annual Survey*, op. cit.
[6] Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer, Key Facts about Americans without Health Insurance* (Washington: Kaiser Family Foundation, October 2008); The Urban Institute and the University of Maryland, Baltimore County, *Uninsured Americans with Chronic Health Conditions: Key Findings from the National Health Interview Survey* (Washington: Robert Wood Johnson Foundation, May 2005).
[7] Jack Hadley and John Holahan, "How Much Medical Care Do the Uninsured Use, and Who Pays For It?" *Health Affairs* Web Exclusive (February 12, 2003): W3-66-W3-81; Jack Hadley and John Holahan, *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending? Issue Update* (Washington: Kaiser Family Foundation, May 2004). See also Kathleen Stoll, *Paying a Premium: The Added Cost of Care for the Uninsured* (Washington: Families USA, June 2005).
[8] Kathleen Stoll, *Paying a Premium: The Added Cost of Care for the Uninsured*, op. cit.
[9] Organizations participating in the Health Reform Dialogue include the following: AARP, Advanced Medical Technology Association, America's Health Insurance Plans, American Cancer Society Cancer Action Network, American College of Physicians, American Hospital Association, American Medical Association, American Nurses Association, American Public Health Association, Blue Cross and Blue Shield Association, Business Roundtable, Catholic Health Association of the United States, Families USA, Federation of American Hospitals, Healthcare Leadership Council, National Federation of Independent Business, Pharmaceutical Research and Manufacturers of America, and U.S. Chamber of Commerce. A copy of the Health Reform Dialogue agreement is available online at http://www.familiesusa.org/assets/pdfs/health-reform/09healthreformdialogue.pdf.
[10] Teresa A. Coughlin, Sharon K. Long, and Yu-Chu Shen, "Assessing Access to Care under Medicaid: Evidence for the Nation and Thirteen States," *Health Affairs* 24, no. 4 (July/August 2005): 1073-1083.
[11] Jack Hadley and John Holahan, "Is Health Care Spending Higher under Medicaid or Private Insurance?" *Inquiry* 40, no. 4 (Winter 2003/2004): 323-342; Leighton Ku and Matt Broaddus, "Public and Private Insurance: Stacking Up the Costs," *Health Affairs* 27, no. 4 (July/August, 2008): w318-w327.
[12] Leighton Ku and Matt Broaddus, op. cit.
[13] Leighton Ku, *The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings* (Washington: Center on Budget and Policy Priorities, May 2005).
[14] Key Findings of the RAND Health Insurance Experiment Study are described in Geri Dallek, *A Guide to Cost-Sharing and Low-Income People* (Washington: Families USA, October 1997).
[15] Kaiser Commission on Medicaid and the Uninsured analysis of 2007 National Health Interview data.
[16] Families USA calculations.
[17] Kaiser Family Foundation, StateHealthFacts.Org, "Health Insurance Coverage of Adults 19-64, states (2006-2007), U.S. (2007)," available online at http://www.statehealthfacts.org/comparebar.jsp?cat=3&ind=130&typ=2&gsa=1.
[18] Kaiser Family Foundation, StateHealthFacts.Org, "Distribution of the Nonelderly Uninsured by Federal Poverty Level (FPL), states (2006-2007), U.S. (2007)," available online at http://www.statehealthfacts.org/comparebar.jsp?cat=3&ind=136&typ=2&gsa=1.

[19] Victoria Wachino and Alice Weiss, *Maximizing Kids' Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling and Retaining Eligible Children* (Washington: National Academy for State Health Policy, February 2009).
[20] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2008 Annual Survey*, op. cit.
[21] Kim Bailey and Laura Parisi, *Too Great a Burden: Americans Face Rising Health Care Costs* (Washington: Families USA, April 2009).
[22] Julie Hudman and Molly O'Malley, *Health Insurance Premiums and Cost Sharing: Findings from the Research on Low-Income Populations* (Washington: Kaiser Commission on Medicaid and the Uninsured, March 2003).
[23] The asset level increases under MIPPA take effect in 2010. The $8,100 and $12,910 asset levels cited in the text are the eligibility levels for the full LIS, which would apply to MSPs if the MIPPA provisions were in effect this year. The actual asset limits in 2010 will be slightly higher because they will be adjusted for inflation. The actual asset limit for MSPs in 2009 is still $4,000 for an individual and $6,000 for a couple.

WRITTEN COMMENTS

OF

SANDY PRAEGER

COMMISSIONER OF INSURANCE

STATE OF KANSAS

ON BEHALF OF

THE NATIONAL ASSOCIATION OF

INSURANCE COMMISSIONERS

FOR THE

SENATE FINANCE COMMITTEE

ROUNDTABLE DISCUSSION ON

"Expanding Health Care Coverage"

May 5, 2009

INTRODUCTION

My name is Sandy Praeger and I am the Insurance Commissioner of the State of Kansas and Chair of the Health Insurance and Managed Care Committee of the National Association of Insurance Commissioners (NAIC). The NAIC represents the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories. The primary objective of insurance regulators is to protect consumers and it is with this goal in mind that I submit these comments today on behalf of the NAIC. And I would like to thank you for this opportunity to discuss an issue that is important to all Kansans and all Americans – expanding health care coverage.

To begin, the members of the NAIC recognize the failures in the current market - they are well documented. Over 15 percent of Americans, almost 46 million people, go without coverage. For most, coverage is simply too expensive, a result of medical spending that has run out of control and consumes 16 percent of our economy. For others, those without coverage through an employer and with health problems, coverage is not available at any price. For Americans lucky enough to have insurance, premiums take ever larger bites out of the monthly paycheck, even as rising deductibles and co-payments shift more of the financial burden of sickness to the patient. Insurance Commissioners see this every day, and we welcome Congress' interest in helping the states tackle this challenge.

State insurance commissioners believe it is important to ensure that affordable, sufficient health coverage is available to small business owners, their employees, and individuals. The NAIC offers its full support in developing federal legislation that will reach this goal - a goal that can only be attained through federal-state coordination. We offer the

experience and expertise of the states to Congress as it attempts to improve the health insurance marketplace.

Based on that experience and expertise, we encourage Congress to consider these four keys for successful health insurance marketplace reform:

Protect the Rights of Consumers. States already have the patient protections, solvency standards, fraud prevention programs, and oversight mechanisms in place to protect consumers; these should not be preempted by the federal government. As the members of this committee know all too well, the preemption of state oversight of private Medicare plans has led to fraudulent and abusive marketing practices that would have been prevented under state law, bringing considerable harm to thousands of seniors. We urge federal policymakers to preserve state oversight of health insurance and avoid preempting or superseding state consumer protections, or interfering with state oversight.

Address Health Care Spending. Any effort to increase access to insurance will not be successful over time unless the overriding issue of rapidly rising health care costs is also addressed. While the health care challenge in this country is generally expressed in terms of the number of Americans without health insurance coverage, the root of the problem lies in the high cost of providing health care services in this country. According to the most recent National Health Expenditures data, health care spending reached $2.2 trillion in 2007, 16.2 percent of GDP and $7,421 for every man, woman and child in the United States.[1] This level is twice the average for other industrialized nations.

[1] Centers for Medicare and Medicaid Services, National Health Expenditures

This level of health care spending has badly stressed our health care financing system. Health insurance reform will not solve this problem, since insurance is primarily a method of financing health care costs. Nevertheless, insurers do have a vital role to play in reforms such as disease management, enhanced use of information technology, improved quality of care, wellness programs and prevention, and evidence-based medicine—all of which have shown promise in limiting the growth of health care spending. Whatever is done in insurance reform should be done in a manner that is consistent with sound cost control practices.

Avoid Adverse Selection. Any program that grants consumers the choice between two pools with different rating, benefit, or access requirements will result in adverse selection for one of the pools. For example, if a national pool does not allow rating based on age or health status, while the state pool does allow rating based on those factors, then the national pool will attract an older, sicker population. Such a situation would be unworkable. While subsidies or incentives could ameliorate some of the selection issues, as costs continue to rise and premiums increase, the effectiveness of such inducements could erode. As for proposals that could result in severe adverse selection, such as guaranteed issue and elimination of preexisting condition exclusions for individuals, State regulators can support these reforms to the extent they are coupled with an effective and enforceable individual purchase mandate and appropriate income-sensitive subsidies to make coverage affordable.

Preserve a Strong State Role. Congress must carefully consider the impact of any new federal reforms on the states' ability to be effective partners in solving the health care

crisis. In developing a national direction for health insurance reform, we encourage Congress to develop broad standards rather than prescriptive rules wherever possible to maximize state flexibility to implement reforms in a manner that is responsive to local and regional market conditions. This includes the design and administration of the exchanges, expansion of assistance to low-income persons, and development of cost containment strategies, among other areas. State regulators also caution against implementing reforms that would limit the ability of states to provide more protections for their consumers.

We also note that states can, and should, play a key role in deciding how reforms will be phased-in to ensure the least amount of negative disruption. The fact is states will be starting from different positions. For example, the difficulty of transitioning to a marketplace that is guarantee issue with no pre-existing conditions and adjusted community rating, as has been discussed by many federal policymakers, will vary from state-to-state. A few states have already adopted similar standards. Most states have not adopted these provisions, especially in the non-group market, and will need to make significant changes to meet new federal requirements. If implemented all at once, these changes could cause severe market disruption as young, healthy individuals find their premiums increasing several hundred dollars per month and may drop out of their coverage. If spread out over a period of years, however, the transition could be more smoothly implemented, especially if they are accompanied by subsidies.

Any federal changes to access or rating rules should set a goal for states to attain and a deadline for attaining it, but leave the mechanics of the transition up to the individual states.

CONCLUSION

Years have been spent talking about broad health care reforms that will ensure that all Americans have access to affordable health insurance coverage and the peace of mind that goes with it. Action is long overdue and we stand ready to assist in whatever way we can.

The NAIC encourages Congress and the Members of this Committee to work with states and learn from past reforms. Together, we can implement successful initiatives that will truly protect and assist all consumers.

THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER
WASHINGTON DC

SCHOOL OF PUBLIC HEALTH & HEALTH SERVICES
DEPARTMENT OF HEALTH POLICY

Statement of Sara Rosenbaum, J.D.
Harold and Jane Hirsh Professor of Health Law and Policy
Chair, Department of Health Policy
The George Washington University School of Public Health and Health Services

United States Senate, Committee on Finance,
Roundtable on Health Care Coverage

May 5, 2009

Mr. Chairman and Distinguished Committee Members:

It is an honor to be part of this morning's national health reform roundtable, which explores three issues related to health care coverage: How can coverage be made more affordable and workable for individuals and small businesses? What are the roles and responsibilities of individuals, employers, and government in achieving health coverage for all Americans? What role should public programs play? I begin with a general observation and then turn to the specific questions.

General Observations

In my view, Congress should care deeply about the issue of coverage because the overarching goal of reform is a health system in which all persons, regardless of wealth, place of residence, or other factors unrelated to need, receive appropriate health care. As Chairman Baucus has underscored in his own report, *Call to Action,* coverage is integral to accessible and high quality health care. The need to focus on appropriate care as the end result is particularly important in the case of certain types of care that bear fundamentally on health, such as: pregnancy-related care, that is, preconception and interconception care that allows women to maintain optimal health during their reproductive years;[1] the care of children, whose healthy growth and development depends not only on primary preventive services but also on treatments to ameliorate physical and mental health conditions; effective clinical preventive treatments for people of all ages;[2] and the care and services to allow people living with chronic physical, mental, and behavioral health conditions to maintain optimal health and avoid loss of function.[3]

To be sure, coverage is not the only intervention essential to achieving this overarching goal. Foundational to success are direct investments to create health care access in medically

[1] Wendy Chavkin et al., *Women's Health and Health Care Reform* (Columbia University, New York, NY 2008).
[2] Sara Rosenbaum and Paul H. Wise, "Crossing The Medicaid–Private Insurance Divide: The Case Of EPSDT," *Health Affairs*, March/April 2007; 26(2): 382-393.
[3] Richard Kronick et al., *The Faces of Medicaid: Recognizing the Care Needs of People with Multiple Chronic Conditions* (Center for Health Care Strategies, 2007) http://www.chcs.org/publications3960/publications_show.htm?doc_id=540806 (accessed April 26, 2009).

underserved urban and rural communities, build a highly trained workforce, spur the adoption and use of information technology, incentivize system reforms to achieve greater efficiencies,[4] generate and apply information on the comparative effectiveness of health care, and stimulate broader public health investments in families, communities, and populations.[5]

In truth, however, in a health care system that is market-based, reform begins with attaining and sustaining good health insurance coverage over time, since it is through insurance coverage that most Americans pay for care. Because health insurance is integral to health care use, our relationship with health insurance is fundamentally different from our interaction with other forms of insurance. For example, when people insure their homes or their cars, their greatest hope is that they will never need to use their coverage. But while good health and the avoidance of illness and disability certainly are universal aspirations, people need health insurance precisely because it *enables* the use of health care, particularly primary and preventive care that help attain and maintain health and avert deterioration in health. Thus, while some focus on the "moral hazard" associated with over-insurance, the current epidemic of under-insurance in the U.S. and its consequences[6] suggest the nation suffers from the opposite problem,[7] one driven by the cost of care as well as a systemic inability to effectively manage the health care risks associated with sickness. In my view, the true moral hazard has been the national failure to come to grips with these problems, and I applaud the Committee for its dedication to finding answers. Indeed, in a nation in which the simple act of immunizing one's child cost more than $1,600 in 2007,[8] even care that is basic to health lies beyond the reach of uninsured and under-insured Americans.

How Can Health Insurance Be Made More Affordable and Workable for Individuals and Small Employers?

In my view, the approach set forth in the *Call to Action,* which involves the establishment of a health insurance exchange to serve individuals and small employers, would make a significant inroad on several fronts. First, if designed to operate nationally, an exchange would foster stability and portability of coverage (state administration is, of course, an option if carried out under uniform requirements). Second, a national exchange could, over time, enhance market power, pooling resources across millions to promote system reform, with more focused efforts to promote the right kind of care and payment.

Third, and in some ways most significantly in the context of today's roundtable, a national exchange, by pooling risk, would reduce the terrible tendency of today's health

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[4] David Blumenthal et al., *Health Information Technology: The Information Base for Progress* (Robert Wood Johnson Foundation, 2006) http://www.rwjf.org/pr/product.jsp?id=15895 (accessed April 26, 2009).

[5] Robert Wood Johnson Foundation, Commission to Build a Healthier America, *Beyond Health Care: New Directions to a Healthier America*, (2009) http://www.commissiononhealth.org/ (accessed April 26, 2009); Trust for America's Health, *Blueprint for a Healthier America* (2008) http://healthyamericans.org/report/55/blueprint-for-healthier-america (accessed April 26, 2009).

[6] Cathy Schoen et al., "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs*, July/August 2008; 27(4): w298-w309.

[7] See generally, Timothy Stoltzfus Jost, *Health Care at Risk: A Critique of the Consumer Driven Movement* (Duke University Press, Durham, NC, 2007).

[8] Andrew Pollack, "Pediatricians Voice Anger over the Cost of Childhood Vaccines," *New York Times* (March 24, 2007).

insurance market to discriminate against the sick.[9] It is the need to ensure access to effective care when we are sick – something that is significantly less likely to happen appropriately in the U.S. than in other wealthy nations today[10] – that makes resolving our crisis so urgent.

In order to achieve the power of pooling, I recommend making insurance available through a national exchange to individuals and small employers, defined as firms with fewer than 200 full-time-equivalent employees. This definition of "small" is used in major national surveys that assess employer-sponsored health insurance practices.[11] Although sixty percent of the 3 million U.S. firms that employ workers have nine or fewer workers,[12] the concept of "small" in the context of sickness should be substantially larger in my view, in order to position the nation for meaningful relief over time. Indeed, my own very large employer, The George Washington University, has found its premium rates affected by a handful of employees' adverse health events.

The importance of a large purchasing pool is a direct outgrowth of the fundamental concepts on which the insurance market rests. In legal parlance, insurance sold in the marketplace is a contract of risk, with sellers operating on the basis of actuarial principles, one of whose core precepts is the concept of "fair discrimination," meaning similar classification of like risks.[13] In significantly unregulated health insurance markets, it has become virtually impossible for individuals or small groups to secure insurance at affordable rates. Furthermore, the problems created by inadequate risk-spreading mechanisms translate into more than coverage at a high cost; they also encourage the use of shielding techniques – *both prior to and following enrollment* – the purpose of which is to avoid individuals whose actual or perceived health creates a risk of health care use. The irony of course, is that the use of health care is precisely the behavior that health care experts typically want to encourage.

The first set of risk-shielding techniques, which has received a fair amount of attention in the literature and in the law, involves the use of enrollment exclusions to bar coverage of sick people – or people regarded as sick in accordance with actuarial principles – at the point of enrollment. Examples are the total exclusion of individuals with pre-existing conditions; medical underwriting at the point of enrollment to classify risks and set insurance rates; post-claims medical underwriting to eliminate sick people after the fact; imposition of excessively high premiums on people with certain health conditions; or the imposition of long waiting periods

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[9] Deborah Stone, "Protect the Sick: Health Insurance Reform in One Easy Lesson," *Jour. Law, Medicine and Ethics: Health Reform* (Sara Rosenbaum and Jeanne Lambrew, ed.) (Winter, 2008) pp. 652-659.

[10] Cathy Schoen et al., "In Chronic Condition: Experiences of Patients with Complex Health Care Needs in Eight Countries," *Health* Affairs, 2008 w1-w16 http://content.healthaffairs.org/cgi/reprint/28/1/w1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=Schoen&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT (accessed April 26, 2009).

[11] Kaiser Family Foundation, *Employer Health Benefit Survey* (2008) http://ehbs.kff.org/ (accessed April 25, 2009).

[12] Id. at http://ehbs.kff.org/?page=charts&id=1&sn=1&p=3 (accessed April 26, 2009).

[13] Rand Rosenblatt, Sylvia Law and Sara Rosenbaum, *Law and the American Health Care System* (Foundation Press, New York, NY 1997; 2001-2002 Supplement); Sara Rosenbaum, "Insurance Discrimination on the Basis of Health Status: An Overview of Discrimination Practices, Federal Law, and Reform Options," *Georgetown University O'Neill Institute for National and Global Health Law* (2009). http://www.law.georgetown.edu/oneillinstitute/projects/reform/Discrimination.html (accessed April 26, 2009).

prior to the commencement of coverage.[14] Congress has taken preliminary steps, principally through the Health Insurance Portability and Accountability Act of 1996, to address these behaviors; further reforms are essential to ending enrollment-related insurance discrimination.

The second set of techniques that also bear directly on the questions posed today come into play post-enrollment and serve to further underscore the need for large pools. These techniques have received less attention in federal law; indeed, discrimination against the sick in the design of health insurance has been held to be exempt from the reach of the Americans with Disabilities Act (ADA); other laws aimed at lessening post-enrollment discrimination, such as the Paul Wellstone Mental Health Parity and Addiction Equity Act of 2008, while important first steps, are limited in scope.

Discriminatory coverage techniques that take place post-enrollment fall under the overall rubrics of *plan design* and *plan administration*; it is these techniques in my view that have helped create a 60% increase between 2003 and 2007 in the proportion of individuals who can be considered under-insured because their coverage falls seriously short of their health care needs.[15] While the cost of health care is certainly a major cause of under-insurance, it is by no means the only cause. It is no coincidence, in my view, that as federal laws aimed at curbing discrimination at the point of enrollment have taken effect, the health benefits industry has focused increasing attention on the matter of coverage itself, developing mechanisms for curbing coverage, once attained, and thereby shifting financial risk back onto sick people. Indeed, these two types of discrimination – pre-enrollment and post-enrollment – are inextricably intertwined, and too-small risk pools offer fertile ground for both to flourish.

Post-enrollment discrimination against the sick can take many forms: very low annual or lifetime limits on certain aspects of coverage, such as behavioral disorders or HIV/AIDS; limited or no coverage of clinical preventive services that involve screening for costly conditions and whose use in the absence of health insurance is highly price-sensitive; the exclusion of certain conditions from coverage entirely, even though there are effective treatments; the refusal to pay for more than limited treatments for certain conditions; the use of restrictive prescription drug formularies; the use of restrictive practice guidelines that lack a reliable basis in evidence; medical necessity definitions that penalize and discriminate against children and adults whose conditions are developmental rather than the result of acute injury or illness from which "recovery" is possible (e.g., defining speech therapy as therapy needed to restore speech, thereby excluding speech therapy for children born with cerebral palsy and the developmentally delayed); excessive cost-sharing for certain conditions (e.g., very high copayments for expensive cancer drugs); excessively burdensome and virtually un-navigable utilization management techniques; restrictions on access to certain types of health care providers with expertise in management of certain conditions; and low provider payment standards that disincentivize participation in networks, thereby shrinking access to primary and specialty care.

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[14] See review of federal laws regulating insurance discrimination, as well as relevant judicial decisions, in Sara Rosenbaum, Insurance Discrimination on the Basis of Health Status, supra note 13. For an excellent analysis of insurance discrimination using cancer as the analytic framework, see Kaiser Family Foundation and American Cancer Society, *Spending to Survive: Cancer Patients Confront Holes in the Health Insurance System* http://www.kff.org/insurance/upload/7851.pdf (accessed April 26, 2009).

[15] See Schoen, "How Many Are Underinsured?" Supra note 6.

The use of post-enrollment techniques to discriminate against the sick was best captured in a landmark 1999 federal appeals court decision, *Doe v Mutual of Omaha,*[16] which held that the ADA's prohibition on disability discrimination does not reach the health insurance content. In its brief in support of its right to discriminate, the insurer expressly stipulated that it "has not shown and cannot show that its AIDS caps are or ever have been consistent with sound actuarial principles, actual or reasonably anticipated experience, bona fide risk classification, or state law."[17] It is difficult to imagine a clearer admission that there is no basis in evidence for what can only be described as an intentional decision to limit the value of health insurance for certain groups of sick people and to push the financial risk back onto individual patients. I have no doubt that there are numerous individual health insurers today at the forefront of efforts to design and administer insurance products in ways that advance rather than impede health; by contrast, the problem I describe here is systemic.

Large pools can create the type of stable enrollment typical of large groups to help alleviate the potential profitability of short and frequently interrupted enrollment periods. But also essential are significant ground rules for defining coverage within health insurance products certified to be sold in an exchange. Whether these ground rules are shaped by Congress or delegated to an expert panel, they should cover certain dimensions of coverage and plan administration: a broad range of benefit classes and benefit definitions; a medical necessity definition that does not exclude children and adults with developmental conditions or those who will never "recover" but for whom health care can ameliorate the burden of illness; a definition of medical necessity for women's health that ensures their ability to develop and maintain good health during reproductive years and to age well, with a similar definition fashioned for men's health; coverage of clinical preventive interventions determined to be effective in identifying and managing health, such as immunizations recognized by the Advisory Committee on Immunization Practices and the U.S. Preventive Services Task Force; a requirement that treatment approval and coverage design employ practice guidelines (particularly those used to set across-the-board treatment limits such as those found in *Doe v Mutual of Omaha)* that rest on objective evidence rather than prejudice against certain people; fair payment and provider network practices; and fair and efficient utilization management.

What are the Roles and Responsibilities of Individuals, Employers, and Government in Achieving Greater Coverage?

Everyone has a role and a responsibility in supporting the cost of health insurance.

Individuals. In certain nations that have experienced national health reform, costs are borne through national tax policy;[18] coverage is not conditioned on payment of premiums, cost-sharing at the point of care may be low, and overall financial exposure is controlled. The U.S. has elected to use premiums, as well as considerable levels of cost sharing (in the form of deductibles, coinsurance and copayments), restrictions of coverage design (which in turn create

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[16] *Doe v Mutual of Omaha Ins. Co*, 179 F. 3d 557 (7th Cir., 1999), reh. and suggestion for reh. en banc. denied; *cert. den., Doe v Mutual of Omaha Ins. Co.*, 528 U.S. 1106 (2000).

[17] *Doe*, 179 F. 3d at 558.

[18] Timothy Stoltzfus Jost, *Disentitlement: The Threats Facing our Public Health Programs and a Rights Based Response* (Oxford University Press, 2003).

cost-sharing liability), and annual and lifetime limits on coverage. As a result, when combined with shrinking benefits, the already high rate of under-insurance (measured by experts as financial exposure above 10% of family income or 5% of family income in the case of low income families) has shot up precipitously in recent years.[19]

All forms of financial responsibility should be considered when designing the individual responsibility component of health reform, particularly if the minimum benefit design is relatively modest. Under such a scenario, costs for sicker members will remain excessively high if cost-sharing protections are not included.

The first consideration is premiums. Affordability of premiums declines both relatively and in absolute terms as family income declines. For persons with monthly family incomes at or below twice the federal poverty level (approximately $2,755.00 monthly gross income for a family of 4), premiums should set at a zero contribution level, with a gradual decline in subsidies for families with incomes between twice and four times the federal poverty level. Research has shown that premiums of more than 1% to 2% of family income are sufficient to deter enrollment among low income families,[20] whose economic circumstances place them in a position of subsistence, particularly in more urbanized areas. Indeed the National Governors Association (NGA) has reported that in 33 states and more than 1,200 cities and counties, the Fair Market Rent is more than twice the prevailing minimum wage.[21]

The second consideration is cost-sharing at the point of care, where too-high exposure can deter precisely the types of preventive and health maintenance treatments that national policy should seek to encourage. For low income and moderate income families (with monthly family incomes below 400% of the federal poverty level), deductibles and cost sharing must be kept low, with total exemptions for preventive services and chronic health management services. For all but the wealthiest families, the total financial out-of-pocket maximums in any year optimally should be allowed to climb to no more than 5% of family income. In the case of higher income families, presumably plans offered to them through an exchange would be much like product offerings today, with a tradeoff built into plan offerings between lower premiums and higher cost-sharing on the one hand, and higher premiums and lower cost sharing on the other.

Employers: The evidence suggests high variability – both within and across employers and by firm type and employee group size – in the proportion of premium that is borne by employers.[22] The objective in designing policy where employer contributions are concerned should be an expectation of a fair, minimum employer contribution level by firm size and average payroll worker wage, so that the playing field is more level. Presumably many small private employers may continue to offer health benefit plans under ERISA and may continue to elect to subsidize worker premiums well beyond this minimum level. But the expectation should be that employers that do not do so will contribute to an exchange and at a minimum level

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[19] See Schoen, "How Many Are Underinsured?" Supra note 6.
[20] Leighton Ku and Teresa Coughlin, "Sliding Scale Premium Health Insurance Programs: Four States' Experiences," *Inquiry,* Winter 1999/2000.
[21] NGA, Center for Best Practices, Increasing Access to Housing for Low Income Families (2002) http://www.nga.org/Files/pdf/032902HOUSING.pdf (accessed April 24, 2009).
[22] Kaiser, *Employer Health Benefit Survey*, supra note 11.

considered fair. It is this sense of fairness, not high contributions, that currently is lacking. Failure to ensure a minimum level of employer responsibility undoubtedly will further erode the employer-sponsored market in years to come, as employers who have contributed to employee coverage out of a moral sense of obligation continue to pull back from doing so.

Government. The role of government is of course foundational. It is government that continues to sustain Medicare and (presumably) to support an expanded Medicaid program for eligible populations. It is government that establishes and operates the exchange system, government that sets minimum design and administration standards for health benefit services plans sold to both employers and individuals who purchase through an exchange, and the government that certifies plans as qualified to participate in the exchange and oversees and reports on all phases of plan and system performance. It is government that will provide the subsidies that will make coverage affordable to employers and individuals who purchase coverage through a health insurance exchange, and it is government that through tax policy makes health insurance affordable to employers and employees who elect to maintain coverage arrangements outside the exchange. Finally, it should be government that will set the coverage ground rules for health plans that elect to sell in an exchange and that concomitantly shield insurers from excessively high medical losses incurred by sick enrollees who have reached their own out-of-pocket maximums as well as what is considered to be the limits of insurability. In essence, where health reform is concerned, the role of government under the model now under extensive Congressional review is to create, foster, and stabilize a vibrant, stable, and effective health insurance market.

What is the Role of Public Health Insurance Programs?

The third question focuses on the role of public insurance, specifically Medicare, Medicaid and CHIP. I focus my remarks on Medicaid and CHIP.

CHIP. The Children's Health Insurance Program represents an important and prescient decision by Congress to utilize government to develop a stable and affordable health insurance market for children. Viewed in this context, the mission of CHIP is highly similar to the mission of a health insurance exchange. Presumably, as a subsidy system is extended to entire families, not only pregnant women and children, the need for a separate mechanism for creating stable and affordable coverage solely for people of certain ages or with certain health conditions will recede. My recommendation would be the absorption of CHIP into the exchange subsidy system at such a time that exchanges are fully functioning and able to offer families certified health plans that meet essential requirements for the coverage of children, as noted above. These requirements, at a minimum, consist of the benefits found in CHIP today, as well as a pediatric medical necessity standard that emphasizes both health care interventions aimed at promoting growth and development as well as interventions necessary to the amelioration of physical, developmental, and mental conditions in children.

Medicaid. Medicaid is a far more complex question, and any thoughts offered to this Committee should be viewed as "opening gambits" in a lengthy process of knitting together a health care system that ultimately will consist of four major sponsors of health benefit plans for the population, virtually all of which are linked to "networked" service delivery arrangements – Medicaid, employer-sponsored coverage, coverage sponsored by a national exchange, and (to a

lesser extent, perhaps, where care through networks is concerned) Medicare. Since its 1965 enactment, Medicaid's evolution has been profound, as one might expect for a program that has been termed by one expert as the "Atlas" of the health care system.[23] Medicaid's functions are enormous, and its contribution to the health care system, incalculable. Aligning Medicaid and a health insurance exchange will take many years, but as the exchange becomes established and operational, certain possibilities come into clear view.

Medicaid plays five critical roles in my view. Its first is as a primary source of health insurance for millions of children and adults without access to coverage. This role increasingly takes the form of sponsored coverage through participating health plans (much as the exchange would sponsor enrollment into certified health benefit plans) as a result of the Medicaid managed care reforms that began in the 1980s.[24] Chairman Baucus' proposal to eliminate categorical restrictions on coverage of the low income population is a long-overdue and much heralded reform.

Medicaid's second role, as a result of its special rules on third party liability, is as a secondary payer for persons who have primary insurance through other sources (e.g., Medicare, employer-sponsored coverage, veterans' health care) but whose needs transcend the limits of even a generous plan. Mr. Grassley's leadership on the Family Opportunity Act is an example of the incredible importance of efforts to make Medicaid work in tandem with and a supplement to other forms of coverage.

Medicaid's third role is as a supporter of the public health infrastructure through its special relationships with public health agencies. Health care experts focus on the conduct of the health care system. Public health experts focus on the conduct of individuals, families, communities, and the population. It is often Medicaid that, through payment for public health nursing, the services of public health laboratories, home visitors, health departments, and other activities, serves as the bridge between changes in health care and changes in families, communities, and the population. This work is so integral to population health goals that Congress' highest aim should be its expansion.

Medicaid's fourth role is as an enabler of other critical social goals, such as child welfare, the education of children with disabilities, the treatment of serious mental illness and addiction disorders, the community integration of children and adults with disabilities, and long term care for the elderly. Medicaid enables these social goals by paying for health care (personal attendants, private nurses, long term therapies, case management, and alternatives to institutional care) that no ordinary insurer – not even a good insurer – would pay for, and paying for health care in settings (schools, public housing and homeless shelters, early intervention child care programs, homes) that no other insurer would recognize.

Medicaid's fifth role is as supporter of the health care safety net – federally qualified health centers, children's hospitals, rural health clinics, school health programs, and public hospitals – without which millions of low income and vulnerable children and adults (especially those living in medically underserved communities) would lack access to both primary and

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[23] Alan Weill, "There's Something About Medicaid," *Health Affairs,* Jan./Feb. 2003, 22:1, 13-30.
[24] Sara Rosenbaum, "A Look Inside Medicaid Managed Care," *Health Affairs,* July/August 1997, 16:4, 266-271.

specialized care. Medicaid supports these providers in three important ways: through the recognition of the special costs that such providers incur (such as translation and patient support); through special payments such as the FQHC and RHC prospective payment system or disproportionate share payments to public hospitals and children's hospitals; and through the coverage of a high volume of patients served by these providers. Congress has long recognized the vital nature of this relationship between the health care safety net and Medicaid; indeed, the recent Medicaid HIT adoption amendments aimed at spurring adoption within the health care safety net represents the most recent evidence of Congress' desire that this relationship flourish. My school's own recent study of the role played by health centers in the wake of Massachusetts' landmark reform efforts underscores the importance of Congressional policy in this area.[25]

The question is how to bring Medicaid and its multiple and special missions together with other reforms now unfolding in the earliest legislative process, particularly for families whose low or modest incomes will result in more frequent movement between Medicaid and an exchange. One important reform is to ensure that an application for Medicaid is also an application for subsidized health insurance through the exchange and to utilize techniques developed in CHIP to more clearly align enrollment and retention in order to virtually eliminate coverage breaks. Attention to this alignment effort will be particularly important in a world in which the exchange operates nationally while Medicaid remains state-operated, a lesson learned in the implementation of Medicare Part D.

Another important reform, and one that can only happen over time, will be the alignment of certification standards between health plans offered in an exchange (once the exchange system is operational) and Medicaid managed care. Through such alignment it will be possible eventually to reach a point at which both state Medicaid programs and a national exchange are able to purchase from a common set of health benefit plan offerings, with variable premium subsidies and cost sharing supports for families in different economic circumstances. This careful movement toward a more unified purchasing vision both preserves the Medicaid entitlement while also seeking to gain more coordinated improvements in health care quality, particularly for children and adults who depend on subsidized care.

At the point at which the coverage parameters of exchange products come fully into view and products actually begin to operate in the market, it will be possible to move forward with a more unified approach to health care purchasing. This positioning toward greater unification has two strengths in my view: the first is to strengthen coverage for special needs children and adults, and the second is to achieve a more coordinated approach to health care quality and efficiency in the case of sponsored health insurance products, whether purchased by Medicaid or through an exchange.

Since managed care was first introduced in Medicaid, state programs have purchased managed care products offering coverage that is more limited than the entire range of services and benefits offered under their state plans (or as part of Medicaid's early and periodic screening

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[25] Leighton Ku et al., *How is the Primary Care Safety Net Faring in Massachusetts? Community Health Centers in the Midst of Health Reform* (Kaiser Commission on Medicaid and the Uninsured and RCHN Community Health Foundation, 2009) http://www.gwumc.edu/sphhs/departments/healthpolicy/CHPR/downloads/massReformHealthCenters.pdf (accessed April 26, 2009).

and diagnosis and treatment benefits).[26] In essence, state Medicaid programs supplement their own sponsored products with additional coverage for children and adults with special needs, as well as with augmented and enriched "carved out" health care in a range of non-traditional settings. To the extent that exchange products ultimately offer comprehensive and affordable benefits so that coverage supplementation can be well defined, the integration of Medicaid and exchange purchasing becomes more feasible. Indeed, this goal of using Medicaid to strengthen and supplement commercial coverage was the principle that guided Mr. Grassley's introduction of the Family Opportunity Act; in my opinion, the extension of Medicaid as supplemental coverage for all children and adults with special needs, as well as a financing mechanism for crucial health care and health related services not considered insurable, exists as a long term goal of reform generally.

The second goal – strengthening system efficiency and quality – is particularly critical for lower income populations, for whom the networked coverage arrangement in which they are enrolled, whether through Medicaid or through an exchange, represents virtually their entire health care system. For this population, there is no "point of service" option of the type enjoyed by more affluent families. The highest goal of insurance reform – high quality health care – thus becomes represented through stable and uninterrupted coverage (whether derived through Medicaid or the exchange system), a robust and accessible provider network that emphasizes high quality accessible primary care in a range of community settings as well as the full and necessary complement of specialty care, fair payment arrangements that reward quality and efficiency while emphasizing and incentivizing prevention and care management, the use of comprehensive health information linked to both health care quality and public health system improvement, and coordination with public health.

This goal of integrating Medicaid and exchange purchasing will take an extensive investment of time and creativity. The goal depends on a strengthened Medicaid program, expanded to serve all low income persons, implementation of a well-functioning exchange system, comprehensive coverage standards applied to exchange products, and a real commitment to system integration by plans and providers. But the end result may be the type of long term reform that enables high performance, while redesigning coverage to be less discriminatory against those who bear the greatest burden of illness and disability. It is a vision that lends itself well to an ultimate stage in health reform, the investment in community health and development projects that work in concert with communities that are disparately burdened by illness and the health care systems that serve them.

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[26] Sara Rosenbaum et al., *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts* (The George Washington University, Washington D.C., 1997).

THE KAISER COMMISSION ON
Medicaid and the Uninsured

MEDICAID AND HEALTH REFORM

Statement of Diane Rowland, Sc.D.
Executive Vice President, Henry J. Kaiser Family Foundation
Executive Director, Kaiser Commission on Medicaid and the Uninsured

Before the U.S. Senate
Committee on Finance
Roundtable Discussion on
"Expanding Health Care Coverage"
May 5, 2009

Medicaid and Health Reform

Over the last 45 years, Medicaid has been on the frontline providing health coverage to many of the poorest, sickest, and most disabled among us – a large low-income population with multiple and complex health needs that go beyond the scope of most private health insurance coverage. Medicaid coverage of the low-income population provides access to a comprehensive scope of benefits with limited cost-sharing that is geared to meet the health needs and limited financial resources of Medicaid's beneficiaries.

Medicaid's experience in covering the low-income population provides a logical and operational framework on which to build broader coverage of the low-income uninsured:

- Medicaid provides essential coverage for 60 million low-income Americans today and has been a strong platform in state efforts to reach more low-income uninsured. The gains in children's coverage over the last decade have demonstrated the effectiveness of expanding public programs to reach more of the low-income uninsured population.
- The comprehensive scope and limited cost-sharing of Medicaid is designed to address the complex health needs of the low income population, including the chronically ill and people with severe disabilities. When the health needs of its beneficiaries are taken into account, Medicaid is a low-cost program; both adult and child per capita spending are lower in Medicaid than under private insurance.
- Medicaid has a proven track record in providing access to care for its beneficiaries. Medicaid enrollees fare as well as the privately-insured population on important measures of access to care. The uninsured fare much worse on every access measure, despite substantial health care needs.
- Medicaid is a tested program with an administrative structure in every state that can be readily adapted to serve more of the low-income uninsured.

As the nation moves forward to consider health care reform, strengthening the base that Medicaid provides for the low-income population and those with special health care needs will help provide the foundation on which broader health reforms can be built and will provide time to develop and implement the many other elements required to move to universal coverage. Medicaid's role in coverage of the low-income population could be strengthened by expanding eligibility for low-income adults; reducing enrollment barriers; placing greater emphasis on preventive and primary care; promoting greater provider participation and care coordination; and supporting the cost of expanded coverage with additional federal financing.

Thank you for the opportunity to participate in this roundtable discussion on health insurance coverage and the challenge of ensuring access to quality and affordable coverage for all Americans. I am Diane Rowland, Executive Vice President of the Kaiser Family Foundation and Executive Director of the Kaiser Commission on Medicaid and the Uninsured. My statement today will focus on the role Medicaid currently fills in our health care system and ways Medicaid could serve as a platform for broader health care reform.

Medicaid Today: Multiple Roles for Low-Income Americans

Medicaid is a fundamental part of our health care system covering 60 million low-income Americans and financing 16 percent of national health spending, including 40 percent of spending on long-term care services. It serves as the nation's health care safety net providing health coverage to one in four of America's children and many of their parents --- 30 million low-income children and 15 million adults who generally have no access to job-based coverage. It is also a particularly important source of coverage for both acute and long-term care for 8 million non-elderly people with disabilities and an essential adjunct to Medicare for the nearly 9 million low-income elderly and disabled Medicare beneficiaries who depend on Medicaid to help with premiums, gaps in Medicare benefits, and long-term care needs. Medicaid financing provides states with the capacity to provide coverage for their low-income families and helps to support safety net clinics and hospitals for the poor and uninsured.

While Medicaid is often viewed in its role as the health insurer of low-income families, it is important to recognize that children and parents in low-income families comprise three-quarters of Medicaid enrollees but account for less than a third of program spending (Figure 1). This is largely driven by the difference in annual spending per enrollee: $1,700 per child and $2,100 per adult compared to nearly $13,000 per person with disabilities and nearly $11,000 per elderly enrollee -- due to the greater use of both acute and long-term services by the disabled and elderly.

Medicaid spending --- like most health spending --- is highly skewed with a small share of enrollees accounting for a large share of the spending. The 5 percent of beneficiaries with the highest health and long-term care costs (over $20,000 annually in 2004) accounted for 57 percent of spending (Figure 2). Medicaid's high need populations include children in foster care and those suffering from spinal cord and traumatic brain injuries, mental illness, intellectual disabilities, and Alzheimer's disease, only some of whom qualify for the program on the basis of their disability. For many of those with the most extensive health needs and severely disabling conditions, Medicaid provides access to diverse services and long-term care options that exceed the scope of most private insurance. Medicaid not only provides access to affordable health care for millions of low-income children and some of their parents, but it also helps to provide comprehensive coverage for the complex and extensive health needs of many of the nation's chronically ill and severe disabled children and adults who have no other source of assistance.

Medicaid and Health Coverage for Low-income Families

Medicaid is at the centerpiece of coverage for the low-income population with incomes below 200 percent of poverty or $44,000 for a family of 4 in 2009 (Figure 3). For most low-income families, health coverage through the workplace is not available. Medicaid and the Children's Health Insurance Program (CHIP) have helped fill the coverage gap for children. Federal law currently requires states to provide Medicaid coverage to all children in families with incomes below poverty and young children and pregnant women at 133 percent of poverty and gives states the option of extending coverage to children at higher income levels through Medicaid and CHIP. Children are now covered at 200 percent of poverty or higher in 43 states and the District of Columbia. However, states set Medicaid eligibility for parents in 33 states at levels below poverty, leaving many parents of covered children uninsured. Under current federal rules, adults without dependent children are ineligible for Medicaid unless they qualify on the basis of a disability or are added through a state

waiver provision. As a result, Medicaid now provides coverage to half of all low-income children, but nearly half of poor and a third of near-poor adults are left uninsured.

Medicaid's comprehensive scope of benefits and limited cost-sharing is central to Medicaid's ability to address the health needs of the population it serves. Cost-sharing can place a disproportionately heavy burden on the tight budgets of low-income families, affecting access to care and health outcomes adversely. For a poor family struggling on an income of $20,000 a year, even minimal cost-sharing can quickly mount up and break the family budget while uncovered medical expenses can be catastrophic.

Within Medicaid there have long been concerns about the level of provider payments and the willingness of providers to treat Medicaid patients. Today, a majority of low-income families on Medicaid receive their health coverage through private managed care organizations under contract with the state to provide both comprehensive services and a provider network for beneficiaries (Figure 4). Through managed care arrangements and primary care case management states have moved to both secure better access to primary care services and restrain costs. Many states have used managed care and pay-for-performance programs as a vehicle to improve the quality of services provided to Medicaid beneficiaries.

Medicaid and Access to Care

Medicaid financing has helped move many low-income families from dependence on charity care to financial access to both public and private providers. In doing so, it has offered assistance to millions of low-income children and adults and provided a healthier start in life --- and fewer disparities in life --- to many of the nation's children. The coverage provided by Medicaid has helped to narrow the gaps in access to care faced by those without insurance and promoted broader use of preventive and primary care services.

Medicaid's success in improving access to care for the low-income population is most notably reflected in the comparability of Medicaid to private insurance on the many access measures where the uninsured fall far behind. For both children and adults, Medicaid, like private insurance, links families to a usual source of care -- the key entry point into the health care system. With Medicaid coverage, children utilize the health system similarly to those privately insured and face far fewer financial and access barriers to care than the uninsured (Figure 5). For those with serious health problems, poor adults with chronic conditions and disabilities with Medicaid coverage fare better than those with private insurance and substantially better than the uninsured on access to medical services (Figure 6).

Medicaid's access comparability to private coverage is especially notable given that the Medicaid population is both poorer and sicker than those who are low-income and privately insured (Figure 7). Because Medicaid covers a sicker population with more health needs, it is often viewed as more costly than private insurance. However, when the cost per adult and per child for medical care is adjusted for health status, Medicaid spending per person is below that of private insurance. While this is in part due to lower provider payment rates, it also reflects greater efficiency in program administration and in managing care.

Medicaid also plays an important role as a source of coverage in rural areas where there is less employer-sponsored coverage and higher poverty rates than in urban areas. Nearly a fifth of poor children live in rural areas. As a result, nearly a third (32%) of rural children compared to a quarter (26%) of urban children have Medicaid and CHIP for their health insurance coverage. As Medicaid promotes access to care for the low-income rural population enrolled, it also serves as a major source of payment for rural providers, and helps fill the gap left by the low level of private insurance in rural areas. By enabling hospitals, doctors, and clinics to get financing support for their services, Medicaid helps maintain the availability of health services for all rural residents and helps sustain rural economies.

Medicaid as a Platform for Reform

As the nation moves forward to consideration of how to provide coverage to the over 45 million uninsured Americans, Medicaid's role for the low-income population can provide a strong platform on which reform efforts can be built. The recent experience with children's coverage has demonstrated the effectiveness of expanding public programs to reach more of the low-income uninsured population. With the expansion of Medicaid/CHIP from 1998 to 2007, the uninsured rate among low-income children dropped from 28 to 15 percent.

The uninsured population is predominantly low-income -- two-thirds of the uninsured have incomes below 200 percent of poverty -- $44,000 for a family of 4 (Figure 8). Among the nation's 45 million uninsured, 16 million are below poverty and 13 million are near-poor. The uninsured have worse health status than those with private insurance and impaired access to care despite greater health needs.

Medicaid provides affordable coverage with a scope of benefits and limited cost-sharing that meet both the health and financial needs of this low-income population. The scope of benefits is well adapted to the needs of a low-income and disabled population. It is a tested program with an administrative structure in every state that virtually every state health reform effort has built upon in seeking to broaden coverage for their low-income residents.

Medicaid provides a base for extending coverage that has public support. In surveys of low-income families, over 90 percent of parents with an uninsured child view Medicaid/CHIP as a good program and say they would enroll their child if eligible for public coverage. Public opinion surveys have consistently shown broad support for public coverage programs with 74 percent ranking Medicaid as a very important program compared to 83 percent for Medicare in our 2005 survey of the general public. When asked about approaches to expanding coverage nationally, 70

percent of the public say they favor expanding Medicaid and SCHIP as one way to achieve broader coverage.

Over the last 45 years Medicaid has been on the frontline providing health coverage to many of the poorest, sickest, and most disabled among us -- a large low-income population with multiple and complex health needs that go beyond the scope of most private health insurance coverage. While there are variations across the states in both eligibility and scope of benefits, the core of care for the poor and the sick has been central to Medicaid's mission and led to many advances in care of the chronically ill. Medicaid has a proven record in coverage and care of these complex populations and has provided access to care for its beneficiaries comparable to that of private insurance for the low-income population. Medicaid's established eligibility determination system and provider and plan relationships combined with low administrative costs provide a solid base in every state for coverage of additional low-income people. Medicaid's administrative system is in place and can be readily adapted to serve more of the low-income uninsured with additional financing to support the costs of expanding coverage.

However, to make Medicaid a more effective platform for extending coverage to the low-income population, several options have been raised for reducing gaps and strengthening the program's base:

- To reach and cover more of the low-income population both expanding eligibility and reducing enrollment barriers could be addressed by: basing Medicaid eligibility solely on income and eliminating the current categorical requirements that exclude childless adults; standardizing income eligibility levels across states for adults to provide a national floor similar to the current requirements for coverage of all children under poverty; and further simplifying enrollment procedures to make coverage more accessible to working families.
- To improve access to care, greater emphasis could be placed on preventive and primary care combined with improvements in the level of provider payments to promote greater physician participation and assure the availability of care in safety net facilities and medically underserved areas.

- To meet the health needs of the complex populations served by Medicaid, greater emphasis could be placed on adopting new strategies and technology to better coordinate care and evaluate quality.
- To underpin these efforts and secure coverage through good and bad economic times, ways to enhance and stabilize federal financing and provide countercyclical aid also need to be addressed. It is important to recognize the variations in capacity across states and the limits of state financing and tie federal standards to additional federal dollars as part of moving to more uniform coverage across states.

Conclusion

The Medicaid program serves a disproportionately low income and disadvantaged population, living in poor and often environmentally and physically hazardous neighborhoods, where poverty and complex social needs combine with a multitude of other factors to shape health outcomes. Health coverage alone cannot be expected to reverse the effects of poverty and deprivation on the health and well-being of America's poorest residents, but Medicaid has demonstrated over the last four and a half decades that it is an important lever to help improve access to health services and the health of America's poorest children and families.

Medicaid's population is not just low-income but also includes many with complex health needs. It provides coverage beyond that of private insurance or Medicare to the most vulnerable and frail in our society - acute and long term care services for persons with chronic mental illness or developmental disabilities; medical and drug therapy for those with HIV/AIDS; assistance with Medicare's premiums, cost-sharing, and coverage gaps for poor Medicare beneficiaries and home-based and institutional care for those with severe physical and mental disabilities that require long-term care. In the absence of Medicaid, it is hard to envision how these enormous societal needs would be met. In a transition to broader health reform, it is critical that care for this population be maintained as disruptions could jeopardize their fragile health.

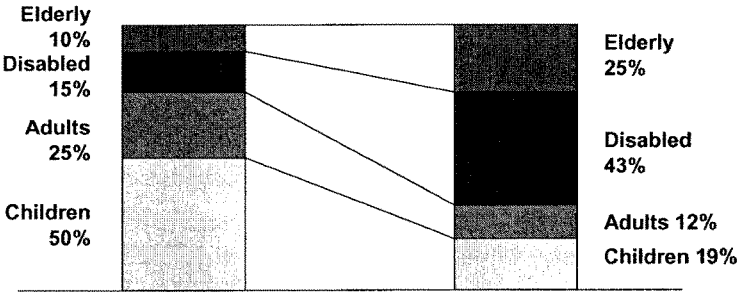
Medicaid with its experience in covering the low-income population provides a logical and operational framework on which to build broader coverage of the low-income uninsured. Medicaid has an established track record in providing the scope of benefits and range of services to meet the health needs of a low-income population that includes many with chronic illness and severely disabling conditions. It offers an appropriate starting point for extending coverage to the low-income uninsured population through health reform with the least disruption in care for the most vulnerable.

As the nation moves forward to consider health care reform, strengthening the base that Medicaid provides for the low-income population and those with special health needs will help to provide the foundation on which broader health reforms can be built and will provide time to develop and implement the many other elements required to move to universal coverage. As a building block in the broader reform effort, Medicaid can provide a stable base to protect the health care of the poor and the sick while providing a vehicle to reach low-income adults with affordable coverage during the transition to a reformed system.

Thank you for your consideration.

Figure 1

Children and Adults Account for Most Medicaid Enrollees but Elderly and Disabled Account for the Majority of Spending



Enrollees — Total = 59 million

Expenditures on benefits — Total = $269 billion

SOURCE: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on 2006 MSIS data.

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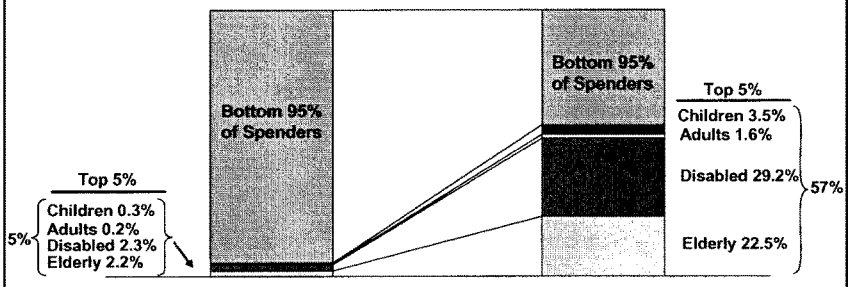
Figure 2

Top 5% of Enrollees Accounted for More than Half of Medicaid Spending



Enrollees — Total = 57.4 million

Expenditures — Total = $265.4 billion

SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on MSIS 2004.

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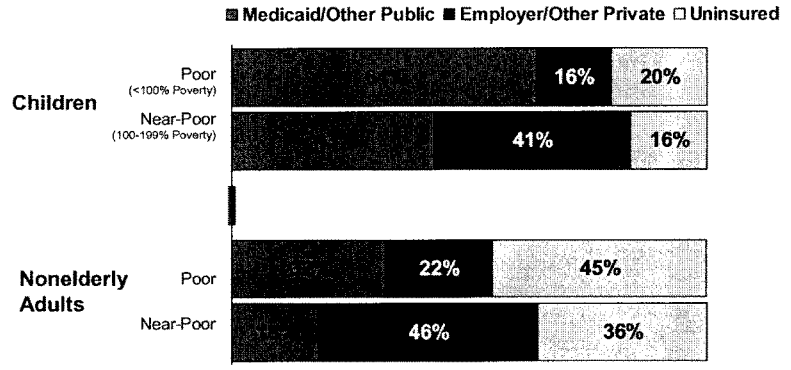
Figure 3

Medicaid Provides a Base for Expanding Coverage to Low-Income Children and Adults



Medicaid also includes SCHIP and other state programs, Medicare and military-related coverage.
SOURCE: KCMU and Urban Institute analysis of March 2008 CPS.

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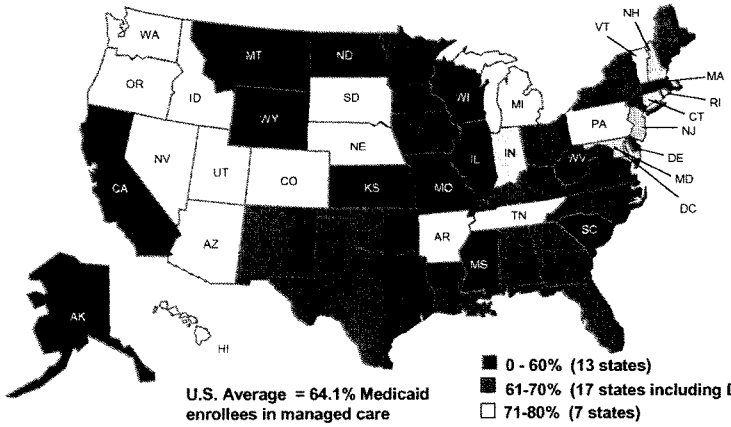
Figure 4

Over 60 Percent of Medicaid Beneficiaries Enrolled in Managed Care



U.S. Average = 64.1% Medicaid enrollees in managed care

- 0 - 60% (13 states)
- 61-70% (17 states including DC)
- 71-80% (7 states)
- 81-100% (14 states)

Note: Managed care includes individuals enrolled in managed care organizations (MCOs) and primary care case management (PCCM) arrangements.

SOURCE: Medicaid Managed Care Penetration Rates by State as of June 30, 2007, CMS, U.S. Department of Health and Human Services.

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Figure 5

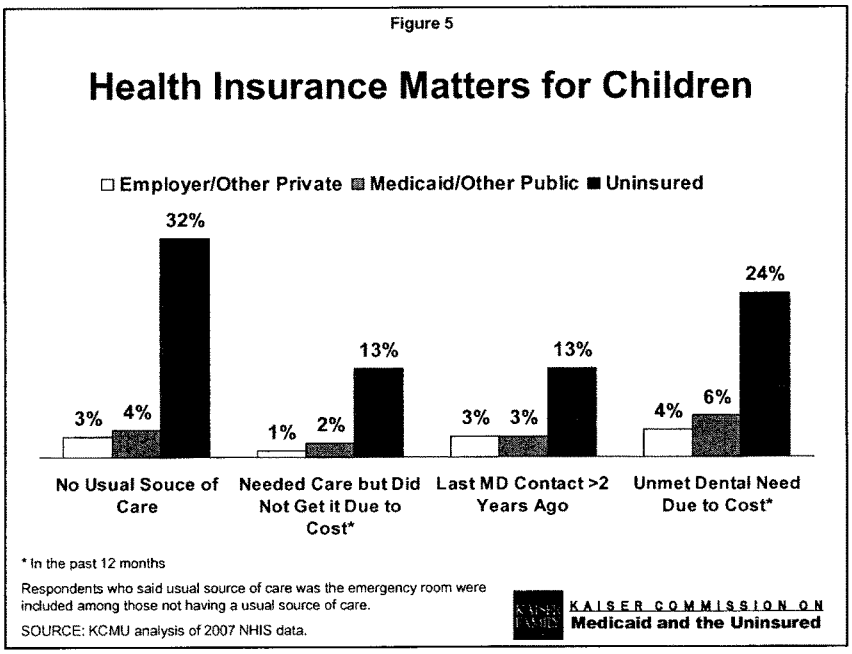


Figure 6

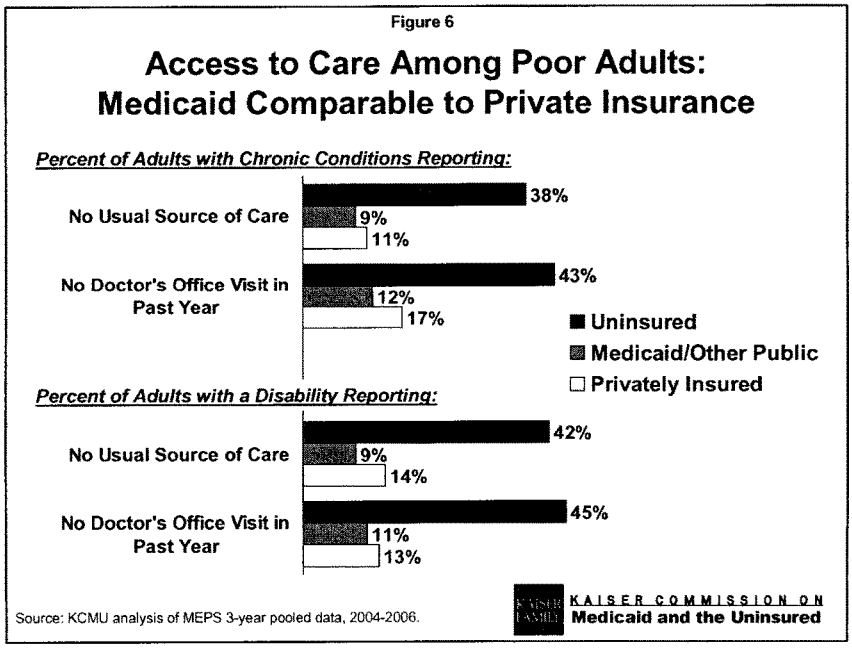
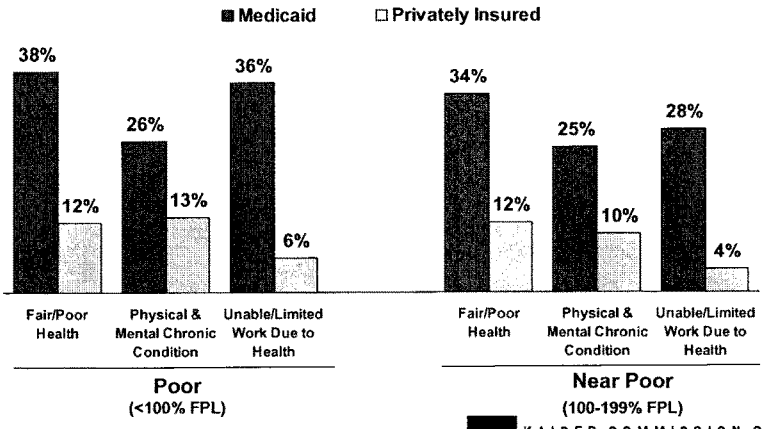


Figure 7

Medicaid Enrollees are Sicker and More Disabled Than the Privately-Insured

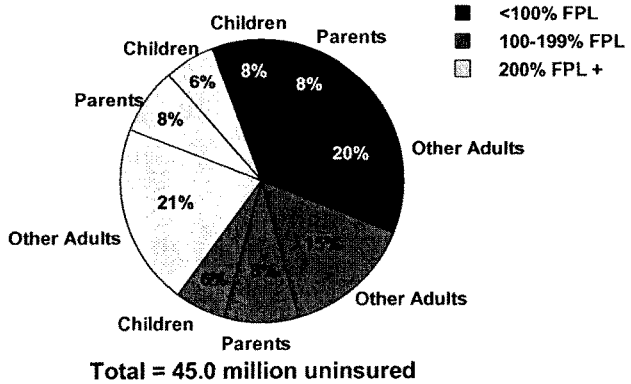


Note: Adults 19-64.
SOURCE: KCMU analysis of MEPS 3-year pooled data, 2004-2006.

KAISER COMMISSION ON Medicaid and the Uninsured

Figure 8

Two-Thirds of the Uninsured are Low-Income



Total = 45.0 million uninsured

*200% of the Federal Poverty Level (FPL) for a family of four in 2008 is $42,400 per year.
SOURCE: KCMU/Urban Institute analysis of March 2008 CPS.

KAISER COMMISSION ON Medicaid and the Uninsured

Written Testimony for the Senate Finance Committee

"Roundtable to Discuss Health Care Reform Coverage"

Presented by the National Governors Association
Executive Director Raymond C. Scheppach, Ph.D.

May 5, 2009

Mr. Chairman and members of the committee, my name is Ray Scheppach, and I am the Executive Director of the National Governors Association. I appreciate the opportunity to be a part of this panel on behalf of the nation's Governors to discuss health reform and specifically the important issues involving health care coverage proposals.

Need for Reform

Governors understand the vital role that health plays in productivity, competitiveness and quality of life and have made providing cost effective health care to their citizens a top priority. To continue their valuable work, the National Governors Association (NGA) formed a 12-member, bipartisan Health Care Reform Task Force to identify and define the gubernatorial priorities. We believe these steps can be used to inform and advise the important work of the Congress, including the Senate Finance Committee, as well as the Administration's efforts.

Health care is now a $2.4 trillion industry, making it a major driver of the nation's economic engine while also having a far reaching impact on the lives of all American families. Despite the vast amount of resources invested, an extensive body of research indicates the health care system is dramatically underperforming. As the number of uninsured Americans continues to rise, health care costs continue their upward spiral, the quality of health care services is increasingly called into question, and in turn, the economic competitiveness of America's businesses is threatened. These realities are heightening the need for health reform.

Given its unsustainable course, significant reforms of the health care system are necessary. Governors are prepared to work with you to build on these initiatives as you advance comprehensive health care reform proposals. Governors understand that in order to develop a uniquely American solution, health reforms must engage all stakeholders – individuals, the private sector, and government, both federal and state – who have a shared responsibility to address the existing limitations of the health care system.

Comprehensive Reform

More than 45 million Americans are currently uninsured, and millions more are underinsured. Achieving greater access to affordable, quality health care is a critically important goal.

However, health reform proposals must recognize that changing any one component will have direct and indirect impacts on other aspects of the health care system, and therefore, reform must move on parallel tracks to expand coverage, improve quality, and contain costs.

It is also critical for the health reform discussion to define which level of government will perform certain roles. Specifically, proposals must be thoughtfully crafted to determine who will finance, regulate, and purchase health coverage. While a number of states have enacted comprehensive reforms, nearly all states have enacted some reforms, including expanded coverage, insurance market reforms, small business reforms, quality improvements, and support for the adoption of electronic health records. Given both the momentum and the expertise that has developed in the states, national health reform should focus on enacting a broad federal framework with incentives for states to build upon their strengths and accomplishments. With that in place, states can build upon the existing policies and structures to expand coverage, protect consumers, evaluate quality, encourage price transparency, and meet the shared health reform goals of governors and federal policymakers.

In other words, health reform cannot focus solely on the federal role. We must strengthen aspects of the existing state/federal partnership and use the combination of their structures, expertise, and capacity to develop a more efficient, value-based health care system that facilitates broader coverage.

Existing Public Programs

A significant component of reform involves the broad range of public programs run by states, including Medicaid, the Children's Health Insurance Program (CHIP), and traditional public or population health programs which serve a vital safety-net function for low-income individuals and vulnerable populations. Health reform proposals must involve decisions about the financing, regulation, and administration of such programs.

Although Medicaid is the largest health care program in the nation, generalizations about the program are difficult to make, because it operates so differently in each of the states and territories. In addition, Medicaid is even more complicated than 56 different programs, because within each state, Medicaid plays a number of very distinct roles while serving a number of very distinct populations.

Expanding Coverage

In the absence of major federal progress, states have acted upon the immediacy of concern about the millions of uninsured individuals and families. In recent years, more than half of states have undertaken coverage increases, including significant initiatives intended to achieve broad-based coverage expansions. However, as this most recent economic recession demonstrates, states lack the financial capacity to pay for coverage over the long term. In addition, states do not have the necessary statutory authority to affect the type of broad-based market changes needed to achieve a rational system.

There is a reasonable federal role in paying for and shaping the type of coverage available and aligning the market incentives to drive quality care and appropriate outcomes. However a careful balance must be struck to preserve the state role of regulator and protector of consumer interests. States must have the flexibility to respond to justifiable variation in local conditions and costs as well as differences in approaches to health insurance coverage, delivery system models, and the types of services delivered.

The following key coverage-related principles could help create such an environment:

- The goal of coverage expansions should be improving options for individuals to access affordable coverage.
- Where possible, the existing system of employer sponsored coverage should be maintained.
- State administered programs can have a role, but careful consideration must be given to state's short and long term fiscal capacity.
- If the federal government establishes a national baseline benefit package model, it must contain a fair amount of flexibility within certain parameters.
- The federal government should establish guidelines for determining sliding scale subsidies for individuals who need assistance in affording insurance.

Medicaid Expansion

Governors recognize Medicaid's important role in meeting the needs of our most vulnerable populations and they are committed to modernizing the program so that it better responds to their needs. There are several aspects of this transformation that I wish to highlight.

There is widespread agreement that Medicaid's role is complicated because of the complex categorical nature of eligibility. Low-income pregnant women, children, seniors and people with disabilities are often eligible, but for the most part, other categories of Americans are not.

Governors understand that proposals under consideration would eliminate the categorical nature of the Medicaid program for individuals under a certain income threshold. While there is a reasonable case for streamlining eligibility policies, proposals to mandate a significant expansion of the Medicaid program raise important questions and some concerns.

First of all is the cost. An increase in the mandatory minimum eligibility threshold to 100% FPL could cost states at least $24 billion in fiscal 2009. This figure represents only the actual cost of additional individuals on the rolls, and does not take into consideration the complex interaction of reimbursement rates and access, which I will discuss later.

Medicaid is a system built upon a complex balance of federal mandates and state options. Just as no state is offering the maximum of all possible options; neither does any state cover only the bare minimum mandates. Every state makes political and fiscal calculations with regard to how expansive they can afford their Medicaid program to be. Therefore, imposing broad new unfunded mandates upon states could force them to reduce spending on optional categories. This

is not ideal policy solution, but unfunded mandates will likely force many states to consider it as an option.

Finally, coverage and delivery system reforms require thorough consideration of the direct and indirect impact on provider reimbursement rates as well as health care workforce capacity, particularly primary care providers. There simply are not enough providers willing to treat additional Medicaid enrollees with complex conditions and situations at current reimbursement rates. Currently, Medicaid reimbursement rates average 72 percent of Medicare rates nationwide, and Medicare rates are often significantly lower than rates paid by private insurance. Those states that have already experimented with expanding Medicaid coverage broadly have demonstrated that Medicaid reimbursement rates must be increased to approximately Medicare rates to ensure access.

Combining the existing program expenditures with those required to meet new requirements and needs, without other changes to the program or adequate federal funding, will overwhelm states' budgets. One initial estimate of the state impact of an expansion of Medicaid to 100 percent of the federal poverty level (FPL), combined with reimbursement rates increases that would be necessary to ensure access are $75 billion per year in state funds alone.

There is support for moving away from quantity-based reimbursement towards quality and outcomes-driven approach. However, any cost efficiencies generated by this approach are unlikely to offset the additional expenditures required to expand coverage and increase provider reimbursements without additional reforms to the program or adequate federal financing.

Finally, Medicaid has become the nation's de facto source of long-term care coverage as well as a critical source of coverage for individuals eligible for both the Medicare and Medicaid program – known as the dual eligibles. Continued coverage of these responsibilities is fiscally incompatible with an increased role in coverage of all low-income Americans using the existing Medicaid framework.

Alternatively stated, the federal government should only consider mandating significant expansions in Medicaid if they are prepared to pay for not only the expansion populations but both the short-run additional costs for the existing population and the additional long-run costs of the demographic changes in long-term care. Changes to Medicaid eligibility policies also will require close collaboration between governors and Congress to determine a reasonable, workable implementation time period.

Medicaid reforms

The following programmatic reforms to the Medicaid program should be considered as a part of overall health reform, regardless of whether or not the program is expanded. If the program IS expanded, these changes MUST also occur.

- For low-income, but relatively healthy individuals who rely on Medicaid as a health insurance product, states should have more flexibility with respect to the benefits package.

- For individuals with disabilities who have no other recourse than to rely on Medicaid, reforms should encourage more consumer choice. Reforms also must allow Medicaid to be more flexible in targeting services to individuals that will improve the quality of their care and produce good outcomes.
- The Medicaid funding formula – the Federal Medical Assistance Percentage (FMAP) – should be adjusted so that it responds in a timely, predictable manner to changing state economic conditions. The existing FMAP formula is based on a three-year rolling average that reflects economic conditions from several years ago that may be vastly different than current conditions, and as a result, can exacerbate problems states have financing Medicaid during fiscal downturns.
- A new national dialogue is needed to confront the issues of an aging population and the potential sources of funding for end-of-life care.

Medicare and Medicaid

It is clear that Medicaid can no longer be the financing mechanism for the nation's long-term care costs and other costs for individuals eligible for Medicare and Medicaid – known as the dual eligibles. The demographic changes and escalating costs make it critical for states to begin to transition to the federal government much of their current financial responsibility in Medicaid for financing of long-term care. As stated in my testimony to the Subcommittee on Health of the Finance Committee last month, postponing the discussion on long-term care perpetuates the fragmented system of care that exists today. Efforts to improve the financing mechanisms, care coordination and quality of long-term care services can be complementary and very important in the efforts related to strengthening the rest of our health care system.

Additionally, more than seven million Americans are dually eligible for full Medicare and Medicaid benefits, and nearly two million others receive financial assistance to cover out-of-pocket costs, such as co-payments and deductibles. These individuals represent just 18 percent of Medicaid's caseload, and despite the fact that they are fully insured by Medicare, a disproportionate percent of all Medicaid expenditures is consumed by filling in the gaps in Medicare services. In fact, they are responsible for over 42 percent of all Medicaid expenditures and 24 percent of Medicare expenditures ($250 billion in FY2008).

Health care reform must include a streamlining of the current dysfunctional silos that dual eligibles currently access. There are at least two options for approaching this challenge. Full federalization of financing the care for this population would serve many policy goals, including creating enormous efficiencies and savings for both states and the federal government and treating the most medically fragile citizens in a holistic manner that dramatically improves the quality of their health care.

Alternatively, if the federal government does not provide the financing to improve the care of these beneficiaries, provide states with the tools to do so. Despite recent state and federal efforts to address structural problems, the existing system for dual eligibles is predominantly a fragmented, uncoordinated, and inefficient system of care. Misaligned benefit structures, opportunities for cost-shifting, and unresolved tensions between the federal and state governments as well as an uncoordinated system of care for beneficiaries remain. Specifically,

states must be credited for generating savings to Medicare when making Medicaid investments for this population. States also should have a certain level of influence over the coverage and financial decisions being made for the duals. And certain administrative rules and policies between Medicare and Medicaid must be streamlined to improve care for the dual eligibles.

In addition to specific reforms to improve care for the dual eligibles, a stronger, more equitable partnership between Medicare and states is essential to the success of health reform efforts. Medicare has significant influence in shaping cost and coverage decisions in the public and private domain and thus has a tremendous impact on health care trends. Yet Medicare largely is not engaged in state specific health reform initiatives which involve both public and private stakeholders.

States administer and help finance Medicaid, and they use the flexibility inherent in Medicaid and other public programs to design and pilot new models and approaches to health care. Many of these policies subsequently have been adopted by other insurers and provider systems, thereby earning states the reputation as "laboratories for reform." Health reform must have a long-term strategy for encouraging ongoing innovation. Policymakers can facilitate this by enhancing the flexibility states currently have to explore new approaches while minimizing any penalty for approaches that may later be found not to meet intended goals.

Conclusion

Any reforms approved at the federal level must allow states flexibility to adapt to local conditions and retain the primary state roles of administration, regulation, and consumer protection. It is also important that this framework support the role that states play in innovations around delivery system reform and value-based purchasing.

If a federal framework is developed it should include sustainable, sufficient financing mechanisms (through a combination of public programs and private sector incentives) to ensure that coverage and delivery system reform goals can be met. On their own, states are not well-positioned to sustain increases in their health care budgets.

Governors look forward to working with our federal partners on a bipartisan basis to address these important issues.

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STATEMENT

Before the

UNITED STATES SENATE FINANCE COMMITTEE ROUNDTABLE

On

Health Care Coverage

Submitted by:

Scott Serota
President and Chief Executive Officer
Blue Cross and Blue Shield Association

May 5, 2009

Executive Summary

The Blue Cross and Blue Shield Association (BCBSA) strongly supports comprehensive healthcare reform that will rein in the cost of healthcare for everyone, improve quality and ensure everyone has health insurance. The most effective way to improve our healthcare system is to build on the employer-based system – which already provides coverage to more than 160 million people today and ensure effective delivery system reforms as we recommended at the April 21 Roundtable. Our statement includes detailed recommendations to extend coverage to all. To accomplish this, all stakeholders have a critical role.

Federal Government

Currently, the federal government plays a vital role in assuring coverage for older Americans, the disabled and lower-income individuals, which must continue. The government should also take on several new roles to expand coverage to all:

- Expand Medicaid to cover all people in poverty while also assuring those who are eligible are enrolled.
- Reform Medicare to pay for quality, strengthen primary care, promote wellness and chronic care management and assure the program's long-term solvency.
- Put in place a new health coverage responsibility program that will assure everyone obtains and maintains health insurance coverage.
- Establish a new set of insurance rules to assure all individuals have access to affordable, private coverage, regardless of health.
- Provide subsides to help those who may have difficulty affording coverage.

State Government

States should continue in their role as the primary regulators of health insurance to best protect consumers. State should be able to build upon federal rules – where appropriate -- and all insurers offering coverage in a state should be required to follow the same rules. States have a long, successful history of regulating health insurance and protecting consumers – a role that could not be replicated effectively at the federal level.

Insurers

Insurers should partner with the government to meet the objectives of health care reform – assuring that everyone has coverage by: expanding existing government programs where appropriate; assuring everyone ineligible for existing government programs can afford private coverage by building on the employer-based system with support for individuals who must purchase coverage but may have difficulty affording it; assuring everyone can purchase health coverage regardless of health status with no variation in premiums based on health; and simplifying the shopping for and purchase of insurance through state-run on-line programs for comparing and purchasing coverage.

Consumers

Consumers must take responsibility to obtain and maintain health insurance to assure everyone is covered. They should also be encouraged to lead healthy lifestyles, follow recommended preventive care and take a greater role in managing chronic conditions.

Introduction

The Blue Cross and Blue Shield Association (BCBSA) commends Chairman Baucus's and Ranking Member Grassley's leadership in holding this important series of roundtable discussions to bring stakeholders together to work toward solutions to improve today's health care system.

BCBSA is pleased Congress and the Administration have made healthcare reform a national priority. BCBSA strongly believes that everyone in our country should be insured. We share the commitment to enacting health care reform legislation this year that expands coverage to all Americans, reins in costs, and improves the quality and safety of care delivered to patients.

BCBSA represents the 39 independent, community-based Blue Cross and Blue Shield companies that collectively provide health care coverage for over 100 million individuals – one in three Americans. With over 80 years of experience, Blue Cross and Blue Shield Plans offer individual, small employer, and large employer market products in every zip code. We also partner with the government in Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Federal Employees Program. As such, the Blue System has a unique perspective on how to improve our health care system.

Recommendations

We believe that the most effective way to expand coverage is to build on the employer-based system – which already provides coverage to more than 160 million people today. Our proposal, *The Pathway to Covering America*, seeks to expand coverage, rein in costs, and improve quality through five recommended steps:

1. **Encourage research on what works** by establishing a permanent, independent comparative effectiveness research institute;
2. **Change incentives to promote better care** instead of more services;
3. **Empower consumers and providers with information and tools** needed to make more informed decisions;
4. **Promote health and wellness** by encouraging healthy lifestyles to prevent disease and managing and coordinating the care of those with chronic illnesses; and
5. **Foster public-private coverage solutions** to make sure everyone is covered, with subsidies for individuals and small employers to purchase private coverage, as well as targeted expansions of Medicaid and CHIP.

Two weeks ago, our Chief Medical Officer, Dr. Allan Korn, participated in the Committee's Roundtable to share our recommendations on delivery system reforms by focusing on our first four *Pathway* recommendations. Our statement today focuses on our fifth recommendation -- fostering public-private coverage solutions for our nation. Specifically, we cover:

- Tailored recommendations to cover the diverse group of uninsured;
- Personal responsibility for obtaining health coverage along with federal subsidies;
- Insurance market reforms to assure everyone has access to affordable insurance;
- Recommendations to simplify the purchasing of insurance; and
- A new, expanded role for the federal government.

Tailored Solutions to Address the Uninsured

Recognizing that the uninsured is a diverse group, BCBSA recommends tailored solutions to help the three key segments:

1. *Those squeezed out by cost*: Approximately 56 percent of the uninsured may have difficulty affording coverage because they are ineligible for government assistance, but earn less than 300 percent of the federal poverty level. BCBSA recommends:

   - *Providing four new types of tax assistance*: Congress should enact: (1) a tax credit for small employers; (2) a refundable tax credit for those whose health premiums represent a large share of their income; (3) a refundable tax credit to help those between jobs; and (4) tax deductibility for those without access to employer coverage.

   - *Expanding the government safety net:* Medicaid should be extended to cover everyone under the federal poverty level who is currently not eligible for Medicaid.

2. *Those missing out on public coverage:* Twenty-five percent of the uninsured (12 million) are eligible for Medicaid or SCHIP under current rules, but are not enrolled.

   - BCBSA strongly supported reauthorization of the Children's Health Insurance Program, including the additional funding for outreach and enrollment for those who are eligible but not enrolled and the new "Express Lane" expedited eligibility process for states. Ensuring expanded enrollment in CHIP is a critical undertaking. Blue Plans, which serve one-third of CHIP enrollees today, look forward to working with states and the federal government to expand coverage to the estimated 4.1 million additional children who will obtain coverage under the reauthorized program.

   - We also supported the inclusion of a new state option for subsidizing employer premiums. Premium assistance is a "win-win" approach to expansion because it leverages employer coverage and employer contributions, and expands access to family coverage for lower-income employees who may not otherwise be able to afford their share of the premium.

3. *Those opting out of coverage:* Twenty percent of the uninsured may be able to afford insurance, but may: (1) not value it because they are young or healthy; (2) be unaware of coverage options and their tax deductibility (for the self-employed); or (3) overestimate the cost of coverage. BCBSA recommends:

   - *Educating Americans about the importance of being insured*: The public and private sectors should partner on a broad-based educational campaign on the value of insurance.

   - *Ensuring all individuals obtain coverage:* create a new health coverage responsibility program as described below.

Personal Responsibility for Obtaining Health Coverage

To achieve universal coverage, BCBSA supports a new health coverage responsibility program for all Americans to obtain and maintain health coverage. This health coverage responsibility program is essential to assuring everyone has coverage and keeping premiums affordable.

Along with this new program, BCBSA supports insurance reforms in the individual market with subsidies to make coverage affordable, as discussed below.

It is important to note that subsidies alone are not an adequate substitute for an effective health coverage responsibility program. A recent RAND analysis estimated that even with full subsidies for persons with incomes up to 200 percent of federal poverty level and partial subsidies up to 400 percent of federal poverty level, only 12.4 million individuals would be newly insured. In contrast, combining these subsidies with an effective health coverage responsibility program would increase the newly insured to 33.5 million.

The primary reason that many individuals lack coverage today is due to cost. To assure coverage is affordable, it is critical Congress provide targeted subsides to help those likely to have difficulty affording insurance. BCBSA supports:

1. **Tax credits for low-wage workers in small businesses.** Low-wage workers in small firms are less likely than those in large firms to have employer-sponsored coverage. According to research conducted by the Employee Benefits Research Institute, many small firms cite that they do not offer coverage because their workers could not afford it. This tax credit is likely to encourage small businesses to offer health coverage. EBRI reports that among small employers who do not offer coverage, 71 percent would be more likely to seriously consider offering health benefits if the government provided assistance with premiums.

2. **Tax-deductible insurance premiums for those without access to employer-sponsored coverage.** Today, the vast majority of individuals without access to employer-sponsored coverage must pay for coverage without an income tax advantage or deduction, unlike those receiving coverage through an employer, who do not pay taxes on the value of their employer-sponsored plan. Adopting this proposal would address this fundamental inequity and improve affordability for individuals without employer coverage.

3. **A refundable, advanceable tax credit for those whose premiums represent a disproportionate share of their income.** This tax credit would help people who would otherwise have difficulty affording coverage while targeting resources to those who are most in need of assistance.

4. **A refundable tax credit to help those between jobs.** People who are unemployed often have difficulty affording coverage, and this tax credit would provide stop-gap assistance, helping to ensure there is no lapse in health care coverage.

Insurance Market Reforms to Assure Everyone has Access to Affordable Insurance

An effective, health coverage responsibility program that includes federal subsidies for those that need help purchasing coverage is essential for insurance market reforms to work. With these components in place, BCBSA supports a new requirement for all insurers to accept everyone in the individual market regardless of their health status ("guarantee issue"). Guaranteed issue can only work if everyone – young and healthy as well as higher risk individuals purchase coverage.

BCBSA also supports new rating rules in the individual market, including:

- *Prohibitions on Health Status Adjustments.* Insurers should not be allowed to vary premiums based on health status once everyone is covered. Experience shows that bans on health-status rating in the voluntary market lead to significant increases in premiums for many people, especially young and healthy individuals. As healthier people drop coverage because of increased premiums, subsidies for sicker enrollees are lost and the remaining enrollment is left with much higher premiums.

- *Continuation of Age Adjustments.* It is extremely important to continue to allow insurers to vary premiums based on age – even with a health coverage responsibility program. Age adjustments are essential to enable younger individuals – who may earn less than older people – to buy coverage and comply with health coverage responsibility program. Younger people often do not value health insurance because they tend to use fewer medical services. If the premiums are set too high, there is likely to be a backlash among younger people.

- *Continuation of Wellness and Geography Adjustments.* Insurers should be encouraged to adjust premiums based on wellness factors (such as non-smoking) and geography. Wellness adjustments provide important incentives for consumers to engage in healthy behaviors and help prevent chronic illnesses. In addition, given the significant variation in healthcare costs across different regions in the country, premium adjustments to account for geography are critical.

These reforms must be appropriately phased-in, taking into account state variations, and actuarially modeled to avoid disruptions and major premium hikes to consumers currently in the market.

States should continue to be the primary regulators of insurance to best protect consumers. Federal rules should set minimum standards upon which states can build, and all insurers offering coverage in a state should be required to abide by the same rules. States have a long, successful history of regulating health insurance and protecting consumers – a role that could not be replicated effectively at the federal level. Further, we recommend exploring broadly-funded state reinsurance programs with federal funding for persons with high medical costs to ensure that individual market premiums are affordable for everyone.

Health coverage responsibility and adequate subsidies are essential to ensuring that guaranteed issue and community rating reforms work. In the 1990s, several states experimented with guaranteed issue and community rating reforms in a voluntary market. These states experienced an adverse selection spiral, where younger and healthier individuals opted out of the insurance market, causing higher premiums for those remaining in the insurance market – who often tended to be older and less healthy. States saw dramatic premium increases, drastic reductions in the number of individuals buying coverage, and fewer insurance products being available to consumers.

Making it Easier to Shop for Coverage: The State Health Insurance Mart (SIM) Model

We also believe insurance needs to be improved for small employers and individuals. In today's health insurance market, small employers and individuals often face challenges in shopping for health insurance and comparing choices based on important criteria such as cost and quality.

As part of a comprehensive health reform plan, BCBSA urges Congress to enact legislation to encourage states to establish "State Insurance Marts" (SIMs) to simplify shopping, increase competition among insurers and help educate purchasers on subsidy options. BCBSA's SIM proposal would make it easier to shop for coverage by creating a central point in each state where individuals and small businesses could easily compare coverage options and apply for both coverage and subsidies.

Under the SIM model, each state – building on its expertise as the regulator of its health insurance market today – would develop a central internet portal listing for all products for sale to individuals and small groups. These sites could be linked via a national framework and would enable:

- **Comparison of all insurance options in a respective state based on key factors**, including benefits, price, quality metrics, and provider networks. Each state would develop easy-to-understand comparison templates to promote transparency and informed decision-making.

- **Real-time price quotes from multiple insurers**. Each state would develop standard applications that individuals and small businesses could use to apply to several insurers simultaneously and to obtain estimated premium quotes instead of completing multiple applications and waiting for each insurer to follow-up.

- **Calculation of any tax benefits and subsidies available or eligibility for Medicaid.** Enrollees could enter basic financial information, learn about the estimated final cost of coverage (considering any applicable subsidies), and learn if they are eligible for Medicaid.

- **Simplified enrollment in the plan of choice.** Individuals and small businesses could easily enroll in coverage online or apply for subsidies directly through interface with the agency verifying eligibility.

BCBSA's SIM proposal would increase competition in the small employer and individual health insurance markets. SIMs would list all products for sale to individuals and small groups by all insurers in the state and for the first time allow consumers and small businesses to compare all plans in a state on price and other important factors.

A number of federal health care reform proposals would create a new federal agency called a "connector" or an "exchange," intended to make it easier for individuals and small businesses to purchase health insurance. However, creating a federal "connector" would be complex, costly and time-consuming. Creation of a federal connector could also undermine state regulation and authority, creating conflicting federal-state rules that would result in regulatory confusion and adverse selection.

A state-based approach would accomplish the goals of a federal connector while ensuring current consumer protections afforded by state oversight and assuring faster implementation at lower costs by avoiding the creation of a new federal bureaucracy. To encourage states to establish State Insurance Marts, federal funding should be provided to offset the cost of development.

In addition, many purchasers today are unaware of the tax advantages for purchasing health insurance, the availability of public programs, and other options for obtaining coverage. SIMs

would address this need by providing a central online site in each state (with a national landing pad for nationwide outreach) where consumers and small employers could learn about coverage and subsidies, and obtain information on public programs, including Medicaid and CHIP.

New, Expanded Role for the Federal Government

BCBSA strongly supports passing comprehensive healthcare reform this year that meets the objectives of Congress and the Administration. We believe the federal government plays a vital role in assuring coverage for older Americans, the disabled and lower-income individuals. There are also several new major roles the federal government should undertake:

- Expanding Medicaid to cover all people in poverty and enrolling all those who are eligible.
- Reforming Medicare to pay for quality and assuring Medicare's long-term solvency.
- Establishing new rules for insurers to assure access for everyone regardless of health.
- Providing subsides to help those who may have difficulty affording coverage.

The recommendations BCBSA has laid out today that build on the employer-based system to extend coverage to all, when coupled with the recommendations we presented to the Committee at its April 21 Roundtable on delivery system reforms, would achieve President Obama's eight healthcare reform principles to: protect families financial health; make coverage affordable; aim for universality; provide portability of coverage; guarantee choice; invest in prevention and wellness; improve patient safety and quality care; and maintain long-term financial sustainability.

Creating a government-run plan – in any form – to compete alongside the private sector for non-Medicare/Medicaid eligible individuals is unnecessary to achieve comprehensive reform and would have devastating consequences.

First, a new government plan would decimate the employer-based system that covers 160 million people today -- the vast majority of whom are very happy with their health plan. Studies have shown that a government program would result in millions of people losing their employer-provided coverage. The Lewin Group estimates that a Medicare-like plan would result in more than 118 million people shifting into the government program almost overnight. As two-thirds of the population moves into a government plan, the employer system will evaporate and leave people with no choice but the government plan.

Second, it would jeopardize much needed delivery system reforms critical to controlling costs. We agree Medicare needs to be reformed to reward high quality care and good outcomes rather than just paying for services. We commend the Committee for issuing delivery system reform options that will help modernize the Medicare program. However, history has shown the government can be slow to innovate and implement changes due to the complex legislative and regulatory processes as well as political pressures. For example, the government has not been successful in selectively contracting with the best providers.

The private sector, on the other hand, is free to innovate, and is having excellent results. For example, BCBSA is significantly improving care outcomes and lowering costs through our national program of nearly 800 Blue Distinction Centers (BDC) across 43 states. This program designates facilities that have demonstrated expertise in delivering quality healthcare in the challenging specialty areas of Transplantation, Bariatric Surgery, Cardiac Care, and Complex and Rare Cancers. Readmission rates at our Blue Distinction Centers for Cardiac Care® are

much lower than at other hospitals (26 percent lower for bypass surgery and 37 percent lower for outpatient angioplasty, based on 30-day cardiac-related readmission rates).

Third, some are looking at government plan alternatives that could "negotiate" rates with providers. No matter how such alternatives are initially structured, history has shown the government will use its built-in advantages to under pay providers, resulting in even greater cost-shifting to the private sector, making private insurance unsustainable. Currently, cost shifts to the private sector inflate family coverage by nearly $1,800 per year.

It is also important to point out that the original Medicare program did not initially set provider rates, however within a few years, budget pressures resulted in government price controls. Underpayments to providers create major access issues. A 2008 MedPAC study found 29 percent of Medicare beneficiaries report problems in finding a physician. The Texas Medical Association reports only 38 percent of primary care physicians in the state will accept new Medicare patients.

Some advocates of creating a new government health plan have responded to cost-shifting concerns by recommending all payers be allowed to use government payment rates. This "all-payer" approach would not be effective in holding down costs and improving quality. Instead it would lock in inefficiencies and undermine efforts to improve our delivery system by stifling innovations currently underway in the private sector. It would also lead to government price setting in order to ratchet down costs and would likely lead to a single payer system.

Lastly, a new government plan option would create an expensive, unnecessary new entity that would be a diversion from the needed goals of health reform: extending coverage to the uninsured, modernizing Medicare and reining in costs. Furthermore, a new government plan likely would end up covering millions of Americans who already have coverage, thereby losing the billions of dollars in employer subsidies that currently help finance our health care system.

Conclusion

BCBSA appreciates this opportunity to share our recommendations for ensuring coverage for all Americans. We look forward to continuing to work closely with Congress, the Administration, and all stakeholders to enact comprehensive health care reform legislation this year.

Statement for the Record

Gerald Shea, Assistant to the President
American Federation of Labor and Congress of Industrial Organizations

U. S. Senate Finance Committee Roundtable
"Financing Comprehensive Health Care Reform"

May 12, 2009

Thank you for the invitation to participate in this roundtable discussion and offer our perspective, on behalf of working women and men, on financing health care reform. The AFL-CIO represents 11 million members, including 2.5 million members in Working America, our new community affiliate, and 56 national and international unions that have bargained for health benefits for more than fifty years. Our members have a significant stake in health care reform as consumers but also, for many, as health care workers or sponsors of coverage.

Through bargaining, our members are among the most fortunate: they have good job-based benefits that help keep care affordable. Yet even the well insured are struggling with health care costs hikes that are outpacing their wage increases and far too many working families increasingly find themselves joining the ranks of the uninsured or under-insured as businesses close or cut back. More than 320,000 Americans lost employer-provided health insurance in March alone, or roughly 10,680 workers a day.[i]

All signs point to a system in crisis. Health care costs too much, covers too little and leaves tens of millions without coverage and many more worried about keeping the coverage they have. Between 1999 and 2008, premiums for family coverage increased 119 percent, three and one half times faster than cumulative wage increases over the same time period.[ii] Workers' out of pocket costs are going up as well, leading to more under-insured Americans who can no longer count on their health benefits to keep care affordable or protect them from financial ruin. Between 2003 and 2007, the number of non-elderly adults who were under-insured jumped from 15.6 million to 25.2 million.[iii] And skyrocketing costs are pushing more workers out of insurance altogether. About 18 million of the 47 million uninsured have household income that exceeds $50,000.[iv]

Future trends indicate far worse conditions. The average cost of a family plan through employer-based coverage is projected to reach $24,000 in 2016, an 84 percent increase over 2008 premiums. At this rate, at least half of American households will spend more than 45 percent of their income to buy health insurance in 2016. [v] By 2017,

health spending is expected to double to $4.3 trillion and administrative expenses are projected to double to $298 billion. [vi] And the implications for our economy are staggering: the Congressional Budget Office has said that unless we take action, health care spending could consume 49 percent of our GDP in 2082, causing wages to stagnate and depressing non-health care sectors of our economy.

No matter how you look at health care, we can no longer afford to not get comprehensive reform done this year. In fact, one study estimates our economy loses between $100 billion and $200 billion each year because of diminished health and shorter lifespan of the uninsured – roughly the range most experts recognize as the upfront cost of comprehensive reform.[vii]

Thankfully, this committee has been consistently leading the call for health care reform that guarantees affordable, high-quality health care for all Americans, noting, like our President, that reform is not only a moral imperative; it is also an economic imperative. Through all the work done last year and with the White Paper released in the fall, this committee has been laying the groundwork to get health reform done.

Our members with health benefits experience everyday what it is like for people with coverage to live in fear of losing it. That is why they are counting on health reform to not only extend coverage to all uninsured Americans but to also lower costs for those who now have it. Comprehensive health reform holds the potential to bring relief to well-insured Americans like many of our members by eliminating the cost shift that results when uninsured and underinsured workers get uncompensated care. And it can provide everyone the security of coverage in the face of continuing and deepening declines in employer-sponsored health benefits.

For all these reasons, we believe the overarching goal of health reform must be to constrain costs: for families, for business and for government at all levels. But we can't constrain costs without covering everyone, and we can't cover everyone without constraining costs.

Key to holding down costs will be inclusion of a public health insurance plan option for all who purchase coverage through an exchange. A public health insurance plan will make coverage more affordable with lower administrative costs. It will also inject needed competition into an imperfect market. And it can help drive delivery system reforms in conjunction with private payers, as Medicare has done with the quality improvement work underway already.

We also applaud the committee for the release last month of an options paper on transforming the health care delivery system. The elements outlined in that paper are essential to increasing value in our health care system – to constrain costs while improving quality. The elements in the options paper will also set us on a path to a more efficient system anchored in continuous quality improvement and scientific advances. Studies indicate that one third of all health care spending is on poor quality care and patients have just a 50/50 chance of getting the right care at the right time. We simply cannot afford to grow the system we have now and it will be especially important to achieve the improvements envisioned in the options paper if we are to bend the cost curve that, if left unchecked, will balloon our federal budget and squeeze out funding for other essential, non-health care priorities. But while these improvements are absolutely necessary to improve the value we get for our spending, they will not be sufficient to fund health care reform

In order to get health reform done, we cannot rely solely on savings in the system; we will need to identify additional revenues. To find those, we agree with the President that health care reform is an urgent national priority that will produce benefits across our economy and improve our future budget outlook; therefore, we should look beyond health care spending to find the revenues needed to fund health care reform. To begin, we support the major elements of the President's budget proposal for more than $600 billion in savings and revenues, half of which comes from savings within Medicare and Medicaid and half of which comes from limiting the itemized deductions for households in the top two tax brackets.

Health reform should include other options that will produce savings for all payers, both public and private, without compromising quality of care. These options would include allowing for greater competition between brand name and generic drugs, for both traditional drugs and biotech drugs, and increasing our investment in comparative effectiveness research in order to give doctors and patients the information they need to make optimal treatment decisions.

Beyond these savings, we urge the committee to consider broader tax reform options, including those put forth by President Obama: increasing the capital gains tax to Reagan era levels; taxing the "carried interest" of private equity managers at ordinary income tax rates rather than at capital gains levels; reforming international tax enforcement and changing rules around deferral of taxes on foreign income, which the Administration has said could raise $210 billion; and eliminating the "Last In, First Out" inventory rules that could raise as much as $60 billion.

Finally, we believe the committee must include an employer requirement to either provide coverage or pay into a fund to make coverage available for their workers, known as "pay or play." There are important policy reasons to do this – to shore up the employer based system, to level the playing field for firms that offer coverage, and to generate the "shared responsibility" that many members of this Congress and the public have recognized will be essential to achieving broadly supported reform. But "pay or play" will also help generate revenues from those firms that opt to "pay" whatever contribution will be required of employers and it will hold down federal costs associated with providing subsidized coverage to low-wage workers in those firms that opt to "play." Without such a requirement, many more employers might eliminate coverage for low-wage workers who would be eligible for subsidized coverage under health reform.

One potential source of funding this committee is considering – capping the current tax exclusion for employer-sponsored insurance, whether by income or benefit amount or a combination of those factors – is, in our view, a step in the wrong direction. We have already noted that we cannot constrain costs without covering everyone. But it

is also the case that we cannot ask people who traded wages for health benefits to pay more for their coverage without undertaking a serious effort to lower costs.

Too often lost in the discussion about capping the tax exclusion is the fact that the cost of coverage reflects much more than the generosity of the coverage. The cost of coverage is a reflection of many factors beyond workers' control: the size of the firm; the demographics of the workforce; whether the industry is considered by insurers to be "high risk;" geographic differences in cost; and whether there are pre-Medicare retirees covered through the same plan.

True cost containment requires a number of elements that we believe are essential to successful reform. First, we need to transform our delivery system from one that rewards better care, not just more care. The options paper presented by this committee makes a significant contribution to that effort. It would also require us to fix our flawed insurance market to prohibit insurers setting rates that effectively discriminate against small firms, older workers, and others deemed too risky to cover. It would require employers to pay their fair share to cover workers, in order to eliminate the cost shift from free riders in our voluntary system. And it would require us to include a public health insurance plan option for everyone purchasing coverage in the exchange in order to make coverage more affordable. A public plan would lower costs for those individuals and firms purchasing coverage in that plan and, through competition, lead to lower costs for coverage in private plans. We believe even large employers should be eligible to purchase coverage in the exchange once it is established and secure, so that the benefits of that price competition can be extended to all purchasers.

I'd like to offer one final note of caution: Congress and the President have indicated that health reform will build on what works and assure Americans that they can keep what they have if they like it. This approach makes enormous sense to us and, in fact, generates broad support from the public. But a cap on the tax exclusion threatens to disrupt the primary source of health coverage and financing for most Americans. Until

we have built a proven, sustainable alternative to employer-sponsored benefits, we should not undertake changes that might threaten that coverage.

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[i] N. Kazzi, "More Americans are Losing Health Insurance Every Day: An Analysis of Health Coverage Losses During the Recession," Center for American Progress, May 4, 2009.
[ii] Kaiser Family Foundation and Health Research & Educational Trust Employer Health Benefits 2008 Annual Survey, September 2008.
[iii] C. Schoen, S.R. Collins, J.L. Kriss and M. M. Doty, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive, June 10, 2008.
[iv] C. DeNavas-Walt, B. Proctor, J. Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2007," U.S. Census Bureau, Issued August 2008.
[v] S. Axeen, E. Carpenter, "Cost of Doing Nothing," New America Foundation, November 2008, accessed at www.newamerica.net
[vi] Centers for Medicare and Medicaid Services, National Health Expenditure Projections, 2007-2017.
[vii] S. Axeen, supra.

Ideas for Financing Health Reform: Revenue Measures that Also Reduce Health Spending

Statement for the Senate Committee on Finance

John Sheils
Vice President
The Lewin Group

Tuesday, May 12, 2009

About The Lewin Group

The Lewin Group is a health care and human services policy research and management consulting firm. We have over 25 years of experience in estimating the impact of major health reform proposals. The Lewin Group is committed to providing independent, objective and non-partisan analyses of policy options. In keeping with our tradition of objectivity, The Lewin Group is not an advocate for or against any legislation. The Lewin Group is part of Ingenix, Inc., which is a wholly owned subsidiary of the UnitedHealth Group. To assure the independence of its work, The Lewin Group has editorial control over all of its work products.

Ideas for Financing Health Reform: Revenue Measures that Also Reduce Health Spending

Thank you for this opportunity to address the committee on approaches to funding health reform. I am a Vice-president with The Lewin Group with 25 years experience in studying and analyzing proposals to reform health care and extend health insurance to the uninsured. We are committed to providing independent, objective and non-partisan analyses of policy proposals. We do not advocate for or against legislative proposals.

Health reform can be funded with new revenues and savings to existing federal programs. In this analysis we examine two tax-based options that would both raise revenues and reduce health spending. These include placing limits on the tax exclusion for employer health benefits and a large increase in the tax on tobacco products. We also discuss potential savings to existing federal safety-net programs under expansions in coverage that could be redirected to help pay for health reform.

We estimate that these three proposals would raise about $1.25 trillion in revenues and savings to federal programs over the 2010 through 2019 period. This is roughly equal the amount of funding required to pay for the health reform program proposed by President Obama in the 2008 campaign ($1.17 trillion).[1] These provisions would also reduce national health spending by about $461.0 billion over this period.

A. Changes in the Tax Exclusion for Employer-Sponsored Insurance (ESI)

Changes in the tax exclusion for employer-sponsored Insurance (ESI) would provide new revenues for reform while reducing health spending. Under current law, the cost of ESI is exempt from taxation as income to the individual for purposes of both the income tax and payroll taxes for Social Security and Medicare. For workers in Section 125 plans, the employee contribution is also tax exempt, and many workers have a tax exempt flexible spending account for payment of uncovered health expenditures.

These tax breaks will represent a loss of federal tax revenues of about $297.4 billion in 2010 ***(Figure 1)***. This includes $173.5 billion in personal income taxes and $100.1 billion in Social security and Medicare payroll tax payments. About 40.5 percent of all tax expenditures will go to families with incomes of $100,000 or more, while only about 2.3 percent would go to families with incomes below $20,000.

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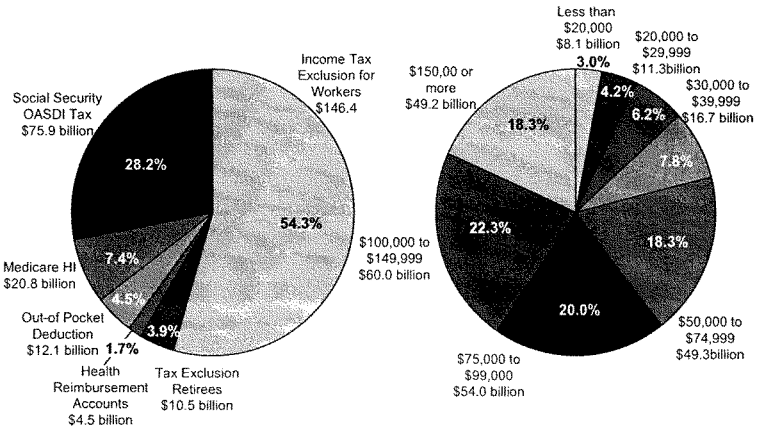
[1] "McCain and Obama Health Care Policies: Cost and Coverage Compared," The Lewin Group, October 8, 2009

Figure 1
Projected Health Benefits Tax Exclusion for 2010



Total Federal Tax Expenditures = $269.4

Source: Lewin Group Estimates using the Health Benefits Simulation Model (HBSM)

For illustrative purposes, we estimated the impact of capping the amount of the exemption and phasing it out for high-income individuals. We also assume that the tax exempt flexible spending accounts for uncovered health expenses are eliminated. These changes include:

- **Cap the Tax Exclusion for Employer-Provided Health Insurance**: We assume that the tax exemption for employer provided benefits is capped at the average cost of employer benefits projected for 2010. The cap is $4,906 for individuals and $13,036 for families. These caps are indexed annually in proportion to the consumer price index (CPI).
- **Phase-out of Employer Benefits Tax Exclusion**: We assume that the employer health benefits tax exclusion is phased-out for taxpayers with between $250,000 and $500,000 in income and that there is no exclusion for people with over $500,000 in income. These income thresholds are indexed annually to the CPI.
- **Eliminate Flexible Spending Accounts (FSAs) for Uncovered Health Expenses:** This measure eliminates uncovered health expenditure reimbursement accounts under Section 125 FSAs (i.e., "cafeteria" plans).

These changes would provide $757.7 billion to finance health reform over the 2010 through 2019 period. The cap on the tax exclusion would raise $583.5 billion in revenues over ten years. The phase-out of the exemption for those with incomes over $250,000 would raise $114.4 billion. Eliminating the tax exempt FSA for uncovered health expenses raises about $59.8 billion.[2]

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[2] An important aspect of this proposal is that the premium cap amounts are indexed annually to the Consumer Price Index (CPI) which is expected to be about 2.8 percent per year, even though health care costs are expected to

These changes in tax policy would effectively increase the cost of health insurance to the individual, thus encouraging people to enroll in less expensive health plans such as HMOs or HSAs. We modeled the number of people shifting to lower cost plans based upon studies of how changes in the price of coverage affect consumer choice of health plans.[3] We then estimate savings resulting from the shift to lower cost plans.[4,5] Using these assumptions, we estimate a reduction in health spending for those shifting to lower cost plans of about $278.7 billion over the 2010 through 2019 period (***Figure 2***). Nearly all of these savings would apply to the privately insured population.

Figure 2
Changes in National Health Spending due to Limits on the Tax Exclusion for Employer Provided Health Benefits (billions)

Year	Changes in Revenues from Limits on the Tax Exclusion for Employer Health Benefits				Changes in Health Spending Due to Changes in Tax Incentives
	Cap on Exclusion for Employer Health Benefits	Phase-out of Exclusion for Incomes over $250,000	Eliminate Flexible Spending Accounts for Uncovered Health Care	Total Changes in Tax Revenues	
2010	$26.0	$5.2	$4.5	$35.7	-$11.4
2011	$30.4	$5.9	$4.8	$41.1	-$13.4
2012	$35.6	$7.0	$5.1	$47.7	-$15.7
2013	$41.7	$8.2	$5.4	$55.3	-$18.3
2014	$48.8	$9.6	$5.7	$64.1	-$21.4
2015	$57.1	$11.2	$5.8	$74.1	-$25.1
2016	$66.9	$13.1	$5.8	$85.7	-$29.4
2017	$78.2	$15.3	$5.9	$99.4	-$34.4
2018	$91.6	$17.9	$5.9	$115.4	-$40.2
2019	$107.2	$21.0	$5.9	$134.1	-$69.5
2010-2014	**$182.5**	**$35.9**	**$27.2**	**$245.6**	**-$80.2**
2010-2019	**$583.5**	**$114.4**	**$59.8**	**$757.1**	**-$278.7**

Source: Lewin Group Estimates using the Health Benefits Simulation Model (HBSM)

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grow at between 6 percent and 7 percent per year over this period. This means that over time, the proportion of ESI benefits that is taxable increases over time. As a consequence, the revenues raised through the tax cap grow by up to 17 percent per year.

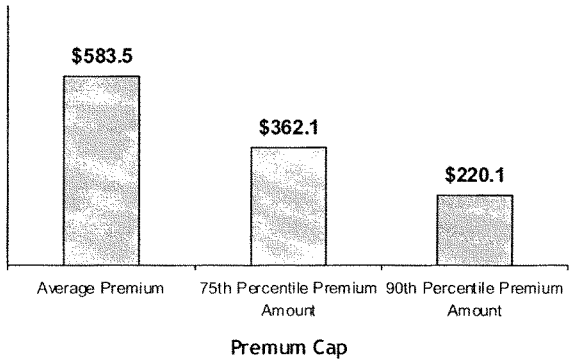
[3] On average, a one percent increase in the price of an insurance product causes about 2.5 percent of members to shift to lower cost products. No savings are calculated for people currently in HMOs. See: Stombom, B.,Buchmueller, T.,Feldstein, P. "Switching costs, Price Sensitivity and Health Plan Choice", Journal of Health Economics 21 (2002) 89-116.

[4] Stapleton, D., "New Evidence on Savings from Network Models of Managed Care," (a report to the Healthcare Leadership Council), The Lewin Group, Washington, DC, May 1994

[5] For a detailed discussion of methods see: "The Health Benefits Simulation Model (HBSM): Methodology and Assumptions," The Lewin Group, March 31, 2009.

The amount of revenues raised by capping the exclusion varies with the level of the cap. As shown above, capping the exclusion at average premium amount would raise $583.5 billion over the 2010 through 2019 period (***Figure 3***). If the cap is raised to the 75th percentile premium amount, revenues fall to $362.1 billion. At the 90th percentile, revenues fall to $220.1 for the 10-year period.

Figure 3
Revenues Raised under Alternative Caps on Employer Tax Exclusion for Employer-Sponsored Insurance: 2010 - 2019 (billions)



Source: Lewin Group Estimates using the Health Benefits Simulation Model (HBSM).

B. Increase Tax on Tobacco Products

Increasing the tax on tobacco products would raise revenues while reducing tobacco use. This reduction in tobacco use would improve health and reduce health care costs for tobacco related illnesses. Health care savings would accrue to all payers including federal programs. Thus, the tax on tobacco will raise federal revenues while reducing federal costs.

In this scenario, we assume that the federal cigarette tax is increased from $0.39 per pack to $2.39 per pack, with taxes on other types of tobacco products increased in the same proportion. Chaloupka et al. (2000) has estimated that for every 10 percent increase in the cost of a pack of cigarettes, consumption declines by 4 percent.[6] Given the current average retail price of $4.27 per pack, the proposed tax increase would result in an 18.8 percent decline in consumption above the current rate of decline in smoking prevalence.[7,8]

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[6] Chaloupka F, The-Wei Hu,Warner K, Jacobs R, Yurekli (2000). "The taxation of tobacco products", Report found at http://www1.worldbank.org/tobacco/tcdc/237TO272.PDF

[7] Report found at: http://tobaccofreekids.org/research/factsheets/pdf/0234.pdf

We estimated the reduction in health spending due to smoking cessation based upon studies of the impact of tobacco use on smoking. One study estimates that care for tobacco-related illnesses accounts for about 14 percent of national health expenditures.[9] Barendregt et al. (1997) estimated that health care costs decline in the first 15 years following cessation. They estimate that if all Americans were to stop smoking, there would be a 1 percent reduction in national health spending in the first year following cessation, and that savings would increase to 2.5 percent by the 5th year.[10]

The tax on tobacco products would reduce the federal deficit by $358.8 billion over the 2010 through 2019 period (***Figure 4***). This includes total revenues from the tobacco tax of $294.5 billion, and reduced health spending under federal programs of $67.2 billion. National health spending for all payers (i.e., employers, consumers and governments) would decline by $182.3.

Figure 4
Impact of Tobacco Tax Increase on Federal Revenues and Health Spending: 2020-2019
(billions)

	Changes in Federal Budget			Reduction in National Health Spending
Year	Increase in Federal Tobacco Tax Revenues	Savings to Federal Programs	Net Federal Impact	
2010	$30.7	0	$30.7	0
2011	$30.4	$1.7	$32.1	$4.9
2012	$29.5	$4.1	$33.6	$11.4
2013	$29.3	$5.5	$34.8	$15.0
2014	$29.1	$6.8	$35.9	$18.6
2015	$28.8	$8.2	$37.0	$22.1
2016	$28.7	$9.2	$37.9	$24.8
2017	$28.5	$10.0	$38.5	$27.0
2018	$28.3	$10.7	$39.0	$28.8
2019	$28.2	$11.0	$39.2	$29.7
2010-2019	**$291.6**	**$67.2**	**$358.8**	**$182.3**

Source: Lewin Group estimates.

C. Offsets to Federal Safety-net Programs

It is often argued that covering the uninsured will be relatively inexpensive because we are already providing large amounts of subsidized care through numerous federal, state and

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[8] Cigarette consumption in the US peaked in 1980 at 631.5 billion cigarettes per year and has since declined to 378.6 billion cigarettes per year. See: 1993-1996 US Department of Agriculture 1997-2005 Alcohol & Tobacco Tax and Trade Bureau, Bureau of the Census

[9] Center for Disease Control (CDC), report found at:
http://www.cdc.gov/nchs/ppt/hpdata2010/focusareas/fa27_tobaccopres.ppt#297,1,Slide 1

[10] Due to improved health, people would live longer, resulting in an eventual net increase in health spending by the 15th year. See: Barendregt JJ, Bonneux L Van Der Maas PJ. "The Health Care Costs of Smoking." *The New England Journal of Medicine*, October 1997.

private sources. This creates an expectation that covering the uninsured will result in offsetting savings to various safety-net programs such as federal Disproportionate Share Hospital (DSH) payments, Federally Qualified Health Centers (FQHC), and various substance abuse and immunization programs.

However, while the need for such safety-net services would decline, these offsets would not occur automatically. Unless Congress acts to explicitly reduce funding for these programs, the spending will continue, regardless of the demand for safety-net services. Of course, reducing funding for these programs would be highly controversial.

Currently, both the Medicare and Medicaid programs provide additional payments to states that are typically paid to hospitals serving large portions of the uninsured population called Disproportionate Share Hospital (DSH) payments. Most of the payments under Medicaid go to hospitals, although much of this money is now used by states to fund coverage expansions (e.g., Massachusetts). The Medicare program also makes additional payments to hospitals serving large portions of the medically indigent population. Total DSH payments under Medicare and Medicaid will be about $19.5 billion in 2010 (***Figure*** 5).

Figure 5
Federal Disproportionate Share Hospital Payments under Current Law 2010-2019

Year	Federal Disproportionate Share Hospital (DSH) Funds under Current Law (billions)		
	Medicare	Medicaid	Total
2010	$10.1	$9.4	$19.5
2011	$10.5	$9.7	$20.2
2012	$11.0	$9.9	$20.9
2013	$11.7	$10.2	$21.9
2014	$12.5	$10.5	$23.0
2015	$13.4	$10.8	$24.2
2016	$14.4	$11.0	$25.4
2017	$15.4	$11.3	$26.7
2018	$16.5	$11.5	$28.0
2019	$17.6	$11.8	$29.4
Total 2010-14	**$55.8**	**$49.7**	**$105.5**
Total 2010-19	**$133.1**	**$106.1**	**$239.2**

Source: CBO projections.

Federal Funding for other health services will be about $5.84 billion in 2009, including:

- Federally Qualified Health Centers: through the Health Resources and Services Agency (HRSA): $1.875 billion
- Health Care Delivery in Rural Areas $0.025 billion
- Substance Abuse and Mental Health Service Administration (SAMHSA) $0.351 billion
- HIV/AIDS treatment programs (Ryan White) $1.103 Billion
- Primary Care: Immunizations for Preventable Diseases $2.489 billion

In addition, the Veterans Administration provides about $5.4 billion in care to uninsured veterans.[11]

There would be a continuing need for some of these safety-net services, even with health reform. There would still be uninsured people including undocumented immigrants and the homeless. Also, some of the services provided under these programs are outside of the scope of services typically covered under private health plans, and would still be needed. Careful analysis of the impact of the coverage expansions under reform will be required to determine the appropriate reductions in funding for these programs.

Moreover, the need for the services provided under these programs often exceeds what can be provided at current levels of funding. For example, the VA could provide substantially more services to veterans if additional funds become available. Therefore it is unlikely that all of this safety-net funding would become available to fund coverage expansions even if all Americans become covered.

For illustrative purposes, we assume that about half of federal safety-net funding can be recovered and used to finance health reform. This would come to about $130.0 billion over the 2010 through 2019 period.

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[11] Jack Hadley et. al, "Covering the Uninsured In 2008: Current Costs, Sources of Payment and Incremental Costs," *Health Affairs*, 27, no. 5 (2008).

Statement of
Glenn D. Steele Jr., MD, PhD
President and Chief Executive Officer
Geisinger Health System

to the
Committee on Finance
United States Senate
April 21, 2009

Thank you for the opportunity to submit this statement for your Roundtable on Reforming the Nation's Healthcare Delivery System.

At Geisinger Health System, we serve a population that is poorer, older and sicker than the national average. Most of our patients have multiple chronic diseases, such as diabetes, high blood pressure and lung disease. Our patients have difficulty navigating through a complex healthcare system. They need help and we have made a concerted effort to put into place electronic and other innovative methods that will provide them with the assistance to maximize their ability to get care.

At Geisinger, we hold ourselves to high standards of assuring quality outcomes in serving these patients. For example, if a patient is readmitted to a hospital after a procedure or an in-patient stay, we believe we have failed that patient. Consequently, we have committed significant resources and have worked aggressively to bring value to healthcare and eliminate failures by redesigning how we provide care.

The innovations we have instituted at Geisinger that bundle payments for acute care procedures, enhance support for primary care physicians and their care teams, better manage chronic disease and the transitions of care for patients from caregiver to caregiver, have produced significant cost

savings and improved quality. Admissions for our patients with multiple chronic diseases have been reduced by as much as 25% and readmissions following discharges decreased by as much as 50% in community sites. I believe that what we have accomplished can be adopted nationally and will achieve similar cost savings while improving quality. This would result in significant positive consequences for large payors, particularly Medicare.

BACKGROUND

I am Glenn Steele, the President of the Geisinger Health System, an integrated healthcare organization located in central and northeast Pennsylvania. Before coming to Geisinger, I spent 20 years as a practicing cancer surgeon at several Harvard hospitals and served as a Chairman of the Department of Surgery at the New England Deaconess Hospital. I then became Vice President for Medical Affairs and Dean of the Division of Biological Sciences and the Pritzker School of Medicine at the University of Chicago. Consequently, I have firsthand experience with patients, their access (or lack of) to care, issues that affect physicians and other caregivers in providing adequate and timely care, and the difficulties in juggling medical education and research, while facing ongoing changes in healthcare reimbursement.

In 2001, I came to central Pennsylvania because Geisinger offered the potential as an integrated healthcare system of developing cutting-edge approaches to increasing efficiency, value, and quality in healthcare. In short, we could attempt to transform healthcare using both our healthcare insurance product, and our clinical delivery system working together to benefit our patients.

We serve a population of 2.6 million located in central and northeastern Pennsylvania. And we have an electronic health record (EHR) that was implemented 14 years ago with now more than

3 million individual patient records. Geisinger has been named as "Most Wired" by *Healthcare's Most Wired* magazine six times. We have our own health care insurance product - Geisinger Health Plan - that has nearly 235,000 members, 35,000 Medicare beneficiaries, 18,000 empanelled physicians, 90 hospitals (not including our Geisinger hospitals) and spans 43 of Pennsylvania's 67 counties.

We also lead our area's regional electronic health information sharing platform[1], called the Keystone Health Information Exchange, with (currently) ten hospitals and approximately 700 private practices sharing valuable medical information. This secure, patient-approved sharing of information means that our doctors, and more than 1,500 non-Geisinger caregivers can access patient information 24/7 from anywhere – a remote two-doctor primary care office, a multispecialty clinic, an operating room, or at 3:00 am from home.

Our patients access their own electronic health record. They can see their lab results, radiology results, request prescription refills, and email their doctors, nurses, and staff with questions anytime. And, they schedule their own appointments on-line.

Geisinger has a large number of elderly patients (many greater than 80 or 90 and more and more now exceeding 100 years of age). Most have multiple chronic diseases and have family living outside of our area who follow their parents' care through the electronic record (with appropriate patient approval).

Geisinger employs about 800 physicians who see patients in more than 50 clinical practice sites; 38 of which are primary care sites in local communities. As clinically appropriate, physicians in these clinical sites admit their patients to nearly 20 local community hospitals - ensuring that

patients receive most of their care near where they live. Only if necessary, are Geisinger patients treated at one of our three specialty hospitals.

Geisinger's innovation[2] is intended to attack fundamental flaws in our country's payment for and delivery of healthcare. The U.S. suffers from a variety of reimbursement and care delivery issues that do not produce good clinical outcomes. There is wide and unjustified variation in care. Fragmentation of care is rampant; our "hand-offs' (that is, transferring important medical and family information as patients are moved from one environment to another) are disjointed and most often result in patient care that is not coordinated and is confusing to the patient. We have a perverse method of payment – one that rewards units of work regardless of patient outcome. At Geisinger, we invest in quality and pay accordingly. Doctors who have better clinical outcomes are rewarded (financially and by recognition) and we constantly measure our outcomes against our peers, both within Geisinger and nationally. Physician, staff and site incentives are built into our system. And we reward quality and value, not just numbers of patients seen or numbers of procedures performed.

GEISINGER'S ACUTE EPISODIC CARE PROGRAM (THE "WARRANTY") [1, 2]

A great paradox in U.S. healthcare is that we get paid for making more mistakes. For example (with few exceptions), if a patient develops a post-operative complication that might have been avoided by proper care, we often receive more reimbursement for that case than for a comparable case without a complication. This does not happen in other industries. Why are healthcare services an exception?

Consequently we believe our care design should be based on best evidence. In 2006, we started tackling the perverse payment incentives noted above by redesigning how we provide elective

cardiac surgical care – what is known as coronary artery bypass grafts (or CABG)[3]. CABG is an episodic acute event – an event with a determined time frame from diagnosis through rehabilitation and recovery (unlike chronic disease, which stays with you for life). Our cardiology service line reviewed the American Heart Association and the American College of Cardiology guidelines for cardiac surgery and translated these into 40 verifiable best practice steps that we could implement with each patient undergoing this surgery. We hardwired these into our electronic health record so that we would be prompted to meet each identified step – or document the specific reason for any exception.

We then established a package price that included costs of the first physician visit when surgery was deemed necessary, all hospital costs for the surgery, and related care for 90-days after surgery, including cardiac rehabilitation. We named this program "ProvenCare", since it is based on evidence or consensus of best practices by our heart experts. Pre-operative, post-operative and rehabilitation are part of the single charge. And we take the financial responsibility for any associated complications and their treatment.

While our cardiac surgery outcome was already well above the national average, (and near the top of Pennsylvania's PHC4 data set) upon initiation of this program only 59% of patients received all 40 best practice steps. Three months into the study, 86% were receiving best care. We raised that to 100% and, with few exceptions, have kept it at that high rate.

As a result of implementing this "warranty" program, our patient care was better – using comparative, standardized data from the Society of Thoracic Surgery. We had a reduction in all complications of 21%, sternal infections were down 25%, and re-admissions fell by 44%. Costs for treatment fell, too. Our average length of hospital stay decreased by half a day[4].

For other high volume, hospital-based treatments, we have now considered every step in the patient's care flow. For instance, in orthopedic surgery, why should one doctor use one set of surgical instruments and prosthetic devices and another insist on a different instrument set-up for the same procedure? That type of variation often has no medical justification, results in unnecessary costs that are passed off to third party payors (such as Medicare) and, we believe, compromises patient outcome.

We have expanded our experience with heart surgery to "warranty" programs that include: hip replacement, cataract surgery, obesity surgery, prenatal care for babies and mothers (supported by the March of Dimes) – from an infant's conception to birth, centrally- managed, evidence-based use of high cost biologicals, such as EPO (erythropoietin), and heart catheterization.

We have improved outcomes and have reduced costs. This is because we have systematically researched how best to deliver care, hardwired the process steps into our electronic health record to prompt us on what best practices are, decreased unjustified variation, and taken financial risk to decrease related complications.

PROVENCARE – CHRONIC DISEASE

In reforming how we deliver care at Geisinger, it isn't enough to simply address acute episodic care. The major challenge of healthcare in the U.S. is now chronic disease treatment and "secondary prevention". We identified the most common chronic diseases – diabetes, coronary artery disease, congestive heart failure, kidney disease – and have applied evidence or consensus-based best practice thought to limit disease progression. Called "bundled" care, we have designed each of these steps into our care pathways and strive to achieve as close to 100% adoption as medically appropriate and feasible. In the case of diabetes, we began to track how

we performed in meeting 100% of the expected "bundle" of best care for diabetic patients three years ago. Our primary caregivers have chosen to receive compensation based on how many of their 25,000 diabetic patients reach optimal levels in the practice "bundle", not solely on how many patients are seen each day or how many tests are ordered.

PROVENHEALTH NAVIGATOR (ADVANCED MEDICAL HOME) [3, 4]

Geisinger's patient-centered medical home initiative (called ProvenHealth Navigator) combines traditional medical home models with patient engagement and is designed to deliver value by improving patient care coordination throughout the system. Our Advanced Medical Home currently covers 30,000 Medicare recipients and 3,000 commercial patients, with plans to expand this base.

We understand that navigating through the complexities of any healthcare system is not easy, so we have invested in programs and staff to help support each patient's journey, placing dedicated nurses in each targeted outpatient clinic. Over 200 Geisinger primary care physicians diagnose and treat their patients locally in 38 community practice sites. Our "embedded" nurses are paid for by the Health Plan, becoming critical members of the community practice team and, with the physicians, are expected to know the patients and their families, to follow all of their care, help them get access to specialists and social services as necessary, follow them when they are admitted to a hospital, contact or see them when they are sent home to confirm that they are taking the appropriate medication dosages, and be available for advice 24 hours a day.

Importantly, we don't just ask these community-based clinicians to "try harder" or "work faster"; we use resources from our health plan to help redesign their work. And, we pay incentives for getting the job done. In our best practices, our sickest chronic disease patients' admissions were

decreased by 25%, days in the hospital decreased by 23%, and readmissions following discharge decreased by 53%. The payback for the health plan occurred within the first year. The benefit to patients and their families avoiding multiple hospital admissions was immeasurable!

For these patients with multiple chronic diseases, transport to and from the hospital or clinic, choosing which doctor should be seen, coordinating their numerous prescriptions, getting their pills, making sure they take their pills at the right time – all of this is what our ProvenHealth Navigator work redesign accomplishes. Increased quality for the patient and their families actually lowers healthcare costs.

SUMMARY

Building on what we have done at Geisinger, I have these recommendations for your consideration:

- payment reform is needed to encourage integrated health care organizations and other providers to be accountable for results and resources
- primary care and patient-centered medical homes need to be rewarded
- a global fee covering hospital, physician, and other services including 30-day follow-up for acute episodes of care is needed
- consider capitation payments linked to quality outcome measures for prevention and chronic care services
- help fund enabling information technology but insist on non-proprietary interoperability

- help hospitals and communities establish transitions of care programs to reduce unnecessary admissions and readmissions.

Thank you again for the opportunity to submit this statement for your Roundtable on Reforming the Healthcare Delivery System.

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Statement for the Record
Service Employees International Union

Senate Finance Committee Roundtable on Health Care Coverage

May 5, 2009

We Can't Afford to Wait to Fix Healthcare

For at least three decades, the cost of healthcare has been rising faster than the increase in overall consumer prices, faster than wages, and faster than the overall rate of economic growth. According to the Congressional Budget Office, the share of our economy devoted to healthcare doubled over the last 30 years. Working families are losing ground as they are forced to pay more for premiums, more out-of-pocket at the pharmacy, doctor's office, and hospital, and as they sacrifice pay raises in a desperate and often futile effort to keep the coverage they have.

Since the beginning of the decade, the full cost of family health insurance premiums has doubled, while the percentage of firms offering coverage has fallen from 69 percent in 2000 to only 60 percent in 2007, according to the Kaiser Family Foundation. The number of adults who are uninsured at some point during the year rose from 38 million to 50 million over the same time period, according to a survey done by the Commonwealth Fund. The relentless rise in healthcare costs is eroding the extent to which employers offer and contribute to insurance for workers and their families, and is shrinking the scope of coverage for those workers who still have health insurance. As the number of uninsured and underinsured people grows, more uncompensated care costs are shifted to employers and workers who pay for insurance, and the cycle of cost increases and coverage erosion continues. An estimated $56 billion was spent by taxpayers and private payers to compensate for the unpaid costs of the uninsured in 2008, according to the Kaiser Family Foundation.

The uninsured are not just statistics. They are hardworking people such as Pat DeJong of Libby, Mont., an SEIU member who works as a home care aide. Pat and her husband Dan were ranchers, but had a hard time finding affordable coverage, and were uninsured when he was diagnosed with Hodgkin's lymphoma in 2000. The medical bills piled up for Pat and Dan, eventually forcing them to sell the land they loved and that had been in Dan's family for generations. Dan succumbed to cancer, and Pat remains uninsured. We can and must do better for hardworking families such as the DeJongs.

As the union representing Pat, SEIU will judge healthcare reform legislation according to whether it provides Pat with affordable choices of private and public health coverage, and whether it begins to slow healthcare cost increases for all SEIU members. SEIU's core principles for healthcare coverage include:

- Coverage must be affordable and meaningful;
- Employers, individuals, and government must share responsibility for financing and everyone must be enrolled; and

- Consumers must have a choice of healthcare provider, and a choice of private and public insurance plans.

If Congress waits to fix healthcare, it will leave families on a path where they can expect their premiums to double again to $24,000 by 2016, crushing their plans to get out of debt, pay for college costs, or save for retirement. According to the New America Foundation, at least half of all American households will spend almost half of their incomes to buy health insurance in 2016 if we stay on our current path. To wait to fix healthcare is to allow Medicare and Medicaid costs to rise from 4 percent of our economy in 2008 to 6 percent of our economy by 2016. According to CBO Director Doug Elmendorf, over the long term the rising costs of healthcare represent the single biggest challenge to balancing the federal budget. The CBO estimated in December 2008 that if we do nothing, the number of uninsured Americans will climb to at least 54 million by 2016, but CBO now acknowledges that number is likely too low, as it did not factor in the sharp hike in the uninsured caused by our current economic crisis.

Costs, Coverage, and Quality Must Be Addressed Together to Restore a Healthy Economy

A comprehensive approach to healthcare reform that expands coverage to everyone is the only approach that will slow healthcare costs and preserve coverage for those who have it now. If we allow high medical bills to drive families deeper in debt, and rising healthcare costs to put a drag on our economic recovery, we will not restore consumer confidence and generate the number of good U.S. jobs needed to put our country back on the right track.

Lisa McSwain is a small business owner in Edgecombe, Maine, and she spent $22,000 last year to cover her family. She has seen one year premium hikes of as much as 30 percent in recent years, and healthcare costs are ravaging her business. Lisa wants to do right by her employees and grow her business. We are counting on Lisa and other small businesses such as hers to generate jobs and help get us on the road to economic recovery, but to do that we must address healthcare costs and coverage together.

Americans are ready to fix healthcare. According to a poll conducted in April by the Kaiser Family Foundation, six in 10 Americans say that they or a member of their household has delayed or skipped medical treatment in the past year. A solid majority of the respondents agree that the current economic crisis makes it more important that we reform healthcare now. More than a quarter of those surveyed said someone in their household has had trouble paying medical bills over the last year, with 41 percent of African Americans struggling to pay medical bills, and households earning less than $30,000 having the most trouble of all (48 percent).

Coverage Erodes, Health Status Declines, Disparities Widen, Values as a Nation Compromised

Being uninsured is harmful to a person's health, a person's pocketbook, and to our productivity as a nation. Moreover, the growing numbers of uninsured Americans undermine our values as a nation committed to equal opportunity and a just society. The Institute of Medicine (IOM) released a report in 2001 which documented the lost productivity as well as shortened lives of uninsured Americans. The New America Foundation recently updated the IOM's estimates and concluded that we are losing $200 billion in economic activity due to the lower productivity associated with the uninsured. The uninsured are sicker and die prematurely, and uninsured children are less likely to develop normally and achieve their educational potential when their health conditions go untreated.

Our healthcare system is riddled with racial and ethnic inequities in access to high-quality care that result in poorer health and higher rates of negative medical outcomes, including serious complications and premature, often preventable death. The costs of these well-documented, persistent gaps in care extend beyond the individual to the entire healthcare system. Paraphrasing President Obama at the recent White House Summit on Healthcare, we will save money as a healthcare system if we begin to close these gaps. Healthcare inequities play a significant role in driving escalating costs. Seventy-five percent of healthcare dollars are spent to treat chronic diseases, such as asthma, heart disease, cancer, and diabetes, and minorities disproportionately suffer from chronic diseases, both in prevalence and in the severity and frequency of costly complications. All minority groups suffer diabetes at rates two to six times higher than whites, and diabetic African Americans, Hispanics, and Native Americans are two to four times more likely to have a limb amputated than white diabetics, according to the National Limb Loss Information Center.

Minorities tend to be disproportionately uninsured, and more than half of America's uninsured are people of color, according to the Kaiser Family Foundation. About 33 percent of Hispanics and Native Americans are uninsured, and 21 percent of African Americans are uninsured. As a result, many African Americans and Latinos have little choice but to rely on emergency rooms for their medical care and are much less likely to have a regular primary care physician to prevent, diagnose and manage chronic diseases.

Increasingly, the ranks of the uninsured are made up of people who work, or live in households with workers, yet they are unable to access coverage. According to the Kaiser Family Foundation, 69 percent of the uninsured live in a household with a full-time worker, and 19 percent of the uninsured live in a household where there is a part-time worker. The Service Employees International Union knows these workers, their families, and their communities well. Sixty-six percent of the uninsured earn less than 200 percent of the federal poverty level, or $24,000 for a family of four. These workers are less likely to be offered coverage at work,

much less likely to be offered spousal or family coverage, and have the most difficult time affording premiums and cost-sharing requirements if they are offered coverage at work. They are the child care workers caring for our children, the nurses' aides caring for our parents, and the janitors and domestic workers cleaning our offices and homes, and they deserve healthcare coverage.

SEIU's Path to Universal Coverage

1. Build on What Works; Build New Alternatives for a Changing Economy

Approximately 160 million people are enrolled in employer coverage, and many are satisfied with that coverage, but each year costs are going up and benefits are being squeezed. Others can't qualify for employer coverage due to waiting periods or minimum hours requirements imposed by employers, or they are classified as independent contractors and not eligible for employer coverage at all. According to the Kaiser Family Foundation's survey of employer-sponsored benefits in 2008, among firms that offer coverage, on average 80 percent of the workforce is eligible for that coverage. The standard of coverage in certain industries, such as the retail and fast-food sectors, is simply inadequate to protect workers and their families from shouldering high healthcare costs.

Small businesses, self-employed workers, students, workers between jobs, early retirees, and others need a place to go to get the same advantages available to workers employed in larger businesses and organizations. SEIU urges Congress to reform the insurance market and establish an insurance exchange to improve affordable choices by:

- Ending insurance market practices such as denial of coverage based on health status, excluding coverage for pre-existing conditions, or charging extreme rates based on age, gender, or health status-related factors. Congress should establish a minimum federal standard (floor, not a ceiling) for insurance market rating rules and phase in the new standards over a period of a few years. Those states that are above the minimum federal standards now should remain above the standards.

- Providing active oversight of the market to ensure the availability of meaningful insurance plans from which consumers can compare and choose. Rigorous standards should be set for insurers that want to participate in the new market, including standards related to marketing, the range and types of plans and coverage levels offered, adequacy of provider networks and measurement of provider and plan performance, reducing care delivery disparities and disparities in outcomes, protecting consumer rights, and limits on administrative costs. Online Web portals should be structured and supervised to rank plans for consumers based on quality scores, income, geographic, and health needs criteria.

States that demonstrate they can provide active oversight of the exchange should be permitted to do so. No other market for small group and individual coverage should be permitted outside the exchange.

- Offering federal financial assistance to individuals and families with low and moderate incomes, and those with high healthcare costs relative to their incomes, to guarantee affordability. Financial assistance should be available on a sliding scale based on income for those enrolling in the exchange, and for workers with employer plans that leave them exposed to high costs as a percentage of their income. Those with the lowest incomes should have no or minimal cost-sharing, and those with incomes between 100 percent and 200 percent of the poverty level should not to be required to spend more than 3 percent to 5 percent of their income on premiums and cost-sharing. Modest income families between 200 percentFPL and 400 percentFPL should not be expected to spend in excess of 5 percent to 8 percent of their income on total healthcare costs, and a 10 percent limit should be set for those with higher incomes in special circumstances related to high catastrophic or chronic costs. Financial assistance should be advanceable and assignable so that eligible individuals can designate a private or public plan of their choice to receive the assistance for which they qualify. Assistance should only be available to individuals in exchanges that meet benchmarks described above for reforming the insurance market.

- Offering a choice of private and public insurance plans to promote competition and contain costs. A reliable public plan assures consumers they will have continuity and stability, while private plan offerings often change year to year, and are often scarce in rural areas. Availability of a public plan is a necessary part of a comprehensive cost-containment strategy. A public plan will have lower administrative costs and offer less red tape through standardized forms and simpler policies for consumers and providers. According to the Urban Institute, there is increasing consolidation of both hospital systems and insurers, and a public plan can help create competition where it is lacking in consolidated markets. Both fully insured private and large self-insured group plans have been unable to drive delivery system reform and contain costs; they must partner with Medicare and a new public plan to adopt payment reforms and quality measurement strategies to reward quality, primary care and prevention, reduction in errors, and to serve patients in the appropriate setting with treatments backed by evidence. Risk adjustment payments may be needed for both the private and public plans, and should be based on measurable criteria not subject to gaming.

- Promoting choice and competition by allowing larger employer groups to purchase coverage and enroll in plans offered in the exchange over time as reform is phased in. As the insurance exchange gains experience in managing enrollment and administering

financial assistance, and competition is demonstrated in both choice and lower premium growth, some self-insured large employers or multiemployer plans may want to enroll in the exchange. Large employers should be able to benefit directly or indirectly from the success achieved by the exchange.

2. Share Responsibility for Financing Healthcare and Promoting Good Health

Employers, individuals, and government must all do their part to make sure we have a sustainable and affordable system that covers everybody. The journal *Health Affairs* recently published a paper by Bob Blendon and colleagues showing stronger public support for a shared responsibility approach to reform compared to an approach that relies solely on individual responsibility. SEIU believes government's role includes:

- Partnering with the states to remove barriers to full enrollment of those who are currently eligible but not enrolled in Medicaid and the State Children's Health Insurance Program. Aggressive outreach and community-based strategies are necessary, paperwork must be streamlined, and eligibility systems for other public programs must be linked with eligibility for health coverage. Allowing legal immigrants to enroll in coverage for which they are income or categorically eligible is necessary to achieve maximum coverage levels, promote prevention and a regular source of care, reduce disparities, assure providers they will be paid, and remain true to our values as a nation of immigrants.

- Covering all poor people (up to 133 percent of federal poverty level) in Medicaid with full federal funding. The federal government should work with states to maintain state fiscal effort with respect to Medicaid and SCHIP eligibility levels. Federal formulas for sharing the costs of Medicaid and SCHIP must have counter-cyclical automatic adjustments during economic downturns.

- Sponsoring new federal financial assistance to guarantee affordability for low and moderate income individuals and families, as described earlier in Section 1.

- Requiring large employers to provide a meaningful standard of coverage for all of their workers or pay into a fund to support the costs of covering them in a new exchange. Most large employers offer good coverage, and some should be recognized for leading the market and setting a high standard. Unfortunately, the voluntary approach of relying on a few responsible employers to keep all large employers at a good standard is leaving out more and more workers. A minimum standard for meaningful coverage in the large-employer segment of the market should be established, and include a minimum contribution rate toward the premium. SEIU supports an approach such as the

Commonwealth Fund's Path proposal, which includes a requirement for employers to contribute 75 percent of the premium for a plan that includes comprehensive benefits, or pay 7 percent of payroll to a fund. Fair rules governing the treatment of part-time workers for coverage are needed. Small employers below a certain size and threshold related to revenue-per- employee should be eligible for assistance to meet the meaningful standard of coverage.

- Over time, after financial assistance and other components of the plan are phased in, requiring individuals to enroll in affordable public or private coverage that meets a meaningful standard, and requiring parents to enroll their children in affordable and appropriate coverage. Any penalty for individuals who fail to enroll in affordable and meaningful coverage must allow for notice, exceptions and appeals. Individuals and parents should utilize coverage appropriately to promote their health and that of their children, and should receive culturally and language appropriate supports and education to better engage in their own self-care.

3. Establish a National Standard for Meaningful Coverage

Health insurance has eroded as deductibles, premiums, and other cost-sharing have all increased. The breadth of coverage for services varies by insurance company, and coverage limitations are often buried in fine print or not disclosed at all.

- Meaningful coverage should include coverage for medically necessary healthcare services, including medical interpretation, prescription drugs, supplies, and equipment. It should cover prevention and primary care with first-dollar coverage for low and moderate income enrollees. It should cover the services needed by patients with chronic conditions to manage their conditions and promote maximum function. It should not have arbitrary limits on the scope or duration of coverage. It should cover catastrophic expenses to prevent financial hardship and limit the annual amount most individuals can be asked to spend on healthcare as a percentage of their income. It should have a network of providers that can meet the needs of diverse patients.

- SEIU supports the creation of a national expert board or council that would be charged with defining, updating, and evaluating compliance with the standard for meaningful coverage within categories of coverage or benchmarks determined by Congress. The board should be composed of experts and stakeholders, including labor and consumer representatives; its deliberations should be open and transparent; and it should consider specific factors and criteria, such as eliminating racial, ethnic, and geographic disparities, the needs of special populations, and the costs of coverage. As a starting

point, Congress should guarantee all Americans a standard of coverage similar to the standard it guarantees itself and all federal employees. The board should limit the amount of "actuarial equivalence" that is permitted to avoid adverse selection. The board should have the discretion to update the standard based on evidence.

- We need more information about what works in healthcare. More reliable and independent evidence is needed to evaluate the effectiveness of various treatments, procedures, benefits structures, and organizational practices. SEIU supports a strong public investment in comparative effectiveness research that can be used to inform coverage decisions by public and private plans, and help assist patients in making decisions with their doctors about what is right for them. Comparative effectiveness research should be conducted in a transparent and rigorously scientific approach, and should include special populations. Patients, doctors, and other researchers should have access to all of the research financed by federal dollars to promote full confidence.

4. Long-term Services and Supports Must be Covered for Those Who Need Them

Each year, millions of individuals and families face the devastating financial consequences of long-term care needs associated with disability and aging. Medicare and private insurance do not cover these costs on a long-term basis, and individuals and families are driven to impoverishment before they can qualify for Medicaid-covered services and supports. Moreover, most states are ill-equipped to provide the range and volume of long-term care services and supports the rapidly aging baby boomers will require, which could result in unnecessary institutionalization.

Beneficiaries who are dually eligible for Medicaid and Medicare suffer disproportionate levels of chronic illness: almost seven out of eight of them have one or more chronic conditions, and one-third have moderate or severe disabilities that make it difficult for them to care for themselves without outside aid. The problem is largely that our healthcare delivery and financing systems are simply not organized to promote primary care, nor are they designed to encourage providers and health plans to coordinate care in a way that systematically improves quality and lowers costs.

We must address the needs of these individuals and families as we reform healthcare in 2009 if we are to be successful at both controlling costs and making healthcare more affordable.

- Medicare and Medicaid per beneficiary costs are highest for enrollees with serious disabilities and conditions associated with aging that limit activities of daily living and

heighten beneficiaries' risk of acute episodes, such as infections and falls. SEIU supports new approaches to long-term services and supports that promote care coordination, especially coordination across Medicare and Medicaid-funded services, which are essential to providing high quality, cost-efficient care to our sickest and most-vulnerable citizens. Special attention should be paid to the integration of acute and post-acute healthcare services, and long-term care and social support programs, especially during transitions between care settings.

- Over the next two decades, millions of baby boomers will find that, due to declining health, they need long-term care services, including nursing homes. As a result of the substantial costs of paying for long-term care, many of them will end up relying on Medicaid to finance their care after their own financial resources have been exhausted. Despite its impoverishment requirements, Medicaid today is the only reliable long-term care financing available for the bulk of its consumers. SEIU supports the relaxation of eligibility requirements for Medicaid, including asset tests, to ensure that individuals can receive much-needed care, in a variety of settings, without impoverishing themselves.

- Despite significant progress over the last 20 years, the majority of states devote the preponderance of their long-term care resources to fund care in institutions. The aging baby boomer generation will only increase the strain on state Medicaid budgets as more and more individuals require long-term care services. While some individuals will require care in institutions, the majority of long-term care consumers prefer care in their homes and communities. Home and community-based services cost significantly less than institutional care and provide consumers with both choice and control over their care. SEIU supports the expansion of home and community-based choices, especially consumer-directed care, as part of healthcare reform.

We Must Seize this Moment

Each year we fail to address the growing healthcare crisis, we fail Americans such as Sarah Posekany of Cedar Falls, Iowa. In 2009, we have a historic opportunity to give Sarah the chance to live the American Dream by enacting comprehensive healthcare reform. Sarah is a young adult who has been living with Crohn's disease since she was 15 years old. The disease made it difficult for her to begin college, so she lost eligibility and was dropped from her parents' health insurance plan. Sarah's condition caused her to incur hundreds of thousands of dollars in medical bills as she had multiple surgeries, and she was forced to declare bankruptcy. Sarah is working now, but her plan won't cover her ongoing costs related to treating Crohn's disease for an entire year, and her specialist is not in the plan's network. Sarah wants to enroll in community college, but her poor credit rating disqualifies her from student loans.

Pat Delong, Lisa McSwain and Sarah Posekany shouldn't have to wait any longer in America for quality, affordable healthcare coverage.

Submitted by John Tooker,
Executive Vice President/CEO

American College of Physicians
Statement to the Senate Finance Committee
Recommendations for Health Care Delivery System Reform

April 14, 2009

The American College of Physicians (ACP) is the largest medical specialty society in the United States, representing 126,000 internal medicine physicians and medical student members. ACP commends Chairman Max Baucus and Ranking Member Charles Grassley for holding this roundtable discussion on reforming the health care delivery system. We appreciate their leadership in supporting policies to improve payments for primary care services and their recognition of the need for an expansion of the primary care workforce. We look forward to working with you to achieve these goals as the Senate Finance Committee considers health care reform in the weeks ahead.

During the last four years, ACP has consistently warned policymakers of the crisis in primary care. The future of primary care is at great risk at a time when the evidence suggests that the nation needs primary care more than ever before. In a previous white paper, the College documented over 100 studies that confirm the value of primary care.[i] Studies at the state, county, local and international levels confirm that the numbers, proportion and availability of primary care physicians consistently is associated with better health outcomes, better quality and lower costs of care, including lower Medicare per capita expenditures. Despite the availability of such evidence, the United States has done little to ensure that the supply of primary care physicians is sufficient to meet current and future needs.

ACP recommends that Congress pursue a two part strategy to reform the health care delivery system by (1) creating a fast track authority to develop and implement new physician payment models that better align payment with effective, efficient, patient-centered care such as the Patient-Centered Medical Home and simultaneously (2) reforming traditional Medicare fee-for-service payments to make primary care competitive in the market and to improve the accuracy and appropriateness of Medicare payment levels.

Reform Medicare Physician Payments

1. **Implement a Fast Track Authority for Payment Reforms to Encourage High Quality, Efficient Care; Including the Patient Centered Medical Home**

There is an urgent need for Medicare and other payers to develop, initiate, pilot, and then expand effective new models of physician payment that re-align incentives from volume of services to effective, efficient, patient-centered, team-based and coordinated care. New payment models that policymakers are considering include: continued expansion of the Patient-Centered Medical Home Model and testing it in the context of alternative payment models; Accountable Care Organizations, paying for bundles of services for an episode of care based on past treatment patterns; paying for bundles of services associated with care that would be provided according to evidence-based guidelines; making a capitation payment to primary care physicians for the full range of primary care services; and others. Some of these models preserve an element of fee-for-services and others would entirely replace fee-for-service with a bundled payment structure.

Most of these alternatives are in the early stages of testing and some are still conceptual and lack definition. This lack of real-world experience poses a challenge to policymakers. The will to act is as rivaled by the number of reform options.

ACP believes that Congress needs to create a framework that would allow the federal government to select the most promising conceptual models for reforming physician payments, based on clear policy objectives, and to move such models rapidly into real-world implementation and evaluation on a pilot basis, followed by more widespread implementation across Medicare and other programs of the models that prove to be most effective.

Specifically, ACP recommends that the Secretary of HHS be given the funding and fast track authority to identify the most promising models for reform, based on policy criteria to be developed in consultation with outside experts, which should receive priority for pilot testing and subsequent expansion under fast-track authority. ACP recommends that the Secretary specifically consider the following elements in development of such criteria for selecting the most promising payment reforms based on the potential of the model to:

- Create incentives that would lead to improvements in measurable health outcomes;
- Create incentives that would support the delivery of patient-centered care;
- Create incentives to foster the delivery of cost-effective care;
- Create incentives for efficient delivery of care without compromising quality;
- Create incentives to appropriately increase provision of preventive services;
- Support the management of chronic diseases and the coordination of patient-centered care;
- Create incentives to engage patients in shared decision-making on the most effective treatments for their conditions and participation in self-management and prevention plans;
- Support care delivered by primary care physicians;
- Support more effective care by non-primary care physicians;
- Be adaptable to a wide range of physician practices (size, geographic location and patient population served), including smaller practices;
- Be scaled up for broader implementation;
- Support team-based care;
- Support accountability across health care sectors, settings, and providers;

- Reduce inappropriate utilization of high cost and high volume services;
- Present evidence-based metrics for evaluation of the model's effectiveness;
- Impact and feasibility of data collection, reporting and other administrative tasks expected of physician and physician practices participating in the model;
- Be implemented by HHS, CMS, and other payers.

Based on such criteria and other policy objectives, the Secretary should be directed to select payment models, for fast-track funding, implementation and evaluation on a pilot basis, not constrained by the usual requirements for research and development funding, such as the requirement that all pilots be implemented on a budget neutral basis.

In making such selections, the Secretary should also be required to establish a technical advisory panel of health policy experts, consumers, physicians (including primary care physicians), and other stakeholders to provide advice to HHS on design, implementation and evaluation metrics for each pilot selected under such fast track authority. Such technical advisory panel shall also assist HHS in ongoing assessment of each pilot as data become available.

Once alternative physician payment models are selected, the Secretary should be required to create processes to allow for voluntary participation by a wide range of physician practices, primary care and non-primary care practices alike, to participate in the projects selected under the fast track authority, recognizing that different models may be more or less applicable to specific types of physician practices and specialties.

ACP suggests that within two years of initial implementation of each fast track project, the Secretary should submit a report to the Senate Committee on Finance, the House Committees on Ways and Means and Energy and Commerce, and the Medicare Payment Advisory Commission on the initial results of each pilot and which ones hold the most promise for widespread implementation based on the results to date. In making such assessment, the Secretary should consult with the technical advisory panel and the Medicare Payment Advisory Commission.

Within three years of the initial implementation of each pilot, the Secretary should have the authority to make broad changes in Medicare payment policies to scale up the most successful pilots to widespread adoption and implementation across the Medicare system. The Secretary should be required to report to the Senate Committee on Finance, the House Committees on Ways and Means and Energy and Commerce, and the Medicare Payment Advisory Commission on the projects selected for widespread adoption and implementation across the Medicare program.

The College believes that our proposed framework for prioritizing the design, testing, evaluation and expansion of promising physician payment reform models, based on policy criteria, would strike the right balance between the urgent need to develop new payment models, and assuring that such models are subjected to appropriate testing in a variety of clinical settings before being implemented on a wider basis.

2. Expand the Medicare Medical Home Demonstration Project to a National Pilot and Transition to a New Payment Model for Qualified PCMHs

The Patient-Centered Medical Home (PCMH) is a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes. The PCMH is responsible for providing all of the patient's health care needs or appropriately arranging for care with other qualified health professionals. This includes the provision of preventive services, treatment of acute and chronic illness, and assistance with end-of-life issues.

The PCMH enjoys the support a wide range of health care stakeholders, including physician organizations, consumer organizations, employers, health plans, and quality-focused organizations. Policymakers view it as a promising reform model, with Congress authorizing the Medicare Medical Home demonstration project through a 2006 law and supplementing it with dedicated funding and increased ability for expansion through a 2008 law. MedPAC recommends a Medicare medical home pilot project to supplement the demonstration currently being developed that focuses on practices that use advanced health information technology. Numerous states are incorporating PCMH tests into reform of their Medicaid and SCHIP programs. There are a myriad of private payers PCMH tests, many involving multiple health plans, underway or being developed across the country.

The current Medicare Medical Home Demonstration, which is limited to eight states, should be expanded to a national pilot. CMS should also set a timeline for expeditiously transitioning to a new payment model for all practices nationwide that have voluntarily sought and received recognition as Patient-Centered Medical Homes following completion of the Medicare demonstration/pilot. Expansion of the current Medical Home demonstration to a national pilot would allow for larger-scale testing of the model in a variety of demographic populations, states, regions, and practices, producing a much larger body of evidence on its effectiveness as a basis for transition to a new payment model for such practices

Specifically, ACP recommends that the Secretary of HHS be required to propose through a rule making process new payment methodology(ies) for qualified PCMHs for implementation no later than January 1, 2013, taking into account the results of the Medicare Medical Home demonstration, as defined in Public Law 109-432, Section 204 and, as expanded to a national pilot of qualifying payment reforms, in developing the alternative PCMH payment structure(s).

We recommend that the Secretary give consideration to different payment models for qualified Patient Centered Medical Homes that align incentives with coordinated, preventive, team-based and patient centered care rather than principally or solely the volume of services. Such model or models should pay PCMH recognized practices, including practices recognized through the National Committee for Quality Assurance (NCQA) Physician Practice Connections-Patient Centered Medical Home (PPC-PCMH) voluntary recognition process or other equivalent process as determined by the Secretary, for the clinical work and practice expenses associated with providing care coordination services. In developing such model or models, the Secretary should give consideration, among other options, to alternative PCMH payment structures that combine risk-adjusted and prospective care coordination fees,

performance-based payments, and payments for specific evaluation and management services, Qualified PCMHs could continue to receive fee-for-service payments for evaluation and management services or participate in an alternate approved payment mechanism that meets the above specified payment criteria.

2. Reform Existing Medicare Fee-for-Service Payments to Recognize the Value of Primary Care and Improve Accuracy of Relative Value Units

Studies indicate that lower compensation for primary care, compared to other specialties, is one of the most important factors in influencing medical students and young physicians to choose specialties and practice types other than primary care. Such disparities also contribute to decisions by established primary care physicians to leave primary care and pursue other career options. This market competitiveness gap has grown over time. ACP recommends that Congress mandate the following reforms of existing Medicare payment policies, at the same time as new models are being developed and tested, as discussed above.

A. Congress should direct the Secretary of HHS to conduct an evidence based analysis of total compensation needed to make primary care physicians competitive with other specialties

Currently, the average primary care physician earns approximately 55 percent of the average earnings for all other non-primary care physician specialties. [ACP analysis based on data from two sources: Medical Group Management Association--2008 and Merritt Hawkins – 2008 Review of Physician and CRNA Recruiting Incentives – Top Twenty Searches]. To eliminate differential income as a critical factor in medical student/resident choice of specialty, the average net income for primary care physicians would need to be raised to be competitive with the average net income for all other specialties. For instance, Medicare and all other payers would need to increase their payments to primary care physicians by 7.5-8 percent per year over a five year period, above the baseline for all other specialties, to bring the average of the median earnings for primary care physicians to 80 percent of those for all other specialties, all other factors being equal.

A market and price sensitivity analysis would model different levels of compensation for primary care, compared to other specialties, to determine the impact they would have on specialty choice. This is similar to what a successful company would do if it was trying to recruit for highly skilled positions in its workforce but was finding that it was failing to do so because competitors were offering a more appealing compensation package.

Based on a market and price sensitivity analysis, Medicare would be able to determine how much its share of total compensation to primary care physicians would need to be increased, over a five year period, to make primary care competitive with all other physician specialty and career options, all other factors being equal. Benchmarks would be created by HHS to determine the impact of the recommended annual Medicare fee schedule increases derived from such sensitivity analysis on increasing the numbers and proportion of primary care physicians.

Because a price and market sensitivity analysis could take some time to complete, the Secretary would begin by implementing a sizeable increase in Medicare fee schedule payment increase for evaluation and management services provided by primary care

physicians, starting in 2010, as a down payment on subsequent annual increases to make Medicare payments competitive with other specialties over no longer than a five year period. Non-Medicare payers should also be strongly encouraged and given incentives to increase their payment rates, over the same time period, to make total compensation to primary care competitive in the market.

The Medicare Payment Advisory Commission has recommended a bonus payment in 2010 of up to 10 percent for evaluation and management services provided by primary care physicians, but this increase would apply only to evaluation and management services, not all services provided by primary care physicians, Accordingly, it would yield a far lower net gain in Medicare compensation to primary care physicians than ACP's estimate of 7-8 percent annual increases in *total Medicare compensation* required to achieve market competitiveness (Medicare's share) over five years at 80 percent of the earnings of all other specialties, all other factors being equal. Consequently, there needs to be further discussion of how much Medicare payments would need to be increased in 2010 to be a meaningful and substantial first step toward achieving market competitiveness for primary care physicians within five years.

B. Provide Medicare Payment for Care Coordination Services

Current Medicare policy fails to pay for many services provided principally by primary care physicians relating to prevention and coordination of care, especially for patients with multiple chronic diseases, because they are considered to be included in the payment for an office visit or other evaluation and management services. This policy has the effect of requiring that patients see their primary care physician in the office in order for the physician to be compensated, even when the patient's condition or question could be managed by email, telephone or remote monitoring. This policy inconveniences patients and results in physicians spending less time with patients who truly need to be seen in the office. Medicare's view that such services are included in the payment for the office visit also does not take into account the physician work and expense associated with such services. Consequently, many primary care physicians are unable to offer patients the convenience of email consultation or other ways of getting medical advice and follow up outside of a face-to-face visit. In addition, studies show that the ability of patients to receive ongoing self-management support from their physicians is critical to achieving better outcomes, especially for patients with multiple chronic diseases, yet current Medicare payment polices will not reimburse for the services needed to provide such support. Separate payment for such services would also help primary care physicians acquire the capabilities to become Patient Centered Medical Homes.

C. Revise Medicare Budget Neutrality Rules to Recognize the Value of Primary Care in Reducing Medicare Baseline Spending

By law, any increases in payments for physician services under the Medicare fee schedule requires offsetting across-the-board "budget neutrality" offsets to all services in the Medicare fee schedule. One argument for making the primary care payment increases "budget neutral" within the Medicare fee schedule is that it not only would increase payments for primary care, but create more parity by lowering payments for higher paid specialties.

This option, however, has several disadvantages. It is opposed by some non-primary care physician specialty societies. Such opposition will make it more difficult to get the political support needed to enact higher payments for primary care. The temptation to reduce offsets to other specialists could result in payment gains for primary care that are too modest to make a difference. It also has the disadvantage of reducing payments for non-primary care services that may not be overvalued, since the budget neutrality adjustment applies to all services, whether over-valued or not. And it even reduces the expected gains for the primary care services the policy is intended to benefit, because primary care services too would be subjected to the budget neutrality offset, taking away on one hand a portion of the gains provided by the other.

A better way to fund primary care would be to re-define budget-neutrality rules to consider the impact of paying more for primary care on total aggregate Medicare spending, Parts A, B, C and D combined. A portion of anticipated savings in other parts of Medicare (such as from fewer preventable hospital or emergency room admissions associated with care coordination by primary care physicians) could then be applied to fund increased payments for primary care.

To illustrate how much can be saved by creating payment incentives for primary care, a recent study in The American Journal of Medicine found that "higher proportions of primary care physicians [in each metropolitan statistical area] were associated with significantly decreased utilization, with each 1 percent increase in the proportion of primary care physicians associated with decreased yearly utilization for an average size metropolitan statistical areas of 503 admissions, 2968 emergency department visits, and 512 surgeries."[ii] Congress should allow for some of the aggregate savings from reduced utilization associated with primary care to be used to fund payment increases targeted to primary care. Congress should also provide such additional funds as may be necessary to fund appropriate increases in primary care services.

D. Eliminate the flawed Sustainable Growth Rate Formula

Over the past several years, ACP has been urging Congress to reform Medicare's flawed physician payment formula known as the Sustainable Growth Rate (SGR). This formula has led to scheduled annual cuts in physician payments for the past seven consecutive years. On January 1, 2010 physicians face a 21 percent Medicare payment decrease unless Congress intervenes to avert this cut. This uncertainty in concerning Medicare reimbursement rates makes it nearly impossible for physicians to plan their budgets for their practices.

Since 2002, Congress has stepped in just about every year to enact temporary "patches" to stop the SGR cut, but hasn't come up with a permanent replacement. Rather than accounting for the difference between the lower amount mandated by the SGR, and the higher amount paid out under the patch, Congress assumed that the higher spending will be made up with even an even deeper SGR pay cut the following year. This is why the "patch" for an estimated 5% SGR cut in 2008 resulted in a scheduled 10.5% SGR cut in 2009. And why the patch for the 10.5% SGR cut in 2009 balloons to a scheduled 21% cut in 2010.

The accumulated SGR debt has growth dramatically as a result of this viscous cycle.

In December 2008, the Congressional Budget Office estimated that it would cost CBO $318 billion over ten years to replace the SGR cuts with a freeze in payments at their current level; and $439 billion over ten years to replace it with an annual update equal to medical inflation.

President Obama's budget is a marked departure from past practices, because it acknowledges what we all know to be true, which is that preventing pay cuts to doctors will require that Medicare baseline spending be increased accordingly. Accounting for funds needed to reform the flawed SGR payment formula, as the President proposes, could remove the greatest single barrier to reaching a consensus on a long-term solution to the SGR payment cuts. Once the true costs of a long-term SGR fix are accounted for in the budget, Congress and the administration should enact a long-term solution that will permanently eliminate the SGR as a factor in updating payments for physicians' services. Instead, payment updates should provide predictable increases based on the costs to practices of providing care to Medicare patients. This is especially important for physicians in smaller practices, where Medicare payments are not keeping pace with their overhead costs.

E. Improve the accuracy and appropriateness of Medicare relative value units.

Inaccurate and mis-valued relative value units under the Medicare fee schedule contribute to the under-valuation of primary care services and may create incentives for increased and unwarranted volume. ACP recommends several reforms to improve the accuracy and appropriateness of Medicare RVUs including:

- Requiring that the Secretary study the processes it uses to obtain expert advice on relative value units, and specifically, the adequacy of representation of primary care and other physicians who have expertise in the work associated with treating patients with chronic illnesses.
- Establishing an expert process to identify potentially overvalued or mis-valued services for further review.
- Improving the methodologies used to determine practice expense RVUs, including the equipment utilization assumptions for major imaging services.

Improve the Effectiveness of the Medicare Physicians Quality Reporting Initiative

The relatively low financial reward for successful PQRI reporting is a barrier to participation. For many physicians, especially those who primarily derive their Medicare revenue from relatively low paid evaluation and management services, the cost of participating exceeds the potential PQRI payment. Basing the PQRI bonus payment on a physician's Medicare allowed charges not only provides the greatest benefit to those with the highest Medicare revenue, it misses an opportunity to provide a financial incentive to improve care in the clinical areas with the largest gap and/or highest impact. Further, stakeholders need assurance that the quality measures used in the PQRI are valid. There continues to be a need for a process for determining the feasibility of implementation of measures and reporting approaches.

The College believes that physicians should have multiple options for reporting on PQRI quality measures so that they can choose the method best for their practice. We are pleased

that CMS allows physicians to report quality data to a registry, an entity that service as a repository of information, that can be shared for PQRI purposes and that the agency is testing direct from EHR reporting. These options, which are available to only a small number of physicians, have great potential to reduce reporting administrative burdens and to assist in improving clinical care. While they continue to evolve, CMS can do more to facilitate the development of these options and making them available for broad use. Structural measures provide another opportunity for physicians to report on their quality improvement activities. We commend CMS for including a structural measure reporting options. However, additional structural measure reporting options should be made available. Development and selection of these measures would be greatly aided by establishing a standard structural measure definition.

The College strongly believes, however, that the significant problems physicians have experienced in their attempt to participate—not qualifying for a bonus they thought they earned, receiving a bonus payment amount less than expected, being unable to access their feedback on the CMS secure website—pose serious challenges to future growth of the program. While we appreciate that CMS issued a December 2008 report on the 2007 PQRI experience and identified solutions to a number of the identified problems, a sustained effort to evaluate and improve the program is essential.

Implement Other Delivery System Reforms to Improve Quality and Effectiveness

In addition to reforms proposed above, the College advocates for the following policies to improve the health care delivery system including:

- Investing in research on the comparative effectiveness of different medical treatments for the same or similar conditions to inform decision-making by the physician and patient at the point of care.

- Redesigning benefits under Medicare, Medicaid and private health plans to cover evidence-based preventive, wellness and screening services.

- Creating incentives for physicians and other clinicians to serve in medically underserved areas and specialties facing imminent shortages, including programs to provide scholarships or loan forgiveness for primary care physicians in facilities or areas of the country facing a critical shortage and increased funding for the National Health Services Corps and Title VII primary care training programs.

- Redesigning Medicare graduate medical education funding to support national workforce goals.

- Establishing a permanent national commission to recommend national goals relating to the numbers and distribution of physicians and other health care professionals, including policies to expand primary care workforce capacity in the United States, policies to achieve such goals, and benchmarks to evaluate the impact of such policies.

- Providing assistance to clinicians, financial as well as support to their practices, to encourage adoption and use certified electronic health records that have

the functional capabilities needed to support patient-centered, preventive and coordinated care.

- Research into unwarranted regional variations in the quality and cost of care and best practices to reduce such variations.

- Research into the causes of and solutions to racial, gender, and ethnic disparities in health care.

Conclusion

ACP recommends a two-component process to realize the comprehensive payment reform that will result in better value for health care spending in the United States. The first is to develop, test, and evaluate innovative payment models that align incentives with quality, effective, and efficient care instead of paying on the basis of the volume of services. The second component is to improve the current fee-for-service payment system. We believe that such reforms, combined with improvements in the Physicians Quality Reporting Initiative, research on comparative effectiveness, redesign of benefits to promote prevention and wellness, and creation of a national workforce policy to ensure adequate numbers of primary care physicians and other clinicians facing shortages, would result in major gains in improving the quality, effectiveness and efficiency of care at the same time as coverage is expanded, as we hope it will be, to all Americans.

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i American College of Physicians. How Is A Shortage of Primary Care Physicians Affecting the Quality and Cost of Medical Care? A Comprehensive Evidence Review. October 2008.

ii Kravet, et al, Health Care Utilization and the Proportion of Primary Care Physicians, The American Journal of Medicine, February 5, 2008

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Statement
of the
American Hospital Association
to the
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Roundtable on Health Care Delivery System Reform
Washington, DC

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The American Hospital Association (AHA), on behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 38,000 individual members, appreciates the opportunity to share its views on America's health care delivery system and the need for comprehensive health care reform.

It is often said that the U.S. has the best health care in the world, and indeed there is much of which we can be proud. But, for all its strengths, the system of delivering and paying for care that has evolved over the decades is in need of change. The health care system of today prevents patients, providers and others from experiencing what could and should be a much more coordinated system of care. The payment system, as currently designed, discourages care coordination by creating silos of care that reward volume instead of quality.

A Framework for Change

America's hospitals are committed to health care reform that is achieved in a bipartisan manner, and the time for that reform is now. For the past three years, the AHA has led a discussion among disparate fields, including health care, business, insurance, labor, consumers and others, about what kind of change will best serve America now and in the future. The AHA Board of Trustees convened hundreds of hospital leaders in addition to leaders from nearly 100 different organizations to develop policy ideas to lead the effort.

The result: *Health for Life*: *Better Health. Better Health Care. Health for Life* centers on five pillars of reform upon which we must build:

- **Health Coverage for All, Paid for by All.** Everyone – individuals, businesses, insurers and government – must play a role in expanding and paying for health coverage for all. Coverage for all will be our toughest challenge, politically and financially. There are many ways to accomplish this goal; we must remain firm on the objective but flexible on how to achieve it.

- **Focus on Wellness.** Good health – physical, mental and oral – is essential for a productive and vibrant America. A focus on wellness must be integrated into the lifecycle, from birth to death, and be encouraged in our homes, schools, workplaces and communities.

- **Most Efficient, Affordable Care.** Reform must include efforts to make the costs of insurance and health care more affordable. We need to better manage chronic disease; spend limited resources on care, not paperwork; and address the growing shortage of well-trained health care workers. And, useful information on quality and pricing must be made public, so that patients, providers and payers have the information they need to make informed decisions.

- **Highest Quality Care**. The best care is provided when caregivers and patients work as a team to make the right decisions with the best possible information. We need to invest in research that will identify the best treatments, technologies and protocols, and then reward providers who use them. We must coordinate the treatment of physical and behavioral health needs; reward care outcomes, not the number of patients seen; and make palliative care more available and better understood. And we have to ensure that we have enough trained health care workers to deliver the care communities need.

- **Best Information.** Good information is the gateway to good care and good research. We have to accelerate the adoption of health information technology by addressing financial, regulatory and technological barriers, including inter-operability and standardization.

Components of Change

Policy decisions affecting the health care of Americans should be made explicitly by Congress. We urge Congress to offer robust, detailed proposals that are then subject to the input of the public and others. We urge Congress to determine specifically how savings are to be achieved in financing health reform. Proposals that leave too much discretion to implementing agencies, or self-implement policies, to achieve savings without the direct input of Congress are not acceptable or appropriate.

When it comes to reform, policymakers have many options. But success will require balancing the desire for sweeping reform with some measure of stability – to ensure that patients have access to care that continually improves, consumers and employers have health coverage with manageable costs, and providers remain financially able to handle the demand for care. To achieve this, we need reform that is thoughtful, deliberate and

gradual. Several areas of our health delivery system need to be addressed as we look to reform.

Financing
Consumers, providers, employers, payers and government should share in the responsibility to achieve comprehensive reform that leads to coverage for all. This means fair and balanced reform that considers all funding options, including new revenues or taxes. Reform should reflect both the immediate need for change and the long-term savings reform can bring. We support a flexible approach to financing that recognizes the need for up-front investment to set the health system on the path toward significant long-term savings and improvement in the long-term fiscal health of the nation. The Congress' recent investment of $19 billion in health information technology in the *American Recovery and Reinvestment Act* is a perfect example of the type of investment needed to spur innovation and improvement.

Administrative Simplification
Even limited reductions in administrative costs could yield significant savings. The Congressional Research Service estimated the administrative costs of private insurance and government programs last year alone at about $465 billion – not including the administrative costs borne by health care providers to comply with those entities' requirements. Most estimates cite administrative requirements as accounting for a quarter of total hospital spending; physicians' offices spend a little more.

An AHA task force that looked at the issue of administrative simplification came up with several recommendations to improve the delivery system by decreasing costs and making it easier for patients to navigate care. Several changes are needed to our insurance system, including standardizing and simplifying:

- access to up-to-date eligibility and enrollment information, benefits, coverage and cost sharing information;
- elements of the billing, claims processing and adjudication processes; and
- collection and reporting of clinical information for quality measures.

Coverage and Social Responsibility
The AHA believes that everyone deserves health care coverage that provides the right care, at the right time, in the right place. Health coverage for all, paid for by all is an essential element of health reform supported by the AHA. The economic recession gripping the nation has brought into sharp focus the need for health care reform so that the many millions uninsured will have health care coverage and access to health services.

Coverage also is key to cost control. Health care costs are higher when patients don't receive care at the right time or in the right setting. Many uninsured people delay needed care until it is an emergency. And the costs of the uninsured are reflected in higher health insurance premiums for those purchasing insurance. Providing coverage to all will help mitigate the "cost shift" that moves the financial burden of non-coverage from public to private payers. The AHA supports enhanced access to affordable private health

insurance, but is concerned that implementing another public program could continue the under-payment of providers.

In addition, both Medicare and Medicaid have in place hospital funding mechanisms designed to mitigate the financial stress faced by hospitals serving a disproportionate burden of poor and uninsured patients, and to provide support for the training of future physicians and other practitioners. While the Medicare and Medicaid disproportionate share hospital (DSH) programs differ in scope and size, they serve as the nation's primary source of support for safety-net hospitals providing health care to the most vulnerable populations – Medicaid beneficiaries, low-income Medicare beneficiaries, the uninsured and the underinsured.

The DSH program funds are the health care safety net for millions of people. Even as universal coverage is achieved, there will be populations that will remain uncovered and hospitals will be asked to bear the burden of their health care and essential community services. As a result, until universal coverage is fully achieved, no reductions should be made in the DSH program.

Another societal good is the clinical training of our nation's health professionals. Both the Medicare and Medicaid programs have recognized this important need since their 1965 inception. Medicare's payments for the direct cost of graduate medical education and payments for the higher operating costs of teaching hospitals, the indirect medical education (IME) adjustment, are crucial to the ability of teaching hospitals to carry out their academic missions of education, research and high-intensity patient care. These payments fund a social good that benefits all Americans and should not be reduced. A strong clinical workforce, including the need for additional primary care providers, must be the foundation upon which reform is built. The AHA urges Congress to make the investments necessary to ensure a strong and sustained primary care workforce.

Improving the Delivery System

Patients often find themselves filling out clinical and insurance forms multiple times because information is not easily transferred from one caregiver to the next, even within the same organization. They are unsure about who is in charge of their care. This lack of coordination can mean necessary steps to prevent illness and restore wellness may be missed, diagnostic tests may be redone, health problems may go unnoticed or unaddressed, and mistakes may be made in care.

Barriers to Care Coordination

Bringing physicians, hospitals and others together to coordinate care with the patient and the patient's family is critical to the success of any care coordination program. While some payment reforms may hold promise, the ability to respond to payment incentives is hampered significantly by multiple laws and regulations. Many were developed to address problems created by our system's traditional payment silos. In a new system, with payment reforms that provide incentives for hospitals, physicians and other

providers to work together, these laws and regulations must be removed or modernized to recognize a new model of care delivery.

Hospitals have been working to improve clinical integration with physicians, but the existing barriers limit their abilities. To address the regulatory impediments to clinical integration, the AHA provided to its members *Guidance for Clinical Integration*, a document we hope the antitrust agencies will use to provide guidance to hospitals and doctors on establishing clinical integration programs.

In addition to the antitrust laws, four federal statutes have a significant impact on hospitals' ability to form financial relationships with physicians: the *Ethics in Patient Referrals Act,* known as the "Stark law;" the antikickback statute; the Civil Money Penalty (CMP) law; and the tax-exemption provisions of the Internal Revenue Code. Each has a unique purpose, and is implemented largely independently of the others.

Each of these statutes creates a tension around hospital and physician financial relationships. Under the Stark and antikickback laws, payments from hospitals to physicians are often seen by policymakers as a means to induce referrals, interfere with clinical decisions, or increase payments from federal health care programs. Under the CMP law, the concern is that hospitals might encourage doctors to limit or reduce services provided to program beneficiaries by offering a share of the resulting financial gains. Under the Internal Revenue Code, the suspicion is that payments to physicians will be for the private benefit of the physicians and not to advance the charitable purpose of the hospital.

Congress and regulatory agencies should change laws and regulations to allow physicians, hospitals and others to work together as teams, and to use financial incentives to reduce costs and improve care. Such changes should include:

- Establish a simpler, consistent set of federal rules for how hospitals, physicians and others may construct their financial and contractual relationships;
- Provide clearer guidelines under federal antitrust law to enable clinical integration and joint hospital-physician contracting with payers to ensure aligned performance incentives;
- Amend the CMP law to allow implementation of best practices and clinical protocols by only prohibiting incentives for physicians to withhold medically necessary care;
- Provide a "safe harbor" under federal laws and regulations to encourage the development of real or virtual delivery "networks" (such as accountable care organizations); and
- Reevaluate the impact of state laws governing the corporate practice of medicine on the ability of providers to collaborate.

Policymakers are looking for strategies that will both improve the quality of care patients receive and reduce costs. Among the more recent ideas to promote better coordination of care: value-based purchasing; bundled payments; accountable care organizations; and reductions in payments for avoidable readmissions.

Value-based Purchasing
A number of public and private payers are testing "incentive payments" to reward provider performance. In late 2007, the Centers for Medicare & Medicaid Services (CMS) issued a report to Congress outlining options for a value-based purchasing incentive program that would reward hospitals for meeting certain performance thresholds.

Since 2002, the Hospital Quality Alliance (HQA), a public-private partnership of hospitals, consumer groups, labor, business and government agencies such as CMS and the Agency for Healthcare Research and Quality (AHRQ), has enabled hospitals to share reliable, credible and useful information on hospital quality with the public. As a result of this volunteer partnership, hospitals are far ahead of other provider groups in reporting quality information and having their payments tied to quality measures. In 2003 Congress recognized the importance of this initiative and began requiring hospitals to submit the quality data to Medicare in order to receive a full market basket update for their hospital inpatient payments. The quality improvement effort has expanded to include new measures each year. Today, 4,900 hospitals voluntarily report their quality data on the HospitalCompare Web site.

Hospitals currently face multiple requests for quality data from insurers, employer groups, accreditors and government agencies. Rather than helping to illuminate key aspects of quality, these myriad demands create confusion and frustration for hospitals and the public alike. Hospitals strongly urge that quality data should be reported in just one way to just one place.

The HQA provides a firm foundation for further transparency and for what may be the next step in the national quality movement – pay-for-performance programs that reward providers with payment incentives for demonstrating excellence in patient safety and effective care. For these programs to be successful, they must be implemented in a budget-neutral manner. They can reduce health care spending, but those savings should be the result of better and safer care, not across-the-board budget reductions. To be successful, pay-for-performance approaches should:

- align hospital and physician incentives to encourage all to work towards effective and appropriate care;
- be developed collaboratively with all stakeholders;
- focus on improving quality, not act as a cost cutting mechanism;
- provide rewards that will motivate change;
- be implemented incrementally;
- recognize and reward both high levels of performance and substantial improvements;
- use measures that are developed in an open and consensus-based process and selected to streamline performance measurement and reporting;
- use measures that are evidence-based, tested, feasible, statistically valid and recognize differences in patient populations; and
- be designed carefully so as not to perpetuate disparities in care.

Bundled Payments

Policymakers have shown significant interest in the idea of bundling payments for an episode of care. While bundling may improve care coordination and quality, and reduce health care costs, CMS should establish a reliable evaluation system to assess bundling's impact and report back to Congress on the approaches that warrant broader consideration.

Therefore, bundling payments should not be automatically implemented by law or regulation. A variety of demonstration projects with proper evaluation is needed to determine what best serves patient needs. For example, in some cases, the bundle could consist of only acute hospital and physician services. Others have proposed a bundled payment for hospital and post-acute care services. A third model could bundle only the post-acute services. Those approaches that create greater integration across the health care system should be eligible for greater rewards.

At this time, there is no common assessment tool to evaluate patients across care settings after a hospitalization. CMS is currently running the CARE Tool demonstration program, which is testing a common assessment instrument, but results are not yet available.

As it appears in the administration's budget outline, bundling of hospital and post-acute payments is problematic. The AHA encourages Congress to take an incremental approach by testing different models of bundling to determine what works and what doesn't before broad adoption. For example, starting with a subset of high-volume/high-cost diagnoses or procedures, Congress could allow different organizational entities to receive the bundled payments, such as health systems, hospitals that employ physicians, physician-hospital organizations, and multispecialty group practices or designated "medical homes."

Proposals to bundle Medicare payments for general acute hospital and post-acute care (PAC) services call for a paradigm shift in health service delivery. Numerous regulations would need to be revised or withdrawn since their policy rationale would be eliminated. These regulations were put in place to manage the silo approach to care that dominates our delivery and payment systems today. For example, today's requirement that hospitals provide a list of all local home health providers to patients at the point of discharge would need to be eliminated. In a new bundled payment system, hospitals working in collaboration with physicians and post-acute providers will need the ability to choose the post-acute setting that is appropriate for patient care. Otherwise providers' ability to manage care with the patient would be severely hampered. Other examples of needed regulatory change are elimination or modification of the many rules constraining where patients may receive post-acute care.

A similar approach should be applied to "accountable care organizations" (ACOs). ACOs offer an opportunity to improve integration of inpatient and outpatient care and promote joint accountability for care delivery. AHA supported a similar concept of care delivery in the early 1990s called Community Care Networks and we believe there should be opportunities to test the ACO approach today.

Hospital Readmissions

Readmission policies should distinguish between factors that are within the control of the hospital and those that are not. Policies that seek to provide incentives to hospitals to reduce readmissions should begin by focusing on the group of unplanned readmissions that are related to the original admission. These unplanned yet related readmissions offer the greatest opportunity for hospitals to take actions that may prevent readmissions. Our understanding of the causes of hospital readmissions is still in its early stages, but some things are clear. First, some readmissions are planned because they are needed to get the patient the best care. Any proposal that does not separate these planned readmissions from unplanned readmissions may penalize hospitals and doctors for providing appropriate services for patients in need of re-hospitalization.

Among the unplanned readmissions, there are some factors that are within the control of the hospital, and holding hospitals accountable for these factors through the payment system may be appropriate. For example, hospitals should ensure that timely information about the patient's care is communicated to post-acute providers when the patient is discharged. However, other factors are outside the control of the hospital, such as patients' ability to access necessary post-hospitalization care, patients' willingness and ability to adhere to recommended treatment and lifestyle changes, the presence of family and other support systems, and other factors that may affect patients' conditions. Regardless, the goal of all efforts to reduce hospital admissions should be to improve patient care. Readmission policies should not simply be used as a blunt cost-cutting tool.

Policies to reduce the occurrence of hospital readmissions also should recognize differences among hospitals, their communities and the patients they serve. The limited availability of important post-acute and ambulatory health care services in some communities, the level of poverty of hospitals' patients, and the availability of community services could affect a hospital's performance on readmission measures and should be addressed in any measurement process.

Transparency in Health Care

Hospitals have made significant efforts to be more transparent about the cost and quality of care. The HQA has worked for more than five years to publish hospital quality data. And more than 40 states report hospital pricing information to consumers. CMS also released pricing information based on Medicare data for all hospitals as part of the hospitalcompare.hhs.gov Web site. Similar transparency efforts should be adopted for physicians and other providers, pharmaceuticals, devices and insurance plans and premiums. Public release of information is not only helpful to consumers, it also drives improvement activities.

Transparency efforts should also include measures to understand the comparative effectiveness of drugs, devices and services. The AHA strongly supports comparative effectiveness research (CER) that provides clinicians, patients and others with valid and reliable information about the relative effectiveness of various treatment alternatives. CER is an important step in reforming the nation's health care delivery system, and will be a key mechanism to improve health care quality, eliminate variation in care, and

reduce health care costs. Additionally, it will provide credible information allowing patients, clinicians and others to make better medical decisions.

Conclusion

Now is the time to enact major health care reform, and America's hospitals are committed to change that is thoughtful and achieved in a bipartisan manner. While some reform measures are ready for broad-scale adoption, other options require more study. What's clear is that change must include all stakeholders, and be started as soon as possible.

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Financing Health Care Reform

Presented to

Committee on Finance Round Table
United States Senate

By

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On

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Mr. Chairman and Members of the Finance Committee: Thank you for inviting me to participate in your roundtable on financing health care reform. I am currently a senior fellow at Project HOPE and president of the Defense Health Board, a federal advisory board to the Secretary of Defense. After many years as a policy researcher, I spent most of the 1990's primarily focusing on issues relating to Medicare and Medicaid--as Administrator of the Health Care Financing Administration, chair of the Physician Payment Review Commission and chair of the Medicare Payment Advisory Commission. During much of this decade, I have also worked on issues relating to health care for the military and veterans populations as co-chair of the President's Task Force on Ways to Improve Health Care Delivery for Our Nations Veterans, co-chair of the Task Force on the Future of Military Health Care, commissioner on the President's Commission on Care for America's Returning Wounded Warriors (Dole/Shalala Commission) as well as my current work with the Defense Health Board. The views I am presenting here reflect what I have learned from these various experiences as well as my training as an economist. These views are my own and not necessarily the views of Project HOPE or any of the other organizations I have mentioned.

We are here today to discuss financing issues in healthcare, with particular interest in ways to produce savings in the healthcare system. The questions you have posed indicate a willingness to consider revising the current tax treatment of health care, particularly as it relates to employer-sponsored insurance.

Fundamentals

Although it is sometimes hard to tell, there is wide-spread agreement on many of the fundamentals regarding health care reform.

First, people need health insurance coverage. Although the numbers are subject to both fluctuation and measurement error, current estimates are that approximately 46 million people, some 15% of the population, are without coverage. Being without coverage adversely affects the person without coverage both medically and financially and also has consequences on the community where he or she lives. We need to make affordable insurance available to every American. We can debate whether or not to require that each person have coverage. There are some obvious advantages to such a requirement but it also raises a variety of issues that need to be resolved.

Second, the current growth rate in health care spending is unsustainable. We are currently spending around $2.4 trillion on health care. At more than 16% of the economy, it represents a significantly larger share devoted to health care than any other country. Even more alarming that the absolute level of spending, is the growth rate in spending. Economists have frequently remarked on the so-called "excess spending gap" in health care—growth that has averaged around 2.5 percentage points fast than the rest of the economy, in real terms. This spending gap has been more or less present for several decades. If it continues in the future, it will have profound effects on the Federal budget, crowding out other important programs and functions and/or increasing the

government's share of the economy to unprecedented levels. It is also stressing the budgets of employers and consumers. Throughout the decade, rising health care costs have been associated with rising premiums and small increases in cash wages.

Third, there is also clear evidence that despite high, rapidly growing spending, the U.S. has persistent problems providing clinically-appropriate care to its population. In addition, there are significant problems with patient safety. Research suggests that adults receive only about 55% of the known clinically appropriate care for their medical conditions. Also, as the Institute of Medicine made known a decade ago, as many as 100,000 patients may die each year from medical errors. More recent studies have suggested little progress in this area. It seems quite obvious that the United States is not receiving appropriate value for the large sums of money being spent on health care.

The controversy and conflict starts to arise in how best to respond to these fundamental problems that the country faces. The more detailed and specific the strategies and solutions, the greater is the potential for dispute.

Options

Estimates of the cost of extending coverage to all Americans run as high as $1.5 trillion over the next ten years, some estimates even a little higher. The Administration's "down-payment" in the budget represents less than half of that amount, suggesting the need for a lot more financing, a lot more savings or a combination of both. It also suggests a roll-

out of several years duration may be needed in order to get the spending in balance. The experience in Massachusetts suggests expansion of insurance coverage to almost the entire population can occur very quickly.

There are many ways to provide funding for expanding coverage. The Congressional Budget Office provided 115 options in the first volume of its December publication on Health Care. Other ideas could undoubtedly be generated. However many of them raise relatively small amounts of revenue and may only modestly address issues of encouraging more clinical appropriate or safe care, if they address these issues at all. I am going to focus on only a few areas for change.

The current tax treatment of healthcare

The current tax treatment of health care has long been a focus of concern for economists. According to the CBO, the cost of the current tax treatment in terms of foregone income and payroll taxes was $246 billion for 2007; estimates for FY 2009 put the cost at $315 billion. It thus represents one of the largest tax expenditures in the Federal budget and is regarded by most economists as being both an inefficient and inequitable way to subsidize the purchase of insurance.

The current treatment is inequitable because the exclusion is worth more the higher the person's income and not available to those without employer sponsored insurance. It's inefficient because it distorts the choice between cash wages and other forms of

compensation, frequently doesn't reflect the type of insurance that would be purchased if it was the employee's choice and may encourage the purchase of more extensive insurance than would be purchased under neutral tax treatment between wages and insurance. How, how fast and how much to limit the current tax treatment of employer sponsored insurance and what to put in its place will determine how much revenue can be obtained.

My preferred alternative is to move from the current exclusion to a refundable credit that declines with income but provides some amount of subsidy even at high incomes. Capping the current exclusion, could be viewed as an alternative, or as part of the phase-in to a move away from the exclusion. Capping it at relatively high levels but indexing it to general inflation rather than medical expenditures would generate less pain and perhaps less resistance but also less revenue. It also maintains the current inequity although that could be partially offset depending on the type of subsidy used for those without employer health insurance.

Concern has been raised that many or most employers would stop offering insurance coverage if the current tax treatment were changed. What is likely to happen depends on what else is available, under what terms and whether coverage is required. These requirements can be structured in ways that would make it more or less likely for employers to continue offering insurance. To the extent that employer sponsored insurance remains a way to help attract more skilled employees, employers—especially large employers—are likely to continue offering coverage for at least the near-term.

Reforming Medicare physician reimbursement

Although many of the ways Medicare reimburses for services needs to be changed if it is to be part of a move to a value-based-based system of reimbursement, the way Medicare pays physicians is particularly egregious. Fees have remained essentially flat throughout the decade while the cost of providing services has not. This means that physicians who practice a conservative style of medicine, and have not changed their billing or practice behavior are unlikely to have covered their costs under Medicare. At the same time, total spending under Part B, including spending for Part B drugs, has been increasing at rates of 10-12% per year.

The use of a Sustainable Growth Rate (SGR) that ties the growth in overall Part B spending to the growth of the economy, attempts to achieve this growth rate by relating the fees for some 7000 billing codes to a level that would achieve the desired spending. The pressure on fees occurs whenever the growth in the economy slows and/or increases in the volume and mix of services occurs. Both of these have occurred for much of the decade. The fundamental problem with the SGR is that its objective of controlling total spending is inconsistent with the incentives it produces for individual physicians. Nothing physicians do as individuals or even as large groups will affect overall Part B spending but their fees will be affected by what other physicians do collectively, irrespective of their own behavior.

The use of the SGR would control spending if it were implemented—which has rarely occurred because of concerns about access but even if it were, it would do nothing to improve quality or clinical appropriateness. The removal of the SGR, with no other changes, would probably result in even bigger increases in Part B spending, if behavior in the 1980's is any guide.

Some short term patches could help, such as using multiples SGRs or the use of separate SGRs for multispecialty group practices, and having CMS more aggressively review billing by physicians who are clear outliers in terms of their use of medical procedures and ancillary services. But unless the Congress is prepared to consider SGRs at the practice level, I believe the key to reform is developing a more aggregative payment strategy. In the near term, payments need to be developed that cover all the services that a physician provides to a patient for the treatment of one or more chronic diseases. Also, bundled payments should be developed for high-cost, high volume DRGs, to include at a minimum the payment of all physician services associated with the DRG and perhaps to include the cost of the hospital stay as well.

Developing a new payment strategy and adopting the administrative changes to implement it will take several years. There are no quick fixes to physician payment reform.

Comparative Clinical Effectiveness Research and Value-Based Insurance

The development of more and better information on comparative clinical effectiveness, particularly if its use were encouraged by such concepts as value-based insurance and value based reimbursement, could both improve care quality and potentially slow health care spending. The well known variations on geographic spending in the U.S., particularly now that it appears that the high spending areas have no better health outcomes or responses to patient preferences, offers ample evidence that there are substantial differences of opinion on how best to treat patients with various medical conditions that are not based on good clinical evidence.

The question is how best to generate the information on which medical interventions work best, for whom, and under what circumstances and then how best to make use of the information. Several pieces of legislation were introduced in 2007 and 2008, including S.3408, The Comparative Effectiveness Research Act of 2008, attempting to initiate such efforts. These efforts have now been jump-started with the $1.1 billion for comparative effectiveness research provided in the Stimulus bill. As important as this provision is, it needs to be recognized as the first step in what will need to be a long-term commitment in investing in such efforts. If we are to gain the kind of information that will be needed to produce more effective clinical guidelines, it will take substantial investments over time in order to better understand the data from existing studies as well as generating new information through the use of registries, epidemiological studies and even new prospective trials. These studies will need to occur wherever there are substantial variations in how medical conditions are being treated now as well as investing in similar efforts for new medical procedures.

The Stimulus bill provided important new funding for the initiation of such efforts but did not indicate how future funding will be provided. It also has not answered many difficult questions such as who should be responsible for generating or at least funding new studies, where should the information be stored and how it should be disseminated and otherwise made available to both professionals and the public. Further legislation will be needed to address these issues.

As important as generating new information is, new information alone may not be enough to change physician or patient behavior. Changing incentives for clinicians and their patients, better aligning financial incentives between clinicians and institutional providers and combining information on effectiveness with cost data in setting reimbursements rates will also be important if spending is to change. Value-based insurance concepts which encourage the use of lower co-payments for more clinically appropriate treatments and value-based reimbursement which reimburses the clinicians and institutions more favorably who provide more clinically appropriate care and do so more efficiently, will also help change behavior.

I believe that changing behavior to encourage the use of more clinically appropriate behavior and discouraging what is less clinically appropriate (that is, don't say "no", make it more expensive for the patient and less well reimbursed for the clinician) needs to start with creating credible, objective, transparent information. This means that keeping these functions separate is very important. The groups creating the information

should be separate from the payers as much as that is possible. Otherwise the information is likely to be regarded as "tainted" or at least portrayed as a way of keeping physicians from providing the "best care they can for their patients", even if there is little evidence to suggest that is true.

The use of value-based insurance and value-based reimbursement has more general use than only reinforcing the evidence from comparative clinical effectiveness studies. Varying co-payments to encourage the choice of more efficient physicians and institutions is a strategy that is starting to be used by private payers, reportedly with positive effects. It would be useful for CMS to be granted similar authority for use in Medicare. Current legal deference to individual physician decision-making and the general inability of CMS to make use of information on cost and quality in most of its reimbursement policies would need to be changed.

Concluding Note

Evidence from Massachusetts suggests that expanding coverage can be done quickly. Many of the savings that are under consideration, particularly those that are also aimed at improving quality and clinical appropriateness, may take several years to implement and produce savings. That's a reality that is sometimes hard for people to acknowledge.

Testimony of

Ronald A. Williams

Chairman and Chief Executive Officer, Aetna Inc.

before the

United States Senate Committee on Finance

"Delivery System Reform"

Tuesday, April 21, 2009

[Written Submission]

Introduction

Good morning Chairman Baucus, Ranking Member Grassley and members of the committee. My name is Ronald A. Williams, and I am the Chairman and Chief Executive Officer of Aetna Inc. Headquartered in Hartford, Connecticut, Aetna is one of the nation's leaders in health care, dental, pharmacy, group life, disability insurance and employee benefits. We provide products and services in all 50 states, serving over 36.5 million unique individuals. Our customers include employer groups, individuals, college students, part-time and hourly workers, health plans, governmental units, government-sponsored plans, labor groups and expatriates.

Thank you for the opportunity to participate in today's roundtable and share with you my views on our top priorities for reforming our nation's health care delivery system.

While access to health care is deservedly much-discussed, the scope of comprehensive health care reform must be broader to ensure that the system successfully delivers high-quality health care. We need a health care system that can help Americans achieve their optimal health by delivering the right kind of care to everyone who needs it every single time. Today, we simply do not have such a delivery system in place.

I believe achieving the ideal delivery system requires us to focus on several key areas of reform:

1) We need to **harness the power of health information technology** so that we can turn complex health data into knowledge that physicians and patients can act on to improve health outcomes;
2) We need to **make wellness and prevention a priority in our health care system**. Our seat belt laws and anti-smoking efforts have achieved great results and we need this same type of commitment in the wellness challenges facing us in the areas of obesity and encouraging healthy behaviors; and
3) We must **reform our payment system**, utilizing public programs alongside private sector innovation, so that our focus rests on value and quality, rather than volume.

To a large degree, the value of these reforms is demonstrated in the positive outcomes we have achieved through programs for our customers and employees. It is clear that health care marketplace innovations can be utilized for the benefit of all Americans, and I want to highlight some of these experiences while discussing our priorities for delivery system reform.

Priorities for Reforming the Delivery System

1) Leverage the power of health information technology to enhance care coordination and improve outcomes

We need to change delivery paradigms by using health information technology (HIT) tools that enable providers and patients to make better use of the right data, at the right time to

make quality care decisions. HIT can facilitate vast improvements in individuals' health care experiences by offering them a clearer picture of their own health, a more coordinated interaction with multiple health care providers and better, safer health outcomes.

There is widespread recognition of the problems that could be partially solved through enhanced use of HIT – as many as 98,000 individuals die annually in U.S. hospitals as a result of medical errors[1] and at least 1.5 million Americans are injured every year because of medication errors, at a cost of at least $3 billion.[2] Yet, we have witnessed a very slow adoption curve among U.S. providers for tools such as Electronic Health Records (EHRs). The slow rate of EHR adoption among physicians has been documented, and a recent *New England Journal of Medicine* survey found a similar trend among hospitals; only 1.5 percent of U.S. hospitals have a comprehensive electronic records system.[3]

Aetna applauds the efforts of both Congress and the Administration for making the $22 billion down payment in the American Recovery and Reinvestment Act to incent providers to purchase and implement electronic record platforms. While absolutely necessary, Aetna believes that EHRs are only a partial solution if we are to fully realize the $80 billion in projected annual savings generated from the use of electronic record technologies. More important will be "smart" technologies that enable data exchange across providers as well as the companion services which deliver advanced, intuitive clinical decision support. These tools will ensure that providers are able to quickly rationalize the growing volume of data on their patients and to use that data to make the right treatment decisions. It is from these latter two areas – data exchange tools and clinical decision support tools – that the public will realize true value for its HIT investment, and I would encourage Congress and the Administration to make these investments.

Data Exchange Tools

We need continued focus and investment to develop the infrastructure needed to support data exchange tools. All Americans should have access to a secure, interoperable health system that provides administrative and confidential medical information. Health information technology, coupled with evidence-based medicine, translates into fewer errors, improved patient safety and better doctor-patient communication.

Aetna Experience

Aetna and its ActiveHealth Management division are working closely with regional health information organizations around the country to embed the value of evidence-based technologies and services to assist the clinical providers who are connected to the information exchange network. An exciting program is underway with the Brooklyn Health Information Exchange in New York City where ActiveHealth's clinical decision support technology and services are to be used to aggregate, analyze and connect otherwise disparate information

[1] Linda T. Kohn, Janet M. Corrigan and Molla S. Donaldson, "To Err is Human: Building a Safer Health System," Institute of Medicine, November 1999.
[2] Philip Aspden, Julie Wolcott, J. Lyle Bootman and Linda R. Cronenwett, Eds., "Preventing Medication Errors," Institute of Medicine, July 2006.
[3] Ashish K. Jha, Catherine M. DesRoches, Eric G. Campbell, "Use of Electronic Health Records in Hospitals," *New England Journal of Medicine*, April 2009.

from lab results, pharmacy data, diagnostic and procedural claims data. This technology allows for identification of gaps in care, medical errors and quality of care concerns via evidence-based guidelines. ActiveHealth is also providing specialized Personal Health Records to Brooklyn patients that will be populated with patient-centric data drawn from the exchange. From this data, ActiveHealth will be able to generate care alerts to be sent to both patients and their providers to create a customized care plan for the patient. Our work with the health information exchange in Brooklyn has been an important milestone for ActiveHealth, and we are pleased to now be working with a number of other regional exchanges to implement similar programs.

Clinical Decision Support

Aetna believes the key to leveraging the power of health information technology is to ***make data actionable***. Giving providers greater visibility to patient data to make better decisions for their patients – and Aetna members – has been a central driver for much of the $1.8 billion Aetna has invested in HIT since 2005. This was the impetus for our acquisition and continued deployment of an interoperable clinical decision support service, ActiveHealth Management and its CareEngine® clinical decision support solution.

Aetna Experience

As envisioned in the collaboration now underway between ActiveHealth and the Brooklyn Health Information Exchange, advanced clinical decision support is a vital tool that enables providers to "meaningfully use" their electronic health record system. Many commercial payers already recognize the value of this technology, as it serves more than 19 million plan members and their physicians. ActiveHealth services generated more than 7 million care alerts in 2008. Most importantly, these alerts are having a measurable impact on both the quality and economic value of the care patients are receiving, especially in higher cost chronic disease areas where effective care coordination makes a tremendous difference. Some real world results include the following:

- Alerts calling for the right use of ACE inhibitors in the appropriate cardiovascular patient population delivered $510 per member per month reduction in submitted charges when compared to a matched control group that did not receive such alerts;
- Compliance improvements of 47 percent were achieved in ensuring chronic kidney disease patients received the standard of care to prevent bone disease;
- Use of alerts improved compliance with national osteoporosis guidelines by up to 23 percent; and
- There was an incremental 12.5 percent boost to overall patient compliance with their providers' care recommendations when patient alerting was used.

These and other examples underscore the vital role that advanced clinical decision support can, and should, play in ensuring providers maximize the value and potential of electronic health information.

Recommendations

While ActiveHealth Management's CareEngine® is a leading technology in the clinical decision support and care management category, this area as a whole is a rapidly emerging space for innovation and one which merits continued public policy focus and support for its ability to drive a measurable return on investment. Specifically, Congress and the Secretary of Health and Human Services should give additional consideration to how Medicare and Medicaid incentive payments to providers could be used to help providers acquire these services and tools as part of their effort to use EHRs, improve care coordination and enhance quality of care for patients. In the months ahead, as this committee and the Congress consider comprehensive health care reform, I encourage Members to become familiar with how these decision support tools function, how they provide a necessary complement to enable the "meaningful use" of EHR technology and how they can foster quality and value for providers, patients and payers. In addition, I believe we must invest in the infrastructure necessary to facilitate the establishment of a truly interoperable health information technology system.

2) Focus our system on prevention and lifelong wellness to get and keep Americans healthy

Today, our health care delivery system is largely oriented toward treating disease once it surfaces rather than preventing it before it has the chance to appear. Refocusing our system to prevent disease and promote wellness can shift the pendulum toward better health for all Americans, giving individuals the support and resources they need to lead longer, healthier lives.

Overall, we are simply not as healthy as we could be. More than half of Americans are living with at least one chronic disease.[4] Nearly one in five four-year-olds is obese, with significant disparities in prevalence among different racial and ethnic groups.[5] Unhealthy behaviors have severe human and economic consequences. Obese children face risk factors for cardiovascular disease (e.g., Type II Diabetes, high blood pressure) previously only seen in adults, and they are likely to be obese as adults, as well.[6] Smoking alone accounts for 400,000 annual deaths[7], and obesity is associated with more than 111,000 excess deaths each year.[8] The United States spent $217.6 billion on direct costs in treating non-institutionalized

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[4] Ross DeVol, Armen Bedroussian, Anita Charuworm, et al., "An Unhealthy America: The Economic Burden of Chronic Disease Charting a New Course to Save Lives and Increase Productivity and Economic Growth," Milken Institute, October 2007.

[5] Sarah E. Anderson and Robert C. Whitaker, "Prevalence of Obesity Among U.S. Preschool Children in Different Racial and Ethnic Groups," *Archives of Pediatrics and Adolescent Medicine*, 2009; 163(4):344-348.

[6] David S. Freedman, Zuquo Mei, Sathanur R. Srinivasan, Gerald S. Berenson and William H. Dietz, "Cardiovascular Risk Factors and Excess adiposity Among Overweight Children and Adolescents: the Bogalusa Heart Study," *The Journal of Pediatrics*, 2007, 150(1):12–17.

[7] National Committee for Quality Assurance, "State of Health Care Quality," 2007.

[8] Katherine M. Flegal, Barry I. Graubard, David F. Williamson and Mitchell H. Gail, "Excess Deaths Associated with Underweight, Overweight and Obesity," *JAMA*, April 20, 2005; 203(15): 1861-1867.

Americans for chronic disease in 2003, while experiencing an added $905 billion in losses associated with indirect costs.[9]

Our delivery system reform efforts must refocus our system on getting and keeping people healthy throughout their lives. I believe a number of strategies are critical to refocusing our system on wellness and prevention, including:

- *Developing an integrated, holistic approach to care management to allow for early intervention and education;*
- *Using consumer engagement and targeted incentives to encourage sustained healthy behavior and change unhealthy behaviors; and*
- *Promoting coverage policies and initiatives that encourage the use of high-value health care and address the needs of specific population segments.*

Integrated, Holistic Approach to Care Management

All too often, patients can find themselves in a maze of multiple physicians and providers, lacking a coordinated, holistic view of their total health and the range of needs they face. For health care to be as effective as possible for each individual, care must be integrated and coordinated among providers and with health plans to ensure the right kind of focus on all aspects of a patient's health and needs. I believe that a holistic approach to care can have a positive impact on quality while also reducing costs.

Aetna Experience

Aetna Health Connections Disease Management helps people with chronic conditions get the treatment and preventive care they need by taking a wider view of an individual's health, rather than focusing solely on a single disease. Aetna's nurses and clinicians help members understand and follow their doctor's treatment plan and better manage ongoing conditions with the goal of helping members achieve their optimal level of health. These programs include foundational care management capabilities; effective use of data that provides a 360° view of a member's health; and personalized, actionable information through pinpoint identification that can measure changes in engagement levels over time. Employers who invest in this program have seen a 2 to 1 return on their investment. Moreover, through disease management programs, we have seen reductions in emergency room visits and inpatient admissions, including a 7 percent reduction in ER visits for asthma, a 13 percent reduction in inpatient admissions for coronary artery disease and an 18 percent reduction in inpatient admissions for strokes.

Consumer Engagement and Behavior Change

Wellness and prevention require consumer engagement and sustained behavior change. The path to engagement and behavior change begins with involving people in programs that will set them on their way to improved health, while providing continuous support and interaction to keep them moving in the right direction. This can be achieved by providing education,

[9] Devol, Bedroussian, Charuworm, et al. Indirect costs include decline in worker productivity, presenteeism and overall reductions in the labor supply.

interactive and easy-to-use tools and access to a range of services. These should include health risk assessments, fitness programs, weight management, disease management, smoking cessation, employee assistance and incentive programs.

Aetna Experience

Wellness Works Programs. We believe so strongly in the value of wellness programs that we implement them widely for our own employees. The goals of our *Wellness Works* programs include promoting positive, healthy behaviors; offering prevention and early intervention services; promoting appropriate utilization through our expertise in evidence-based medicine; and supporting a healthy culture that gives employees "permission to be healthy." As a result, engaged Aetna employees are getting healthier and contributing to lower medical costs. In fact, the suite of Aetna wellness programs were a strong contributor to Aetna's maintenance of a just over 3 percent trend in growth of health care costs. Two examples among many include the *Get Active Aetna* program, a fitness action campaign through which 55 percent of employees logged 970,000 exercise hours in 2008, and the *Healthy Lifestyles* programs, through which employees can receive up to $600 in financial incentives for participating in the company's health assessment and for tracking individual physical activity and healthy eating.

Value-Based Insurance Design. Based on evidence in the medical literature that co-payments and/or coinsurance can create barriers to care, value-based insurance design eliminates or reduces co-payments or coinsurance for certain medications or types of care that are demonstrated to be crucial in preventing or managing disease. In other words, insurance is designed so that costs are not a deterrent to individuals in seeking out the right kind of care. One important example is the various types of care that are provided with first-dollar coverage, including preventive care, routine physicals, gynecological exams and medications for chronic care conditions. In addition to offering these products in the market, Aetna and the Aetna Foundation are supporting two clinical studies to evaluate the efficacy of value-based insurance design with researchers at Brigham and Women's Hospital and the University of Pennsylvania.

Coverage Policies and Initiatives to Address Critical Needs

Another important approach for improving health and wellness on a large scale involves identifying groups of people – based on health condition, ethnicity or another unifying characteristic – that can benefit from a specific intervention and then providing that intervention. Such interventions have the potential to improve the wellness of individuals who may have otherwise fallen through the cracks. Aetna has worked hard to identify areas where we can have an impact on individuals, quality improvement and the health care system at large.

Aetna Experience

Childhood Obesity Pilot. In 2009, Aetna launched a childhood obesity pilot in cooperation with the Alliance for a Healthier Generation (partnership between William J. Clinton Foundation and American Heart Association), Aetna's employer clients and the medical

community. The program, currently available to five large employer groups totaling 74,000 employees, includes coverage for obesity and nutritional counseling provided by physicians, access to clinically-based community resources, educational materials distributed at the worksite and educational resources for physicians. We believe the program is breaking new ground; currently there is no evidence-based protocol for treating childhood obesity with counseling absent a co-morbid condition (e.g., diabetes). By addressing childhood obesity *before* it leads to serious health complications, this program takes an important, proactive step in improving health and quality of life for children in need. Our program offers a uniquely comprehensive approach by combining proactive treatment of childhood obesity with collaboration among insurers, employers, the medical community and families.

Aetna Compassionate Care Pilot. Although 70 percent of Americans say it is their wish to die at home, just under 25 percent do so.[10] In the advanced stages of illness, individuals and families too often face the challenging all-or-nothing decision of choosing between curative care in a hospital setting and palliative care in a hospice or home setting. In 2004, Aetna introduced a pilot program to evaluate whether liberalized hospice benefits (i.e., offering access to curative care whether in a hospital, hospice or at home) and specialized nurse case management support could improve quality of care and quality of life for members in the final stages of life. Through a study comparing three groups of members,[11] we found that the proportion of members using hospice increased across the board (71 percent for commercial health plan members and 63 percent for Medicare members); outpatient days spent in hospice more than tripled; and members were rushed to the ER less and had fewer hospitalizations. Most importantly, in a member satisfaction survey Aetna conducted of family caregivers of members enrolled in the program, 96 percent said they believed the member's needs for pain management and symptom relief were met in the final months of life.

Breast Health Ethnic Disparities Initiative. Through the Breast Health Initiative, we aim to improve women's compliance with screening mammograms by identifying those African American and Latina members who have not had annual screening mammograms, identifying barriers to screening mammograms and conducting personalized, culturally competent outreach.

Recommendations

Investments should be made in programs that promote the health and wellness of our population and encourage the use of preventive care. The programs enumerated above are only a sample of the many specific initiatives being implemented nationwide, but they demonstrate the value and efficacy of engaging individuals in the pursuit to achieve and maintain better health and wellness. Importantly, the employer-based system provides a critical venue for implementation of wellness and prevention programs, as insurers can help employers target interventions to the needs of their employees and their families. Congress should consider providing tax incentives to employers for offering evidence-based wellness programs, while also considering vehicles for pre-tax purchase of wellness-promoting

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[10] Robert Wood Johnson Foundation, "Means to a Better End: A Report on Dying in America Today," November 2002.

[11] Three member groups were: those receiving hospice benefits and case management from trained nurses; those receiving case management support only; and Aetna Medicare members.

activities. Grants for community-based wellness and fitness programs should also be considered in order to reach a larger segment of the population. In addition, wellness and prevention initiatives should be implemented in public programs in order to improve the quality of care provided and reduce costs. In all cases, programs should: be implemented with an eye toward consumer engagement and behavior change; utilize new and existing tools (e.g., care management, HIT) to ensure care is integrated; and enact coverage policies that encourage (rather than discourage) people to access care that promotes wellness and prevents disease.

3) Reform our payment system to focus on value, rather than volume

Though we as a nation have the highest per-capita health care spending in the world, the quality of care delivered by our health care system falls far short of expectations. Incentives in our payment system that reward providers for quantity of care rather than quality of care are an important part of the problem. Improving our delivery system starts with reforming our payment system to focus on quality and value. Aetna supports transforming the payment system into one that aligns provider reimbursement incentives with achieving high quality outcomes for patients.

Various payment reform approaches linking payment to performance and aligning care across the continuum of providers are being piloted and tested across the country. I believe we must work together to test and identify those that achieve value and sustain robust health care systems, including the following:

- *Consider new payment models to align care and recognize performance;*
- *Expand pay-for-performance;*
- *Revitalize primary care and support the patient centered medical home*
- *Increase transparency*
- *Include public programs in payment reform*

New Payment Models and Pay-for-Performance

The goals of both new payment models and pay-for-performance are: (1) to recognize and reward physicians, hospitals, other health providers and health systems for delivering high value; and (2) to create incentives for improvements in performance, outcomes and quality of care (e.g., safety, effectiveness and efficiency).

New Payment Models to Align Care and Recognize Performance: Reform should focus on meeting consumers' needs as they try to successfully navigate through our health care system by paying for coordinated care driven by intelligent decision-support systems. Approaches that dominate the payment reform debate and need to be considered include bundled payment for an episode of care and gainsharing (rewards for greater efficiencies), recalibrating the current fee-for-service system, global payment through capitation and other mechanisms. The private sector has been and will continue to be a useful laboratory for testing these approaches.

Pay-for-Performance: Pay-for-performance initiatives that are evidence-based and focus on continuous improvement can help bridge the transition to more comprehensive payment reform. Our collective ability to differentiate and measure performance and performance improvement is a fundamental component of payment reform. Investment in this area must focus on measures that are credible to physicians, clinically important, transparent to all stakeholders and understandable and useful to consumers.

The following are some examples of Aetna's efforts to try new payment structures that are designed to promote a team approach to medicine and improve outcomes for the patient.

Aetna Experience

Aetna's Pathways to Excellence.[SM] Pathways to Excellence initiatives are focused on engaging providers to improve both the patient experience and outcomes of care. This set of innovative solutions advances value-driven healthcare purchasing by aligning recognition, incentives and/or payments to providers with the delivery of high quality, safe and efficient care. It includes such diverse initiatives as pay-for-performance with physicians and hospitals; our High Performance Provider Initiative health care improvement collaboratives; Aetna's Institutes[SM] Program for designating top performing facilities and providers for specific health services; and Aetna's Aexcel® Specialty Designation High Performance Network.

Currently, nearly 80,000 physicians and 350 hospitals participate in *Pathways to Excellence*. To ensure that our provider partners are actively engaged in achieving successful outcomes, we work with them to select mutually agreed-upon measures for improvement assessment. As part of this program, a multi-hospital, metropolitan system experienced significant improvement in antibiotic management along with a 10 percent reduction in length of stay over a two-year period. In our High Performance Provider Initiatives, we work with hospital and health plan data to identify variations in care and implement targeted interventions to reduce these variations. These collaborations have reduced hospital readmission rates, increased post-discharge physician visits, increased the use of generic drugs and decreased unnecessary high-cost radiology procedures.

Both our Aetna Institutes and Aexcel Programs identify high performing providers and designate High Performance Networks. In Aexcel, specialists who have met clinical quality and efficiency standards are recognized. Aetna's performance network is associated with high-quality care that saves up to 4 percent in medical costs annually. **Aetna Institutes™** facilities are publicly recognized, high-quality, high-value health care facilities. By identifying these providers in our provider search engines and, in some cases, providing incentives to members, we reward these facilities for their performance. Our Institutes for Bariatric Surgery have achieved exceptional outcome results for our members, resulting in medical costs in the year post surgery that are 15 percent lower than the year prior.

Revitalizing Primary Care and Supporting the Patient Centered Medical Homes

We need to build on the Patient Centered Medical Home models now being tested and refined in both the private and public sectors. Fundamental to these programs should be the establishment of methodologies for compensating primary care practices in a way that

recognizes the value of care coordination. Investment in formal evaluation of the impacts of the Medical Home on quality, cost and patient experience should be an integral component of all demonstrations undertaken in the public sector. Payment reform should also directly address practical methods to recognize the value of telemedicine, electronic visits and other technology-enabled approaches to delivering more effective care, especially for those patients with chronic medical conditions.

Aetna Experience

Primary Care Revitalization and Patient Centered Medical Home. Aetna is engaged in four Patient Centered Medical Home demonstrations and is planning several others. In each of these, payment structures can range from allowing payment for care coordination services and consultation within an interdisciplinary team to innovative gainsharing strategies. In our Medicare Advantage program we also are making nurse care coordinators available on-site at physician offices to support primary care. Our rigorous methods of measurement will help identify effective strategies for reaching our common goals among the diverse populations, communities and practice-types that must be supported through such initiatives.

Transparency

Health care consumers often lack quality and price information before they receive care, often leading them to pay too much for care without being assured of the standard of care they expect. Conventional wisdom might suggest that more expensive health care is better care, but researchers have found that neither quality of care nor patient satisfaction is correlated with costs. The system should demand transparency in health care quality, network membership and pricing to give consumers easy access to health care information to make good decisions. We believe that investments in transparency should be accompanied by rewards and other incentives for providers that efficiently deliver evidence-based care.

Aetna Experience

Healthcare Transparency Tools. Aetna has a leading suite of online health care transparency tools that provide our members, prior to receiving care, with clinical quality, cost and efficiency information. Online access to this information helps members choose health care providers, make informed health care decisions and better plan for their health care expenses. Ensuring transparency on all three levels – quality, cost and efficiency – makes certain that price information will not disproportionately drive health care decisions.

We have integrated transparency information directly at the point of member selection of providers through Aetna's DocFind search-engine. Today, members can learn which physicians are participating in the American Board of Internal Medicine Quality Improvement Program and the American Society of Clinical Oncology Practice Improvement Initiative, and which physicians are recognized by the National Committee for Quality Assurance (NCQA) or Bridges to Excellence.

Members can utilize our hospital comparison tool with direct links to the Leapfrog Group and hospitalcompare.gov to better understand hospital care and quality. We continue to expand

our partnerships for external recognition while also building our own internal recognition programs.

Include Public Programs in Payment Reform

Among all payers in our system, the government is the largest individual payer of health care costs. Public programs must be part of payment reform. Under Medicare's current fee-for-service payment structure, providers are paid on the basis of volume rather than value, often with suboptimal results. Moreover, lower payment rates paid by public programs result in cost shifting to those who are privately insured. In 2007, commercial payers paid physicians at much higher rates than public payers, with Medicare rates at 89 percent of the overall average rate, Medicaid rates at 60 percent of the average and commercial rates at 114 percent of the average. On an aggregate level, the cost shift from public programs to commercial plans is about $89 billion, leading the average privately insured family to spend an additional $1,788 annually.[12] By addressing the challenges within the public program payment systems, we can begin to tackle payment reform head-on, while also reducing some of the negative externalities associated with the payment structures within these programs.

In addition to payment reforms needed within Medicare to improve quality and reduce costs, and in light of budgetary needs for a down payment on health care reform efforts, we may also have to address the related issue of Medicare's operational structure and the Medicare Advantage bidding process. In particular, if we decide to follow a pathway to Competitive Bidding in Medicare Advantage, we should look at the development of a viable structure that exhibits the following guiding principles: (1) generates meaningful cost savings from the Medicare Advantage program; (2) maintains access for all beneficiaries and minimizes disruption; and (3) provides incentives to improve quality.

Recommendations

We must continue to test new payment models and pay-for-performance programs as we implement the most promising approaches in both private insurance and public programs. We should take steps to revitalize primary care, recognizing its importance to providing integrated, quality care at a lower cost. Beyond investigating new primary care models, such as the medical home, Congress should offer loan forgiveness to medical students choosing to practice primary care. Congress should push for greater transparency in public programs, in order to provide consumers with the critical price and quality information they need to make good choices when it comes to their own health care. For all interventions related to payment reform, I urge Congress to recognize and act on the importance of implementing payment reform in public programs, including Medicare, Medicaid, CHIP and the Indian Health Service, in order to expand the reach of effective approaches for the benefit of a broader segment of the population.

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[12] Will Fox and John Pickering, "Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid and Commercial Payers," Milliman, December 2008.

Conclusion

We cannot ensure a high standard of care for all Americans until we repair our health care delivery system. To repair our system, we must encourage the widespread adoption of the health information technology tools that can provide for better care coordination and better care. To repair our system, we must achieve a renewed focus on getting and keeping people healthy by maintaining a primary focus on wellness and preventive care. And finally, to repair our system, we must reform payment structures to facilitate provision of the highest possible quality of care.

Aetna has been at the forefront of bringing about innovations to improve the health and lives of our members and to enhance the functioning of the many parts and players in the health care system with whom we interact. I believe the competitive marketplace has played – and can continue to play – an important role in fostering the innovation necessary for our country to achieve true and widespread greatness in our health care system. I encourage Congress to accelerate the implementation of these innovations on a wider scale for the benefit of our entire population.

Thank you for the opportunity to share my thoughts with you today.

Statement for the Record

Steven E. Wojcik
Vice President, Public Policy
National Business Group on Health

May 12, 2009

Senate Committee on Finance
Roundtable on Financing Health Care Reform

NATIONAL BUSINESS GROUP ON HEALTH

Good morning, Chairman Baucus, Ranking Member Grassley and members of the Committee. I am Steve Wojcik, Vice-President of Public Policy for the National Business Group on Health, a member organization of 300, mostly large employers—including 64 of the Fortune 100—that provide coverage to more than 55 million U.S. employees, their families, and retirees. The National Business Group on Health is devoted exclusively to finding innovative and forward-thinking solutions for large employers' and our nation's most important health care and related benefits issues. Thank you for the opportunity to participate in today's roundtable to share our organization's views on health reform generally, and financing health reform in particular.

Health care in the United States is very expensive and, although we have some of the best health care in the world, too often we have uneven, inadequate and unsafe care. At the same time, millions of people cannot afford health coverage. The strains caused by all three of these problems increasingly call into question the sustainability of the status quo.

The per employee cost for health care averaged $9,144 in 2008.[1] Compared to just seven to eight years ago, employers are paying 100% more for health care and people who purchase insurance on their own have seen even greater price increases. As a result, it is increasingly difficult for employers to provide affordable health benefits to employees, for employees to pay their cost sharing, and for people without employer-sponsored coverage to purchase insurance.

Although the rate of increase in health care costs has slowed in recent years, increases are still well above the overall level of inflation and the lower percentage is on top of an ever rising base. American employees have been giving most or all of their pay raises to health care for the past eight years. Rising health care expenses contribute significantly to stagnating wages, leaving consumers with less money for food, housing, education and other goods and services. High costs are also making it more difficult for American companies and American workers to compete in the increasingly global economy. With national health expenditures exceeding $2.5 trillion, a projected 17.6% of the gross domestic product (GDP) in 2009, and is estimated to be over $4 trillion dollars in 2018, (20.3% of GDP)[2], the problem is not just that the country spends too much on health care. The United States spends much more on health care per person than any other country in the world, including other countries with high standards of living, and the price tag makes many American goods and services relatively more expensive than those produced in other countries.

The National Business Group on Health believes that the degree to which we can expand access to health care services depends greatly on our ability to achieve greater affordability, value, quality and safety in health care. Health care costs cannot be contained if we continue to provide

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[1] Towers Perrin. 2008 Health Care Cost Survey. January 2008. Available at: http://www.towersperrin.com/tp/getwebcachedoc?webc=HRS/USA/2008/200801/hccs_2008.pdf

[2] Centers for Medicare and Medicaid Services. Office of the Actuary. National Health Statistics Group. 2008 Available at: http://www.cms.hhs.gov/NationalHealthExpendData/
(Historical data from NHE summary including share of GDP, CY 1960-2007, file nhegdp07.zip; Projected data from NHE Projections 2008-2018, Forecast summary and selected tables, file proj2008.pdf).

and pay for large amounts of inappropriate and poor quality care. An effective, workable health reform must successfully address the interrelationships among costs, quality and access. We applaud your leadership and this Committee's wisdom in holding these roundtables, each of which addresses one of these three interconnected aspects of health reform.

The financial crisis and subsequent economic recession has made it even more imperative that we waste less and produce more real value for what we spend on health care. Virtually all experts agree that, with a few notable exceptions, health care in the United States is inefficient, with enough genuine waste to produce real savings. **The Office of Management and Budget (OMB) Director Peter Orszag recently testified that "health care costs could be reduced by a stunning 30 percent—or about $700 billion a year—**without harming quality if we moved as a nation toward the proven and successful practices adopted by lower-cost areas and hospitals."[3] **That amounts to $15,000 per uninsured person—more than enough to pay for their health coverage.**

The National Business Group on Health believes that, to achieve a lasting and workable health reform, we must improve efficiency, reduce costs and improve the quality and safety of health care delivery. Without them, any expansion of coverage will only be temporary and exacerbate cost problems. The following elements are critical to effective and efficient health care delivery:

— A culture of quality and patient safety,
— Payment systems that reward outcomes not just utilization,
— Payment systems that support primary care and care coordination,
— Transparency of health care price and quality information,
— Comparative effectiveness research of health care interventions,
— Evidence-based medicine wherever possible,
— A secure, nationwide electronic health information network,
— Portable, personal health records for all,
— A focus on prevention and primary care,
— Capital spending only where truly needed,
— Personal responsibility for health and engagement in care decisions, and
— Reform of the health care legal system.

Stakeholders agree on so many matters, such as the critical importance of health information technology, better information and more transparency; patient safety and quality; a focus on wellness, primary care, care coordination and prevention; a reduction in obesity; elimination of health care disparities;, and the need to *reduce* the costs of health care, not just moderate the rate of growth. We must seize this opportunity for workable, lasting health reform so that we all can enjoy affordable, high quality care efficiently delivered.

In addition to our strong belief that workable, sustainable health reform must simultaneously address the cost and quality challenges as we expand access to coverage and care, our toolkit on

[3] Orszag, Peter. Testimony of the Director of the Office of Management and Budget before the Committee on the Budget. U.S. House of Representatives. March 3, 2009. Available at: http://budget.house.gov/hearings/2009/03.03.2009_Orszag_Testimony.pdf

the "Imperative for Health Reform," released in early 2008, also emphasizes the importance of the following:

- Every adult should be required to have health coverage for themselves and their dependent children.

  The following conditions are needed to make this possible: A strong health care safety net and public programs such as Medicaid and SCHIP that provide effective and efficient care will be a critical part of the solution and should provide high quality care to those with little or no income who cannot afford coverage.

  People under age 65 should have access to a range of coverage choices through employers, the federal or state governments, insurers, or other pooling arrangements that includes at least one option with a core benefits package that includes essential evidence-based preventive, primary, prenatal, maternity, urgent and emergent care, chronic condition management, care coordination, and hospitalization insurance.

- Oppose Mandates Requiring Employers to Either Offer Health Coverage or Pay the Government

  States and the federal government should be working with health plans, employers and other stakeholders to develop, offer, and promote low cost, voluntary programs (including health insurance exchanges, new pooling arrangements, and the ability to purchase coverage approved in other states) to cover working families who have low or moderate incomes, and programs to assist small employers in offering health coverage to their employees.

- Support the Federal Framework of ERISA for Employer-Sponsored Health Benefits

  Employers must continue to have the flexibility to determine the types of benefits they offer and to tailor benefit plans to the specific needs of their employees and the circumstances of their companies.

- Maintain the Current Favorable Tax Treatment of Employer-Sponsored Coverage and Level the Playing Field for Individually-Purchased Insurance

As requested, this statement will highlight both the key role of the current tax treatment of employer-sponsored health coverage in assuring coverage for so many Americans and identify some areas to improve efficiency and reduce waste to help finance health care reform.

THE IMPORTANCE OF THE TAX EXCLUSION TO EMPLOYEES AND EMPLOYER-SPONSORED COVERAGE

As you know, today, employers are the principal source of health coverage for non-elderly people in the United States, voluntarily providing health benefits to about 161 million

Americans.[4] More than 60 percent of the population under age 65 is currently covered by employment-based plans.[5] The decision to provide health coverage, the level and scope of benefits, and the amount of money that employers contribute to employees' health care depend on a number of factors including the importance of employee health and productivity; the needs and preferences of employers' workforces; its use as a recruiting tool to attract and retain the best talent; labor market conditions; economic conditions; company growth and profitability; the relative cost of health and other benefits; and the tax advantages, which play a very important role.

As sponsors of health plans, employers currently use their flexibility, under the Employee Retirement and Security Act (ERISA), to innovate and close the gap between the quality of care that we have and the quality of care that we should have and need. Many employers develop and implement strategies aimed at improving the quality and value of the health care for employees.

Current tax rules permit employers to deduct their contributions for employees' health care from corporate income just as they deduct employees' wages and salaries as ordinary business expenses. Simultaneously, employees can exclude the value of these contributions from their income for tax purposes. They can also use pre-tax dollars to pay for their share of health premiums and often use pre-tax dollars for their out-of-pocket health expenses through flexible spending accounts (FSAs), other health accounts, and cafeteria plans offered by their employers.

For a long time, the Federal government has consciously used this favorable tax policy to encourage health coverage and the current favorable tax treatment of employer-sponsored coverage is a key reason that so many families have affordable coverage. This policy helps employers provide more comprehensive health benefits at a lower cost to employees and their dependents. **In the context of health reform and the push to expand coverage, it seems counterproductive and incongruous to talk about taxing the source of coverage for the majority of non-elderly Americans, making it more expensive for them and potentially jeopardizing their coverage. Though some may believe that this is an easy way to "finance" reform and "bend the cost curve," it does nothing to solve the crisis of affordability in the long-run and sidesteps the hard payment and delivery reforms that would create lasting, workable reform.**

- **Tax Advantages Help Make Health Care More Affordable for Employees**

For some employees, the tax advantages make the difference between taking up their employers' coverage and declining it because it is too expensive. Younger, healthier employees elect to participate in employer-sponsored coverage because the personal tax exclusion for benefits, along with their employers' tax-deductible contribution, makes the coverage more affordable. Many are at the lower income levels when just beginning their families and careers; their first priority is typically net pay. These employees frequently do not have an immediate expectation of requiring health care and in fact may only occasionally utilize the coverage. They participate

[4] Fronstein, Paul and Dallas Salisbury. Health Insurance and Taxes: Can Changing the Tax Treatment of Health Insurance Fix Our Health Care System? EBRI. September 2007.
[5] Ibid.

primarily because health care benefits are so heavily subsidized by employers and there are no adverse personal tax consequences.

- **Employees Value Employer-Sponsored Coverage**

Employees and job candidates expect and value health benefits as a key part of their employment and compensation. A soon-to-be-released survey of over 1,500 employees in March 2009, commissioned by the National Business Group on Health, found that 75 percent of employees considered their employment-based health plan their most important benefit and 83 percent would rather see their salary or retirement benefit reduced over their health benefit. About three out of four employees (75 percent) who responded to the survey said they would prefer to continue obtaining health benefits through their employer rather than receiving additional salary to purchase benefits on their own.[6]

Other surveys have found similar results about the value that employees place on their health benefits. A recent Kaiser Family Foundation Health Tracking Poll found that when people who are currently covered through their employers were asked for their initial reactions to buying health insurance on their own, 63 percent said it would be harder to find a plan that matches their needs as well; 64 percent said they would find it harder to handle administrative issues such as filing a claim or signing up for a policy; 80 percent said they would find it harder to keep health insurance if they were sick and 81 percent said they would find it harder to get a good price for health insurance.[7]

- **A Majority of Employees Oppose Taxing Employer Health Care Contributions**

A 2007 survey of over 1,600 employees with employer-sponsored coverage, conducted by Matthew Greenwald & Associates for the Business Group, found that **the majority of the employees, 57 percent, oppose treating employers' contributions to health plan premiums as taxable income, while only 30 percent favored this change.**[8]

- **Taxing Employees' Health Benefits Will Increase the Uninsured**

Many families would simply find health coverage unaffordable, particularly in these economic times, if they were taxed on their employers' portion of their health care costs and/or they were unable to use pre-tax dollars to pay their premiums and out-of-pocket expenses under employer-sponsored plans. Removing this ability and/or imposing a tax burden on them for their employers' contribution toward their health care plan costs would result in a significant number of employees simply discontinuing their coverage, causing an increase in adverse-selection in employers' plans, a decrease in their ability to cross-subsidize, and subsequent cutbacks in health care benefits offered.

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[6] Greenwald, Matthew and Associates. National Business Group on Health Employer-Based Health Benefits Survey. April 2007.
[7] Kaiser Family Foundation. Kaiser Health Tracking Poll: Election 2008. Conducted June 3-8, 2008. Available at: http://www.kff.org/pullingittogether/062608_altman.cfm
[8] Greenwald, Matthew and Associates. National Business Group on Health Employer-Based Health Benefits Survey. April 2007.

The favorable tax status of employer-sponsored coverage plays an important role in keeping employer risk pools intact so they are able to cover people of every age group and health status. Depending on the industry and labor market conditions, some employers who continue to offer health care at the same level could see increased labor costs as they are pressured to compensate employees for their higher tax payments.

Studies by the Urban Institute-Brookings Tax Policy Center and the National Bureau of Economic Research (NBER) estimated that eliminating the tax exclusion of employer health care contributions from income and payroll taxes would reduce employer health benefit offerings by 17 to 30 percent, and would decrease employer premium shares for those who continue to offer coverage by 30 to 42 percent.[9] The study by the NBER also found that smaller employers would be more likely to stop offering coverage if the tax exclusion were eliminated and larger employers would be more likely to cut back on the amount they subsidize, both of which would increase the number of the uninsured substantially. **Another study estimated that the total number of employees offered health insurance would drop by 15.5 percent if all of the exclusions were repealed and by 9.7 percent if the income tax exclusion were repealed, but the payroll and state tax exclusions remained.[10]**

IMPROVEMENTS IN QUALITY, REDUCTIONS IN WASTE AND INCREASES IN EFFICIENCIES TO PRODUCE SAVINGS IN HEALTH CARE DELIVERY

- **Use Health Information Technology to Identify Waste in Health Care**

The National Business Group on Health and the business community believe that it is critical to target the unprecedented level of federal funds for health information technology (HIT) in the American Recovery and Reinvestment Act (ARRA) to physicians, hospitals, and other health care providers who demonstrate that they will use it to improve the effectiveness and efficiency of care. Helen Darling, President of the National Business Group on Health, recently submitted testimony to the National Committee on Vital and Health Statistics on the "meaningful use" of HIT, which would eliminate waste in current health care delivery.[11]

As you know, studies at The Dartmouth Institute have shown significant variation in health care spending between regions of the United States with no difference in outcomes, only 40 percent of which can be attributed to different rates of illness and price[12]. The remaining variation can be explained in part by practice variations that have little or nothing to do with evidence-based medicine, but rather with local medical opinion and local supply of medical resources, regardless of whether such care is warranted. **This "over spending" is substantial and one report indicates that Medicare spending would decrease by 30 percent (approximately $133 billion based on OMB Fiscal Year 2009 historical spending tables) if spending in medium- and**

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[9] Burman, Leanord. Et al. Tax Incentives for Health Insurance. Discussion Paper 12. The Urban-Brookings Tax Policy Center. May 2003.: Gruber, Jonathan, and Michael Lettau. How Elastic Is the Firm's Demand for Health Insurance? NBER Working Paper 8021. National Bureau of Economic Research. 2000.

[10] Gruber. Jonathan and Michael Lettau, "How elastic is the firm's demand for health insurance?" Journal of Public Economics. Vol. 88. 2004. Pages. 1273-1293.

[11] Darling, Helen. Testimony to the National Committee for Vital Health Statistics on the "Meaningful Use" of Health Information Technology. April, 28, 2009. Available at: http://www.businessgrouphealth.org/pdfs/TLST-%20HIT%20Testimony%20to%20the%20NCVHS%20Final%20%20-%2042809.pdf

[12] Fisher, Elliot. Et. al. The Implications of Regional Variations in Medicare Spending. Part 1, Part 2: Health Outcomes and Satisfaction with Care. Annals of Internal Medicine. 2003. 138. Pages 273-298.

high-spending regions fell to the level of that in low-spending regions.[13] An interoperable HIT system could quickly identify and target areas of over spending and reduce unnecessary costs and produce savings.

Recently, a study by the National Priorities Partnership (NPP)—a collaborative effort of 28 major national organizations that collectively influence every part of the heath care system—concluded that a significant portion of care is actually redundant and unwarranted—and, in some cases, even harmful.[14] An interoperable HIT system could also effectively focus on the 8 areas of waste, overuse or harm identified by the NPP including inappropriate medication use, unnecessary laboratory tests, unwarranted maternity care interventions, unwarranted diagnostic procedures, inappropriate non-palliative services at the end of life, unwarranted procedures and consultations, preventable emergency department visits and hospitalizations, and potentially harmful preventive services that have no benefit. Providers could use this information to eliminate waste and produce savings that could be used to finance needed care such as primary care and care coordination.

- **Increase the Use of Evidence-Based Care**

Increasing the use of evidence-based care will also produce savings that could be used to finance health reform by eliminating duplicative, unnecessary and potentially harmful care. Objective evidence is needed to support national and regional decisions about Medicare coverage, development of practice guidelines and performance measures, design of value-based insurance plans, and informed patient and clinician decision making about treatment alternatives. Critical gaps in evidence are widespread for both new and existing technologies and services. A prominent and tragic example was the use of autologous bone marrow transplant/high-dose chemotherapy (ABMT/HDC) to treat metastatic breast cancer. Rigorous trials performed in the 1990s showed that contrary to the preliminary findings from the late 1980s, conventional therapy is superior to ABMT/HDC. By then, some 30,000 women had already been unnecessarily subjected to AMBT/HDC, and an estimated 600 women died prematurely as a result.

The Institute of Medicine (IOM) has set a goal that, by 2020, 90 percent of clinical decisions should be supported by accurate, timely, up-to-date clinical information. The additional $1.1 billion in funding in the economic recovery package for comparative effectiveness research that will be conducted by the Agency for Healthcare Research and Quality (AHRQ) and the National Institutes of Health will produce additional savings so that instead of more care, we start paying for the right care, for patients at the right time.

- **Improve Patient Safety**

Billions of dollars in savings are available to finance reform of our nation's health care system by simply improving patient safety and the quality of care.

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[13] Congressional Budget Office (CBO), Geographic Variation in Health Care Spending, 2008. CBO. February 2008. Available at: www.cbo.gov/doc.cfm?index=8972 : Wennberg, John E.. Et. al. Geography and the Debate Over Medicare Reform. Health Affairs. Web exclusives. February 13, 2002. Pages W96-W114. Available at: http://content.healthaffairs.org/cgi/content/full/hlthaff.w2.96v1/DC1

[14] National Priorities Partnership. National Priorities and Goals. National Quality Forum. November 2008. Available at: http://nationalprioritiespartnership.org/uploadedFiles/NPP/08-253-NQF%20ReportLo[6].pdf

AHRQ recently released a report that patient safety measures have worsened by nearly 1 percent each year for the past 6 years and that one in seven hospitalized Medicare patients experience one or more adverse events.[15] This lack of progress on improving patient safety measures is unacceptable.

Approximately 1.7 million healthcare-associated infections (HAIs) occur annually in U.S. hospitals and are responsible for nearly 99,000 deaths; patients who survive them frequently have longer and more expensive hospital stays and longer recovery times.[16] Expanding Medicare's National Coverage Determination and non-payment policy for "never events" to HAIs could produce significant health care savings and reduce the additional costs when patients contract deadly and expensive infections.

- **Implement Pay-for-Performance**

Too often, payment under Medicare, the federal government and throughout the health care system in the U.S. is made without regard to whether services are needed or are performed well. We need to pay for value, not volume. As stated earlier, up to 30 percent of Medicare spending may be for excessive and unnecessary care.[17]

Medicare claims data from 2003-2004, suggest that the U.S. needs better discharge planning, patient education, and payment methods that provide hospitals incentives to discharge healthier, better-informed patients—which could save up to $17.4 billion spent annually by Medicare for unplanned rehospitalizations.[18] Another study by AHRQ found that reducing preventable hospitalizations by only 5 percent for ambulatory care-sensitive conditions could result in savings of more than $1.3 billion.[19]

While payment is tied to quality or performance in most other industries, in health care, including in Medicare and the federal government, the opposite tends to happen—we end up paying more for poor service and the additional health care needed to "correct" poor quality. Fortunately, Medicare is beginning to reverse this tendency in its recent National Coverage Determinations and by not paying the additional costs for so-called "never events." We encourage CMS to go farther, faster in rationalizing payment in Medicare.

Mr. Chairman, thank you and the Committee for this opportunity to share the National Business Group on Health's perspective on the financing of health care and the essential importance of effective, efficient health care delivery that will produce more than enough savings to create sustainable health care reform that covers all Americans. Changing the tax status of employer-sponsored coverage would only increase health care costs for 161 million employees and their families and would not address the inefficiencies and poor quality that are too costly for our nation to afford any longer. We understand the challenge that you—and we all—face. Only by

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[15] Agency for Health Research and Quality (AHRQ). National Healthcare Quality Report. Publication No. 09-0001. Page 8. March 2009. Available at: http://www.ahrq.gov/qual/nhqr08/nhqr08.pdf

[16] Klevens RM. Et al. Estimating health care-associated infections and deaths in U.S. hospitals, 2002, Public Health Report, 2007.

[17] Fisher, Elliot. Et. al. The Implications of Regional Variations in Medicare Spending. Part 1, Part 2: Health Outcomes and Satisfaction with Care. Annals of Internal Medicine. 2003. 138. Pages 273-298.

[18] Jencks, Stephen. Rehospitalizations among Patients in the Medicare Fee-for-Service Program. New England Journal of Medicine. April 2009.

[19] AHRQ. Preventable Hospitalizations: Window into Primary and Preventive Care. AHRQ. 2000.

restructuring the way we pay for and deliver care will we "bend the curve" and keep health care spending sustainable for the long-term. We look forward to continue working with you on this most important endeavor that is essential for our future health and economic well-being.

COMMUNICATIONS

STATEMENT FOR THE RECORD

SUBMITTED TO THE

SENATE FINANCE COMMITTEE

ON

REFORMING AMERICA'S HEALTH CARE DELIVERY SYSTEM

April 21, 2009

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AARP appreciates the opportunity to share with the Committee our priorities for delivery system reform in health care reform legislation. We commend Chairman Baucus and Ranking Member Grassley for their bipartisan leadership and commitment to enacting comprehensive health care reform legislation this year.

AARP has identified four primary goals for health care reform: ensuring Americans age 50 to 64 have a choice of affordable health care plans; strengthening Medicare for current and future generations by lowering health care costs and improving benefits; ensuring both the benefits and the cost of health reform is shared by Americans of all generations; and helping people to stay in their homes and out of often more costly institutions.

One out of every six dollars in our economy is for health care. Yet our health care system costs too much, makes too many mistakes, and gives us back too little value for our money. Patients face problems including medical errors, a lack of preventive care, duplicative and unnecessary tests, a lack of evidence to inform decisions about care, and expensive care. Payment systems are misaligned and do not encourage quality care. Fraud is too prevalent. Consumers may have poor health literacy skills, unhealthy behaviors, and not adhere to properly prescribed medications and other medical recommendations. Payers, providers, patients, and others all have a role to play in improving the health care system. Delivery system reform is critical to reducing skyrocketing health care costs and improving the quality of care. Bipartisan action this year is essential.

We are recommending delivery system reforms that include: a Medicare transitional care benefit; additional steps to strengthen and improve Medicare; nursing and other workforce improvements; comparative effectiveness research and other evidence-based improvements; payment reforms to improve quality; long-term care improvements; and better care coordination for those who are dually eligible for both Medicare and Medicaid.

Transitional Care and Hospital Readmissions

Better care coordination, especially for those with multiple chronic conditions, is an essential part of delivery system reform. Many gaps in care often occur at care transitions, as individuals move from one setting to another, such as from a hospital to home. A lack of coordination and follow-up care can lead to unnecessary hospital readmissions.

Unnecessary hospital readmissions mean unnecessary health care costs and poor quality of care for individuals, especially those with multiple chronic conditions who are high users of the health care system. A study published this month in the *New England Journal of Medicine* found that almost one-fifth of Medicare beneficiaries studied who were "discharged from a hospital were re-hospitalized within 30 days" and about one-third were re-hospitalized within 90 days. Additionally, one-half of the individuals re-hospitalized within 30 days after a discharge to the community had not visited a

physician since their discharge, indicating a lack of follow-up care. The study also estimated that Medicare spent $17.4 billion in 2004 on unplanned re-hospitalizations.

Too frequently, coordination and continuity of care do not occur and the quality of care breaks down, especially for individuals with multiple chronic conditions. They often experience multiple transitions across settings, seeing many different types of providers. For example, an eighty year-old woman with five chronic conditions is likely to see an average of 14 different physicians each year. In addition, if she is hospitalized, she will likely be cared for by multiple health professionals during her stay. She may be discharged to a skilled nursing facility for rehabilitation after the hospital stay and finally return home where she may receive some home health care or personal care to help ensure that she or she and her caregiver can take care of her needs.

Research has shown that she is vulnerable to breakdowns in care during each transition. Among the factors that contribute to gaps in care during critical transitions are poor or incomplete communication and transfers of information, inadequate education and support for older adults and their family caregivers, and the "absence of a single point person to ensure continuity," according to an article by Mary Naylor and Stacen Keating in the *American Journal of Nursing*. All too frequently, family members, partners, friends, or neighbors find that they are the sole care coordinators. In addition, individuals may have their medications changed by different physicians in different settings as they move across the care continuum, often contributing to adverse reactions, confusion for individuals and their caregivers, and patient noncompliance.

When providers across settings do not sufficiently and regularly communicate and coordinate among themselves and with individuals and their caregivers, quality of care suffers. Lack of communication and coordination produces quality problems, such as medical errors; duplicative or unnecessary tests; hospital readmissions; and adverse drug interactions. In addition, individuals and their caregivers may not always understand the information they receive from health professionals for a number of reasons, including poor communication, dementia or other conditions that impair understanding of the information, and language access or literacy barriers. Medicare beneficiaries report greater dissatisfaction related to discharges than to any other aspect of care that the Centers for Medicare & Medicaid Services (CMS) measures.

AARP believes that one key way to reduce unnecessary hospital readmissions, reduce unnecessary Medicare spending, and improve quality of care is to establish a transitional care benefit in the Medicare program. Such a benefit could be coupled with payment reforms to align payment incentives to discourage unnecessary hospital readmissions. This transitional care benefit would be specifically designed to support Medicare beneficiaries as they enter the hospital and move from the hospital to home or another setting, such as a skilled nursing facility or a rehabilitation facility. Congress could also consider expanding or giving the Secretary of Health and Human Services (HHS) the flexibility to expand the transitional benefit to include discharge from other institutional settings, such as a nursing home or rehabilitation facility.

The goals of such a benefit include reducing unnecessary hospital readmissions; ensuring that beneficiaries receive necessary follow-up services, supports, and education; ensuring communication among all members of the care team and management of medications; and supporting beneficiaries' family caregivers who coordinate their care. The benefit would be voluntary, evidence-based, and phased-in over time to ensure more effective and workable implementation. It would also complement efforts in 14 communities across the country to reduce re-hospitalizations under the Centers for Medicare & Medicaid Services (CMS) Care Transitions Project. The benefit could provide an infrastructure to further build on, disseminate, and implement evidence-based practices from the Care Transitions Project, as well as other research and experience over time. Valuable research has been conducted on improving transitions of care, such as the work by Dr. Mary Naylor, who pioneered the Transitional Care Model.

An effective way to structure this transitional care benefit has been rigorously tested and found to yield positive results. As we envision it, the benefit would at first be targeted at individuals at most risk for poor transitions and readmission to a hospital. For example, high-risk beneficiaries could have more than one characteristic such as serious chronic conditions, cognitive impairment, depression, or other potential characteristics that increase the likelihood of hospitalization; prior admission to a hospital within the past 30 days; and multiple admissions within a certain period of time. Attributes of high-risk patients might also be captured by an existing measure, such as a high Medicare Hierarchical Condition Category (HCC) score. Under existing models, which have been proven in the marketplace, nurse-led interdisciplinary teams assess the beneficiary (and his or her caregiver) at or close to the time the individual is admitted to the hospital and before hospital discharge. The nurse and other providers, in consultation with the beneficiary and caregiver, develop an individualized plan for appropriate follow-up during and after the transition.

Another approach to implement a transitional care benefit could target not only high-risk beneficiaries, but with appropriate targeting and risk adjustment, target middle- and lower-risk individuals for tiered evidence-based services of lower intensity. For example, a tiered approach could target three different levels of transitional care services to low, middle, and high-risk beneficiaries, based on meeting eligibility criteria for each level of services.

We believe a variety of evidence-based transitional care services could be made available to high-risk beneficiaries and their caregivers with services tailored to the specific needs of the individual. Examples of such services could include:

- Transition Care Coordinator – A trained health professional – a nurse in the evidence-based models -- with an interdisciplinary team that intervenes as needed;
- Geriatric Assessment – A comprehensive review of a beneficiary's physical and mental condition, including cognitive and functional capacities, medication regimen and adherence, social and environmental needs, caregiver needs and resources;

- Care Plan – Develop a comprehensive care plan for the beneficiary and their family caregiver identifying problems, current therapies, and future services that may be needed;
- Face-to-face visits – Such visits would begin during hospital admission and resume after discharge at home or in the next care setting as needed during the episode – about 30-90 days – with the Coordinator able to work across settings
- Physician Visits – Accompany beneficiary to follow-up physician visits as needed;
- Medication Reconciliation -- Review medications to avoid adverse drug reactions, and teach the patient and caregiver how to organize, manage and take medications;
- Advice – Provide information and resources about conditions and care;
- Patient Navigation – Provide guidance on navigating the health care system;
- Patient Coaching – Advise beneficiary and caregiver how best to follow the clinician's instructions and how to best care for conditions;
- Provider Care Coordination - Educate and assist the beneficiary and their caregiver to arrange and coordinate provider visits and health care services;
    - Assure that providers are aware of services that have been ordered for and received by beneficiaries from other providers;
    - Work with providers to assure appropriate referrals to specialists, tests and other services.
- Support Service Coordination - Educate and assist beneficiary and their caregiver with arranging and coordinating support services (such as medical equipment, meals, homemaker services, assistance with daily activities, shopping, and transportation).

The benefit would not: provide transportation; pay for arranged services; limit access to physicians or other health care services; or require the beneficiary to follow the advice of the Transition Care Coordinator. We view the benefit as the glue or link in the chain that helps ensure continuity and quality of care for beneficiaries across the current silos of care.

Under existing models, participants are typically eligible to receive transitional care services during an admission and as needed during that episode -- about 30-90 days. It is critical that the model be team-oriented to ensure that care is properly coordinated. Interdisciplinary team members could include the primary care physician or practitioner, pharmacist, therapists, medical social worker, and other health care professionals as appropriate. The Transition Care Coordinator would be expected to collaborate closely with all the individual's physicians and other clinicians and have timely access to information about admissions and discharges to health care facilities. The Coordinator or other team member would also need to have knowledge of and access to community support services and payment options for appropriate health care and support services.

AARP believes a variety of payment mechanisms could be used for transitional care services. Indeed, we believe it is critical to get away from the silos of care that have contributed to these difficult transitions for patients. It is important for the services to

follow the patient. As long as they comply with participation criteria, the Transition Care Coordinator and any appropriate team members could be employed by an institutional care provider, a home health agency, a Medical Home (physician or other clinical practice), an insurer, a managed care organization, or other appropriate entity. Providers of transitional care services should be encouraged to use health information technology (HIT) with financial support available for start-up costs. If providers can effectively provide the transitional care services and coordinate care, the lack of HIT should not be a barrier to offering these services.

It is important that this new benefit be held accountable and be measured for quality. Performance measures should be used to evaluate the transitional care benefit and could include: admission rates to health care facilities; readmission rates; cost of transitional care and all other health care services; quality of transitional care experiences; measures of quality and efficiency; beneficiary, caregiver and provider experience; health outcomes; and savings to Medicare over time. However, realizing Medicare savings should not be the paramount factor for the adoption and continuation of a transitional care benefit. We note that this transitional care benefit could also be used in other public programs or in private health insurance.

Improving transitional care will also require mechanisms to provide information about national, state, and community-based resources for family caregivers upon a Medicare beneficiary's admission to or discharge from a hospital, post-acute care, or other setting. We urge the inclusion of such a provision, as in the Retooling the Health Care Workforce for an Aging America Act (S. 245), in the Committee's health care reform bill. Similar steps could also be taken beyond the Medicare program.

Strengthening and Improving Medicare

Strengthening and improving Medicare is a critical part of comprehensive health care reform. Medicare provides vital health care coverage to 44 million people. Yet, skyrocketing health care costs combined with an economic crisis are making the program's gaps ever more apparent. Today, people on Medicare spend about 30 percent of their incomes, on average, on out-of-pocket health costs – including premiums for supplemental coverage. This is six times greater than for people with employer-sponsored coverage and comes at a time when millions of Medicare beneficiaries have seen their retirement savings shrink and health care costs increase. We support reforms to improve quality of care for Medicare beneficiaries while lowering health costs by eliminating the waste and inefficiency that we cannot afford, and that often result in medical errors and poor care. We believe that payment reforms are necessary to improve the quality of care. The following are important Medicare improvements that should be included in comprehensive health care reform (in addition to the transitional care benefit):

- **Closing the Donut Hole and Lowering Rx Costs:** Taking steps to close the Part D coverage gap (donut hole) and lower drug costs through: gradually making the donut hole smaller over time; drug price negotiation; safe importation; expanding

access to generic drugs, including by creating a pathway for generic biologics; and requiring drug companies to provide Medicaid rebates for dual eligibles in Part D. Narrowing the Part D donut hole would reduce the amount of time that individuals have to pay premiums without getting insurance coverage and provide additional relief for those entering the coverage gap.

- **Keeping Medicare Affordable:** Ensuring total premiums and out-of-pocket costs do not become excessive.

- **Helping the Most Vulnerable:** Improving the patchwork of programs that help low-income Medicare beneficiaries afford to pay for their prescriptions, premiums, deductibles, and other health costs. First, raising the income threshold for assistance to 150 percent of poverty, ideally making the standard the same across programs. Second, eliminating the stringent asset tests that prevent people who did the right thing and saved a small nest egg for retirement from receiving vital assistance. Third, making sure beneficiaries know that these low-income assistance programs exist and simplifying the application process to ensure our most vulnerable are getting the help they need.

- **Reducing Racial and Ethnic Disparities:** Taking steps to address racial and ethnic disparities in health care so all Americans receive high quality care, such as: issuing comprehensive federal requirements for the collection of racial and ethnic data; strengthening the capacity of the Office of Civil Rights and providing the resources to enforce existing federal language access requirements; ensuring adequate reimbursement for the provision of language services in Medicare fee-for-service and Medicare Advantage; and, increasing cultural diversity and competencies in the health workforce.

Congress must act now to address affordability and solvency, or Medicare will not be able to effectively serve current or future beneficiaries. Commonsense ways to help put Medicare on stable financial ground include:

- Revising the way Medicare pays doctors and hospitals to reward high quality care rather than how much care is provided, including through "medical home programs";
- Promoting care coordination programs for people with multiple chronic conditions, such as through individualized assessments and care plans (as in the Independence at Home Act), and improving care at the end of life;
- Reducing overpayments to private insurance companies;
- Reducing waste, fraud and abuse, while protecting beneficiaries; and,
- Lowering drug prices by allowing Secretarial negotiation and importation as well as creating a pathway for generic versions of biologic drugs – medications that treat diseases such as cancer and multiple sclerosis.

Models, such as the medical home, have the potential to improve the quality of care and care coordination, increase access to care, improve payments for primary care and care

coordination, and possibly reduce costs. A number of states are also embracing the medical home concept and some states, including North Carolina, have reported reduced costs through a medical home project. More broadly, effective practice models that emphasize, encourage, and improve primary care should be expanded and incentives should be created to encourage individuals to practice in primary care. Interdisciplinary care teams should be encouraged, as they can provide quality care for individuals and recognize the valuable role and contributions of multiple care providers. The workforce should also be adequately prepared and trained to address the needs of an aging population. Strengthening the primary care workforce is an essential part of ensuring the provision of quality affordable health care for all.

Nursing Workforce

Congress should take some important steps to help ensure a nursing workforce that is prepared to address the needs of those with chronic conditions and long-term care needs and the growing aging population more broadly. AARP recommends a new approach to funding nursing education to better prepare and ensure a highly-skilled nursing workforce to meet the needs of Americans.

Congress should modernize Medicare funding to prepare advanced practice registered nurses with the skills to care for Medicare beneficiaries with chronic conditions. Currently, Medicare pays hospitals to prepare nurses at the basic education level. This is based on the predominant way nurses were educated in 1965 at the inception of Medicare, but it is outdated and does not adequately prepare nurses to care for Medicare beneficiaries. We propose that Medicare's nursing education dollars be dedicated to graduate nursing education costs for the preparation of advanced practice registered nurses with the skills necessary to provide primary and preventive care, transitional care, chronic care management, and other nursing services in interdisciplinary teams for the Medicare population. Under this approach, hospitals would still accept the Medicare dollars but would be required to pass them to affiliated schools of nursing to cover the costs of such educational activities. This would ensure that nurses educated in part by Medicare funds would be trained to provide the services that Medicare beneficiaries will need in the settings where they will be provided.

Comparative Effectiveness Research

AARP strongly believes that one of the fundamental building blocks of a reformed health care system is the availability of scientifically valid, objective, comparative information about treatment options. According to some estimates, less than half of all medical care is based on or supported by adequate evidence about its effectiveness. AARP is pleased with the down payment of $1.1 billion for comparative effectiveness research (CER) included in the American Recovery and Reinvestment Act (P.L. 111-5). However, we need a long-term and robust investment in CER. AARP supports the creation of an independent entity that would conduct and disseminate comparative effectiveness research.

Long-Term Care and Helping People Live at Home

AARP believes that all Americans should have the choice to get needed care at home, since 89 percent of Americans age 50+ want to remain at home as long as possible. Yet home and community-based care is often unaffordable or unavailable. Many with long-term care (LTC) needs – including those with multiple chronic conditions – rely on Medicaid, the largest payer of long-term care in this country. But Medicaid has an institutional bias – institutional care is a mandatory service, while home and community-based services are provided at the state's option. Nationally, 75 percent of Medicaid LTC spending for older people and adults with physical disabilities pays for institutional services, with only 25 percent going to the home and community-based services that people prefer. Yet states that invest in HCBS can, over time, slow their rate of Medicaid spending on LTC. In addition, on average, Medicaid dollars spent on HCBS can support nearly three older adults and individuals with disabilities for every person in a nursing home, according to a report released by AARP last year. Congress should make changes to expand access to HCBS and work to end Medicaid's institutional bias.

Family caregivers are also critical to the health and LTC systems in this country. At any given point, about 34 million family caregivers help loved ones live at home. These caregivers provide and coordinate care, risking their own health and financial security while providing unpaid assistance with an estimated economic value of about $375 billion in 2007, according to AARP's Public Policy Institute. Family caregivers reduce Medicare inpatient expenditures of single older persons, as well as expenditures for home health and skilled nursing facility care. Assistance by family caregivers also delays or prevents the use of nursing home care.

We urge Congress to include in comprehensive health care reform important improvements in Medicaid HCBS and support for family caregivers to enable more individuals to live in home and community-based settings and not in often more costly institutional settings. Specifically, Congress should:

- Raise the income eligibility level, broaden the scope of covered services, and make other improvements in the Medicaid HCBS state plan option, as in the Empowered at Home Act (S. 434);
- Provide an enhanced Medicaid match to states to expand HCBS;
- Require spousal impoverishment protections in Medicaid HCBS (just as they exist in institutional care), as in the Empowered at Home Act (S. 434); and
- Establish a state plan option or requirement to assess all HCBS beneficiaries' family caregiver needs and connect them to supports, as in the Retooling the Health Care Workforce for an Aging America Act (S. 245).

Dual Eligibles

Finally, as part of improving coordination of care, Congress should focus on improving the quality of care and reducing costs for individuals eligible for both Medicare and Medicaid – the dual eligibles. Individuals who are dually eligible are often in poor health

and have long-term care costs. The high costs of their care increase both Medicaid and Medicare spending. According to a recent report by the Kaiser Family Foundation, almost nine million dual eligibles accounted for 18 percent of Medicaid enrollment and 46 percent of all Medicaid expenditures for medical services in fiscal year 2005. Significantly, 1.6 million of these dual eligibles "who had per capita Medicaid spending of $25,000 or greater in 2005 accounted for more than 70 percent of all dual eligible spending."

Congress should improve care coordination for the dual eligible population by:

- Establishing a Medicare and Medicaid pilot to integrate care and financing for dual eligibles;
- Improving Special Needs Plans, including through contracts with state Medicaid programs; and
- Requiring or providing incentives for sharing information regarding dual eligibles, such as claims and Part D utilization data, between Medicare, Medicaid and other health plans.

Conclusion

We stand ready to work with members of the Finance Committee, and others on both sides of the aisle in the House and Senate, and the Administration to enact comprehensive health care reform this year that includes the important system delivery reforms we have outlined. System delivery reform is essential to reducing health care costs, improving quality, and providing affordable coverage for all Americans.

ACCESS community HEALTH NETWORK

Leveraging the Federally Qualified Health Center Program
to Build the Nation's Primary Care Infrastructure

Statement for the Record
Submitted by
Access Community Health Network, Chicago

Increasing Access to Health Coverage
Health Reform Roundtable
Senate Finance Committee

May 5, 2009

When Office of Economic Opportunity architects first developed the Federally Qualified Health Center (FQHC) program over 40 years ago, their intent was to create a primary health care infrastructure of small centers to serve low income, predominately rural patients. Now, in the current decade, the FQHC program has been widely lauded for its expansion of a cost-effective model for delivery of care of demonstrable quality.

As the nation's largest FQHC organization, Access Community Health Network (ACCESS) has implemented strategies that illustrate the potential of community health centers to facilitate growth of the nation's preventive and ambulatory care resources. Since its inception in the early 1990s, ACCESS has expanded to serve 215,000 patients at 50 health center locations across the greater Chicago area.

As our nation becomes poised for health reform, the ACCESS experience can inform the way in which large health center organizations can reshape the delivery of care on a broad scale.

Building on the FQHC program

FQHCs are able to leverage two critical health sector advantages:

- Enhanced Medicaid reimbursement for professional clinical services, and
- Federal Tort Claims Act (FTCA) coverage that relieves medical providers who are employed by an FQHC (or in a direct practice contract with an FQHC) from malpractice concerns and costs.

By providing relief from two pressing barriers to health care delivery—that is, low Medicaid reimbursement levels and also malpractice pressures—the FQHC program provides an important point of departure for building the nation's preventive and primary care infrastructure.

The ACCESS growth experience points to two replicable approaches in particular: (1) leveraging FQHC advantages to build a community health infrastructure of sufficient scale to care for hundreds of thousands of patients, and (2) building an integrated system of care through negotiated

partnerships to provide access for FQHC patients to the continuum of specialty, diagnostic and inpatient services they require.

ACCESS growth through strategic partnerships

Much of the growth of the ACCESS network has occurred within a partnership context to build better systems of care for patients. As our organization grew from a small localized health center network into a large system, ACCESS developed pioneering partnerships with multiple hospitals – both community hospitals as well as academic medical centers — in each case expanding the reach of the local health system to serve a broader group of low and moderate income patients. While the terms of each partnership is unique, each of these partnerships offers access for patients of all payer classes to a continuum of care spanning an affordable FQHC medical home, neighborhood-based diagnostic and specialty care services, and hospital resources for inpatient care.

The success of these partnerships lies in key replicable practices:

- Use of FQHC Medicaid reimbursement to expand funding for the partnership,
- Development of pathways for an integrated continuum of linked preventive, primary care, diagnostic and specialty services, and inpatient care, and
- Commitment at a leadership level to relentless pursuit of actions intended to improve community health status.

None of our partnerships has generated sufficient resources to "be all things to all people," and in this regard, FQHC program leverage is limited. While each of the ACCESS partnerships has built or fortified safety net systems, none serve the entire low income population and none strive to guarantee universal access. However, in all cases, ACCESS has been able to work with partnering hospitals to create a sustainable program open to large panels of Medicaid beneficiaries, uninsured patients and others facing structural barriers — bringing resources to thousands of families who formerly lacked medical care.

Policy recommendations for building FQHC programs of scale through strategic partnerships

The country's current FQHC organizations have the potential to become a significant resource for fostering the growth of high quality prevention-oriented systems and for stabilizing regional health systems at risk of decline. The following approaches would facilitate this progress.

HRSA policies

- Give funding priority to large FQHC organizations that have developed multiple hospital partnerships to offer integrated delivery of care for health center patients.
- Offer FTCA coverage to physicians who volunteer to provide specialty care consultation services in a FQHC.

CMS policies

- Require states to annually update the Medicaid and Medicare managed care wrap around payment rate for FQHCs.

- Require states to adjust the Medicaid prospective payment rate for FQHCs that experience a cost increase of 5 percent or more due to a change in the type, intensity, duration and/or amount of services provided.
- Incentivize state Medicaid programs to reimburse for telemedicine services in urban as well as rural settings.
- Incentivize states to define and enforce a minimum charity care obligation for non-profit hospitals that can be met, in part, through an investment in a partnership with an FQHC organization.
- Require states to allocate a share of their disproportionate share hospitals payments to FQHCs that partner with hospitals to offer an integrated system for delivery of care.
- Require state provider tax programs, designed to benefit hospitals serving low income patients, to include large FQHC organizations in the distribution of funds.

Contact information
Further information is available upon request, including a case study on ACCESS' approaches to strategic growth and partnership and additional policy recommendations.

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Statement by

American Cancer Society Cancer Action Network
901 E Street NW, Suite 500, Washington, DC 20004

Submitted to

Finance Committee
United States Senate
Tuesday, May 5, 2009

Roundtable Discussion on "Expanding Health Care Coverage"

Introduction

The American Cancer Society Cancer Action Network (ACS CAN), the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. ACS CAN works to encourage elected officials and candidates to make cancer a top national priority.

The American Cancer Society is a nationwide, community-based, voluntary health organization, dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer through research, education, advocacy, and services.

Inadequate access to timely, quality health care is one of the greatest barriers to winning the war on cancer. As a nation, we're making progress in the fight against cancer. Advances in the prevention, early detection, and treatment of cancer have resulted in an almost 14% decrease in the death rates from all cancers combined from 1991 to 2004 in the overall US population, with significant declines in mortality for the top 3 causes of cancer death in men (lung, colorectal, and prostate cancer) and 2 of the top 3 cancers in women (breast and colorectal cancer).

The nation cannot continue to make progress in the fight against cancer without improving access to quality health care. Millions of Americans aren't benefiting because they don't have access to quality health care. Nearly 46 million people in America are uninsured and an additional 25 million Americans are underinsured -- their insurance will not provide adequate coverage if they're diagnosed with cancer. Insured or not, millions of people do not have access to cancer prevention, early detection, and evidence-based treatment options that give them a fighting chance against cancer. In order to fight cancer, access to affordable, quality health care must be improved.

The American Cancer Society has long worked to expand access to care for cancer patients. Since 2006, the Society and ACS CAN have undertaken a broad, joint initiative to promote access to the full continuum of evidenced-based health care necessary to optimize health and well-being for all Americans, from prevention and early detection of disease to assuring quality of life through the end of life. The Society and ACS CAN have focused emphasis on Access to Care *by looking through the Cancer Lens.* The Society and ACS CAN are obviously concerned about how change would affect cancer patients and survivors, but both organizations also believe that a health system that works well for cancer patients will probably work well for individuals

who have any serious medical condition. With this frame of reference, the Society and ACS CAN are committed to taking a comprehensive view of Access to Care, looking at the full cancer continuum -- from prevention and early detection, through the end of life -- and defining signature areas of focus and activity. Health care reform is a key component in achieving this vision and ensuring all Americans have access to affordable and adequate coverage that is administratively simple and understandable.

Little Help Available for Those Diagnosed with a Serious Condition, Like Cancer
In February 2009, the American Cancer Society and the Henry J. Kaiser Family Foundation released a report that examined the financial difficulties cancer patients face in the current health insurance system because of increasing out-of-pocket costs for lifesaving treatment and the high cost of health insurance.

The jointly authored report, "Spending to Survive: Cancer Patients Confront Holes in the Health Insurance System," profiles 20 cancer patients and survivors from across the country who had private health insurance that did not protect them from running up large debt, filing for bankruptcy, and delaying or forgoing lifesaving cancer treatment in wake of their diagnosis.

The report highlights five key gaps in the health insurance system that can force cancer patients into financial ruin:

- High cost-sharing forces patients to pay a larger portion of the coverage and caps on benefits leaves cancer patients with the bill for uncovered services, which result in high out-of-pocket costs.
- Employer-sponsored coverage may not protect against catastrophically high health costs if a patient becomes too sick to work.
- Cancer patients and survivors are often unable to obtain adequate and affordable coverage in the individual market.
- High-risk insurance pools, which are designed to help patients who have problems obtaining insurance, are not available to all cancer patients, and some find the premiums difficult to afford.
- Waiting periods, strict restrictions on eligibility, or delayed application for public programs can leave people who are too ill to work without any affordable insurance option, both public and private.

All of the cancer patients and survivors featured in the report called the Society's Health Insurance Assistance Service (HIAS), which is a free resource that connects callers with health insurance specialists who work to address their needs through the American Cancer Society's National Cancer Information Center (NCIC). The service currently serves 36 states and the District of Columbia.

The specialists at NCIC handle inquiries about health insurance, coverage dynamics, and state programs – all specific to the caller's needs. Since 2005, the American Cancer Society's Health Insurance Assistance Service has taken calls from more than 22,000 cancer patients who are struggling with coverage issues. HIAS receives calls from individuals who are uninsured, those who are transitioning between coverage either as a result of their cancer diagnosis or economic

issues beyond their control, and cancer patients who are currently insured. Many of these callers are people who have been recently diagnosed or who are in treatment for cancer.

The volume and type of calls received are captured as part of an internal database that allows for analysis of trends and emerging issues. While the database is not systematic or representative of all Americans, the volume and type of calls HIAS receives identify serious problems that exist in our insurance system today. A recent analysis of the cases in the database revealed interesting information about cancer patients who have inadequate health insurance. In general, the Society is only able to assist 1 in 9 cancer patients who contact HIAS about their health insurance problems. This is down from 1 in 6 that HIAS was able to help just one year ago. Many factors contribute to this decrease in successful resolution of cases, some being increased call volume due to the economy and limited resources available to those needing financial assistance. The health insurance specialists that support HIAS report increases in the frequency of patients calling because hospitals and doctors are requesting payments up-front before services begin. The specialists also reported in recent months an increase in calls related to loss of employer coverage due to layoff, which is always an issue, but with the current economic situation, much more common. Another trend HIAS is capturing is changes in employer coverage – in response to the economy. Employers are cutting costs either by changing the benefit design of the insurance plan to one with less coverage, or shifting costs to employees by increasing their premium contributions, deductibles, and co-pays.

In the cases where HIAS was unable to help the cancer patient, barriers in the current health insurance system facing cancer patients can be identified. Since December 2008, HIAS has seen a significant increase in the volume of calls, mostly related to the economy. HIAS had about a 21% increase in the number of calls in March 2009 when compared to March 2008. Many of the cancer patients and survivors are calling because they are about to lose their employer-sponsored health insurance as a result of a lay-off or they are struggling to continue their health insurance because of the costs. All too many times, HIAS is not able to offer these patients relief because the coverage options for people with chronic disease are limited.

Defining Meaningful Health Insurance

ACS CAN and the Society are dedicated to ensuring that quality health care coverage (insurance) is available to all Americans, but our current U.S. health care system is not up to the job. Achieving that goal demands the U.S. health care system change. ACS CAN and the Society believe meaningful reform must include available, adequate, affordable, and administratively simple health insurance coverage for all Americans without regard to health status or risk.

Health insurance must be available – meaning it is renewable, portable, and continuous. It must not be based on, or constrained by, actual or perceived health status or history of health care services use. Pre-existing medical condition restrictions must be eliminated if universal participation is established. ACS CAN supports guarantee issue of all health plans along with adjusted community rating of premiums and other insurance market reforms that provide access to all Americans without regard to health status or claims history. Health reform must provide everyone the ability to purchase meaningful private health insurance based on his or her ability to pay.

Health insurance must be adequate. As defined by the Society, adequate health insurance ensures timely access to the full range of evidence-based health care services (i.e., rational, science-based, patient-centered) -- including prevention and primary care -- necessary to maintain health, avoid disease, overcome acute illness, and live with chronic illness. Benefits should be at least equivalent to what is currently available to Federal employees through the Federal Employees Health Benefits Plan (FEHBP). Evidence-based prevention services should not be subject to a deductible and have little or no co-insurance or co-pay.

Affordable coverage should be comprehensive and protect the individual from incurring catastrophic expenditures. All health plans must also include an out-of-pocket limit that protects the individual and family from catastrophic financial losses with additional assistance to lower income individuals and families in meeting premium and out-of-pocket costs.

Finally, health insurance must be transparent and simple to understand, both pre- and post-enrollment. Covered benefits, financial liability, and terms for making claims must be clear. Specifically, administrative forms and processes (e.g., coverage appeals) should be simplified and standardized to lower costs and facilitate consumer understanding. Consumers must be able to compare and contrast different health insurance plans and easily navigate health insurance transactions and transitions. Comprehensive and standardized disclosure of out-of-pocket costs and benefit restrictions for serious medical conditions like cancer must be available so people know the extent of coverage and can make comparisons among plans.

The Link Between Coverage and Care

Individuals and families who lack meaningful insurance often go without preventive care despite research showing that early detection and timely treatment are effective in improving outcomes. Four peer-reviewed studies from the American Cancer Society have shown that cancer patients without insurance may not receive adequate preventative screenings and treatments, resulting in poorer outcomes across a range of cancers.[1] Those who are uninsured are less likely to receive cancer prevention services, more likely to be treated for cancer at late stages of disease, more likely to receive substandard care and services, and more likely to die from cancer.

A recent American Cancer Society study of 12 types of cancer among more than 3.5 million cancer patients dramatically demonstrates the problem of access today for uninsured cancer patients.[2] The study found uninsured patients were significantly more likely to present with advanced stage cancer compared to patients with private insurance. The study found consistent associations between insurance status and stage at diagnosis across multiple cancer sites.

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[1] Halpern MT, Bian J, Ward EM, Schrag NM, Chen AY. Insurance status and stage of cancer at diagnosis among women with breast cancer. *Cancer* 2007; 110: 403-11.

Halpern MT, Ward EM, Pavluck AL, Schrag NM, Bian J, et al. Association of Insurance Status and Ethnicity with Cancer Stage at Diagnosis for 12 Cancer Sites: A Retrospective Analysis. *Lancet Oncology* 2008; 9:222-31.

Chen AY, Schrag NM, Halpern MT, Ward EM. The impact of health insurance status on stage at diagnosis of oropharyngeal cancer. *Cancer* 2007; 110: 395-402

Ward E, Halpern M, Schrag N, Cokkinides V, DeSantis C, et al. Association of Insurance with Cancer Care Utilization and Outcomes. *CA: A Cancer Journal for Clinicians* 2008; 58: 9-31.

[2] Halpern MT, Ward EM, Pavluck AL, Schrag NM, Bian J, et al. Association of Insurance Status and Ethnicity with Cancer Stage at Diagnosis for 12 Cancer Sites: A Retrospective Analysis. *Lancet Oncology* 2008; 9:222-31.

Compared to patients with private insurance, uninsured patients had significantly increased likelihoods of being diagnosed with cancer at more advanced stages. The greatest risk for diagnosis with moderately advanced cancer (stage II) instead of the earliest stage (stage I) was in colorectal cancer, while the highest risk for diagnosis at the most advanced stage of cancer (stage III/IV) was in breast cancer. The study shows that too many cancer patients are being diagnosed too late, when treatment is more difficult, more expensive, and has less chance of saving lives.

The Society and ACS CAN know that individuals and families who are uninsured or have inadequate insurance often go without preventive care despite research showing that early detection and timely treatment are effective in improving outcomes.

The Society and ACS CAN know that cancer patients who are uninsured or have inadequate insurance often do not receive necessary and appropriate treatment in a timely manner, and that they have worse health because of these problems.

And, the Society and ACS CAN know the American Cancer Society's goals of reducing cancer mortality by 25 percent and cancer incidence by 50 percent by 2015 cannot be met if greater improvements in our nation's coverage and health care delivery systems are not achieved.

Health Care, Cancer, and the Economy

The problem of paying costly medical bills affects Americans of all income levels, including middle-class families and particularly those with chronic diseases such as cancer. Often insurance policy deductibles, co-payments and limits on health services may leave cancer patients without access to the timely, lifesaving treatment they need. Cancer patients may have to deal with major financial burdens because of out-of-pocket costs in addition to their cancer diagnosis. The Society's National Cancer Information Center receives calls every day from cancer patients with these problems and published research is available that supports these problems individuals have with inadequate and unaffordable health insurance as illustrated through the HIAS stories.

ACS CAN also recently analyzed data from the household component of the Medical Expenditure Panel Survey (MEPS) from 2004-2006. The MEPS household survey, sponsored by the Agency for Health Care Research and Quality (AHRQ), collects information from the non-elderly, non-institutionalized U.S. population. The survey asks American families questions about health insurance coverage, health care utilization, and health care expenditures. In this analysis, ACS CAN defined "under-insured" as people with insurance spending 10 percent or more of their tax-adjusted family income on health care services, excluding insurance premiums. Approximately 1 in 10 (9.7%) of cancer patients aged 18-64 are uninsured and nearly 1 in 5 (17.8%) are under-insured. This means that before the rescission began nearly 1 in 3 cancer patients were struggling to find and afford health care.

Cancer patients who have inadequate or no coverage have higher medical costs and must deal with the additional stress of financial instability. A survey of cancer patients and their families found that 1 in 5 cancer patients with insurance uses all or most of their savings when dealing

with the financial costs of cancer.[3] The situation is much worse for the uninsured. The same survey found that nearly 1 in 2 uninsured cancer patients use all or most of their savings when dealing with the financial costs of cancer.[4] Another study found that more than 1 in 5 people with chronic conditions have problems paying medical bills. Furthermore, the incidence of burdensome out-of-pocket spending among low-income, privately insured people with chronic conditions is rising dramatically.[5]

Medical debt has been an important cause of bankruptcy filing in the US. An analysis of national survey data found nearly six of ten adults who had current-year difficulty paying medical bills and 70 percent of those reporting medical debt said they were insured at the time their problems began.[6] Another study examined the causes of bankruptcy and found that 1.9-2.2 million Americans experienced bankruptcy related to medical problems in 2001.[7] Among those with illnesses that led to bankruptcy, their out-of-pocket costs average $11,854 and three-quarters had insurance at the time of their diagnosis.

With the recent economic downturn, it can be anticipated that the number of cancer patients who are uninsured or under-insured will grow. On behalf of ACS CAN, Lake Research Partners and American Viewpoint recently conducted a national omnibus survey among N = 1,004 Americans nationwide from April 17 through 20, 2009. The purpose of the survey was to understand how Americans are dealing with health care costs in the current economic environment, whether they are delaying preventive cancer care, and how prepared they may be to deal with an illness like cancer in the future.

Among the key findings are:

- Four in ten Americans (41%) feel they would not be able to afford all the treatment and care needed if they were suddenly diagnosed with cancer. This perception spans income levels, even among those making up to $100,000 a year.
- One in five women (19%) says they or a family member in their home has put off getting a cancer screening test in the past year because of cost. Nearly one-third (29%) of Americans with household incomes less than $35,000 say the same. One in five African Americans (22%) report themselves or a family member having delayed preventive cancer care because they could not afford it.
- In addition to many Americans feeling financially unable to afford treatment and care, a slight majority (53%) is not sure whether or not their current insurance has a limit on the out-of-pocket costs they would be required to pay.
- One in five (20%) Americans with health insurance feel it is likely they or someone in their household will lose coverage over the next year.

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[3] *USA Today*, the Kaiser Family Foundation, the Harvard School of Public Health. National survey of households affected by cancer, August 1 – September 14, 2006.

[4] *USA Today*, the Kaiser Family Foundation, the Harvard School of Public Health. National survey of households affected by cancer, August 1 – September 14, 2006.

[5] Tu HT. Rising health costs, medical debt, and chronic conditions. Center for Studying Health System Change Issue Brief No. 88, September 2004.

[6] Doty MM, Edwards JN, Holgren AL. Seeing red: Americans driven into debt by medical bills. The Commonwealth Fund, August 2005.

[7] Himmelstein DB, Warren E, Thorne D, Woolhandler S. Illness and injury as contributors to bankruptcy. *Health Aff* 2005; Web exclusive: 63-73.

- Some Americans are also going without other health care because of cost. More than one in four (28%) say they or a family member has "put off or delayed seeing a doctor" because of cost, including 45% of African Americans, 45% of those with incomes less than $35,000, and 37% of 18 to 34 year olds.

Conclusion

Cancer death rates are decreasing and we know what we must do as a nation to defeat cancer. Much of the public debate today is about the need to cover the 46 million uninsured, and the American Cancer Society and ACS CAN fully share that concern. However, we must also recognize more fully the very significant problem of underinsurance. Health plans vary enormously in their deductibles, co-pays, benefits covered, and exceptions. Insurance plans are written in very detailed legalistic language that very few lay people can begin to comprehend, and the summary plan documents that are provided to enrollees almost never begin to convey the adequacy of coverage. Put another way, if you were to look at an array of plans that might be available to you as a consumer, and you were to ask, what would be the adequacy of your coverage if you were to be diagnosed with cancer or some other serious disease, you would probably conclude that you have no idea whether the plan would be adequate. As the Society and ACS CAN sees all too often in the HIAS cases, people often discover after their diagnosis what their plan really provides and that is a point where it is virtually impossible for most patients to change coverage.

ACS CAN and the Society are dedicated to ensuring that quality health care is available to all Americans. Meaningful reform must include available, adequate, affordable, and administratively simple health insurance for all Americans without regard to health status or risk, and should cover the full array of necessary services, from prevention and early detection through treatment and survivorship. Your hearing today is a valuable contribution to the discussion of these important issues.

Roundtable to Discuss
Reforming America's Health Care Delivery System
April 21, 2009

American Medical Rehabilitation Providers Association
Statement for the Record
Submitted to the Senate Committee on Finance

1710 N Street, NW
Washington, DC 20036
202-223-1920

On behalf of the medical rehabilitation providers and their patients whom it represents, the American Medical Rehabilitation Providers Association (AMRPA) is pleased to provide its recommendations for reforming America's health delivery system. AMRPA represents over 350 inpatient rehabilitation hospitals, rehabilitation units, outpatient rehabilitation service providers, and several skilled nursing facilities providing medical rehabilitation services to over 700,000 people a year. AMRPA looks forward to working with the Congress and the Administration in addressing the critical health care issues facing our nation. We note the Committee's tremendous work in this area as evidenced by the Senate Finance Committee Roundtables, and the paper "Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs."

AMRPA members provide a wide range of medical rehabilitation services to all age groups, including a growing population of veterans with service-related injuries. Medical rehabilitation involves intensive rehabilitation therapy for individuals experiencing serious illness or injury, including stroke, spinal cord injuries, and traumatic brain injury (TBI), among others. The goal of medical rehabilitation is to maximize health, functional skills, independence, and participation in society. Our members' goal is to ensure that persons who experience these serious illnesses or injuries have access to medically necessary rehabilitation services, which enable patients to return to home, work, or an active retirement.

AMRPA is conscious of the public's growing concern about the state of the American health care system. The millions of uninsured and underinsured individuals and high insurance costs for those without coverage demonstrate the inadequate access to quality, affordable health care.

AMRPA is concerned that the health care reform debate has not focused adequately on the needs of medical rehabilitation patients. Medical rehabilitation can prevent people from being admitted to other settings, such as nursing homes, for costly long-term care and, in so doing, can produce tremendous health care cost savings.

The AMRPA offers a new approach to the delivery and financing of the medical rehabilitation services delivered by today's inpatient rehabilitation hospitals and units (IRH/Us), hospital based skilled nursing facilities (HSNFs) and long term care hospitals (LTCHs). AMRPA proposes the creation of a Continuing Care Hospital (CCH) that would organize care around the patient instead of the facility. The model could be implemented in a *real* (all levels in a common building), or *virtual* (all levels operated as a single entity, but in physically disparate settings) manner. The CCH would enhance quality of care by eliminating boundaries among the current hospital-based post acute care providers and implementing common quality standards, outcome measures, and accountabilities. It would result in enhanced care coordination, in smoother transitions among the acute and post acute settings, in reduced costs to deliver post acute care and also improve the cost benefit and cost effectiveness of post acute services. AMRPA proposes the development of one or more demonstration projects by CMS to test the model of the CCH. Such a demonstration project would add to, rather than detract from, health reform by identifying critical steps that are prerequisites to achieving reform safely and correctly. Congress must ensure that health reform in this area is done thoughtfully and correctly, especially in light of the highly compromised and highly vulnerable patients treated in these post-acute settings. Starting in the 1960s, reimbursement for IRH/U care became more widely available with the advent of the Medicare program. In the mid-1980s, medical rehabilitation programs expanded significantly in the wake of Medicare's new inpatient prospective payment system (IPPS) for short-term acute care hospitals. With a fixed payment for each diagnosis-related group (DRG), acute care hospitals were

incentivized to shorten their lengths of stay by discharging patients earlier to alternative settings, thus increasing the demand for post-acute care. The supply of post-acute hospitals and other facilities increased accordingly.

With the passage of the Balanced Budget Act of 1997 (BBA '97), Congress sought to arrest this growth by also phasing in a PPS for each post-acute venue starting with home health agencies (HHAs) and SNFs and, later, IRH/Us and LTCHs. BBA'97 had varying degrees of impact on limiting post-acute growth. The number of HHAs declined considerably before increasing again. SNFs and IRH/Us grew more modestly; LTCHs became the fastest growing post-acute segment in the post-BBA'97 era.

With this growth has come confusion about how best to distinguish among the various post-acute facilities and the services they provide. Moreover, there is confusion about what care is clinically necessary, what is effective, what the best practices are, and what value is being received by patients and payers for that care. With increasing pressure on the funding for this care, and the growing numbers of facilities competing to offer these services, it is not surprising that many perceive that the current post acute care market is chaotic, confusing, costly, and less than clinically optimal. Geographically, post-acute facilities are unevenly distributed across the nation with an apparent oversupply in some markets and significant undersupply in others. The new Obama Administration has proposed a number of budget changes that directly impact the providers of medical rehabilitation. At least one of these proposals (bundling) seeks to realign financing and the delivery system.

AMRPA has developed several guiding principles in order to reshape the future of medical rehabilitation. These principles include:

- Any health care delivery system change needs to be patient-centered with a focus on restoring health, enhancing function, and returning patients to their homes, schools, jobs and communities.
- Any change in the delivery or financing of health care services must serve the needs of persons with disabilities and chronic conditions in particular, as well as those with acute health problems.
- Physician direction and oversight are key and essential to medical rehabilitation care delivery.
- Medical rehabilitation service delivery should be organized to optimize serving the needs of patients.
- High quality care should be sought, delivered and fairly reimbursed.
- Providers should be able to receive reasonable returns for delivering high quality care.
- Cost-effective and cost-efficient care should be promoted.
- Care should be provided based on the best available clinical evidence and expert judgment.
- Incentives should encourage facilities to care for more complex and needy patients without fear of adverse consequences.
- Reimbursement and measures of success for providers should be risk-adjusted to promote the care of those with the greatest need.
- Persons with functional loss must have access to medical rehabilitation that is:
  - Expert and based on the best available evidence;

- Delivered in the medically appropriate setting;
- Focused on prevention of further medical complications;
- Intended to optimize function; and
- Based on goals that are relevant to health, function, activity and participation in society, not just survival.

AMRPA has developed a proposal to change the post acute care delivery system structure that it believes would be compatible with these principles, strengthen the delivery system and improve its cost benefit and cost effectiveness in the delivery of post acute services.

Continuing Care Hospital (CCH)

We propose a significant change in the delivery system for post acute care to resolve the problems and issues discussed above: creation of the Continuing Care Hospital (CCH) that would be an amalgam of the care settings currently described as LTCHs, IRH/Us, and HSNFs that are organized, in part, to deliver rehabilitation therapy programs. The CCH would also provide or coordinate home health and outpatient rehabilitation services for those patients who need them after discharge. It would be paid on a per-episode basis. The episode of care recommended is the full period of stay in the CCH (which, obviously, would vary by patient characteristics) plus the first 30 days following discharge. The data analysis mentioned below may lead to a different definition of the episode however.

The CCH could be an actual building (a hospital building offering all three levels of care) or a virtual entity (an organization that provides under common management the three levels of care in more than one building or unit). A physician would make the admission decision regarding whether a patient should receive care within the CCH and also determine which level of care the patient would need. Payment would be determined by the patient's clinical and functional characteristics and the program resources needed to provide that care. A prospective payment method would be constructed using data currently being collected by the Post Acute Care Payment Reform Demonstration project (PAC- PRD) being conducted by RTI or the next iteration. Providers would be allowed to care for certain types of patients if they demonstrated the ability to provide care, as defined by law and regulation, met specific program standards of care, and demonstrated certain outcomes.

Each CCH could accept patients of the highest level of complexity for which it is licensed by the state as well as any patient whose needs are less complex. Such a system would account for the intensity of services provided, patient complexity and need for care by physicians and nurses and the skill set of those available to treat patients. For example, a patient with both intense continuing medical needs and functional deficits could be served by a CCH provider that met specific standards regarding the provision of intense medical care, rehabilitation services, and follow up care. Payment would be determined prospectively based on both medical and functional resources that were anticipated to be required (as developed from the data now being collected by the PAC-PRD project).

CCHs could operate distinct units that correspond to different levels of care recognized today by Medicare. In such cases, the facility would admit the patient, and the clinical staff would place the patient in the appropriate specific unit or building (which might resemble today's LTCH), and move the patient from setting (to what today looks like an IRH/U) to setting (to what today looks like an HSNF) as clinical needs dictated (all within the single payment). This is similar in principle to how an acute hospital admits a patient to the ER; transfers them to an ICU; moves them to an OR; cares for them in a recovery room; transfers back to an ICU; then to a ward, and finally to discharge. Payment would

generally be pre-determined by the CCH predetermined payment (PDP) and an outlier payment methodology to acknowledge extraordinary circumstances and other adjustments would be required.

A. Performance and Quality Measures

Creating and using performance and quality measures would be a key and critical component of this model. The performance measures selected would need to include those currently available such as discharge destination, mortality, presence of co-morbidities on admission, and improvement in medical and functional status. As the ICD-10 coding system becomes adopted, the parallel adoption of the World Health Organization's International Classification of Function (ICF) should also be pursued. This would provide data to monitor the CCH outcomes in the domains of Activity and Participation, as well as disease and disability.

Despite the desirability of using measures of functional improvement as an important assessment factor, there needs to be clear recognition that the current functional measures do not capture some important benefits in the quality of life domain for certain extreme patient conditions, such as severely impaired tetraplegics and brain injured patients, among others. In these types of cases, other measures of benefit will need to be developed and adopted.

Use of performance measures would allow development of incentive payment methods to reward those institutions that constantly achieve better risk-adjusted medical and functional outcomes, which probably require longer lengths of stay. Such performance incentives can be developed in a budget neutral manner. Development of performance measures would be coordinated with those entities that have already been exploring the issue such as CMS, the AAPM&R Clinical Quality Improvement Committee, CARF, the Joint Commission, NQF, IOM, etc.

B. Special Care and Other Considerations

The CCH model is intended to create incentives to treat patients with special care needs and hence, increased cost. Therefore special payment policies would be included and carved out of any payment model such as:

- High cost outliers
- Patients receiving special care such as dialysis and high cost drugs such as chemotherapy, other
- High cost DME

Other cost variations that are not within the providers' control should also be accommodated for in the payment system. They may be a function of governmental (state, local, or federal) requirements or unique system delivery factors and need to be recognized. These may include:

- Wage adjustment
- Teaching adjustment
- Geographic location
- Low income patient load
- Local market conditions
- Local practice patterns

C. Advantages and Disadvantages

1. ***Advantages***

- The CCH would allow for appropriate patient care based on patient characteristics and not on provider type or payment incentives.
- A single post acute care entity has the potential to remove the numerous barriers to access that the current provider requirements and current payment systems create. Hence various disincentives to care could be removed.
- Streamlining care delivery based on patient characteristics would eliminate administrative costs to the payers as well as eliminate costs to providers if the regulations are simplified.
- A single post acute care entity would eliminate the cost of admission and discharge from one post acute setting to another and the need for a separate payment to each post acute setting the patient needs.
- The focus of the system would be on the patient's need for care, and the quality of the care delivered. Care and outcomes would be measured in order to provide disincentives to stinting on care.
- HSNF's, IRH/Us and LTCHs would likely collaborate or merge to form the new CCH entity, simplifying the provider complexity in a community.
- Alliances would emerge among the various providers to create real or virtual CCHs.
- Discharge from acute care hospitals would be simplified by eliminating the confusing array of post-acute care requirements.
- The current Post Acute Care Payment Reform Demonstration (PAC-PRD) project mandated by the Deficit Reduction Act of 2005 would be directly applicable to this type of enterprise, offering a patient assessment tool and possibly a model for payment. From the payer's perspective (primarily Medicare in this instance) once the care entity is paid, the payer is removed from further decision making or expense, except perhaps for monitoring the performance and quality of care given to patients. Theoretically it would save considerable funds now going to administrative expenses for the programs.
- Providers would have a clear picture of the payment for various types of patients, services and period of service, and could structure their care accordingly.
- As a hospital, the CCH could manage all the medical and rehabilitation care for patients through the entire continuum of care and ideally assure overall better outcomes for patients than currently occurs in the non-hospital settings.
- The CCH model is consistent with the conceptual framework of moving toward actual or virtual bundling proposed by the Medicare Payment Advisory Commission (MedPAC) and the Obama Administration's proposal on bundling of care for 30 days subsequent to an acute care hospitalization.

2. ***Disadvantages***

- A CCH runs the risk of diluting or eliminating the distinctions that identify the various types of providers of rehabilitation services, e.g. IRH/Us, SNFs, and LTCHs. All these entities might then be considered inpatient rehabilitation facilities by policy makers in that they all provide some level of rehabilitation services.
- If all IRH/Us, HSNFs and LTCHs are replaced by CCHs, and payment for care in those levels is bundled, patients might not have the ability to choose one provider for an initial level of care and a different provider for a subsequent level of care that is offered by the CCH.

- The final payments may be reduced below the cost of delivering the services in the government's continuing efforts to reduce provider payments.
- State licensing laws and CON constraints might make it difficult to create these new entities.
- Adopting this approach would require time to develop and gain experience with the model through a demonstration project.
- The entity that controls the payment and chooses the providers will have inherent incentives to manage to the dollar and may have less incentive to meet the service needs of the patient, putting access in jeopardy, and promoting competition among facilities on the basis of price rather than service quality or value.
- Current data do not provide adequate information on patients' clinical characteristics and resource use in all post acute settings in order to devise a carefully calibrated payment model, particularly beyond acute care where factors other than medical status are part of the care and cost equation.
- Experience with capitation payment methods popular in the 1990's suggests that managing risk is difficult for entities that do not deliver the care themselves, and care providers will optimize their own primary business needs at the expense of other sectors (hospitals will manage for their benefit first, and shop the patients to the cheapest provider, not the best provider).

D. Steps Required to Implement the CCH

1. Data Collection and Data Base Design

Measure all the services received by patients in IRH/Us, HSNFs and LTCHs as well as the following 30 to 60 days, in order to be able to describe attributes such as diagnosis, function on admission, function on discharge, age, co morbidities, LOS, current medical information on admission and discharge, impairments and cost. Also measure discharge destinations, death rates, and readmission rates, status prior to acute care admission, home status, and infection rates. The objective would be to compare medical and functional status among the patients currently being served in various settings. This work, at least conceptually, is part of the focus of the PAC PRD demonstration program currently underway by CMS which is referenced above. Consider collecting the data using the ICD-10 –CM which is to be implemented over the next two years and/or ICF nomenclature.

2. Create Patient Groups

From these data, create new patient groups that would reflect function, age, diagnosis, LOS, age, status prior to onset, outcome expectations, and co morbidities for medical status, at a minimum. The conceptual and methodological approach undertaken by the RAND Corporation in the creation of the Case Mix Groups ultimately used in the Inpatient Rehabilitation Facilities Prospective Payment System (IRF PPS) is a good model to follow. Severity adjustments would be included in the creation of the groups to address the impact of single or multiple co-morbidities in lieu of tiers.

3. Create Patient Group Weights

Match the new patient groups with cost reports, MedPAC, and the additional data from the Cost Resource Utilization tool used in the PAC PRD to create new Continuing Care Hospital Care Groups (CCHCGs) and develop weights.

This step should result in a patient characteristic sensitive and expanded list of patient groups correlated with costs for the episode of care discussed below. The expectation is that, for example, some of the patients would require fewer rehabilitation services and fewer medical services (such as some current HSNF patients) with lower weights and that some of the higher intensity patients with higher medical and lower rehabilitation needs may result in higher weights. The goal is to assure that the patient groups are risk adjusted and accurately reflect the cost of service delivery.

4. Develop the Payment Unit

Base the CCHCGs on a per episode unit of payment using the CCH length of stay and the subsequent 30 days. Patients who exhaust their Medicare days should be tracked separately after they exhaust their care and convert to private pay or Medicaid for one year to establish total costs for that period.

5. Calculate the Standard Payment Amount (Sometimes Referred to as Standard Conversion Factor)

Calculate and norm the standard payment amount to determine the CCHCG payment per episode.

6. Provide for Adjusters and Special Payment Rules

Provide for facility adjusters (wages, LIP, rural, others) and special payment rules such as transfers, short stay, interrupted stay and outliers as noted above.

7. Include Performance and Quality Measures

Tie payment incentives to these measures with an emphasis on providing incentives in terms of increased payment for higher quality care, such as increased functional ability even if it requires a longer length of stay.

8. Amend Existing Laws and Regulations

Rewrite the definitions of HSNFs, LTCHs, and IRH/us to create a category of provider known as a Continuing Care Hospital. This would require amending the Medicare Act, regulations and adjustment by accreditation organizations, and possibly state certifying agencies and laws.

9. Outcomes Based Initiative

After initial implementation, revise the payment system to be based on bonuses for better functional outcomes.

10. Estimate Savings

Streamlining the delivery system, eliminating various administrative requirements, such as the 25% rule for LTCHs and the 60% rule for IRH/Us as well as others, would result in savings and as would eliminating admissions and discharges internal to the CCH since there would no longer be a need for separate medical records since the care is consolidated within the CCH. Improved coordination of care is likely to reduce preventable readmissions to acute care as well.

11. Coordination of Care

The CCH would work directly with the acute care hospitals to assure seamless and complete coordination care. There would be significantly fewer entities participating in the transition to post acute care, and the administrative burden to acute hospitals would be diminished. These

efforts will result in process improvements to ensure proper post discharge follow-up on both sides, as well as lower acute care readmissions.

E. Special Considerations for the Virtual CCH

While some of the considerations for the actual CCH model are similar, there are some that are quite different for the virtual model. The separate entities would remain, e.g. IRFs, HSNFs, and LTCHs. A common ownership or management entity would be identified as the provider. Admission and management of the patient would be through a single point of entry. The provider would continue to be responsible for, and be paid based on, the episode of care and receive full payment based also on the outcomes measures.

F. Issues to Be Addressed

Real and Virtual CCHs would need to be held accountable to the same measures and standards. For both, decisions will need to be made as to what shall be considered as the episode of care. At this time, we propose that the episode would be the CCH stay and the 30 days after discharge from the CCH.

Conclusion

This paper is intended to promote consideration, debate and discussion as to how to resolve the major challenges being faced by the American public, patients and families, providers of medical rehabilitation, LTCH services, HSNF services, the Administration, and the Congress in moving to the next phase in the delivery of inpatient medical rehabilitation and other forms of post acute care.

One thing is clear: maintaining the current system of conflicting incentives, restricted access, quality of care risks, and economic jeopardy for patients and providers is untenable. We must all work towards improvement of the current health care system in a deliberate and visionary manner with the needs of people needing inpatient medical rehabilitation services first in mind.

We propose that the development of one or more demonstration projects by CMS to test the model of the CCH should be developed, funded, studied, and considered as a prudent course of action.

In closing, the American Medical Rehabilitation Providers Association applauds the commitment to health care reform and is eager to work constructively with Congress and the Obama Administration to ensure access to medically necessary medical rehabilitation for Medicare beneficiaries, persons with disabilities and other Americans in need of this care.

May 4, 2009

Senate Committee on Finance
Attn: Editorial and Document Section
219 Dirksen Senate Office Building
Washington, DC 20510

Re: May 5, 2009 roundtable discussion on "Expanding Health Care Coverage." Statement submitted by John H. Graham IV, CAE, President & CEO of the American Society of Association Executives

American Society of Association Executives. The American Society of Association Executives ("ASAE") is a section 501(c)(6) individual membership organization of more than 22,000 association executives and industry partners representing nearly 12,000 tax-exempt organizations. Its members manage leading trade associations, individual membership societies, and voluntary organizations in every state as well as in 50 countries around the globe.

Associations as Providers of Health Care to all Americans. From early on in America's history, associations have been a key vehicle for the delivery of services and benefits such as health care. Because people and businesses join associations for the purpose of personal and professional development, associations are uniquely positioned to provide this array of benefits not only for members but for members' organizations and business partners. Because of the common interest of their members, associations are organized for greater purposes than merely selling insurance, a critical distinction in the debate over the underlying motivation in providing access to health insurance.

Associations are not affinity groups or businesses with the goal of profiting from the insurance market. They are, however, structured to represent their members and possess the infrastructure, administrative and communicative mechanisms, and experience necessary to unify employers and employees into stalwart providers of health services. Associations can serve as a conduit for health insurance coverage by covering not only their own employees, but their members and their members' employees as well. With the Committee debating how to provide affordable insurance to all Americans, it is important that associations be considered one such vehicle to ensure affordable and universal coverage.

Issues to be Addressed in Health Care Reform. Despite the inherent advantage to associations as conduits for providing health care, a minority of associations currently provide health insurance to their members. This is due, in large part, to the myriad of federal regulations surrounding the insurance market. In a 2007 ASAE health care survey, only 24% of over 1,000 associations CEOs said their association provides health insurance to members. However, 61% of respondents said that if federal regulations that limited their ability to offer some insurance to members were removed, they would consider offering insurance to their members.

Many associations also have increasing concerns about providing health insurance to their own employees. The same 2007 CEO health care survey revealed that *half of respondents characterized health care as "one of the most significant problems facing practitioners in our industry or profession."* This data reinforces other surveys that show how many associations, which many times are also small businesses, are struggling with increasing health care costs. Associations on average have experienced an 11% increase in health care costs for employees and dependents, according to ASAE's 2008 Employee Compensation and Benefit Study. Increasing costs have affected all small businesses – data from Mercer's Survey of Employer Sponsored Health Plans shows that only 64% of employers with fewer than 500 employees offer medical benefits to employees, down from 70% in 2001.

Key Component for Universal Health Care Reform. In order for associations to make their health insurance coverage affordable and available to their employees and their members, a series of reforms are needed. First, on the issue of affordability, the average annual spike in premiums needs to be addressed. For associations to provide insurance options for members, small businesses and associations must have a level playing field in the insurance arena with larger corporations. ASAE is happy to have worked with committee members Mr. Enzi and Mr. Nelson on these issues in the past and looks forward to working with the entire committee this session.

A viable solution is contained in the Small Business CHOICE Act (HR 859), bipartisan legislation that seeks to address both of the problems associations see in providing coverage. The CHOICE Act allows small businesses that belong to a common association to create an insurance pool ("cooperative") in the excess claims insurance market. This allows a small business to have catastrophic insurance backstop that covers costs exceeding a small business's primary care coverage. The cooperative also levels the playing field between small businesses and larger corporations by allowing the pool to use its number of people to create affordable coverage as it would a larger business.

A major concern with any proposal to create new insurance pools is ERISA exemptions, particularly relating to individual state mandates and insurance regulations. The CHOICE Act requires the cooperative to create a captive insurance company based in one state, and that state's insurance regulations and mandates would apply to the cooperative's coverage regardless of location. This guarantee of state mandates has widespread support from some associations in the medical community that traditionally oppose pooling legislation. The other advantage to this structure is that insurance captives are already in existence, and if the language contained in the CHOICE Act was signed into law, small businesses could ***immediately*** begin forming cooperatives and see the medical benefit savings within a year. Plans like the CHOICE Act do more than create exemptions for small business – it gives a viable option for providing affordable coverage to more Americans.

The CHOICE language has been endorsed by a variety of organizations, including the American Academy of Actuaries, American Medical Association, Coca-Cola Bottlers Association, International Franchise Association, Mercer, National Association for the Self-Employed, National Association of Realtors, National Restaurant Association, and the U.S. Women's Chamber of Commerce. On the House side, the CHOICE Act has bipartisan support including members of the Blue Dog Coalition, Congressional Black Caucus, the Congressional Hispanic Caucus, Congressional Progressive Caucus, the New Democrat Coalition, and the Republican Study Committee.

Conclusion. As you debate "Expanding Health Care Coverage" and create legislation to make health care coverage affordable and universal, I would ask that you include the language in the Small Business CHOICE Act. By doing so, you will create cost relief for small businesses and their employees, and well as expand coverage through associations. The Small Business CHOICE plan will allow the reinsurance market to keep small business premiums low, lowering costs for businesses and employees while allowing businesses to increase their coverage.

Sincerely,

John H. Graham IV, CAE
President and CEO
ASAE
1575 I Street NW
Washington, DC 20005
P: (202) 626-2703
F: (202) 371-1673

Senate Committee on Finance
Re Socialized Health-Care legislation.

Sirs:
This is to express opposition to Health-Care legislation being considered. I believe, as do countless others, that coverage can be achieved through subsidized private plans. Please do not destroy the best medical care in the world!

Yours truly,
Hugh & Ruthie Badger
3081 State Park Rd.
Dresville, N.C. 29609

May 13, 2009

May 18, 2009

Senate Committee on Finance
Attn. Editorial and Document Section
Rm. SD-219
Dirksen Senate Office Bldg.
Washington, DC 20510-6200b

Please include this testimony in the hearing record
5-12-09 Roundtable Discussion on "Financing Comprehensive Health Care Reform"

Please sponsor and vote FOR (S 540) The Medical Devices Safety Act of 2009.

I had a Tornier lateral elbow prosthesis (TEA total elbow replacement) 5/19/2008 at the Rochester, MN Mayo Clinic. It was "revised" 9/29/2008. My surgeon who designed the device wants to distance himself and not provide follow up leaving me in pain and on maximum Vicodin/narcotic (with serious lapses in the prescription).

The FDA accepts voluntary adverse event reports (11/18/2008, MW5009052) but only follows up when there is a trend. Response to my Freedom of Information (FOI) inquiry stated that the "file could not be located". Research shows less than 3,000 of these surgeries (all manufacturers) a year, so it will be quite a while before it is recognized as a "trend".

I am in contact with Senator Klobuchar (and Senator Franken) to ask for their support.

The true costs of inadequate testing and shoddy manufacturing of medical devices are currently transferred to U.S. taxpayers and patients. My family could very well be in a desperate situation if I do not find a solution to this issue – and I must do it when I am in severe pain and without adequate resources.

Please question the FDA about my Adverse Event Report and the FOI request.

Thank you so much for your public service.

With gratitude,

Steven Baker

8200 Stanley Road #41

952.261.5204

Bloomington, MN 55437

May 4, 2009

To:
The Senate Committee on Finance

This plan could ruin our present Heart Care System.

My husband and I are retired, and have numerous Medical problems. We rely on Medicare and BC/BS to Cover our Medical expenses.

If we could have the same benefits as our Destinguished politicians, we would accept this, but we realize with the present Administration we do not think that will happen.

Thank you!

Cecil L. Ballenger (age 74)
Marguerite H. Ballenger (age 70)

6 Dexter Drive
Sanford, SC 29687

1 May 09

Dear Senators —

I urge you to vote against a socialized medicine model. It has never worked — medical decisions by bean crats will lessen the health care of Americans — will cost more — will be inefficient. Our doctors know what is best. Help the uninsured through subsidies but leave the rest of us alone! Government is too big.

Ms Harriet Brenner
21 Rivoli Ln
Greenville, SC 29615-3090

Harriet Brenner

308 Rainwood Drive
Simpsonville, SC 29681-3317
6 May 2009

Senate Committee on Finance
Attn: Editorial and Document Section
Room SD219
Dirksen Senate Office Bldg
Washington, DC 20510-6200b

Subject: Health Care

Sirs:

I have heard that there is a proposal being assembled to redo health care coverage in your committee. I have also heard that this project will drastically alter our current system to a more socialized health care. Would you be kind enough to inform the public as to what is in this package? I have further read in the newspapers that this proposal is being quietly pushed through your committee. I, as well as the rest of the public, would appreciate any information about this reform package to our health care; especially before it goes to the legislature.

Sincerely,

James J. Cevasco

Statement of Consumers Union[1]

U.S. Senate Committee on Finance
Roundtable to Discuss

Reforming America's Health Care Delivery System

April 21, 2009

Americans spent $2.4 trillion on health care in 2008, more per capita than any other nation. As is now well know, we don't get good value for the money – by any measure. Among industrialized nations, the U.S. ranks 29th in infant mortality, and 48th in life expectancy. And an estimated one third of annual health spending in the U.S. – some $800 billion in 2008 – was wasted on inappropriate, unnecessary, or even harmful care.

Our nation's wasteful spending and less than optimal healthcare is due to numerous factors. Prominent among them: our failure to determine which treatments work best for which patients and the concomitant failure to deliver those treatments effectively and efficiently. Accordingly, we believe strongly that delivery system reform must address the knowledge gap in medicine and health care. It must also initiate new ways to quickly transform knowledge into practice and to guide clinicians and patients to safer, better care models.

The Need for More Comparative Effectiveness Research (CER)

We thank Congress for including $1.1 billion for CER in the stimulus package. We understand that HHS and the IOM are being flooded with good ideas on the kind of research that is needed.

We clearly need more than a one-time program, however. Consumers Union supports a permanent, all-payer trust fund to finance independent, evidence-based research. We supported the Baucus-Conrad legislation in the 110th Congress (S.3408) and the CER provision of the House-passed HR 3162. Both bills would have provided about $2.7 billion over ten years.

We urge you to include such a program in reform legislation, with amendments:

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[1] For more than 70 years Consumers Union, the nation's expert, independent, nonprofit consumer organization, has been working for a fair, just, and safe marketplace for all consumers and empowering consumers to protect themselves. We're a leading advocate for patient safety, health-care quality and effectiveness, and affordable health coverage for all.

- *Make it even clearer that a CER priority should be to help identify areas of harmful disparities in treatment and ways to eliminate those disparities.* CER should be the way to finally help end our nation's shameful health disparities. It should be clear that all future clinical trials include a full representative sample of the American patient population, and that ethnic and minority members are fully represented in the CER advisory and administrative process;

- *Strengthen conflict-of- interest provisions.* We need independent CER, because the current clinical trial results and publication process is terribly flawed and biased to report good news for funders.

- *Make sure that the results of this research are disseminated to doctors and patients in accessible, easy-to-use formats.* CER can yield no benefit if nobody uses it. Make CER evidence available in drug and device labeling and ads through the use of a 'drug facts box.'[2] Consider developing quality ratings of Medicare MA-PD and PDPs depending on how much priority their formularies give to CER.

Improve Health Care Safety: Transparency Policy Initiatives:

About 100,000 Americans are estimated to die of healthcare acquired infections (HAI) each year. That is about one person dying every 5 and a half minutes! The extra cost of treating infections in the health care system is around $35-$45 billion per year. According to the IOM's 1999 report, To Err is Human, perhaps another 44,000 to 98,000 die from medical errors such as falls, incorrect surgery, and wrong medications. It has been estimated that there are about 1.5 million harmful medication errors per year.

These are largely avoidable mistakes that must be stopped. We support the President's and MedPAC's ideas to bundle post-hospital care and to deny payments for hospital re-admissions within 30 days of discharge when the re-admission is due to poor quality. In addition, we believe public reporting of error rates further focuses provider attention on doing better. We urge you to include legislation to:

- *Make public the rates of health-care acquired infections (HAIs).* Adopt legislation similar to that proposed by Senator Menendez's (S.2525 of the 110th Congress). This disclosure movement is already underway. Twenty-five states now have laws requiring public reporting of HAI rates. Making infection rates public spurs hospitals to improve their care by actively taking steps to reduce infections – steps as simple as washing hands between visiting patients and sterilizing stethoscopes. Pennsylvania, an early leader in infection-rate reporting, showed an 8 percent

[2] See the work of Doctors Schwartz and Woloshin of the White River Junction, Vermont VA which has been endorsed by the FDA's Risk Mitigation Advisory Committee.

reduction in infection rates statewide from 2006 to 2007. While not all hospitals in the state reduced their rates, the majority did--evidence that public reporting leads to improved patient safety.

- *Make public Medicare's non-payment for hospital never events;*

- *Adopt a program like Minnesota's in which the National Quality Forum's 28 'never' events* are to be reported, perhaps starting with the most obvious self-evident errors which do not need validation, and growing the disclosure list as systems of validation become available;

We urge these additional steps to prevent medical errors:

- With early data showing that e-prescribing reduces errors, adverse reactions, and drug duplications, we urge Congress to accelerate the rewards for physicians who adopt e-prescribing, and after a 'date certain' require all physicians to use e-prescribing.

- Improve emergency response throughout the U.S. by adopting the Institute of Medicine recommendations for major improvements in the nation's Emergency Response Systems, which include requiring communication compatibility among ambulances and ERs; ensuring coordination among ERs to ensure coverage of specialty services; and linking future Medicare capital payments to hospitals to the adoption of 'best practices' in new ER construction to eliminate 'hallway boarding,' improve flow-through of patients, and reduce waiting times.

Reform of provider payment systems and licensure

Consumers Union supports well-designed "pay for reporting" and "pay for performance" initiatives, with strong protections to ensure the treatment of difficult cases through good risk adjustment systems.

We also support efforts and experiments in chronic care coordination and management and in testing the concept of medical homes—of returning to the day when one had a family doctor who knew your history and needs.

In its decade old report—on which so little has been done-- the IOM in To Err is Human suggested periodic licensure of health professionals (as we do for police and firemen and even for drivers) to ensure continuing competence. We urge you to make progress on that recommendation. We recommend a GAO or IOM study on the feasibility of various methods of increasing the Medicare payment rate for physicians who are in medical societies which require a periodic (once every 5 years at a minimum) re-certification competency examination.

Divided We Fail

Statement for the Record

Senate Finance Committee Roundtable on

EXPANDING COVERAGE IN HEALTH CARE REFORM

May 5, 2009

Chairman Baucus, Ranking Member Grassley, distinguished Committee members, on behalf of the more than 50 million people represented by Divided We Fail, we thank you for this timely discussion on expanding health care coverage.

Divided We Fail is a national movement to engage the American people, businesses, non-profit organizations and elected officials in finding bipartisan solutions to bring health and financial security to every American. Divided We fail is lead by AARP with the Business Roundtable, National Federation of Independent Business, and Service Employees International Union, and joined by more than 100 supporting organizations from across the political spectrum.

We believe that all Americans should have access to affordable, quality health care, including prescription drugs, and that these costs should not unfairly burden future generations. We believe wellness and prevention efforts, including changes in personal behavior such as diet and exercise, should be top national priorities. And we believe Americans should have choices when it comes to long-term care - allowing them to maintain their independence at home or in their communities with expanded and affordable financing options.

Since its formation in 2007, Divided We Fail has mobilized 1.6 million Americans and organized nearly 1,000 local events including 500 "Community Conversations" to inform Americans about the options to address health care and financial security and gather new ideas from the public.

We continue to work diligently together to ensure that we enact comprehensive, bipartisan health care reform legislation this year. Given the current economic challenges, it has never been more important to invest in a better, stronger, more efficient health system.

We must make health care coverage more affordable and accessible for individuals, businesses and society to sustain improvements in health and our financial security for future generations. Doing so will save lives and money, improve the safety and delivery of care, and help fuel our economic recovery. Health care is inextricably tied to America's economic well-being.

There is broad agreement among the four lead organizations in Divided We Fail on many aspects of health reform, including the need to expand coverage by:

- Enacting insurance market reforms to improve and provide access to individuals and employers seeking affordable, high-quality health care options by creating marketplaces to enable firms and individuals to purchase insurance efficiently;
- Providing sliding scale subsidies to make coverage affordable;
- Building on private coverage through policies that promote greater "take up" and enrollment of workers in job-based coverage;
- Enacting outreach and enrollment policies to ensure individuals who are eligible for public coverage are enrolled in public coverage, and establishing eligibility for public coverage for all individuals living at or below the poverty level;
- Refocusing payment incentives to reward quality rather than quantity of care, through expanded efforts to implement pay-for-performance systems that can help keep coverage more affordable;

- Promoting provider collaboration and accountability by rewarding, rather than penalizing, collaboration across care settings to provide patient-centered care to improve both quality and efficiency and keep coverage affordable;
- Strengthening primary care and chronic care management which are proven ways to promote quality, cost-effective care by providing more accurate payment and expanded testing of the "medical home" model that holds great promise for improving quality, coordination and efficiency;
- Promoting health information technology, decision support tools, and unbiased research on the effectiveness of all aspects of our health care system to give doctors the best information available to make health care decisions with their patients, and
- Strengthening the health care workforce with more primary care providers.

Given the broad range and disparate constituencies in Divided We Fail, we of course do not have unanimous agreement on all aspects of something as complex as comprehensive health reform. However, we and other stakeholders share a broad and growing consensus that we cannot allow these differences to stop us from finding common ground and enacting comprehensive, bipartisan health care reform this year.

AARP and our Divided We Fail allies will continue to work diligently together to find workable solutions to bridge these differences because we all understand that the status quo is unsustainable and we cannot afford to fail.

We again commend this Committee for its leadership and look forward to working with the Committee and members on both sides of the aisle to make enactment of meaningful, comprehensive health reform a reality this year.

April 20, 2009

The Honorable Max Baucus
Chairman, Committee on Finance
United States Senate
511 Hart Senate Office Building
Washington, D.C. 20510-2602

The Honorable Charles Grassley
Ranking Member, Committee on Finance
United States Senate
135 Hart Senate Office Building
Washington, D.C. 20510

Dear Chairman Baucus and Ranking Member Grassley:

On behalf of the Healthcare Leadership Council, I am happy to share our thoughts on healthcare delivery system reform with you.

The Healthcare Leadership Council (HLC) is a not-for-profit membership organization comprised of chief executives of the nation's leading healthcare companies and organizations. The HLC is committed to advancing a consumer-centered healthcare system that values innovation and provides affordable, accessible, high-quality healthcare to all Americans.

HLC believes that payment and delivery system reform policies should reward quality, safety, and efficiency. Improving the care for American patients is within our cooperative reach, but proposals regarding payment and delivery system reform must be considered carefully so as to avoid unintended consequences of hampering patient-centric care.

We applaud the Finance Committee for recognizing the integral role that delivery system reform plays in a reformed system that is sustainable. We advocate for a healthcare delivery model that ensures quality and value for all. Enhancing access is a key step toward creating an optimum healthcare delivery system, but access improvements must be paired with steps to improve the system that currently rewards volume over value and sickness over wellness. Over the course of the last year, HLC has been working across health sectors and with diverse partners on specific recommendations regarding overall health care reform. With that in mind, HLC has developed specific delivery system and payment reform policy options for your consideration.

Paying for value

There is currently a disconnect between the way we pay for healthcare services in this nation and our desire to achieve the best possible health outcomes for all Americans. The current system pays providers based upon the volume of services provided. There is no

linkage between the amount paid to providers and the resulting effect on patients' health or well-being.

- Payments to healthcare providers should be based on rewarding value, where value is defined as quality divided by cost over time. The most cost effective, and therefore valuable, system of care is not necessarily achieved by utilizing the least expensive procedure for a given episode or condition. Rather, comprehensive value can be created by integrating systems of care across multiple settings, instead of focusing solely on individual episodes or procedures.

- Hospital and physician quality reporting measures should be aligned. The proliferation of piecemeal quality measures in public and private value-based purchasing programs has created a complex web that healthcare providers are finding increasingly difficult to navigate. Although in some cases measure sets are similar, data sources for hospitals and physicians can be substantially different. Separating hospital and physician measures encourages the silo-effect of care provision and payment. The goal of a nationwide value-based purchasing program should be to drive physicians, hospitals, and other providers to work together to coordinate care. Likewise, value-based purchasing should align measures and reimbursements by episode of care, regardless of public or private setting, with a focus on key drivers for quality attainment, such as better chronic disease and overall care management, and services that emphasize prevention and wellness.

- Value-based purchasing (VBP) programs should also put greater focus on outcomes measures. It is important not to lose sight of the end goal in implementing a national VBP program; that end goal being a high-quality outcome that coincides with a satisfied patient. To date, the myriad of measures adopted by multiple VBP project sponsors focus on the process of care delivery, rather than on the health outcomes that reflect the impact of care for a particular condition. To this end, VBP programs should adopt an evidence-based process for establishing valid and consensus outcomes measures. HLC believes that with the patient at the center of our healthcare system, measures should clearly be linked to relevant patient outcomes over the duration of a condition or illness, not just process adherence.

Care coordination

The healthcare delivery model should be changed to emphasize integrated care coordination in a continuous learning environment. Healthcare delivery can become more effective by promoting the integration of care, involving clinicians and all providers who meet patients' needs, around a patient-centered, evidence-based medicine model.

- Research has shown that work in teams across disciplines and between care providers results in better outcomes. Unfortunately, this is not the current culture within the healthcare delivery system. A new way of delivering care is needed

that emphasizes this team approach, focused on evidence-based medicine. Care coordination teams will also be better able to deliver patient-centered, evidence-based care that focuses on prevention of and intervention with chronic diseases, which drive the majority of healthcare spending.

- Federal health coverage programs and private plans alike must insist upon care coordination and structure financial incentives to encourage innovation in this area. To that end, HLC encourages the federal government to continue to fund demonstration programs and pilot projects geared toward coordinated care models that focus on prevention and management of chronic disease. Incentives in these programs should be aligned to promote patient-centered care including innovative delivery models, including but not limited to, the patient-centered medical home model.

- We should ensure an adequate healthcare delivery workforce, including funding for training and loan forgiveness programs and payment reforms directed at primary care, public health and nursing, and other high-priority areas facing imminent workforce shortages – many of whom are essential to providing a coordinated care model for patients.

Comparative Effectiveness Research

HLC believes that comparative effectiveness assessment can be a useful tool in advancing high quality health care. Clinicians and patients both would find objective information comparing interventions to be helpful in tailoring health care to the patient's individual needs. The aim of comparative effectiveness research should be patient-centered and the underlying goal should be to help providers deliver better health care. Appropriately designed, comparative effectiveness assessments would involve, whenever possible, considerations about:

  - quality of life
  - functional status
  - economic productivity, and
  - other factors beyond medical efficacy that are important to patients, their caregivers, and society.

However, it should **not** make decisions or recommendations related to insurance coverage, payment policy, or financing of care.

- In structuring a national comparative effectiveness entity, the entity should be an independent public-private partnership that operates with transparency. Stakeholder representation should include patients and their caregivers, payers and insurers, providers, clinical researchers, and product developers. Such an entity would require a stable and adequate funding stream and would need to be insulated from politics. Its work product should be widely disseminated in

multiple formats that consider the specific needs of various subpopulations.

- In the establishment of research priorities, priority should be given to diseases and conditions with the greatest prevalence, including those that impose the greatest clinical and economic burdens on patients and society.

- The scope of comparative effectiveness research should be to examine healthcare delivery from a comprehensive perspective and not limited to a specific sector, examining all types of interventions for a condition, including no intervention. The research should also examine health benefit and delivery designs and care management, as well as other factors that affect health such as lifestyle and nutritional choices. The goal of the research should be to identify effective, efficient interventions that achieve better value and health outcomes over time.

- HLC believes that comparative effectiveness research should not pigeon-hole medical services and treatment into a one-size fits all framework. Rather, given the variation in patients' response to different interventions, comparative effectiveness assessments should not determine that an intervention is either absolutely effective or not-effective, but should provide population and subpopulation-based assessments that clinicians and patients may use and apply to an individual patient's circumstances. As medicine becomes more individualized, assessments should recognize that various interventions may work for specific subgroups of the population but not for others, based on genetic variability and other factors. Thus, research must be flexibly designed to target smaller populations with certain characteristics.

Health Information Technology

The American Recovery and Reinvestment Act of 2009 (ARRA) allocated significant funds to encourage health information technology (HIT) adoption and established a process for national standards development, certification and implementation of HIT on a nationwide level. It is critical that we build upon the significant progress that has begun in this area.

- Now that financing mechanisms have been put in place to assist healthcare providers in purchasing the infrastructure and training to participate in a health information network, work must begin to ensure that the funds are used appropriately to encourage the exchange of information necessary to improve the value of our healthcare system. The HIT Policy Committee within the U.S. Department of Health and Human Services should ensure that entities and individuals eligible to receive HIT funding under ARRA do not face difficulty in attaining those funds. Likewise, once those funds are dispersed, the federal government should be responsible for accounting that those funds are truly pushing the nation toward an integrated and well-functioning nationwide network of medical information that serves everyone.

- As we move toward a truly interoperable nationwide HIT system, HLC believes it is important to build upon the standards and certification processes that have been developed over the course of time. Particularly, the work of the Health Information Technology Standards Panel (HITSP) and the Certification Commission on Health Information Technology (CCHIT) has been far-reaching and should not be disregarded as the HIT Standards and Policy Committees develop policies to move our nation forward in linking all providers with the medical information necessary to treat patients more efficiently and with better safety.

- For a nationwide health information network to achieve its full potential in improving the quality of patient care, further efforts must be made to ensure that appropriate information is available to the right professionals at the right time. Specifically, while the current Health Insurance Portability and Accountability Act (HIPAA) rules provide protections, a multi-state data network requires the creation of a national patient privacy standard to replace differing, and sometimes conflicting, state laws, rules and guidelines. Such a standard must protect patient confidentiality without imposing unnecessary and harmful restrictions that would impede the flow of patient information to healthcare professionals and medical researchers.

Transparency

HLC encourages a healthcare environment that is transparent to consumers, providers, payers, and all who have a legitimate need to know where the value of their healthcare dollar lies. It is essential that consumers have the information necessary to choose healthcare providers and products based on value. This will empower consumers to shop wisely and, in turn, motivates the delivery system to provide better care for less money.

* * *

We offer these comments constructively and in the spirit of future collaboration with you on delivery system reform, which is critical to achieving our mutual goal of improving the value of healthcare delivery for all.

Sincerely,

Mary R. Grealy
President

May 4, 2009

The Honorable Max Baucus
Chairman, Committee on Finance
United States Senate
511 Hart Senate Office Building
Washington, DC 20510-2602

The Honorable Charles Grassley
Ranking Member, Committee on Finance
United States Senate
135 Hart Senate Office Building
Washington, DC 20510-2602

Dear Chairman Baucus and Ranking Member Grassley:

On behalf of the Healthcare Leadership Council, I am happy to share with you our thoughts on increasing access to healthcare coverage. These comments are intended to build upon our previous letter, dated April 17, which focused on healthcare delivery system reform.

The Healthcare Leadership Council (HLC) is a not-for-profit membership organization comprised of chief executives of the nation's leading healthcare companies and organizations. HLC is committed to advancing a consumer-centered healthcare system that values innovation and provides affordable, accessible, high-quality healthcare to all Americans.

HLC believes every American should have health coverage. We cannot sustain an environment where 46 million Americans are without it. Several steps can and should be taken to provide all Americans greater access to quality health coverage. We applaud the Finance Committee's efforts to consider policies to expand health coverage to all Americans, including proposals to expand access to private health insurance by providing premium assistance to low-income Americans, reform the individual and small group health insurance markets, and strengthen the healthcare safety net.

HLC is pleased to be working closely with a variety of interest groups representing employers, workers, physicians, nurses, consumers, insurers, public health professionals, and others on the Health Reform Dialogue. Together, we believe that any health reform proposal should build upon the key-pillars of healthcare coverage today: employer-sponsored insurance and public safety-net programs for low-income individuals and families. We have developed a comprehensive proposal that seeks to ensure coverage for all, strengthens the public safety-net programs, and makes private health coverage more affordable, while also providing fair and adequate payment for care. We are pleased to submit our ideas for your consideration.

Individual Responsibility and Market-Based Reforms

Changes can be made to the existing health insurance market to help contribute to a well functioning marketplace and ensure that everyone has access to quality and affordable health

coverage. HLC supports a requirement for all Americans to possess health coverage, coupled with a guarantee that every individual can purchase health insurance regardless of pre-existing health conditions. It is imperative that health insurance pools include the healthy as well as those who are in immediate need of health services. By having everyone in the system, insured individuals will no longer bear the financial burden for care provided to the uninsured. Increasing the number of individuals in insurance pools will also have a compounding effect that will serve to lower costs and make coverage more accessible.

In determining an appropriate level of coverage individuals should be required to purchase, there must be a balance between providing coverage that is as comprehensive as possible with affordability. While it is important that benefit designs ensure that individuals with rare and serious diseases receive the care they need without facing obstacles, HLC believes that there must be flexibility in health plan benefit design to meet individual needs and to avoid creating onerous financial burdens for individuals, employers, and the government.

HLC supports providing assistance for low-income individuals to purchase health insurance either in the form of advanceable, refundable tax credits or targeted sliding-scale premium subsidies. For either policy, it is important to acknowledge geographic differences in medical costs and average premiums. HLC also recognizes additional support may be needed to help certain low income individuals afford cost sharing.

HLC has examined state programs that help low-wage workers afford employer-sponsored insurance, and their experience underscores the importance of carefully considering the structure of such subsidies in order to preclude burdensome requirements on employers or complicated programs that limit access for the individual. In Oklahoma, for example, the program had predictable rates, the eligibility requirements were fairly simple to meet and there was a well coordinated outreach effort to promote the program. In contrast, in Nevada, eligibility to participate in the program was more limited; the employer had to "jump through many more hoops" to participate; and there was little marketing money available to promote the program. Enrollment in Nevada has been extremely low compared to Oklahoma.

Immediate steps should be taken to eliminate the tax disparity treatment that exists between employer-sponsored coverage and individually-purchased health insurance. As you have pointed out numerous times, employees receive an unlimited tax exclusion on health benefits received through their employer, but individuals without employer-sponsored coverage must pay for private health insurance with after-tax dollars. HLC supports providing individuals the same tax benefits as those people in the group market.

Coupled with efforts to increase access to coverage, HLC recognizes the importance of focusing attention and resources on wellness and prevention. HLC supports coverage of effective clinical preventive services in public programs and private plans as a means to improve the health of Americans, as well as to reduce costs and alleviate future burdens on the delivery system.

Maximize the Effectiveness of Employer Provided Health Insurance

HLC supports leveling the playing field so all employers can offer their employees access to health coverage. Today, nearly 60 percent of all Americans have access to employer provided health coverage. The majority of employers who can afford to offer health coverage are doing

so. Alternatives must be available for employers who cannot afford to offer coverage to their employees. Subsidies should be provided for small businesses to provide health insurance for their employees. Employers should also have considerable flexibility in choosing the benefit packages they offer in order to foster innovation and avoid undue burdens.

Individuals working for employers that do offer insurance do not always accept it. Eighty percent of the uninsured live in wage-earning households, and half of this group is offered insurance by an employer but does not accept it—often times due to unaffordable health insurance premiums. Health insurance premiums for employer-sponsored family coverage have increased 119 percent since 1999, resulting mostly from cost shifts created by increased payments from private insurance to cover underpayments by Medicare and Medicaid.

HLC supports providing subsidies to employees who cannot afford their share of premiums for their employer-sponsored coverage. If the employees are eligible for public programs, HLC supports using CHIP and Medicaid dollars to help pay an employee's share of the premium for employer-sponsored insurance. In this way we can leverage the dollars being offered by employers to help pay for health insurance.

Strengthening and Preserving Public Programs

While millions of uninsured Americans can have greater access to private health coverage through market reforms, tax incentives, and the use of Medicaid/CHIP dollars to help subsidize employer sponsored private insurance premiums, HLC believes it is essential to maintain a safety net for those individuals who cannot afford private health coverage even with assistance.

Federal and state governments must maintain fully-funded public coverage programs with more effective outreach to enroll and retain eligible families and individuals. Medicaid should be available to all Americans at or below 100 percent of the federal poverty level at a minimum. In addition, governments must make clear to qualifying individuals that they have a responsibility to utilize their options and access public coverage programs.

Finally, we cannot ignore the inadequate payments that exist for providers in public programs and contribute to provider shortages in some geographic areas and practices of medicine. Any coverage proposal must ensure that these programs provide adequate payments to clinicians and providers so individuals covered by these vital programs have access to quality healthcare services.

Responding to New Market Innovations

It is essential that any legislative and regulatory changes to the current health coverage system be performed in a deliberate, prudent manner to avoid adverse effects for the 250 million Americans who have health coverage. Laws and regulations should support innovation in the market to provide and expand health coverage. To that end, HLC believes any proposal:

- Should enable innovation in coverage and plan design.
- Should offer consumer choice and competition among plans.
- Should not create an unlevel playing field.
- Should emphasize portability, for a society that is increasingly mobile and frequently changes jobs.

- Should recognize that government should not impede private sector innovation or market responsiveness, but rather perform its primary role in healthcare to financially enable low-income Americans gain access to health coverage and to appropriately regulate the marketplace.

Information Dissemination

As you and your colleagues continue to craft vital legislation to implement much needed policy changes to increase health coverage, we want to point out it is possible to take immediate steps within the existing system to make health insurance more accessible. HLC commissioned research that found more than 50 percent of the nation's uninsured do not know where to turn for information about how to acquire health coverage. With that in mind, HLC developed *Health Access America* to address this information gap. In nine U.S. cities, community organizers arranged more than 1,000 informational events where attendees could enroll in public health coverage programs or purchase private health insurance. The events were targeted toward groups with high rates of uninsurance (small businesses, young adults, children, and the Latino community). More than 33,000 people received information from these events and more than 16,000 of those individuals acquired either private or public health coverage.

We offer these comments constructively and in the spirit of future collaboration with you on healthcare coverage, which is critical to achieving our mutual goal of providing all Americans access to quality and affordable healthcare.

Sincerely,

Mary R. Grealy
President

Cc: The Honorable Jeff Bingaman
The Honorable Jim Bunning
The Honorable Maria Cantwell
The Honorable Tom Carper
The Honorable Kent Conrad
The Honorable John Cornyn
The Honorable Michael Crapo
The Honorable John Ensign
The Honorable Michael Enzi
The Honorable Orrin Hatch
The Honorable John Kerry
The Honorable Jon Kyl
The Honorable Blanche Lincoln
The Honorable Robert Menendez
The Honorable Bill Nelson
The Honorable Pat Roberts
The Honorable John Rockefeller
The Honorable Charles Schumer
The Honorable Olympia Snowe
The Honorable Debbie Stabenow
The Honorable Ron Wyden

Hewitt

Written Statement
On behalf of Hewitt Associates LLC

By

Kenneth L. Sperling
Global Health Management Leader

For

Senate Finance Committee

Roundtable Discussion on Coverage

On

Expanding Coverage in Self-Insured and Fully Insured Markets
May 5, 2009

Executive Summary

Chairman Baucus, Ranking Member Grassley, and Members of the Committee: Thank you for the opportunity to submit our thoughts for this important roundtable discussion on reforming America's health care system and on expanding health care coverage. I am Ken Sperling, Hewitt Associates' Global Health Management Leader. Hewitt Associates is a global human resources outsourcing and consulting company, providing services to major employers in more than 30 countries and employing 23,000 associates worldwide. Headquartered in Lincolnshire, Illinois, we serve more than 2,000 U.S. employers from offices in 30 states, including many of the states represented by the members of this distinguished Committee.

As the nation pursues a path leading to universal coverage, we believe the most important consideration is how to accomplish this worthy goal in a way that preserves, strengthens, and stabilizes existing employer-based coverage. Employers are the single largest source of coverage for working Americans and their families, and the system is highly valued by both employers and employees. As we look to expand coverage and improve the health of all Americans, we can learn a great deal from the experience of large employers.

Our statement today summarizes some of these insights based on our extensive experience advising large employers on their health care plans. But our statement will also show that reforms to the U.S. health care system are imperative to reduce future cost increases and improve the quality of care. Although nearly all large employers offer health care benefits to their employees, the rapidly escalating cost of this care places an ever-increasing burden on employers and their employees that puts the entire health care system at risk. And smaller employers increasingly cannot overcome the cost barriers that keep them from providing health care coverage for their employees.

As the Committee pursues ways to expand coverage, the question of what level of health benefits should be provided will be a key decision. Our statement provides information on what larger employers currently offer their employees. Large employers tailor their health benefits to fit the needs of their specific employee population by balancing cost, affordability to employees, and the desire to encourage appropriate choices and healthy lifestyles. Hewitt's various data sources show that large employers provide employees with quite comprehensive benefits. Many large employers also provide an unlimited lifetime maximum benefit. Employers want their employees to be protected and they often use auto-enrollment and default plan options to ensure that employees who need coverage are enrolled.

While health care costs for employers are largely driven by the underlying price and utilization of health care services, costs can vary widely based on several factors, including demographics, dependent enrollment, employee contributions, plan design, geography, and health risk. Large, multistate employers prefer to provide uniform benefits to their employees and family members across the U.S. and this allows them to realize the economies of large-scale purchasing. Taking advantage of preemption under ERISA also means that employers' health plans are not burdened by expensive state mandates. Large employers often use self-insurance techniques that eliminate or reduce premium tax and insurer risk margins. These factors alone can lower employer costs by 8–10 percent; nevertheless, employers large and small continue to pay more for health care because of cost-shifting from uncompensated care and public payers.

In response to the rapid escalation in health care costs, employers have used many cost-containment strategies. Among the most promising are a variety of efforts to promote informed health care decision-making and improve employee health. The prevalence of programs to manage chronic illness and promote healthy lifestyles is widespread. In this regard, the large-employer marketplace is an innovation laboratory for new ideas that can be applied to the small-employer and individual health insurance markets. Mechanisms that work well for large, self-insured employers can also be used as a model for reforming insurance markets to enhance opportunities for those who currently struggle to obtain comprehensive health care coverage for themselves and their families.

There is no one-size-fits-all solution for health benefits. When expanding coverage, it is important not to disrupt a coverage system that is tailored to the needs of both the employer and the employee. To illustrate the point, if the Federal Employees Health Benefits Program (FEHBP) were used as a standard benefit model for all employers, most employers would have to *increase* benefits under at least one of the options. And to use the FEHBP's most popular plan design as the model for a new public plan would undermine the current system if it were priced below what private employers are able to provide to their own employees.

While a recent Hewitt survey of large employers showed that 9 out of 10 support health care reform, they have not yet reached consensus on a preferred approach. Most large employers do not currently support an employer mandate based on the limited information currently available, in part, because the details really matter. The specifics of such a mandate, of which some of the most important are outlined in our statement, will greatly influence the impact and the reactions of large employers and their employees.

Hewitt Associates is pleased to make its rich data sources and extensive knowledge of the large-employer marketplace, coverage, and drivers of cost available to the Committee as the Committee pursues the goal of expanding access to high-quality, affordable health care for all Americans. While reform is clearly needed, and is welcomed by large employers, we must accomplish this in a way that builds on what is already working efficiently for the majority of Americans and encourages employers to stay in the game.

Hewitt Statement

As the Committee discusses expanding coverage, it is critical that health care reform efforts further strengthen and stabilize employer-based coverage. New legislation must not disrupt existing coverage or inadvertently add incremental costs that are becoming increasingly difficult for both employers and employees to shoulder.

As reported by the Kaiser Family Foundation, 99 percent of employers with more than 200 employees offer health care benefits to their employees.[1] In contrast, only 62 percent of employers with less than 200 employees offer health care benefits to their employees. The overwhelming reason cited by these employers for not offering benefits is cost.

According to a recent Hewitt survey of more than 500 human resources executives, 85 percent were in favor of achieving universal coverage for all Americans. There was no clear consensus, however, in the preferred method to meet this goal, and employers are eagerly awaiting the detailed recommendations of this Committee.

Our statement addresses seven important questions about the employer-based health care system:

I. Why Do Employers Voluntarily Provide Coverage?
II. What Do Employers (and Employees) Pay for Health Coverage?
III. What Are the Cost Drivers in the Employer-Sponsored System?
IV. What Benefit Designs Do Large Employers Adopt?
V. How Does the Actuarial Value of Large-Employer Benefits Compare to FEHBP?
VI. What Efforts Are Large Employers Taking to Manage Cost and Improve Health?
VII. What Are the Implications for Large Employers of a "Pay or Play" Requirement or an Employer Mandate to Provide Coverage?

The data and observations used to answer these questions (except where otherwise noted) are derived from several proprietary Hewitt databases, including:

- The Hewitt Health Value Initiative™, containing detailed census, cost, and plan design data for 325 large U.S. employers representing 13.1 million participants and $50.5 billion in 2009 health care spending.
- SpecBook™, Hewitt's database of plan design prevalence information on 706 large U.S. companies offering benefits to their employees.
- Enrollment data from 200 employers that use Hewitt for benefits administration services, representing over 6.5 million eligible participants.

This statement also draws heavily upon the experience of Hewitt's consultants and actuaries who have extensive knowledge of—and direct experience with—the employer-sponsored health care system, the health insurance marketplace, and the emerging market trends and strategies aimed at broadening access, controlling cost, and improving the health and productivity of the U.S. workforce.

[1] 2008 Kaiser/HRET Employer Health Benefits Survey

Controlling spiraling health care costs will benefit every American seeking access to quality, affordable care. It will also make it possible for employers to continue their role as voluntary sponsors of health plans for their employees while remaining competitive in a global marketplace. The Committee's work to develop policy options to reduce cost and improve quality in the health care delivery system will be a critical part of the necessary reforms that must happen to ensure the continuity of the employer-based system.

I. Why Do Employers Voluntarily Provide Coverage?

Employers believe it is good business practice to provide health care benefits for several reasons:

- People are an organization's most important asset, and there is a direct link between employee wellness and workforce absenteeism and productivity.
- Employers believe it is their responsibility to protect employees from the risk of catastrophic loss arising from the expense of serious illness.
- Under current tax laws, providing coverage under an employer-sponsored program is the most efficient way to provide these benefits.
- Providing health care benefits allows employers to attract and retain key talent in a competitive marketplace.

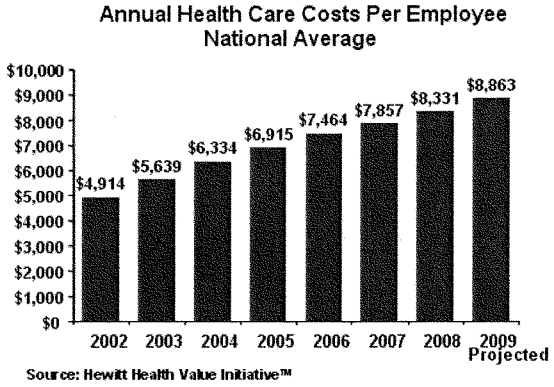
As important as it is for employers to design and offer programs that provide comprehensive protection and encourage employee wellness, it is equally important that eligible employees elect and maintain health insurance coverage. Accordingly, companies use several strategies to ensure that employees take advantage of the health insurance provided. The Committee may wish to consider adoption of these strategies as part of health reform.

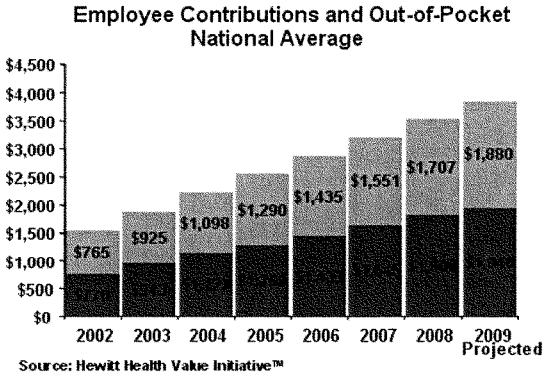
- **Automatic Enrollment:** Hewitt administers annual enrollment for over 200 large-employer clients, each with an average of 32,000 participants. All Hewitt health and welfare administration clients use automatic enrollment, commonly referred to as default coverage, because it is the industry best practice for both annual enrollments and new hire enrollments. Employers define the plans in which employees will be "automatically enrolled" if they do not make an enrollment choice.
  - For new hires, approximately 50 percent of Hewitt health and welfare administration clients "automatically enroll" employees into single coverage in the lowest-cost medical plan.
  - For annual enrollment, or so-called "open season," approximately 87 percent of employers "automatically enroll" employees in the same coverage they had the prior year.
  - With respect to employees, in 2008, eighty-three percent of employees were not required by their employers to make an active election. If they did not elect, they would be assigned their current coverage option. The remaining 17 percent were required by their employers to make an active election. If they did not do so, they would be assigned either the low-cost medical plan option or no coverage.
- **Internet Enrollment:** In 2008, Internet enrollment accounted for 86 percent of large-employer plan enrollments, with the balance enrolling with help from a customer service associate.
  - Within this group, 87 percent of actively employed participants used electronic enrollment, compared to 41 percent of retirees.

II. What Do Employers (and Employees) Pay for Health Coverage?

According to Hewitt data shown in Exhibit 1, annual large-employer health care costs (i.e., total costs for all health plan participants divided by the number of enrolled employees) have more than doubled since 2001 and are projected to reach $8,863 in 2009. Over the same period, annual employee contributions and out-of-pocket costs are expected to increase by 190 percent to $3,826.

Exhibit 1:





Average Employee Contribution
Average Employee Out-of-Pocket Costs

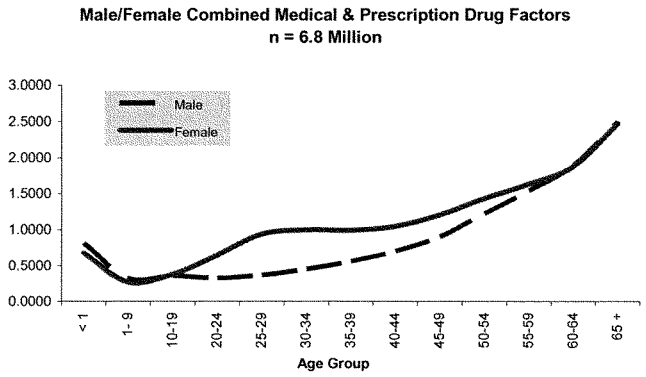
III. What Are the Cost Drivers in the Employer-Sponsored System?

While the cost of health coverage to employers is largely driven by the underlying price and utilization of health care services, this cost can vary widely based on several factors, including demographics, dependent enrollment, employee contributions, plan design, geography, and health risk. While there may be a number of initiatives that the Committee might recommend to help employers manage their costs, it is important to remember that not only is all health care local, it is also population-specific for the employer.

Meaningful change will require a thorough understanding of the underlying drivers of employer health care cost.

- **Demographics** is the age and gender mix of the population. An older workforce will have higher health care costs than a younger workforce. Exhibit 2 provides the relative cost of medical and prescription drug coverage based on age and gender. In this graph, 1.00 equals the average health care cost of a 40-year-old female.

Exhibit 2: Demographic Risk Factors by Age and Gender



- **Dependent Enrollment**, or the number of spouses and dependents covered under the employer's plan, can significantly drive overall cost. On average, 47 percent of employer health care spending is attributable to the cost of covering spouses and dependents. Large employers tend to absorb a larger proportion of these costs either because the spouse's employer does not offer coverage or the large-employers' plans are more generous.

- **Employee Contributions** for health coverage vary widely. Each company makes this determination based on what is considered competitive in their industry and by balancing what the company can afford with what employees can afford. Each year, Human Resources executives wrestle with the appropriate amount to charge employees through payroll contributions, how much exposure employees will share in the cost of health care services, and what share of the cost the company can absorb. As noted above, in 2009, large employers will spend $8,863 per employee[2][3] on health care coverage. Of this amount, employees will contribute 22 percent of the cost of coverage, or $1,946.

- **Plan Design** is another important driver of overall health care cost, and is very employer-specific. Companies select plan design provisions such as deductibles and copayments, taking into consideration the affordability of employee payroll contributions. Plan designs are also tailored to drive certain behaviors, such as lower copayments to encourage the use of generic drugs, 100 percent coverage for preventive screenings to incent wellness, or higher copayments to discourage over-utilization of

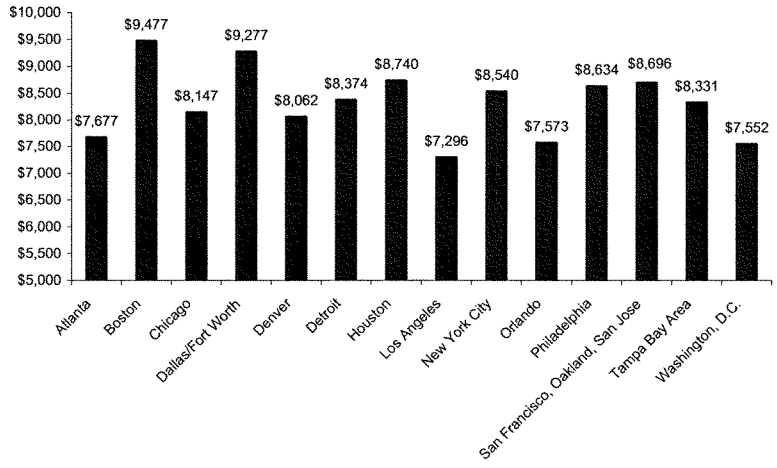
[2] The "per employee cost" is an average of the total cost for all health care participants divided by the number of enrollment employees.

emergency room visits for non-emergency care. More detail about plan design prevalence is included later in this statement. In 2009, the average employee covered by a large company's health care plan wil pay a projected $1,880 in health care expenses through plan design cost sharing.

- **Geography** can be a cost driver because health care costs vary based on the cost of doing business in that community, local practice patterns, and the degree of competition among health plans and providers Exhibit 3 illustrates the average health care cost per employee in 2008 for 15 major metropolitan areas.

Exhibit 3:

2008 Health Care Costs Per Employee in Major Metropolitan Areas



Source: Hewitt Health Value Initiative™

- **Health Risk**, or the burden of illness in an employer population, is an emerging focus of employers' health care strategies. The body of evidence proving that investment in health and wellness can both lower health care cost and improve productivity has become a central tenet of employers' buying criteria, and by extension, health plan product development. The traditional focus on acute and chronic care is being replaced with a more intense concentration on preventing the onset and progression of disease in the at-risk population.

In our Hewitt Health Value Initiative database of 325 major U.S. companies, the variation of 2009 health care cost per employee ranges from a low of $5,323 per employee to a high of $13,553 per employee. Exhibit 4 attributes this variation to differences in the underlying cost drivers.

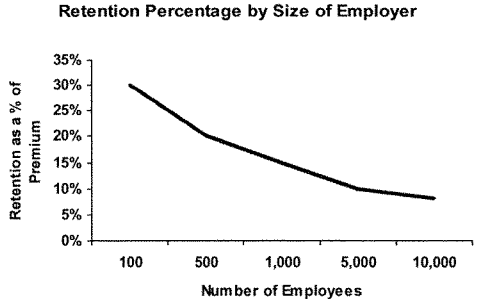
Exhibit 4: Explanation of Variation in Employer Cost

Factor	Relative Importance in Explaining Variation
Dependent Enrollment	27.5%
Demographics	21.1%
Health Risk	20.3%
Employee Contributions	13.1%
Plan Design	11.1%
Geography	6.8%
Total	**100.0%**

Economies of Scale are another factor that influences the price of the employer health plan. Health plan expenses are made up of both fixed and variable costs.

- Fixed costs include expenses for the setup and administration of any insurance contract, regardless of size. Systems costs such as eligibility file protocols, claims administration parameters, summary plan descriptions, billing arrangements, and account service are other examples of fixed costs.
- Variable costs, which are sensitive to employer size, include claims processing and customer service staffing levels.
- Small employers' fixed costs are a larger percentage of the total, so the percentage of total cost dedicated to expenses is high. As employer size increases, these fixed costs are spread over a larger employee base, reducing the overall percentage expenses and allowing the employer to fund more actual health care services. Approximate retention percentages (defined as all non-medical claims expenses) by size of employer are illustrated in Exhibit 5.

Exhibit 5:



As the Committee looks for ways to expand access to affordable coverage for employees of small firms, it is especially important to consider programs that enable small employers to band together. Larger groups can then take advantage of these economies of scale when purchasing plans, which will significantly lower their overall costs.

Self-Insurance is commonly used by large employers to maximize purchasing efficiency. Currently, 55 percent of employees participating in employer-sponsored programs are covered under self-insured arrangements. Employers large enough to absorb the risk involved in health benefits—both the risk of individual large claims and the aggregate risk of higher-than-expected claims volume—can save costs. These savings accrue from three sources:

- Under ERISA, self-insured programs are not required to comply with state-mandated benefit requirements. While the estimated cost impact of compliance with state mandates varies, the Congressional Budget Office estimates that, in general, state-mandated benefits increase premiums by about 5 percent.[4]

- Self-insured plans do not pay a premium tax, which varies from a low of approximately 1.7 percent to a high of approximately 4.5 percent, with an average of close to 2 percent of premium.

- Because the self-insured plan absorbs the risk of claims fluctuation, it does not pay risk charges to the insurance company. These risk charges can range from 3–10 percent of premium, and they are also sensitive to employer size. As the risk pool gets larger, variability in claims decreases, and risk charges correspondingly decrease.

These three items alone can easily add 8–10 percent or more to the total cost of purchasing health care. This again underscores the obstacles that small employers face in providing affordable health care benefits to their employees. This also makes a strong case for the need to preserve the current ERISA preemption of state law for large, multistate employers. Indeed, weakening ERISA preemption would pose probably the greatest single danger to the current employer-based system.

External Factors driving cost to employers have been well documented. Most notably, costs are shifted to the private health care system because of uncompensated care and below-market reimbursements by public payers. Estimates vary regarding the precise impact of this cost-shift, but it is clear that a reduction in the number of uninsured Americans as well as full and fair reimbursement by the Medicare and Medicaid systems would certainly relieve the upward pressure on employer health care spending. If it is not fiscally feasible to close this gap in public/private reimbursement rates to providers, at a minimum, health reform should ensure that the payment differential does not worsen further. Increased cost-shifting pressure on private payers would very likely create a two-tier system where employers offering their own plans are at a significant cost disadvantage.

IV. What Benefit Designs Do Large Employers Adopt?

Large employers tailor their health benefits to fit the needs of their specific employee population, balancing cost, affordability to employees, and the desire to encourage appropriate choices and healthy lifestyles. When designing a benefit package for health reform, it is important not to disrupt existing benefit designs or add to the cost of existing coverage. To aid the Committee in understanding current benefit design, Exhibit 6 provides a summary of the prevalent design provisions of the companies in Hewitt's SpecBook database that offer Preferred Provider Organization (PPO) network benefits to their employees.

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[4] *Increasing Small-Firm Health Insurance Coverage Through Association Health Plan and HealthMarts*, Congressional Budget Office, January 2000.

Exhibit 6:

Design Provision	Typical Large Employer Benefit
Annual individual deductible	■ Average: $496 ■ Median: $350
Plan coinsurance (typically the amount paid by the plan after the deductible has been met)	■ 80%: 44% of companies ■ 90%: 33% of companies ■ 100%: 9% of companies ■ Other: 14% of companies
Out-of-pocket maximum (typically the individual's maximum exposure in a calendar year)	■ Average: $1,786 ■ Median: $1,900
Lifetime maximum	■ $1 million (M) or less: 8% of companies ■ >$1M to $2M: 37% of companies ■ > $2M to $5M: 15% of companies ■ >$5M: 1% of companies ■ Unlimited maximum: 39% of companies
Physician office visit copayment	■ Average: $21 ■ Median: $20
Retail prescription drugs: Generic	■ $5 copayment or less: 25% of companies ■ $6–$10 copayment: 39% of companies ■ 80%–100% coinsurance: 25% of companies ■ 50%–79% coinsurance: 4% of companies ■ Other: 7% of companies
Retail prescription drugs: Brand (formulary)	■ $11–$20 copayment: 24% of companies ■ $21–$30 copayment: 21% of companies ■ 70%–89% coinsurance: 31% of companies ■ 50%–69% coinsurance: 9% of companies ■ Other: 15%

V. How Does the Actuarial Value of Large-Employer Benefits Compare to FEHBP?

It should be noted that many large employers currently offer a choice of plans to their employees, in order to respond to the needs of a diverse workforce and to provide options that allow employees to trade-off cost-sharing in plan design with employee contributions toward the cost of the plan. There has been considerable discussion about a creating a new government-run plan as a part of health care reform and establishing a standard or minimum benefit level for other private plans to follow. In these discussions, the Federal Employees Health Benefits Program (FEHBP) has been suggested as the standard of what might be provided to all Americans. For that reason, we compared the actuarial value of the FEHBP Blue Cross/Blue Shield Standard Option (hereafter referred to as the Standard option) with the average actuarial value of large employer plans. The actuarial value of the Standard option is relatively high (i.e., on average, the benefits are richer than the generous benefits that many large employers provide today). If that popular FEHBP option were to become the minimum standard for employer-sponsored coverage, most employers (83.7 percent) would have to increase benefits for at least one of the options currently offered to employees. In other words, despite most large employers providing comprehensive benefits to their employees, using the FEHBP Standard option would set the bar at even a higher level than what employers and employees are currently struggling to afford.

Further, if a new public plan were to be created using the FEHBP Standard benefits as a model and with below-market provider reimbursements, its pricing would most likely drive large numbers of employees currently in employer plans to the public plan. This migration would seriously undermine the current employer-sponsored system in the self-insured and insured marketplace and likely lead to its eventual demise. Among other serious concerns, such a shift would break the link that employers have established between workforce health and productivity that is so critical to keeping America's businesses competitive globally.

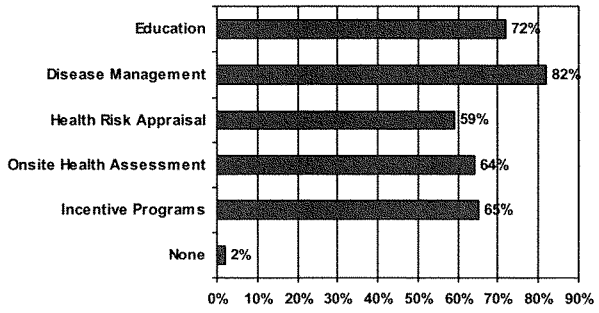
VI. What Efforts Are Large Employers Taking to Manage Cost and Improve Health?

Faced with ever-rising health care expenditures, employers have utilized many strategies to control cost, which offer potential lessons-learned to this Committee.

- Large employers are implementing aggressive vendor management programs, often with the assistance of the procurement arm of their organizations, to ensure that health plans are delivering value.
- They are also conducting frequent bidding exercises, creating an extremely competitive marketplace where the health plans aggressively vie for market share.
- They are also implementing measurement scorecards to encourage a constant state of innovation, discarding programs of questionable return in place of new or improved programs that will deliver improved results.

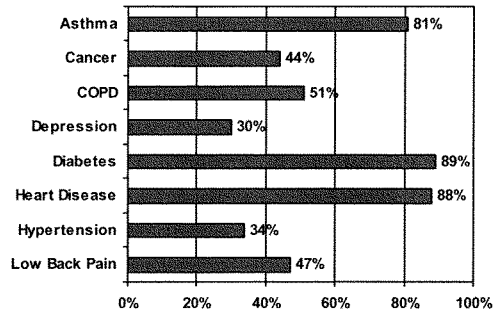
Many employers understand that efforts to improve employees' health has multiple benefits, including improving quality of life, optimizing productivity, lowering the rate of absence and disability, and lowering overall health care spending for both employer and employee. The prevalence of various health promotion programs among large employers is shown in Exhibit 7.

Exhibit 7: Percentage of Employers Offering Various Health Promotion Programs



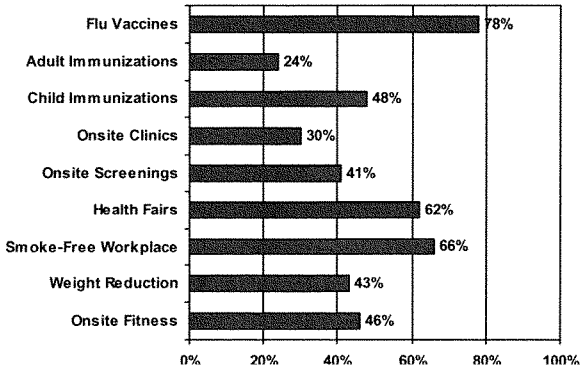
Large employers also offer a range of condition-specific disease management programs to assist employees in managing chronic illness, as shown in Exhibit 8. Both the number, scope, and sophistication of these programs has matured significantly in recent years.

Exhibit 8: Prevalence of Disease Management Programs



Wellness programs have become a mainstream part of most large employers' benefit programs. Employer involvement in promoting these programs, offering on-site access to screenings and immunizations, and developing a "culture of health" has notably increased in the last few years. Exhibit 9 provides examples of the most popular wellness programs sponsored by large employers.

Exhibit 9: Prevalence of Wellness Programs



However, employers have found it takes more than just program design to create a culture of health. The following elements are almost always present in organizations who embrace wellness as part of their core beliefs:

- Active support from senior leadership;
- Promotion of health-related activities across the organization;
- Incentives to drive behavior change;
- Metrics to track success; and
- A long-term view of the return on investment.

Another innovation that has emerged in recent years is the use of techniques to encourage the development of better educated employee consumers. Consumer-Driven Health Plans (CDHP), for example, seek to encourage employees to make informed decisions about health care utilization, with financial rewards for health conscious behavior.

The major health plans (Anthem, Aetna, CIGNA, and United Healthcare) have all performed longitudinal studies on the effectiveness of CDHPs. Results and methodologies vary, but the general findings have been:

- Populations enrolled in CDHPs had lower overall rates of cost increase than populations enrolled in traditional PPO plans.

- Reductions in cost were driven by lower utilization of health care services across all risk categories.

- CDHP participants utilized more preventive care services (primarily due to most CDHPs covering preventive care at 100 percent).

- Overall prescription drug utilization and cost decreased, at the same time as medication compliance for chronically ill individuals increased.

VII. What Are the Implications for Large Employers of a "Pay or Play" Requirement or an Employer Mandate to Provide Coverage?

In a recent Hewitt survey of large employers, 9 out of 10 say that health care reform needs to happen, but these employers have not yet reached consensus on a preferred approach. In part, that is because the details really matter. Take, for example, an employer mandate, or "pay or play." Most large employers do not currently support an employer mandate based on the limited information currently available. Hewitt itself does not endorse a pay or play approach at this time, in part because the critical details required to fairly evaluate such a plan are still not defined. The specifics of such a mandate will greatly influence the impact and the reactions of large employers and their employees.

For example, with respect to an employer mandate, these are just some of the details to be carefully evaluated:

- What would be the form and size of a "meaningful" employer contribution? Would it be a fixed dollar amount or percentage of pay? At what economic level would the requirement be set?

- Would the mandate apply to both part-time and full-time workers? There would be more consensus around full-time employees. Mandating contributions for part-time employees is more controversial. Part-time workers often change jobs frequently, and workers who take these jobs as supplemental family income often have coverage available through other sources.

- Would the mandate apply to covering all family members? And would the contribution amounts for large employers be the same for single employees and married employees? Many large employers now tier the employer and employee contributions to provide equitable treatment for single employees, single parents, and larger households.

- Would a working couple still have a choice between their respective employers' plans? And if so, how would that work in terms of any mandated contribution?

- Could employers satisfy the mandate by substantiating that they provide a plan of equivalent overall value to the standard? Or would they have to comply on a benefit-by-benefit basis?

- If a national health exchange is created, would large employers and their employees be permitted to participate in this program? Or would participation be available only to individuals and small businesses?

- Would employees of large employers be permitted to opt out of the employer's plan and enroll in a national health exchange plan? And if so, what would be the terms and the consequences for opting out of the employer's plan? The group health plan "insurance" concept would face a sure demise if younger and healthier employees could opt out and take the full average employer health care contribution with them.

Conclusion

The majority of Americans currently receive health care coverage through their employer and like it that way. This is a voluntary system where employers choose to participate and cover employees as well as their dependents. Employers subsidize approximately 78 percent of the premium costs despite an expense burden that clearly impacts their ability to compete in a global marketplace.

The employer-sponsored model offers many features that should be emulated as the Nation seeks viable ways to expand health coverage. It allows for large scale purchasing and pooling of risks enabling those who are less healthy to secure affordable coverage for themselves and their families. Employer-based plans typically waive pre-existing conditions and cannot limit coverage based on individual health status. HIPAA regulations ensure that people can move from job to job without concern for being denied coverage due to health status. And employers use auto-enrollment and default plan options to ensure that employees take advantage of the comprehensive health care coverage available to them.

The large employer system is a laboratory where innovative ideas for controlling cost and improving health are created and tested continually. Proven strategies then trickle down to the small employer marketplace and individual plans, as health plans adopt successful programs into their mainstream products. Examples of this process include the development of value-based purchasing, competitive bidding, health risk analysis, consumer-driven health initiatives, disease management programs, and innovative pharmacy management programs.

As good as it is, however, the employer-based health care system is increasingly at great risk. Costs are high due to the underlying cost of care and shifting of cost from other segments. Some employers pay as much as $13,000 annually for every employee they cover. While it is important not to disrupt the system that provides coverage for so many Americans, changes need to be made both in the payment and delivery system as well as the ways in which small employers and individuals access affordable coverage.

As the Committee develops specific proposals to expand coverage, Hewitt would be pleased to share our extensive data on, and knowledge of, the large employer marketplace to help support the public policy goal of creating positive reforms in the U.S. health care system.

HIV Health Care Access Working Group

Statement of the HIV Health Care Access Working Group

to the

Senate Committee on Finance

Relating to the April 21, 2009 Roundtable to Discuss

Reforming America's Health Care Delivery System

On behalf of its constituent organizations, the HIV Health Care Access Working Group ("HHCAWG" or "the Working Group") applauds Senate Finance Committee Chairman Baucus and Ranking Member Grassley for focusing the Committee's attention on the urgent matter of reforming America's health care delivery system. HHCAWG is a coalition of eighty-four national and community-based AIDS service organizations representing HIV medical providers, advocates and people living with HIV/AIDS and providing critical HIV-related health care and support services. The Working Group is actively engaged in efforts to increase early and affordable access to quality, comprehensive care for people living with HIV/AIDS.

HIV disease provides a benchmark for reforming the nation's health care system—a system that meets the needs of people living with HIV will meet the needs of anyone in the United States. Successfully reforming health care in the U.S. requires (1) dismantling existing barriers to care, and (2) investing in delivery models that facilitate provision of comprehensive, quality care:

1. Focus on developing a system that promotes early access to care.

No disease better illustrates the frailties and disparities of the current health care system than HIV. Remarkable advances in HIV treatment have transformed it to a chronic condition—*for people with ongoing access to care*. But despite the best efforts of the discretionary Ryan White Program, nearly 50 percent of people living with HIV in the United States lack access to a secure source of HIV treatment.[1] National health care reform must address current systemic barriers to care for people living with HIV/AIDS.

Currently, Medicaid and Medicare are the two largest insurers of HIV care in the United States—together, these programs provide access to health care for approximately half of the people living with HIV/AIDS in the United States. Health care reform should build on these important programs, but move away from the current disability-based system and toward one that provides early access to meaningful health care coverage for everyone. Among others, the following are critical measures to removing barriers to care and promoting early access:

- Provide Medicaid to all low-income people by (a) eliminating the current disability requirement that often fails to prevent disease progression and results in more costly medical interventions; and (b) allowing states to provide Medicaid coverage

[1] Institute of Medicine of the National Academy of Sciences, Board on Health Promotion and Disease Prevention. Public Financing and Delivery of HIV/AIDS Care: Securing the Legacy of Ryan White. 2004.

for persons with HIV with income above the federal poverty level, as proposed in the Early Treatment for HIV Act (H.R.1616, S.833);

- Ensure access to quality health care by establishing a comprehensive, standard Medicaid benefits package that includes the full range of services critical to successful management of HIV disease and other chronic conditions. It is imperative that the standard benefits package include prescription drugs, mental health and substance abuse treatment, and coverage for prevention services including routine, voluntary HIV testing and counseling. And to ensure that the full range of services covered by the standard benefits package is actually available, reform legislation must bar states from applying arbitrary service limits that do not support the basic standard of care;
- Maintain protections under Medicaid that ensure low-income consumers do not go without health care because of inability to pay, and minimize consumers' out-of-pocket costs to ensure that Medicaid and Medicare health care services and prescriptions are affordable for everyone;
- Guarantee equitable Medicaid and Medicare reimbursement to primary care providers and experienced HIV providers to support effective chronic disease management; and
- End the two-year waiting period for Medicare coverage for people with disabilities and eliminate "donut hole" coverage gaps by counting AIDS Drug Assistance Program expenditures toward TrOOP.

Without system-wide improvements in these and other areas, people living with HIV/AIDS will continue to face barriers to accessing the health care they require even if cutting-edge delivery systems are deployed.

2. Invest in, build upon and integrate the Ryan White model of delivery of care.

While HIV disease spotlights the failures of current health care systems, it also has spurred great successes. For example, the Ryan White Program has been vital in supporting the delivery of comprehensive and coordinated HIV care, treatment and important social services through community-based organizations and clinics. In recent years these programs have struggled to meet the needs of uninsured and underinsured people living with HIV/AIDS. Many have nonetheless developed successful models for the delivery of comprehensive and coordinated care and services. Congress can and should look to the Ryan White community-based delivery system as a model for high-quality, cost-effective management of chronic conditions generally.

Additionally, the Ryan White program has helped build the capacity of community-based programs in racial/ethnic minority and low-income communities to provide primary medical care and other critical services to underserved populations. With the continuing, significant racial disparities in access to health care in the United States, the strength of Ryan White programs cannot be overstated.

In light of their great successes in providing access to high-quality care to people living with HIV, the Ryan White programs should continue to play an integral role in a reformed health care system. The Working Group urges the Senate Committee on Finance to consider ways to

facilitate the integration of the network of Ryan White-funded community-based providers into the broader health system—for instance, by providing them with cost-based reimbursement and ensuring that Medicaid programs and private insurers will build these providers into their disease management or medical home networks. Finally, to ensure the successful integration of ongoing Medicaid and Ryan White programs, a reformed health care system must support strong collaboration at the federal and state levels.

Thank you for the opportunity to comment on this important matter as the Committee investigates health care reform. For more information, please contact Working Group co-chairs Laura Hanen of the National Alliance of State and Territorial AIDS Directors at (202) 434-8091 or Robert Greenwald of the Treatment Access Expansion Project at (617) 390-2584.

Sincerely,

Laura Hanen

Laura Hanen
National Alliance of State and Territorial AIDS Directors

Robert Greenwald
Treatment Access Expansion Project

hivma

Ryan White Medical Providers Coalition

HIV Medicine Association and the Ryan White Medical Providers Coalition
Statement for the Record
Submitted to the Senate Committee on Finance
Roundtable: Reforming America's Health Care Delivery System
April 21, 2009

Respectfully submitted by:

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Dear Chairman Baucus and Ranking Member Grassley:

We applaud you for your leadership on health care reform. As frontline HIV medical providers, we have witnessed first hand the best and the worst that our health care system has to offer from patients that die prematurely because they are diagnosed too late to benefit from HIV treatment to patients diagnosed with HIV 20 years ago that are experiencing healthy, productive lives. Health care reform offers a critical opportunity to develop an equitable and cost effective health care system that affords all of our patients early and reliable access to lifesaving HIV care and treatment.

We submit this statement on behalf of the HIV Medicine Association (HIVMA) and the Ryan White Medical Providers Coalition (RWMPC) to share with you our collective experience developing high quality, cost effective programs for managing HIV disease. As the strains on our health care system have grown, many of these HIV programs have been struggling to maintain the models of care that they developed for successfully managing HIV. Rising caseloads coupled with workforce and funding challenges have forced programs to reduce services, cutback on clinic hours and have even left some facing eviction. Furthermore, as we work to identify the 21 percent of people infected with HIV that are unaware of their HIV status through routine HIV testing, it is critical to their health and the public health of the community to ensure that we can provide them with reliable access to effective HIV care and treatment. We urge you to sustain and expand through health care reform the model HIV programs developed with Ryan White funding for delivering high quality, cost-effective care to people with chronic conditions to ensure we have the capacity to better meet the demand for HIV care.

HIVMA represents more than 3,600 frontline medical providers and researchers dedicated to the field of HIV medicine from across the U.S. The Ryan White Medical Providers Coalition (RWMPC) represents Ryan White Part C programs from nearly all 50 states that deliver comprehensive HIV care to low-income people with HIV disease.

HIV Treatment: Highly Effective but Complex

HIV treatment is one of the most effective medical interventions available today and has transformed HIV disease from an acute to a chronic condition for those with ongoing access to medical care. Management of HIV disease requires a hybrid of specialty and primary care expertise and services to effectively suppress the virus; address serious treatment side effects and treat the co-occurring conditions common among many with HIV. A survey of Ryan White Part C clinical programs found that on average 37% of Part C patients had a serious mental illness; 35% had a substance abuse disorder and 23% had hepatitis B or C.[i] Many patients also develop other serious conditions, such as diabetes, lipid disorders and heart disease.

Early and stable access to HIV care and treatment helps patients with HIV live healthy and productive lives and is more cost effective to the health care system. One study from the 1917 Clinic at the University of Alabama at Birmingham found that patients treated at the later stages of HIV disease required 2.6 times more health care dollars annually than those receiving earlier treatment largely due to increased medication and hospitalization costs.[ii]

The HIV Care Delivery System

A majority of HIV patients rely on Medicaid and Medicare for access to care and it is critical that these programs are strengthened through the health care reform process. While the Medicaid program is well-designed to serve low-income individuals with intense medical needs – the geographic variability in the program means that the care and treatment available to our patients depends on where they live. We urge you to address these disparities by enhancing the mandatory benefits required under Medicaid to include medical services that are vital to the treatment of HIV disease, such as prescription drugs, mental health and substance abuse treatment, and dental care. We also recommend that you bar states from applying arbitrary service limits that do not support the basic standard of care for HIV disease.

The Ryan White program has played an absolutely vital role in filling the significant coverage and benefits gaps left by our current health care system. Without this program, many of our low-income patients with HIV would go without lifesaving HIV care and treatment. Despite the success of the Ryan White program – which as you know is a discretionary program not an insurance program – nearly 50 percent of people with HIV in the U.S. do not have a reliable source for HIV care. This figure will increase if we fail to address critical components of the care delivery system, such as shortages of HIV medical provides; reimbursement that does not support the cost of care, and coverage of comprehensive, coordinated care for chronic conditions, such as HIV disease.

HIV Clinical Programs Serving as Medical Homes

As defined by the American Academy of Pediatrics, American College of Physicians, American Academy of Family Physicians, and the American Osteopathic Association,[iii] medical homes take a patient-centered approach to providing ongoing, comprehensive and well-coordinated care. With the help of Ryan White Part C funding, many HIV clinics have evolved into medical home programs that provide the range of services that their patients need to stay healthy. This

approach has been critical to retaining patients with HIV in care; supporting adherence to their daily treatment regimen and treating co-occurring conditions.

Services in these programs are delivered by a multi-disciplinary team led by an experienced HIV medical provider and including nurses, nutritionists, social workers, case managers, pharmacologists and adherence counselors. Many of the programs have developed state-of-the-art quality improvement systems to evaluate and monitor the effectiveness of their interventions as well as the cost of care.

Lessons Learned from HIV Programs

The flexibility afforded by Ryan White funding to fill in coverage gaps has been critical to supporting many HIV clinics in developing model chronic disease management programs and serving as medical homes to their patients with HIV. Other key factors include:

- Care delivered by a multi-disciplinary team led by an HIV experienced medical provider;
- Ability to provide or coordinate access to comprehensive medical and social services; and
- Dedicated and culturally competent staff.

Additionally, resources to support quality improvement; data management and program evaluation also are critical to fully realize the potential of these programs.

Case Studies

The profiles below describe the comprehensive HIV programs developed with Ryan White Part C funding from diverse communities across the country.

University of New Mexico Health Sciences Center (UNMHSC)

The UNMHSC has been an important provider of HIV primary care in Albuquerque since 1985, serving nearly 900 HIV-infected patients in 2008. The University teams with New Mexico AIDS Services (NMAS) to ensure patients have access to an array of primary care as well as support services at or through the Truman Street Health Services Clinic. The Truman Clinic is the largest HIV-dedicated primary care clinic in New Mexico. Since 2000, the University's HIV primary care clinic has been co-located with NMAS in an Albuquerque neighborhood convenient to public transportation and offering residents of the greater Albuquerque area with HIV/AIDS one-stop access to primary care and social services. Emergency, pharmacy, hospitalization and the full spectrum of diagnostic and treatment services are available through UNMHSC. A range of other important services also are available at or through Truman Clinic, including pediatric HIV care, case management, home care and hospice services, housing, nutritional assistance, social service support, patient/family education, multidisciplinary medication adherence counseling, as well as comprehensive mental health and substance abuse treatment.

Primary Care Alliance, Clinic1A, University of Utah Health Sciences Center, Salt Lake City

The University of Utah (UU), Clinic1A has played a key role in the delivery of HIV care in Utah since 1988. The Clinic is the medical home for a growing population of people living with

HIV/AIDS in Utah. It provides full specialty HIV care as well as primary care and employs a multi-disciplinary team of Infectious Diseases physicians and physician assistants, pharmacist, case managers and social workers. Obstetric and Gynecology services are available on site as well as Neurology and Psychiatric services. Clinic staff also support "Traveling Clinics" to St. George, Utah located 300 miles south of Salt Lake and to the Utah State Prison.

St. Luke's Roosevelt Hospital Center: Center for Comprehensive Care, New York City

Since 1997, the Center for Comprehensive Care (CCC) has been providing a comprehensive model of care to the most low-income and marginalized HIV infected individuals in New York City. Ryan White Part C funding has been critical to supporting the delivery of high quality, comprehensive HIV primary care to patients with no other source for lifesaving HIV care and treatment. The CCC provides the continuum of care through the Samuels Clinic at Roosevelt Hospital and Morningside Clinic at St. Luke's Hospital. There are dedicated inpatient services at both hospitals. The CCC provides full-service co-located care ("one-stop shopping") delivered by experts in HIV medicine at both clinic sites. Services include: HIV counseling and testing, HIV primary care, specialty care (Gyn, Endocrine, Gastroenterology, Neurology, Dermatology, Cardiology), mental health services, case management and social work, on-site pharmacy, treatment adherence support, dental care, screening and referral for substance abuse, nutrition counseling, domestic violence screening and intervention, complementary therapies, special programs and events, and linkage to community based services.

Tri-City Health Center - HIVACCESS, Oakland, CA

HIV ACCESS cared for 1,150 patients in 2007. Nearly 80% of the program's patients are from communities of color with approximately 54% being African American. Many patients are dually or triply diagnosed with serious mental illnesses and/or substance use and lack of availability of these services makes it difficult for them to initiate and stay in HIV care. The program offers a wide range of services, including: HIV counseling, testing, referral, and partner counseling services; physical exams; diagnostic laboratory tests; antiretroviral therapy; prophylaxis and treatment of opportunistic infections; treatment adherence support; routine immunizations; nutritional services; tuberculosis, hepatitis B and C and sexual transmitted infections screening. The sites provide these services using a client-centered treatment plan and also offer after-hours and weekends coverage; referrals for specialty care; coordination of hospital discharge; linkage to clinical trials; and case management. Additionally – referrals for oral health care; outpatient mental health and substance abuse treatment and optometry services are available. HIV ACCESS is struggling to maintain its state-of-the-art care model. Due to a growing funding shortfall, one of its clinics is now only open 4 days a week and was forced to lay off 40% of its staff, including a physician, multiple nurses, social workers, clerks and the lone patient educator. The largest site, based at the county hospital, also is losing its outpatient space at the hospital and is relocating to a less convenient but cheaper location in the community. Other sites in the program are showing similar strains; several are triaging laboratory monitoring or medications for diabetes and high lipid conditions.

University of Alabama at Birmingham (UAB), 1917 Clinic

The 1917 Clinic is a dedicated, not-for profit outpatient HIV/AIDS medical and dental clinic established in 1988 at the University of Alabama at Birmingham. Ryan White Part C funding has provided critical assistance in helping the clinic meet the needs of its patients. Today 40% of the 1917 Clinic's new patients are uninsured and would be at risk for losing access to lifesaving services without Ryan White funding. The Clinic offers the range of primary care and social

services critical to successful HIV treatment, including primary medical care; on-site case management; mental health and substance abuse treatment services; onsite access to clinical trials; adherence, spiritual, risk reduction, and nutrition counseling; infusion therapy, coordination of hospital discharge planning, and home health care/hospice referral. To avoid emergency room visits, the 1917 Clinic provides 'sick call' services five days a week. Subspecialty care is available at the University's Kirklin Clinic – which is located just two blocks from the 1917 Clinic.

Special Immunology Associates, El Rio Community Health Center, Tucson, Arizona

Special Immunology Associates (SIA) is a Ryan White Part C grantee that has been providing HIV early intervention services and comprehensive primary care services to persons living with HIV/AIDS since 1991. The clinic is part of El Rio Health Center, a federally qualified health center providing a medical home to Tucson residents for more than 37 years and currently serving more than 70,000 patients. SIA provides care for more than 1200 patients, 36 percent of whom report incomes below the federal poverty level. Funding from Ryan White Part C allows SIA to offer diagnosis and treatment of HIV disease and support the range of services critical to effective HIV care and management. Services provided include prevention and treatment of opportunistic infections and other complications, referral for clinical trials and specialty care, as well as laboratory and pharmacy services, oral health, mental health services, substance abuse and nutritional counseling, and medical case management including treatment adherence services. Inpatient care is provided at a community hospital adjacent to the clinic. An on-call SIA physician is available at all times to address clinical emergencies and to ensure optimal care coordination for our patients. SIA also offers HIV testing and counseling to the patients' partners.

Conclusion

As you engage in the important work ahead, we urge you to consider the needs of our patients with HIV and the many people with HIV without access to lifesaving care. Ensure that these programs are sustained and expanded to create a stable, robust and cost effective HIV care system. Please contact the HIVMA executive director, Andrea Weddle, at (703) 299-0915 or aweddle@idsociety.org or the RWMPC convener, Jenny Collier, at 202-295-7188 or jennycollierjd@yahoo.com with questions or to arrange a meeting to discuss the issues that we raise in more detail.

Thank you.

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[i] HIVMA-FCHR Survey on Workforce Needs. Presented at the 2008 National Summit on HIV Diagnosis, Prevention and Access to Care. 21 November 2008.

[ii] Chen RY, et al.. Distribution of health care expenditures for HIV-infected patients. Clin Inf Dis 42:1003-1010, 2006.

[iii] See Joint Principles of the Patient-Centered Medical Home. American Academy of Family Physicians. American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. March 2007. Available at www.medicalhomeinfo.org/joint%20Statement.pdf.

Reforming America's Health Care Delivery System
April 21, 2009
James & Mary Judd
126 Lake Forest Circle
Easley, SC 29642

Our views for this hearing as you consider health care reform is that government controlled health care is not the answer. Nor is government control coming in small piece's at a time the answer. We need free market health care. What we now see in Canada and England is a good example of the results of government control health care. This we do not want, as we have the best health care in the world and we want to keep it that way, as needed reform is considered. We are now currently experiencing what government control is doing to the banking and auto industry.

Andy Koons-Graff
227 Jones rd.
Winlock, WA 98596

4-21-09 Roundtable to Discuss Reforming America's Health Care Delivery System

Pierre Lemieux (a Canadian Economist) wrote an article about the Canadian health care system. He made some very good points that would do us a lot of good to consider. I couldn't possibly say it better than this;

The Canadian public health system is often put forward as an ideal for Americans to emulate. It provides all Canadians with free basic health care: free doctors' visits, free hospital ward care, free surgery, free drugs and medicine while in the hospital -- plus some free dental care for children as well as free prescription drugs and other services for the over-65 and welfare recipients. You just show your plastic medicare card and you never see a medical bill.

This extensive national health system was begun in the late 1950s with a system of publicly funded hospital insurance, and completed in the late 1960s and early 1970s when comprehensive health insurance was put into place. The federal government finances about 40 per cent of the costs, provided the provinces set up a system satisfying federal norms. All provincial systems thus are very similar, and the Quebec case which we will examine is fairly typical.

One immediate problem with public health care is with the funding. Those usually attracted to such a "free" system are the poor and the sick -- those least able to pay. A political solution is to force everybody to enroll in the system, which amounts to redistributing income towards participants with higher health risks or lower income. This is why the Canadian system is universal and compulsory.

Even if participation is compulsory in the sense that everyone has to pay a health insurance premium (through general or specific taxes), some individuals will be willing to pay a second time to purchase private insurance and obtain private care. If you want to avoid this double system, you do as in Canada: you legislate a monopoly for the public health insurance system.

This means that although complementary insurance (providing private or semi-private hospital rooms, ambulance services, etc.) is available on the market, sale of private insurance covering the basic insured services is forbidden by law. Even if a Canadian wants to purchase basic private insurance besides the public coverage, he cannot find a private company legally allowed to satisfy his demand.

In this respect, the Canadian system is more socialized than in many other countries. In the United Kingdom, for instance, one can buy private health insurance even if government insurance is compulsory.

In Canada, then, health care is basically a socialized industry. In the Province of Quebec, 79 per cent of health expenditures are public. Private health expenditures go mainly for medicines, private or semi-private hospital rooms, and dental services. The question is: how does such a system perform?

The Costs of Free Care

The first thing to realize is that free public medicine isn't really free. What the consumer doesn't pay, the taxpayer does, and with a vengeance. Public health expenditures in Quebec amount to 29 per cent of the provincial government budget. One-fifth of the revenues come from a wage tax of 3.22 per cent charged to employers and the rest comes from general taxes at the provincial and federal levels. It costs $1,200 per year in taxes for each Quebec citizen to have access to the public health system. This means that the average two-child family pays close to $5,000 per year in public health insurance. This is much more expensive than the most comprehensive private health insurance plan.

Although participating doctors may not charge more than the rates reimbursed directly to them by the government, theoretically they may opt out of the system. But because private insurance for basic medical needs isn't available, there are few customers, and less than one per cent of Quebec doctors work outside the public health system. The drafting of virtually all doctors into the public system is the first major consequence of legally forbidding private insurers from competing with public health insurance.

The second consequence is that a real private hospital industry cannot develop. Without insurance coverage, hospital care costs too much for most people. In Quebec, there is only one private for-profit hospital (an old survivor from the time when the government would issue a permit to that kind of institution) but it has to work within the public health insurance system and with government-allocated budgets.

The monopoly of basic health insurance has led to a single, homogeneous public system of health care delivery. In such a public monopoly, bureaucratic uniformity and lack of entrepreneurship add to the costs. The system is slow to adjust to changing demands and new technologies. For instance, day clinics and home care are underdeveloped as there exist basically only two types of general hospitals: the non-profit local hospital and the university hospital.

When Prices Are Zero

Aside from the problems inherent in all monopolies, the fact that health services are free leads to familiar economic consequences. Basic economics tells us that if a commodity is offered at zero price, demand will increase, supply will drop, and a shortage will develop.

During the first four years of hospitalization insurance in Quebec, government expenditures on this program doubled. Since the introduction of comprehensive public

health insurance in 1970, public expenditures for medical services per capita have grown at an annual rate of 9.4 per cent. According to one study, 60 per cent of this increase represented a real increase in consumption.1

There has been much talk of people abusing the system, such as using hospitals as nursing homes. But then, on what basis can we talk of abusing something that carries no price?

At zero price, no health services would be supplied, except by the government or with subsidies. Indeed, the purpose of a public health system is to relieve this artificial shortage by supplying the missing quantities. The question is whether a public health system can do it efficiently.

As demand rises and expensive technology is introduced, health costs soar. But with taxes already at a breaking point, government has little recourse but to try to hold down costs. In Quebec, hospitals have been facing budget cuts both in operating expenses and in capital expenditures. Hospital equipment is often outdated, and the number of general hospital beds dropped by 21 per cent from 1972 to 1980.

Since labor is the main component of health costs, incomes of health workers and professionals have been brought under tight government controls. In Quebec, professional fees and target incomes are negotiated between doctors' associations and the Department of Health and Social Services. Although in theory most doctors still are independent professionals, the government has put a ceiling on certain categories of income: for instance, any fees earned by a general practitioner in excess of $164,108 (Canadian) a year are reimbursed at a rate of only 25 per cent.

Not surprisingly, income controls have had a negative impact on work incentives. From 1972 to 1987, for instance, general practitioners reduced by 11 per cent the average time they spent with their patients. In 1977, the first year of the income ceiling, they reduced their average work year by two-and-a-half weeks.2

Government controls also have caused misallocations of resources. While doctors are in short supply in remote regions, hospital beds are scarce mainly in urban centers. The government has reacted with more controls: young doctors are penalized if they start their practice in an urban center. And the president of the Professional Corporation of Physicians has proposed drafting young medical school graduates to work in remote regions for a period of time.

Nationalization of the health industry also has led to increased centralization and politicization. Work stoppages by nurses and hospital workers have occurred half a dozen times over the last 20 years, and this does not include a few one-day strikes by doctors. Ambulance services and dispatching have been centralized under government control. As this article was being written, ambulance drivers and paramedics were working in jeans, they had covered their vehicles with protest stickers, and they were dangerously

disrupting operations. The reason: they want the government to finish nationalizing what remains under private control in their industry.

When possible, doctors and nurses have voted with their feet. A personal anecdote will illustrate this. When my youngest son was born in California in 1978, the obstetrician was from Ontario and the nurse came from Saskatchewan. The only American-born in the delivery room was the baby.

When prices are zero, demand exceeds supply, and queues form. For many Canadians, hospital emergency rooms have become their primary doctor -- as is the case with Medicaid patients in the United States. Patients lie in temporary beds in emergency rooms, sometimes for days. At Sainte-Justine Hospital, a major Montreal pediatric hospital, children often wait many hours before they can see a doctor. Surgery candidates face long waiting lists -- it can take six months to have a cataract removed. Heart surgeons report patients dying on their waiting lists. But then, it's free.

Or is it? The busy executive, housewife, or laborer has more productive things to do besides waiting in a hospital queue. For these people, waiting time carries a much higher cost than it does to the unemployed single person. So, if public health insurance reduces the costs of health services for some of the poor, it increases the costs for many other people. It discriminates against the productive.

The most visible consequence of socialized medicine in Canada is in the poor quality of services. Health care has become more and more impersonal. Patients often feel they are on an assembly line. Doctors and hospitals already have more patients than they can handle and no financial incentive to provide good service. Their customers are not the ones who write the checks anyway.

No wonder, then, that medicine in Quebec consumes only 9 per cent of gross domestic product (7 per cent if we consider only public expenditures) compared to some 11 per cent in the United States. This does not indicate that health services are delivered efficiently at low cost. It reflects the fact that prices and remunerations in this industry are arbitrarily fixed, that services are rationed, and that individuals are forbidden to spend their medical-care dollars as they wish.

Is it Just?

Supporters of public health insurance reply that for all its inefficiencies, their system at least is more just. But even this isn't true.

Their conception of justice is based on the idea that certain goods like health (and education? and food? where do you stop?) should be made available to all through coercive redistribution by the state. If, on the contrary, we define justice in terms of liberty, then justice forbids coercing some (taxpayers, doctors, and nurses) into providing health services to others. Providing voluntarily for your neighbor in need may be morally good. Forcing your neighbor to help you is morally wrong.

Even if access to health services is a desirable objective, it is by no means clear that a socialized system is the answer. Without market rationing, queues form. There are ways to jump the queue, but they are not equally available to everyone.

In Quebec, you can be relatively sure not to wait six hours with your sick child in an emergency room if you know how to talk to the hospital director, or if one of your old classmates is a doctor, or if your children attend the same exclusive private school as your pediatrician's children. You may get good services if you deal with a medical clinic in the business district. And, of course, you will get excellent services if you fly to the Mayo Clinic in Minnesota or to some private hospital in Europe. The point is that these ways to jump the queue are pretty expensive for the typical lower middle class housewife, not to talk of the poor.

An Enquiry Commission on Health and Social Services submitted a thick report in December 1987, after having met for 30 months and spent many millions of dollars. It complains that "important gaps persist in matters of health and welfare among different groups."3 Now, isn't this statement quite incredible after two decades of monopolistic socialized health care? Doesn't it show that equalizing conditions is an impossible task, at least when there is some individual liberty left?

One clear effect of a socialized health system is to increase the cost of getting above-average care (while the average is dropping). Some poor people, in fact, may obtain better care under socialized medicine. But many in the middle class will lose. It isn't clear where justice is to be found in such a redistribution.

There are two ways to answer the question: "What is the proper amount of medical care in different cases?" We may let private initiative and voluntary relations provide solutions. Or we may let politics decide. Health care has to be rationed either by the market or by political and bureaucratic processes. The latter are no more just than the former. We often forget that people who have difficulty making money in the market are not necessarily better at jumping queues in a socialized system.

There is no way to supply all medical services to everybody, for the cost would be astronomical. What do you do for a six-year-old Montreal girl with a rare form of leukemia who can be cured only in a Wisconsin hospital at a cost of $350,000 -- a real case? Paradoxically for a socialized health system, the family had to appeal to public charity, a more and more common occurrence. In the first two months, the family received more than $100,000, including a single anonymous donation of $40,000.

This is only one instance of health services that could have been covered by private health insurance but are being denied by hard-pressed public insurance. And the trend is getting worse. Imagine what will happen as the population ages. There are private solutions to health costs. Insurance is one. Even in 1964, when insurance mechanisms were much less developed than today, 43 per cent of the Quebec population carried private health insurance, half of whom had complete coverage. Today, most Americans not covered by Medicare or Medicaid carry some form of private health insurance.

Private charity is another solution, so efficient that it has not been entirely replaced by the Canadian socialized system.

Can Trends Be Changed?

People in Quebec have grown so accustomed to socialized medicine that talks of privatization usually are limited to subcontracting hospital laundry or cafeteria services. The idea of subcontracting hospital management as a whole is deemed radical (although it is done on a limited scale elsewhere in Canada). There have been suggestions of allowing health maintenance organizations (HMO's) in Quebec, but the model would be that of Ontario, where HMO's are totally financed and controlled by the public health insurance system. The government of Quebec has repeatedly come out against forprofit HMO's.

Socialized medicine has had a telling effect on the public mind. In Quebec, 62 per cent of the population now think that people should pay nothing to see a doctor; 82 per cent want hospital care to remain free. People have come to believe that it is normal for the state to take care of their health.

Opponents of private health care do not necessarily quarrel with the efficiency of competition and private enterprise. They morally oppose the idea that some individuals may use money to purchase better health care. They prefer that everybody has less, provided it is equal. The Gazette, one of Montreal's English-speaking newspapers, ran an editorial arguing that gearing the quality of health care to the ability to pay "is morally and socially unacceptable."4

The idea that health care should be equally distributed is part of a wider egalitarian culture. Health is seen as one of the goods of life that need to be socialized. The Quebec Enquiry Commission on Health and Social Services was quite clear on this:

> The Commission believes that the reduction of these inequalities and more generally the achievement of fairness in the fields of health and welfare must be one of the first goals of the system and direct all its interventions. It is clear that the health and social services system is not the only one concerned. This concern applies as strongly to labor, the environment, education and income security.5

A Few Lessons

Several lessons can be drawn from the Canadian experience with socialized medicine.

First of all, socialized medicine, although of poor quality, is very expensive. Public health expenditures consume close to 7 per cent of the Canadian gross domestic product, and account for much of the difference between the levels of public expenditure in Canada (47 per cent of gross domestic product) and in the U.S. (37 per cent of gross domestic product). So if you do not want a large public sector, do not nationalize health.

A second lesson is the danger of political compromise. One social policy tends to lead to another. Take, for example, the introduction of hospital insurance in Canada. It encouraged doctors to send their patients to hospitals because it was cheaper to be treated there. The political solution was to nationalize the rest of the industry. Distortions from one government intervention often lead to more intervention.

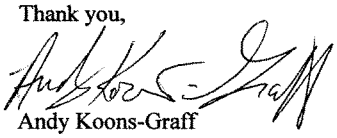
A third lesson deals with the impact of egalitarianism. Socialized medicine is both a consequence and a great contributor to the idea that economic conditions should be equalized by coercion. If proponents of public health insurance are not challenged on this ground, they will win this war and many others. Showing that human inequality is both unavoidable and, within the context of equal formal rights, desirable, is a long-run project. But then, as SaintExupery wrote, "Il est vain, si l'on plante un chene, d'esperer s'abriter bientot sous son feuillage."6

1. Report of the Enquiry Commission on Health and Social Services, Government of Quebec, 1988, pp. 148, 339.
2. Gerard Belanger, "Les depenses de sante par rapport a l'economie du Quebec," Le Medecin du Quebec, December 1981, p. 37.
3. Report of the Enquiry Commission on Health and Social Services, p. 446 (our translation).
4. "No Second Class Patients," editorial of The Gazette, May 21, 1988.
5. Report of the Enquiry Commission on Health and Social Services, p. 446 (our translation).
6. "It is a vain hope, when planting an oak tree, to hope to soon take shelter under it."

I would like to share a story with you of a family we know, Their granddaughter was injured on her farm. Because the doctors are so busy and only perform a number of surgeries per day, it was a year before she was scheduled for surgery. A year! Is this what we want for our country? It certainly in not what I want for my children!

Please take this information into careful consideration. This topic is so crucial to our health and wellbeing!

Thank you,



Andy Koons-Graff

JOHN AND BETHANNA KORTIE

April 22, 2009

Senate Committee on Finance
Attn. Editorial and Document Section
Rm. SD-219
Dirksen Senate Office Bldg.
Washington, DC 20510-6200b

RE: Hearing on April 21, 2009

Dear Sir or Madam:

We want to urge you to not move our healthcare system towards nationalization. We recently had dinner with some friends from Ireland who have lived under a nationalized healthcare all their lives. They are concerned with America's headlong rush into all things socialist, as we are. To nationalize our system would only cause delays in service, overtaxing a system that is already the envy of the world. Do not be nearsighted in thinking that this would be a good move for the United States to make simply because we want to be in line with the rest of the world. Why do you think that people from other countries, take Canada for example, come to the United States for their healthcare needs? They don't want to be put on the long waiting lists in their country only to receive poor service when they do finally get to the top. We cannot do this to the patients and doctors here in the United States of America. Please vote against any legislation that would move us towards nationalization.

Sincerely,

John and Bethanna Kortie

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(864) 895-1482
DARKCORNERFOLKS@YAHOO.COM

49191 Cherokee Road
Newberry Springs, CA 92365

April 22, 2009

Senate Committee on Finance
Room SD-219
Dirksen Senate Office Bldg
Washington, DC 20510-6200b

Attention: Editorial and Document Section

Ladies and Gentlemen:

Subject: Senate Finance Committee hearing concerning the healthcare system, April 21, 2009

A friend of mine had dinner with a couple from Ireland. They voiced concern and shock at the way that America seems to be rushing toward socialism. They, of course, have lived under a socialist European system their entire lives. One of their main points of concern was that our healthcare system. This couple has dealt with that, with the wife having major health problems recently they have failed to receive the kind of care she needs. They said in no uncertain terms that we do NOT want nationalized healthcare in America.

I agree that health insurance has it's problems, but I appreciate that I have the option to choose my healthcare. Aren't we always screaming "FREEDOM OF CHOICE!" in this country? Yes, it is hard to afford health insurance, yes, it is inconvenient and sometimes even painful when we can't get the kind of care we need, but I have found that we do have some very compassionate doctors, caregivers, friends, & neighbors that rally when we are in need. I don't think we will ever have a perfect system because we are imperfect human beings, but I do believe that when you take away personal responsibility and give all of the decision making to the government we are bordering on socialism, a very dangerous territory.

You cannot "fix" the world, but you can give us the freedom and opportunity to make personal choices that benefit our families. Please do not take away our freedom of choice in this matter.

Sincerely,

Jennifer Magee

Mrs. Jennifer Magee

May 2, 2009

Dear Sirs:

To whom it may concern:

Please do not send us down the path of socialized health-care!

Guaranteed coverage for all can be achieved thru subsidized private plans while maintaining personal control, competition, choice and quality of care!

Please listen and pray as I do for all Americans.

Sincerely,

Armelia L. Mayfield
205 Kendrick St.
Greer SC
29651-1418

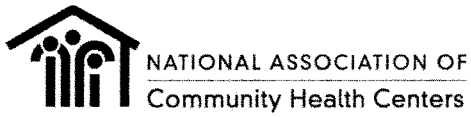
April 22, 2009

Senate Committee on Finance
Attn: Editorial and Document Section
Rm. SD-219
Dirksen Senate Office Bldg.
Washington, DC 20510-6200b

Dear Senators,

We ***do not*** want the U.S. Government directing and/or controlling our health care issues or exercising any additional authority in this regard. We respectively request that you give careful consideration to 42109 Roundtable to Discuss Reforming America's Health Care Delivery System.

Dallas McKnight
1366 Heathbrook Circle
Asheville, NC 28803
828-684-3433



Submitted Written Testimony of Daniel R. Hawkins, Jr.
Senior Vice President, Policy and Programs
National Association of Community Health Centers
Submitted to the Senate Finance Committee, "Roundtable on Coverage"
Tuesday May 5, 2009, 10:00 a.m.
Room 106, Dirksen Senate Office Building

Introduction

Chairman Baucus, Ranking Member Grassley, and Distinguished Members of the Committee:

On behalf of the more than 1,200 health center organizations nationwide, and the more than 18 million patients we serve, I want to thank you for your leadership, and for the opportunity to submit written testimony contributing to the expert pool of knowledge at this Roundtable on Coverage.

Mr. Chairman, I have personally seen the power of health centers to lift the health and the lives of individuals and families in our most underserved communities. As a VISTA volunteer assigned to south Texas in the 1960s, the residents of our town asked me to work on improving access to health care and clean water in our community. We decided to apply for funds through a relatively new, innovative program – the Migrant Health program. I stayed on and served as executive director of the health center from 1971 to 1977. That health center is still in operation today, and has expanded to serve over 40,000 patients annually.

The community empowerment and patient-directed care model thrives today in every one of our health centers in over 7,000 communities in America; I am honored to be able to share this success story and how health centers' 40-plus year track record and successful model of care delivery uniquely positions us to be important participants in a reformed health care system.

My testimony submitted for today's Senate Finance Committee Roundtable on Coverage will cover the following:

- **A Brief Overview of the Health Centers Program**
- **Community Health Centers, Access to Primary Care and Health Reform**
- **Primary Care Access as an Essential Building Block of Health Reform**
- **Health Center Participation and Payment in a Reformed Health Care System**

On behalf of the 18 million patients served by community health centers nationwide, as well as the volunteer board members, staff, and countless members of the health center movement, I want to thank you for this Committee's unyielding support for health centers and your dedication

to the all-important goal of providing affordable, accessible primary health care to all Americans. In this time of enormous challenges to our health care system and our economy, your faith in us and your support through the Recovery Act will allow us to rise and meet these challenges and continue to excel. With your ongoing support, our cost-effective, high quality system of care can continue to expand, reaching our goal of serving 30 million Americans by 2015, and eventually every individual in need of a health care home.

Health Centers are uniquely qualified to provide comprehensive health care to traditionally hard to reach uninsured and underinsured populations with demonstrated quality care, successful patient outcomes at a savings to the health care system of 18 billion dollars annually. Health Centers are America's health home to 1 in 8 Medicaid beneficiaries and 1 in 9 children enrolled in the Children's Health Insurance Program, as well as 1 of every 5 low-income uninsured individuals.

Brief Overview of the Health Center Program

For the past 43 years, the Health Centers program has grown from a small demonstration project to an essential element of our nation's primary care infrastructure. Today, health centers serve as the primary health care safety net in thousands of communities across the country, and – thanks to bipartisan support in Congress and the current and past Administrations, the federal Health Centers program enables more low-income, underserved and uninsured patients to receive care each year.

Health centers currently serve as the family doctor and health care home for one in seven rural Americans, and one in every five low-income children. Health centers are helping thousands of communities address a range of increasingly costly health problems, including prenatal and infant health development, childhood obesity, chronic illnesses, mental health, substance addiction, oral health, domestic violence and HIV/AIDS.

Federal law requires that every health center be governed by a patient majority board, which means that care is truly patient-centered and patient-driven. Each health center must be located in a federally designated Medically Underserved Area (MUA), and must provide comprehensive primary care services to anyone who comes in the door, regardless of ability to pay. Because of these characteristics, the insurance status of health center patients differs dramatically from those of other primary care providers. As a result, the role of public revenues is substantial.

Federal grant dollars, which make up roughly twenty-one percent of health centers' operating revenues on average, go toward covering the costs of delivering care effectively to our medically underserved patients and communities. Just over 40% of health centers' revenues are from reimbursement through federal insurance programs, principally Medicare and Medicaid. The balance of revenues come from State and community partnerships, privately insured individuals, and low-income uninsured patients' sliding-fee payments.

Community Health Centers, Access to Primary Care and Health Reform

In discussions about reforming the health care system, one element remains constant across all platforms and proposals: the need to invest in accessible, affordable, high-quality primary care for all as a down payment on a more effective and efficient health care system.

Even before the recession, a lack of access to affordable primary health care posted one of the most persistent challenges to our health care system. In our 2007 report, *Access Denied*, NACHC found that 56 million people lacked adequate access to primary care because of shortages of physicians in their communities. Even those with insurance coverage can be medically disenfranchised. Yet low income, uninsured, and minority populations are disproportionately affected. These are the very populations that experience some of the most egregious health care disparities. **In an updated study released in March, we found that the number of medically disenfranchised has risen to 60 million people nationwide.**

The medically disenfranchised, the uninsured and the under-insured, along with millions of others who confront additional barriers to care require a source of regular, continuous, primary and preventive care - a "health care home" - to maximize the value of our investments in health reform. Health centers stand at the ready to be full participants in health reform with our **ACCESS for All America** plan to provide a health care home to over 30 million people by 2015, and to eventually serve every individual who today is without a health care home.

Primary Care Access: Essential Building Block of Health Reform

Clearly, the expansion of insurance coverage, while a vital step, can only take the country so far. From states and communities already experimenting with their own reform efforts, we know that federal, state, and local governments must continue investing in the health care safety net even if universal coverage is achieved. We also know that true progress in resolving this crisis entails removing all barriers to care, including provider shortages, the lack of insurance coverage, and cost, as well as geographic, linguistic, and cultural barriers. Most importantly, the increased demand for care that comes from expanding coverage must be met with an augmented primary care infrastructure.

Producing a high performing health care system – one that improves access to needed care, reduces health disparities, and is cost-effective – is dependent upon broader access to primary care, particularly in the form of medical or health care homes. Moreover, targeting the medically disenfranchised and underserved for such efforts will produce significant gains in national health. Building on their success as leaders in primary care, community health centers stand as exemplary partners in national health reform. Their well-regarded experience in meeting the needs of underserved communities includes effective outreach and enrollment, care coordination and integration, chronic care management, and cultural competency – all essential elements in expanding access to effective care.

Health Center Participation and Payment in a Reformed Health Care System

From the perspective of the nation's health centers, our current public health insurance programs – Medicare, Medicaid and CHIP – are uniquely qualified to meet the needs of our most vulnerable communities. Patients can access not just primary care, but a full spectrum of services tailored to meet their individual and family needs including case management, transportation and language assistance as well as dental care, mental health services and prescription assistance programs. **Community Health Centers strongly support expanding Medicaid to cover at least everyone with incomes up to the federal poverty level without restriction, and higher if possible**. These are the very people who most need the services and benefits offered through Medicaid.

However, as coverage expands, we must also ensure patients have access to doctors and other health professionals who will treat them. Health centers support adequate and reliable primary care provider reimbursement by all public and private payers to reflect the value – in system-wide cost savings and improved health outcomes – that these doctors provide. **We also support making Medicare coverage available to those over age 55 or even age 50, who do not have access to employer or other public coverage, on a "buy-in" basis.** This generation is currently the fastest-growing age group of health center patients, and far too many have NO access to affordable coverage.

Not only, as noted above, are current public programs the **ONLY** insurers that cover services necessary to meet the unique health care needs of low-income and underserved people. They are also the **ONLY** payers that both recognized the unique role of safety net providers like Health Centers in serving their beneficiaries and the only insurers that pay them adequately. By contrast, nationwide, the private insurance market pays health centers less than 50 cents on the dollar for the care they furnish to the 3 million privately-insured individuals they serve. For all of these reasons, **we believe there is a real value to including a public plan option as part of any health care reform effort this Committee undertakes.**

Literally dozens of studies – and research over the past three decades and up through this year – conclude that health center patients are significantly less likely to use hospital emergency rooms or to be hospitalized for ambulatory care-sensitive (that is, avoidable) conditions, and are therefore less expensive to treat than patients treated elsewhere.[i] In fact, a recent national study done in collaboration with the Robert Graham Center found that people who use health centers as their usual source of care have 41% lower total health care expenditures than people who get most of their care elsewhere.[ii] **As a result, health centers saved the healthcare system up to $18 billion last year alone.** Thus, in effect, the investment in primary and preventive care that Medicaid and CHIP, and for the most part Medicare, make in paying health centers adequately for their care yields significant savings to the health care system and to taxpayers as well.

In the early 1990s, Congress instituted a health center-specific Prospective Payment System (PPS) to guide health center reimbursement under Medicaid, complementing the existing cost-based reimbursement structure under Medicare. The PPS structure ensures that health centers receive adequate payment through an all-inclusive per-visit payment rate that balances both higher and lower costs for all of the services provided to our publicly insured patients. With the

passage earlier this year of the Children's Health Insurance Program Reauthorization Act (CHIPRA), the CHIP program will begin paying health centers according to the same PPS structure.

Mr. Chairman, in your "Call to Action" White Paper earlier this year, you cited health centers' Medicaid PPS as a "successful model" and called for mirroring that system in the Medicare program. Bipartisan legislation introduced by Senators Bingaman and Snowe, S. 648, would do just that, and NACHC has strongly endorsed that legislation. Yet in health reform, it makes sense to **align health center payments from all insurers** with the structure currently in place under Medicaid, to assure the continuity and quality of care that health centers have been proven to deliver. The PPS structure for health centers appropriately and predictably reimburses health centers for the comprehensive care we provide. **The same should be ensured in any expanded insurance model, whether public or private. In addition, it is critical that insurers enrolling people in underserved communities be required to include health care providers located there, and especially health centers and other primary care safety net providers, in their networks.**

Under a reliable and fair payment structure, and with full participation in the reformed health insurance system, health centers stand ready to provide low-cost, highly effective care to millions more individuals and families in need. Reimbursing health center providers appropriately for the comprehensive, coordinated care we provide will help to grow the primary care infrastructure - an essential step toward ensuring that investments in health reform translate into improved health and wellness for the nation.

Conclusion

I know that the members of this Committee are well aware that the Health Centers program is an unprecedented health care success story, improving patient outcomes and reducing health disparities in communities nationwide. Entities ranging from the Institute of Medicine (IOM) to the White House Office of Management and Budget (OMB) to the Government Accountability Office (GAO) have recognized the efficiency and effectiveness of our model, which hinges on our ability to provide comprehensive primary care to all patients.

We, and all of the 125,000 professionals who work at health centers today, as well as the 30,000 community board members who govern and direct the operations of those health centers, fervently believe that health reform must strive to achieve universal coverage that is available and affordable to everyone, especially to low income individuals and families. We believe that this care must be comprehensive, including medical, dental and mental health services with an emphasis on prevention and primary care. And we believe that reform must strive to guarantee that everyone – especially the 60 million medically disenfranchised Americans – has access to a health care home where they can receive high quality, cost-effective care for their health needs.

Thank you.

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[i] McRae T. and Stampfly R. "An Evaluation of the Cost Effectiveness of Federally Qualified Health Centers (FQHCs) Operating in Michigan." October 2006 Institute for Health Care Studies at Michigan State University. www.mpca.net. Falik M, Needleman J, Herbert R, et al. "Comparative Effectiveness of Health Centers as Regular

Source of Care." January - March 2006 *Journal of Ambulatory Care Management* 29(1):24-35. Falik M, et al. "Ambulatory Care Sensitive Hospitalizations and Emergency Visits: Experiences of Medicaid Patients Using Federally Qualified Health Centers." 2001 *Medical Care* 39(6):551-56.

[ii] NACHC and the Robert Graham Center. *Access Granted: The Primary Care Payoff.* August 2007. www.nachc.com/access-reports.cfm.

NHeLP
NATIONAL HEALTH LAW PROGRAM

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Washington, DC 20005
(202) 289-7661
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May 21, 2009

The Honorable Max Baucus
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Charles Grassley
Senate Finance Committee
135 Hart Senate Office Building
Washington, DC 20510

Re: Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans published after Roundtable Discussion on "Expanding Health Care Coverage" on May 5, 2009

Dear Senators Baucus and Grassley:

First, we would like to thank you for your hard work developing these proposals. While the Options Paper does not fully reflect NHeLP's principles of comprehensive coverage and affordability for all, the work of the Committee represents progressive movement towards realization of comprehensive health reform. However, we believe more can be done. Our detailed comments and recommendations follow. We look forward to working with the Committee as health reform moves forward in the coming months.

Section I: Insurance Market Reforms -- Health Insurance Exchange -- NHeLP has several concerns about the health insurance exchange:

- Low-income, childless adults should not be relegated to the exchange. They should be covered in an expansion of Medicaid to include all low-income people up to 200% of the FPL.
- The federal government should operate the exchange. The exchange should not be contracted out to a private entity, which would add an unnecessary additional level of bureaucracy.
- Marketing requirements should not look to the Medicare Advantage rules which are too lax and allow too much deference to the private sector. Several states, including California, offer better examples of good marketing regulations.
- Multiple, competing exchanges offer no clear advantages to the public. If one national exchange is not created, then several geographically distinct, regional exchanges would be an acceptable option.
- Insurance offered through the exchange must meet state coverage and appeals requirements. Institution of an exchange should not facilitate insurance company efforts to exempt themselves from vital, long-standing regulations that protect consumers.

Role of State Insurance Commissioners -- NHeLP agrees with maintaining consumer protections under state insurance commissioners when a state offers stronger consumer protections than under federal law. States that have insurance benefits coverage, accessibility to care, and nondiscrimination requirements must be allowed to enforce those requirements as well.

Section II: Making Coverage Affordable: Benefits Options -- It is critical that the minimum requirements of the basic benefit package of private plans in the exchange be strengthened.

- Plans should not be allowed to charge cost-sharing for preventive services.
- Basic benefits must include comprehensive health care for children, dental care, all reproductive health and family planning services, and vision care.
- The policy options do not address the important health care needs of people with chronic conditions. Benefits options must include habilitative and rehabilitative care to address the needs of this medically vulnerable population.
- Benefits options must also include provisions for insuring consumers against overwhelming medical debt when they encounter catastrophic illnesses.
- Cost sharing limitations should include both monthly and annual limitations

Low-Income Tax Credits -- NHeLP questions whether the refundable tax credit will be sufficient to truly allow low-income families to purchase health insurance. Because the goal of health reform is coverage for all, and because there are penalties if one does not purchase coverage -- it is important that the tax credit or subsidy is adequate to allow persons to purchase the coverage. ***Additionally, we recommend the tax credit should also be available to people between 0-100% FPL.***

The Senate Finance Committee should consider an income measure other than MAGI. MAGI favors income deductions that are useful to higher income taxpayers and ignores deductions and exemptions, such as certain public benefits, work deduction, child care expenses, and child support that are vitally important to lower income families. ***We recommend the Committee consider a proposal that would offer a similar deduction to those who are low income, as to those offered to people who are higher income through MAGI. For example, the Committee could: Calculate Average Difference b/w MAGI and AGI for all tax filers over 400%, quantify that amount and apply that (or some percentage of that) as an across the board deduction or credit to all persons under low-income persons up to 400% (the subsidy population).***

Section III: Public Health Insurance Option -- NHeLP strongly supports the option to create a strong, Medicare-like, affordable public insurance program with a comprehensive benefits package and open to all people who live in the U.S. While a well-regulated, private insurance market must be a major part of health care reform, it should be neither the centerpiece, nor the entirety of the reform. Additionally such a plan should:

- Not hamper the public insurance program with restrictions such as maintaining reserves or reliance on premiums payments that are necessary regulatory measures for private companies but inappropriate and costly hindrances to an efficient and healthy government program.
- Not contract out core functions of the new plan to private administrators. To the extent possible, every dollar should go towards health care, not administrative costs.
- Not delegate health coverage responsibilities to the states. State-run public options would result in 50 widely different plans and exacerbate health disparities.

Section IV: Role of Public Programs -- Medicaid coverage -- Raising Income Eligibility While NHeLP is pleased to see the Senate Finance proposal that income eligibility for pregnant women, children, and parents will be raised, we have two concerns: first, 150% of the Federal Poverty Level (FPL) does not constitute an increase in eligibility for each of these groups; and second the lowest income childless adults do not seem to be included in this proposal for Medicaid coverage. While a proposal to have eligibility be 150% FPL would be an increase from the federal law for some children and parents in some states -- this income threshold would constitute a decrease for pregnant women and children under the age of 1, who are required to be covered up to 185% of FPL and a decrease for some parents in states that cover parents up to 200% under Medicaid expansions. Further, eliminating income disregards, as the proposal suggest, will eliminate coverage for some low-income persons who currently are eligible because they are brought under the income thresholds through use of the income disregards. If the Committee wants to eliminate income disregards to simplify the Medicaid eligibility determination and maintain consistency between Medicaid and the Exchange, goals we support, we urge the Committee to increase the income eligibility threshold to account for persons who might have otherwise been eligible due to an income disregard (for example for work or child care expenses). Income disregards were developed to address the disincentives to work and pay for child care that are established when income eligibility for critical benefits are set too low. ***We recommend the income eligibility level be at least 200% FPL and be inclusive of low-income childless adults.***

We applaud the proposal that would require states initially to maintain the income eligibility levels for all previously eligible populations. However, we are concerned that the proposal allows states to terminate this maintenance of effort when the Exchange is fully operational without a significantly stronger benefit package and greater cost sharing protections in the Exchange. Otherwise, women and children who until now have been deemed by Congress to require the benefits and protections afforded by Medicaid will be cast adrift in the private

market with less adequate coverage and cost-sharing protections. ***We recommend that the income eligibility be raised to 200% FPL so that there are fewer states and eligible populations that will be impacted when the maintenance of effort sunsets, as well as stronger benefits and cost-sharing protections in the exchange for those that are moved from Medicaid to private plans through the Exchange.***

Provider Rates -- We are pleased that the Committee's proposal envisions setting minimum provider reimbursement rates. Our experience and that of our clients and fellow advocates have shown that low rates significantly contribute to lack of access to providers in the Medicaid networks. However, we do not believe that 80% of Medicare may be adequate to provide a sufficient network. ***We recommend that payments for Medicaid providers be paid at the same rate as Medicare providers. Thus, by treating the Medicare and Medicaid populations equally with respect to provider rates, we will be increasing access to providers for Medicaid beneficiaries, taking steps to decrease disparities between the populations, and simplifying administration and payment processes for providers.***

Options for Medicaid Coverage -- Approach 1 – It is unclear under this option whether it envisions Medicaid beneficiaries continuing to receive coverage through the current Medicaid structure and if childless adults would be added as a Medicaid eligible group. ***We support strengthening the current Medicaid structure so that current categories of beneficiaries and childless adults get their benefits through Medicaid.***

Also we have reservations about using Medicaid monies to pay for Employer-Sponsored Insurance, without more information about the benefit package and cost-sharing protections that would be required in that coverage. It seems that there is a great deal of potential in this part of the proposal for spending public money on health care packages that are not as effective as Medicaid in maintaining the health of the working poor. Further, it is unclear from the proposal whether a person will receive Medicaid to wrap-around ESI, or whether the individual is only covered by the ESI plan – which will likely be more limited than Medicaid is now. Either an ESI "grand-fathered plan" or a plan under one of the benefit-structures of the new Exchange is likely to offer a lesser benefit package and an increase in cost-sharing than does Medicaid. Finally, systems that rely on wrap-around coverage are often hard to access and navigate. Given the emphasis on simplifying access to benefits in the recently enacted CHIPRA 2009, it would be ironic at best if Congress were now to reverse course and embrace a wrap-around approach that historically has presented a barrier to receiving needed care. ***Therefore, we discourage the Committee from using federal Medicaid monies for ESI premium assistance. However, we recommend that any plan where Medicaid would pay premiums for ESI plans, also require Medicaid to act as an automatic secondary payer, to fill in anticipated gaps in coverage of benefits and additional cost-sharing.***

Approach 2 – While we appreciate that this option describes a legal entitlement to coverage and services, including EPSDT and transportation, for Medicaid eligible populations, we have serious concerns about requiring children, pregnant women, parents, and childless adults to obtain their coverage through insurance plans in the Exchange, especially through the "low-option plans." By their very nature, these plans have the least coverage of benefits of those in the Exchange. We know that people eligible for Medicaid, who have the very lowest-income, also have great medical needs. This sets up a system where many Medicaid beneficiaries being served in private plans through the Exchange either will not get many of their health needs met or will have to navigate a system not regularly accustomed to providing the benefits that they are entitled to receive, because most of the people in that system will not be afforded those benefits.

We are further concerned that the structure of providing benefits such as EPSDT as a wrap-around to a private plan with a less comprehensive benefits package will make it nearly impossible for Medicaid beneficiaries to obtain these benefits. We know that when faced with a denial and a requirement to find another doctor in another network, low-income people just end up turned away and denied necessary services altogether.

Further, while it is valuable that the Committee proposes that the entitlement to Medicaid would be preserved in this option, it is difficult to envision how that entitlement would be enforced. Would beneficiaries be

required to go through the private insurers internal review procedures? Would they be required to use any review procedures peculiar to the Exchange? Would Medicaid agencies retain a notice and appeal capacity? All of the above? The Committee's reference to running this program as managed care is currently run in Medicaid is not comforting. Medicaid managed care recipients are regularly not informed of their appeal rights, receive inadequate and untimely notices, and almost uniformly get lost in the managed care plan's internal appeal processes when they are required to exhaust those. Before an option like this one is seriously considered, we suggest that issues like these must be fully resolved. Otherwise, the most vulnerable among us will end up with less health care and less ability to redress improper denials of care.

Consequently, we do not recommend using this option, as it is likely to leave Medicaid recipients worse off than they currently are. If this option were to be seriously considered, however, then persons with Medicaid should at a minimum be linked to the Highest Option plans, and much more work would need to be done to insure that the entitlement to Medicaid remains a reality in practice, not just in theory.

Approach 3 – We believe this is the best of the three approaches and could be workable for low-income people. However, we do not believe that setting the eligibility limit for childless adults at 115% FPL is adequate. If health reform accomplishes nothing else, it should be the impetus for finally burying the distinction between the worthy and unworthy poor. Born of Depression Era attitudes toward cash assistance, distinctions between which poor people should be able to obtain coverage never made sense in the health care context. Illness does not observe such a distinction, and in the course of moving toward universal health coverage neither should the Committee. ***We urge the Committee to cover childless adult up to 200% of FPL, as we have suggested for all other poor people, but at a minimum this group should be covered up to 150% FPL, as the Committee has suggested elsewhere for other populations.***

We appreciate the proposals within this option to further protect lowest income childless adults and the recognition that they are among the most vulnerable. ***If moving forward with a variant of this option covering childless adults through private plans in the Exchange, we recommend that additional protection be added, to increase the benefit package, as has already been envisioned to include cost-sharing protections. One way to do that would be to require the lowest-income childless adults be fully subsidized to receive the Highest Option plan. Using the voucher system described to "buy-into" the Medicaid program, might also meet their health needs, as long as additional necessary services that exceed the price of the voucher would be covered at no cost to the beneficiary and that sufficient cost-sharing protections were made available. Additionally, we recommend there be a mandatory pre-enrollment counseling requirement for childless adults to help them in the decision making process between using the voucher to buy into Medicaid or choosing a private plan in the Exchange.***

Furthermore, we seriously discourage the Committee from utilizing the options outlined at the end of this approach allowing the states to "opt" whether to accept vouchers for their Medicaid programs and shifting currently mandatory Medicaid populations into private plans in the Exchange. Both these proposals would be very harmful to a low-income person's ability to access comprehensive health care.

Children's Health Insurance Program -- NHeLP supports the increase in CHIP income eligibility to 275% FPL and the inclusion of the Medicaid EPSDT benefit. We also support the limitation of cost-sharing in CHIP to that found in Medicaid and the full subsidization of CHIP premiums in the Health Insurance Exchange (HIE). We are concerned about switching CHIP enrollees to the HIE because of the possibility that the move will create barriers to enrollment and access of medically necessary services. Additionally, more detail is needed regarding the variations described to fully evaluate them.

Quality of Care in Medicaid and CHIP -- NHeLP supports the application of quality measures established in CHIPRA to all Medicaid populations and the appropriation of $10 million for the Medicaid and CHIP Payment and Access Commission (MACPAC).

Other Improvements to Medicaid: Enrollment and Retention Simplification -- NHeLP supports the elimination of the state option to rely on face-to-face interviews and the asset test for eligibility for acute care services. We also support the additional enrollment and retention requirements, along with others listed in CHIPRA, which states have to meet to qualify of performance bonuses, and the model process the Secretary of HHS must develop for coordination of enrollment, retention and coverage for all Medicaid beneficiaries who change their state residency. ***We believe the provision should mandate that a process be developed for coordination of enrollment, retention and coverage of all Medicaid beneficiaries.***

Family Planning Services and Supplies --NHeLP supports the creation of a new Medicaid optional categorically needy eligibility group that would offer family planning services and related supplies to non-pregnant individuals with incomes up to the highest level applicable to pregnant women covered under a state's Medicaid or CHIP plan. ***NHeLP proposes that the new eligibility group include individuals eligible for states' existing Section 1115 Family Planning Demonstration project, if any.***

- NHeLP supports the inclusion of related medical diagnosis and treatment services as part of the family planning benefits package available to the proposed expansion group.
- ***NHeLP proposes that reimbursement rates for family planning services and supplies and related medical diagnosis and treatment provided to the new eligibility group are equal to existing reimbursement rates for family planning services and supplies in the Medicaid program.***
- NHeLP supports the inclusion of states' option to implement "presumptive eligibility" and ***proposes the inclusion of states' option to implement point-of-service enrollment*** to enable timely access to family planning services and supplies and encourage enrollment.
- NHeLP endorses the proposed prohibition against states provision of Medicaid coverage through benchmark or benchmark-equivalent plans if such plans do not include family planning services and supplies.
- ***NHeLP proposes that family planning services and supplies available to the new eligibility group include over-the-counter family planning devices and supplies.***

Treatment of Selected Optional Benefits -- NHeLP strongly supports giving free-standing birth centers "provider status" to enable direct payment and provide more beneficiaries with a meaningful birthing alternative to hospital births.

Other Improvements to Medicaid: Interstate Coordination Requirements for Child Medicaid Beneficiaries -- Little is said in this proposal regarding how interstate coordination of Medicaid services will be required. The Senate Finance Committee should provide more detail about the framework and federal mandates to ensure that such coordination will be actualized.

Other Improvements to Medicaid: Mandatory Coverage for Prescription Drugs -- NHeLP applauds the mandate that prescription drugs be offered to categorically and medically needy individuals in Medicaid. ***We further suggest, since the goal of health care reform is to have a more uniform approach to health care throughout the country – which any optional Medicaid service currently offered by more than half the states be made a mandatory services for all states going forward.***

Other Improvements to Medicaid: Change the Status of Some Excludable Drugs -- NHeLP supports the elimination of smoking cessation drugs, barbiturates, and benzodiazepines from Medicaid's list of excluded drugs. ***Further, it should be made clear that hard caps on the number of prescriptions per month be impermissible.***

Other Improvements to Medicaid: Transparency in Medicaid and CHIP Section 1115 Waivers -- NHeLP supports the imposition of statutory requirements regarding transparency, including those that require the

convening of open meetings and provision of information to the public on how they can submit comments. NHeLP also supports mandating the publishing of monthly waiver and state plan amendment submissions and approvals in the *Federal Register* and copies of the proposed waivers and state plan amendments on the CMS Web site. ***We believe the proposal should go further by requiring Medicaid and CHIP stakeholder meetings, not simply medical advisory board meetings, to discuss the impacts of proposed Section 1115 waivers and state plan amendments.***

Changes to the FMAP Formula -- NHeLP supports the change in the FMAP formula which would direct more federal Medicaid money to states with a higher percentage of people living under the federal poverty level.

Automatic Countercyclical Stabilizer -- NHeLP supports automatic increases in FMAP to states during economic downturns; however, this proposal must include provisions to require states to maintain both eligibility levels and services to prevent states from merely using the money to backfill their general funds.

Waiver Authority for Dual Eligible Demonstrations -- As a general proposition, NHeLP does not support the expansion of waiver or demonstration project authority, as they are likely to be used in ways that undermine a uniform level of care and will, when viewed nationally, add to health disparities. But if such authority is expanded in any way, any additional Medicaid waiver or demonstration project authority must:

- Make clear that waivers and demonstration projects, once approved, are part of the state Medicaid plan, and that every person receiving Medicaid benefits, through whatever mechanism, receives those benefits under the state plan.
- Actually propose to demonstrate something new, not simply seek permission to ignore enacted federal law
- Not permit the states to waive any protections or benefits otherwise available to Medicaid recipients;
- Provide for meaningful public notice of proposed waivers and timely opportunities for public input at both the state and federal levels

Cost-Effectiveness Test -- NHeLP opposes making more funding available to contracting with Medicare Advantage Special Needs Plans without provisions to ensure that the MA plans have sufficient capacity to serve vulnerable populations well and provisions to ensure better public oversight of the MA plans' services.

Reduce or Phase Out the Medicare Disability Waiting Period -- NHeLP supports eliminating the Medicare disability waiting period at the earliest possible date. The current waiting period serves no purpose other than to save the government money at the expense of needy people.

Temporary Medicare Buy-in -- NHeLP supports Medicare buy-in for the near elderly. However, individuals who desperately need this coverage to pay for costly treatment for medical conditions over which they have no control should not be penalized with higher premiums after reaching the normal Medicare eligibility age.

Section V: Shared Responsibility ***NHeLP*** has several concerns about the personal responsibility coverage requirement:

- ***If a personal responsibility requirement is going to be proposed, it should be required for everyone, with access to a subsidy to help pay for coverage based upon income, and without regard to immigration status.*** In order to eliminate health disparities across racial and ethnic groups, make sound fiscal and health policy, and develop an equitable system, we need everyone who lives in this country to be included in health care reform.
- Suggested initial enrollment periods of either three months in the non-group market or 45 days, are too short, especially for uninsured individuals who need time to compare and contrast health plans in order to determine which plan best suits their needs. Additionally, it is unclear whether under the three month option, there will be guaranteed issue and no limits on pre-existing conditions.

- Other exempted individuals include those for whom the lowest cost option exceeds ten percent of income, individuals below 100% FPL and those who would experience a hardship. If these individuals remain uninsured, they will also lack access to consistent, reliable and necessary medical care. ***We recommend that the Committee address those aspects of the system design that would allow people in these circumstances not to be covered. While it is obviously correct that they should not be penalized, exempting them from a penalty is not sufficient.***

Section VI – Prevention and Wellness -- Access to Preventive Services for Eligible Adults-- NHeLP supports clarifying the definition of "screening and preventive" services in Medicaid in accordance with United States Preventive Services Task Force ratings, supports increasing states' FMAP reimbursement as an incentive for states to cover all optional preventive services rated "A" and "B" and those immunizations recommended by the Advisory committee on Immunizations. ***NHeLP recommends the FMAP incentive vary from 1% to 3% to enable those states with particularly high incidences of preventable chronic diseases (as determined by the CDC or other entity specializing health data collection and evaluation) to more effectively lay the preventive groundwork to combat the applicable diseases.***

Incentives to Utilize Preventive Services and Encourage Health Behaviors -- NHeLP supports removing cost-sharing for preventive services ranked "A" or "B" by the USPSTF in order to encourage beneficiaries to utilize such services. NHeLP supports providing states with a mechanism by which to offer Medicaid beneficiaries other incentives such as refunds to those who complete health promotion programs.

- NHeLP strongly agrees that any behavior modification incentive must include a strong educational component to educate providers of the existence of the incentive so that they encourage their patients to participate, and to educate enrollees about the potential beneficial health outcomes.
- NHeLP supports incentive proposals that acknowledge that not all beneficiaries are in a position to maintain the highest levels of good health due to poverty, environment and/or lack of adequate knowledge regarding the correlation between their behaviors and poor health conditions.

Options to Prevent Chronic Disease and Encourage Healthy Lifestyles -- "Right Choices" Grants NHeLP supports the creation of grants to states to promote prevention and wellness by increasing access to certain evidence-based primary preventive services. However, NHeLP opposes limiting the "Right Choice" grants based on the operation of the Exchange unless the Exchange provides equivalent or better promotion of, and enrollee access to, primary preventive services.

Prevention and Wellness Innovation Grants -- NHeLP supports the option to provide states with grants to develop and promote innovative ways to integrate health and human services and improve delivery of health care services and the proposed HHS study of best practices to improve wellness outcomes for low-income families, and the requirement of states to implement health maintenance plans to better integrate services for low-income families.

Section VII: Long Term Care Services and Supports -- NHeLP believes that the expansion of HCBS waivers holds the potential for positive changes and better supports for people who wish to live outside of skilled nursing facilities. We have a few general concerns:

- People in the waiver programs must continue to receive all of the protections of Medicaid including the entitlement protections.
- Low-income people and people in need of high levels of support services should not be crowded out by higher income people or people who need fewer support services. The HCBS expansion proposals should include language to ensure these protections.
- This section should include provisions for improving the quality of care in long-term care and for closing down institutions that are not meeting quality of care standards.

Reduction in Infant Mortality and Improved Maternal Well-Being - NHeLP supports grant-making to states, tribes and territories to develop and implement targeted approaches to reduce infant mortality and the publication by HHS of an evaluation of funded projects for their potential to improve health care practice and eliminate health disparities. ***NHeLP proposes that HHS provide funding for those projects that are judged effective so that the projects may continue and be replicated where needed.***

Section VIII: Options to Address Disparities -- Required Collection of Data -- NHeLP fully supports the requirement that SSA collect race, ethnicity, and language data on Medicare enrollees, and that funding be provided to upgrade SSA's database.

With respect to Medicaid, while the Medicaid managed care regulations require states to provide race, ethnicity and primary language data to managed care plans, it does not require reporting of the data to CMS or to Medicaid providers. ***We recommend that the states be required to collect and report the race, ethnicity and language data to CMS and ensure that the Medicaid providers, including hospitals and physicians, receive the data of their patients and/or are also encouraged to collect and confirm the information and record it in the patient medical records. If the beneficiary is a minor or incapacitated adult, the language of the parent/guardian should be collected.***

Data Collection Methods -- NHeLP supports the committee's recommendation to ensure a sufficient sampling size of various racial and ethnic groups by federal surveys and strongly supports its proposal to require adequate data collection on race/ethnic subgroups. We also agree that race, ethnicity and language data should be incorporated into quality reporting requirements and support the extension of MIPAA provisions to the Medicaid and CHIP programs.

Standardized Categories for Data -- NHeLP praises the proposal to establish uniform categories for the collection of race and ethnicity data by the states and the use of OMB's policy for aggregation and allocation of subgroups. ***We also recommend requiring the collection of language data for federal purposes. We would also recommend the use of smaller, granular categories of racial groups, such as those used by the CDC, to ensure that data on smaller sub-groups can be collected and analyzed in addition to the broader OMB categories.*** For example, Asians and Latinos are not homogeneous and reflect an enormous heterogeneity, which possesses significant differences in relation to health beliefs, behaviors, and diets, as well as health conditions. Data that is not disaggregated by sub-group masks the health needs of vulnerable populations and is unable to provide useful information for addressing their needs.

We also strongly support the application of OMB standards to Medicaid and all federal health programs, the requirement that CMS collect language data of CHIP enrollees and their parents and/or guardian, and the collection of access, treatment, and type of disability data for people with disabilities.

Public Reporting, Transparency, and Education -- Although NHeLP recognizes that the proposal to require the inclusion of race, ethnicity and gender in health care quality data represents tremendous progress, ***we recommend the committee to include language data as well to ensure linguistically appropriate services are provided to LEP patients. With regard to public reporting and transparency, the race, ethnicity, gender, and language data should be made publicly available to ensure that the cultural and linguistic needs of beneficiaries of federally funded health programs are met, and that there is public accountability.***

Language Access -- NHeLP commends the committee for proposing the 75% federal matching rate for language assistance services for all Medicaid LEP beneficiaries. ***For clarification purposes, we would recommend changing the reference from simply "translation" services to "language assistance services," to cover a broader spectrum of services, such as interpretation and translation services. Further, we recommend proposals to ensure reimbursement for and provision of language services to LEP persons in any public program, including Medicare, Medicaid and CHIP.***

We also applaud the application of the CLAS standards to private insurers in the Health Insurance Exchange, but would specifically include private managed care plans as well. While reference to the CLAS standards is important, specific reference to access to competent interpreters and quality-translated materials would be helpful, as well as access to culturally competent health care services, free of charge to the patient. We also strongly support the provision of grants for outreach and enrollment efforts, but would also include funding to explore, develop and implement technological innovations that can improve language access, such as video medical interpreting and telemedicine.

Further, in order to level the playing field for diverse populations that will be affected by health reform, we suggest that cultural and linguistic diversity in the health care and public health workforce should be encouraged and supported, especially for those in direct contact positions.

We also recommend that HHS establish a Center for Cultural and Linguistic Competence to act as a clearinghouse on best practices, interpretation and translation guidelines and standards, and resources to link providers with interpreters/translators and other best practices.

Elimination of Five Year Waiting Period for Non-Pregnant Adults --We urge the Committee to keep the promise of having health reform provide health care for everyone. Medicaid should cover everyone who lives in the United States and meets the low-income eligibility criteria. At a minimum the proposal should provide full scope Medicaid and CHIP coverage to lawfully present immigrants with no five-year waiting period and no special barriers to access by immigrants with a sponsor, similar to what was enacted in CHIPRA for pregnant women and children. Further, leaving the coverage decision to the discretion of states will result in unequal coverage across states and exacerbate rather than diminish health disparities. We assume the Finance Committee meant to eliminate barriers for sponsored immigrant adults as was done in CHIPRA for children and pregnant women; this should be made explicit in statutory language when it is drafted.

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Statement for the Record

National Medical Association

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President

Presented to the

Committee on Finance

United States Senate

Roundtable on Coverage Issues in Health Reform

May 5, 2009

Chairman Baucus, Ranking Member Grassley, distinguished members of the Committee:

The National Medical Association is pleased to submit this brief statement for the record. We are confident that the input of the very capable witnesses you have assembled, as well as our testimony, will inform this roundtable on coverage in the most meaningful way possible. We look forward to further engaging with you as the health reform process advances toward clear legislative language.

As the nation's premier membership organization for African American physicians, the National Medical Association (NMA) has been historically concerned with the inequities in our nation's health care system, and remains concerned about the disparities that result from this uneven distribution and delivery of care. Before we proceed, we would like to

reiterate our commitment to provide every American with the most affordable and highest quality care available.

We are certain that today's Roundtable will affirm this basic premise – it is impossible to improve delivery and outcomes when more than 47 million Americans are uninsured, and therefore outside the system. Sadly, whenever an uninsured person gets sick, and eventually gets treatment, the bill is passed on to the rest of society. Doctors and hospitals simply charge insured customers more to make up the difference. Hence the 'sticker shock' experienced when private and public payers (as well as individuals who pay cash) receive these onerous invoices for medical services rendered. The real travesty, however, is that by then the bill has escalated beyond what it would have been if the uninsured had been treated earlier. Since uninsured people are much more likely to forego or delay treatment, the likelihood of developing chronic disease is increased in this population, adding to the crushing burden chronic disease already imposes on our over-stretched system.

This crisis also exacts an ominous economic toll on American families. The plain fact is that we cannot build a strong nation on the backs of sick people. If Americans are absent from work, or unproductive when they do show up because they are unwell or worried about medical bills that are driving them toward bankruptcy, all the efforts this Congress makes toward economic recovery will be imperiled. Businesses large and small will continue to carry untenable cost structures, and the federal deficit and state budgets will continue to be assailed by a growing demand for Medicare and Medicaid services. This growth cannot continue indefinitely – hence the emergent consensus that as a nation we must 'bend the growth curve'.

Decreasing the total number of uninsured and underinsured Americans is an urgent imperative. The current economic downturn makes this exactly the right time to do something about it!

We are very encouraged by the approach President Obama has taken to solving this unfortunate problem. He has sounded exactly the right note about our need to rein in health care costs, and has shown a willingness to listen to all voices in the debate.

Your recently released White Paper is indeed a 'Call to Action', Mister Chairman, and we find the ideas you enumerate for improving coverage to be reasonable. They are therefore worth exploring on their merits, within the broader context of improving the health status of all Americans without 'breaking the bank'.

For the benefit of those who have not had the opportunity to examine your proposal[i], it is helpful to highlight your approach to the coverage dilemma.

You insist on building upon the existing **public** framework by:

- Allowing non-elderly the option to buy into Medicare
- Strengthen CHIP by improving enrollment of those already eligible
- Expand Medicaid's reach by increasing FMAP
- End the disability waiting period for Medicare.

Our 'back of the envelope' estimate indicates that the aforementioned could lead to coverage of an additional 15 or 16 million Americans, slashing the ranks of the uninsured by about one third!

Further, you argue that there is a role for **private** options as well, including a strengthening of the employer based system, and guaranteed access to affordable coverage for individuals and small businesses[ii]. You also demonstrate foresight by stressing the need to focus on prevention and wellness, driven by individual responsibility[iii]. We agree with you that collectively these improvements will lead to a reduction of health disparities across the system, which, as you know, is our organization's *raison d'etre*.

Our contribution to this discussion is that we must approach coverage strategically, bearing the following considerations in mind:

- We cannot improve delivery and outcomes if we don't fix coverage
- We cannot fix coverage unless we candidly address the cost conundrum
- A health safety net is critical for those who fall through cracks in coverage
- Community Health Centers, along with Medicaid and CHIP, are valuable tools for caring for low-income and vulnerable populations, and represent the core of the safety net
- We must improve the 'surge' capacity of the system to handle public health emergencies.

Since the term 'coverage' is rather elastic, we should enlighten your audience relative to NMA's perspective on what adequate coverage should entail. In summary, we agree with the Institute of Medicine (IOM)[iv] that:

1. Healthcare coverage should be continuous.
2. Healthcare coverage should be affordable to individuals and families.
3. The health insurance strategy should be affordable and sustainable for society.
4. Health insurance should enhance health and well being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered, and equitable.

With this framework in mind, we would like to highlight one particular aspect of building on currently existing infrastructure.

The President's reauthorization of CHIP earlier this year was a singular achievement in our march toward health reform. It is now commonly accepted that CHIP has been successful reducing the ranks of uninsured children across the nation. The challenges with enrolling those already eligible notwithstanding, CHIP increases the peace of mind

for all the hard working parents of CHIP enrollees, who cannot afford coverage for themselves in the individual market, but make too much to qualify for public assistance.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) prohibits new waivers for adult coverage under CHIP. States that use CHIP funds to cover adults will have to start making changes at the end of this year. The states that cover parents of CHIP enrollees will have to begin to transition these parents at the end of FY 2011. While this was a useful legislative compromise, the uncertainty faced by the U.S. economy is likely to continue for the next few years.

The sad reality is that most states make no provision for these parents even now, and if states' budgets continue to suffer the onslaught of decreased revenues and increased demands on the social safety net, these parents will become increasingly vulnerable. We are very concerned because many of them live in communities served by our members, and their ability to care for sick children is impacted by the quality of their own health, even if their kids happen to be covered by CHIP.

Helping states meet their CHIP and Medicaid enrollment targets will go a long way toward helping states cover these parents. We would urge your Roundtable to spend some quality time brainstorming viable options for identifying and recruiting all those eligible for enrollment. Our members are standing by to help their states meet these targets. The bonuses awarded as a result could be re-invested into:

- More outreach that leads to greater enrollment;
- Covering more parents;
- Increasing reimbursements for providers.

An integral part of the NMA's strategic plan is to improve the health status of the communities our members serve by way of community outreach. We currently run dozens of community-based outreach programs, some underwritten by the federal government. These programs require us to interface with these communities in ways that would achieve the goals we have discussed in this statement. We have existing

infrastructure to get started, and we have some of the requisite experience. We would be very eager to continue this dialogue with all parties concerned, beginning with Finance Committee staff.

Thank you very much for the opportunity to submit our input for the record. We look forward to next steps.

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[i] U.S. Senator Max Baucus (D-MT), "Call to Action - Health Reform 2009", (2008).
[ii] Ibid
[iii] ibid
[iv] Institute of Medicine, "Insuring America's Health: Principles and Recommendations", (2004)

Committee on Finance
Attn: Editorial and Document Section
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April 27, 2009

It is my understanding that this committee is meeting to consider proposals to change our entire health care system. Please do not rush into creating a system that could very well have far-reaching negative consequences as to the availability and quality of care and the reduction of what will be covered. There are reports of many "negative consequences" in other countries where health care is nationalized, such as rationing or denying some expensive treatments such as chemotherapy. I am 74 and have Parkinson's Disease.

My greatest concern is for two granddaughters in Gaithersburg, MD, who have cystic fibrosis. Kia is 15; Karlie is 10. They would not have lived through the many complicated and life-threatening episodes they have encountered in their young lives, were it not for the immediate and ongoing extensive (and expensive) care they have available to them that is covered by private health insurance.

My daughter shares her concerns and her many questions:

"I am concerned about the direction our country is headed with regard to health care. I am personally against a 'socialized' healthcare system similar to what exists in Europe, where people can wait for weeks, even months, for treatment of serious illness. That's why we see people with financial means coming to the U.S. for treatment rather than waiting in their health care line. If the U.S. adopts this type of reform, I fear what Kia and Karlie's cystic fibrosis care will look like.

Will our access to the latest in CF treatments be limited? Will I be able to call my doctor and see her the next day like I can now? Can we get a hospital bed when we need one and for as long as we need it? What about maintaining the quality (and quantity) of their doctors, nurses, respiratory therapists, physical therapists, other specialists, etc. at the hospital, not to mention the availability of the latest in medical technology? Will the many, many expensive prescription medicines that they need continue to be available to them? Will they be able to get a lung transplant when the time comes?

Our health care system is obviously broken and action needs to be taken----carefully planned action, rather than fast-tracked, throw-money-at-the-problem action. I hope and pray that the committee will listen to our concerns, along with those of the health care industry. Unprecedented collaboration has occurred between health care companies resulting in recommendations to the committee that include proposals to keep health care privatized."

Sherri Batchelder

I respectfully request that you listen -- really listen -- to all sides and take the time needed to consider any consequences before making decisions for any -- and all -- changes.

Rosalie Ott

Rosalie Ott
812 Carrigan Avenue
Modesto, CA 95350

OUT OF MANY, ONE

A Multicultural Action Coalition for Eliminating Health Disparities

RACIAL, ETHNIC AND PRIMARY LANGUAGE
HEALTH DATA LEGISLATIVE PRINCIPLES AND RECOMMENDATIONS

Out of Many, One (OMO) is a national multicultural coalition that has advocated for health equity and parity for communities of color, comprising 34% of the nation's population, for the last 10 years. OMO's 25-member Governing Body works to assure that every ethnic and racial group, regardless of its numbers and immigration status, has equal access to health care coverage, access and treatment, and that disparities experienced by these groups are eliminated. OMO premises its goals on an understanding that directly collected, self-reported, and disaggregated data are essential to achieve these purposes, and to develop culturally and linguistically appropriate policies and programs to improve the quality of life, health status and health care outcomes of minority populations.

OMO has convened monthly a Health Data Task Force (HDTF), which represents a broad array of research, policy and advocacy organizations committed to the collection, reporting, dissemination and use of data on race, ethnicity, gender and primary language. OMO and the HDTF believe that health data must be also collected by and with these communities in order to address trust and discrimination issues, and to promote policies and programs at local and state levels in order to eliminate health disparities.

With firm commitments from President Obama and leaders in Congress to pass health care reform legislation this year, there is an opportunity to address the urgent need for systematic data collection in our nation's health care system. In order to eliminate health disparities that continue to impact historically minority and other underserved communities, any effective health care reform proposal must mandate the collection and public reporting of standardized, directly collected, and disaggregated race, ethnicity, gender, and primary language data.

As Congress begins drafting health reform legislation, OMO recommends these legislative and regulatory priorities.

National Data Collection and Reporting

Standardized, disaggregated health and health care data must be systematically collected and reported across the entire health care system in order to measure,

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track and hold agencies accountable for progress toward eliminating racial and ethnic health disparities for our nation.

1. All public and private health system entities receiving funding or reimbursement from the Federal government should be mandated to collect and publicly report data on race, ethnicity, gender, and primary language. Data should be used to assess health care access and quality as well as health status and progress toward eliminating health disparities in communities of color and other underserved communities.

2. Data collection must be standardized nationally so that all Federal, state and/or private institutions utilize the same race and ethnicity categories. At minimum, data collection on race and ethnicity must comply with the 1997 OMB revised standards regarding the collection of data. OMB addresses data collection for the following racial/ethnic groups although additional disaggregation of data by ethnic subgroup is preferable whenever possible: African Americans, American Indians and Alaska Natives, Asian Americans, Hispanic/Latino Americans, and Native Hawaiians and other Pacific Islanders. Executive Order 13125 reinforces the distinctions between Asian Americans and Native Hawaiians and Pacific Islanders. The Institute of Medicine is currently preparing recommendations for standardizing data, which should be considered as guidance prior to implementing new regulations.

3. Existing data systems must be linked with nationwide health system data. To that end, the Social Security Administration (SSA) should collect race and ethnicity at birth on Form SS# 5 and should update the race, ethnicity, gender and primary language data for parents and guardians. Race, ethnicity, gender and primary language should be collected from all those registering for or currently enrolled in Medicare benefits, so that CMS can utilize the data to improve services for all recipients.

4. CMS should at a minimum collect data for Medicaid on the five OMB categories. These are used currently for CHIP but not Medicaid. CMS has various databases that need to be modified and linked appropriately so that they can aggregate and fully utilize existing data to improve services. CMS should also be required to collect data on primary language of CHIP enrollees. Currently this is required for Medicaid but not CHIP.

5. CMS should collect race, ethnicity, gender and primary language data in their surveys, including Medicare Current Beneficiary Survey, Medicare Health Outcomes Survey and the Consumer Assessment of Health Care

Plan Study (CAHPS). Also all Medicare Advantage plans should collect these data.

6. CMS has a data sharing arrangement with the Indian Health Service (IHS). It should adequately report on data it collects and should utilize these data to improve the care of American Indians and Alaska Natives as well as Native Hawaiians and Pacific Islanders.

7. The annual reporting responsibilities of the Agency for Healthcare Research and Quality should be expanded to include an evaluation of the *impact* of health care system reform on racial and ethnic minority groups. These data should be reported utilizing OMB standards at a minimum.

8. Agencies should be held accountable for improving collection, dissemination and utilization of data by race, ethnicity, gender and primary language. Data collection reports should be a requirement for funding of all health and health care agencies.

Investments in Health Data Collection

In order to realize this vision, policy makers must make significant investments in data collection and reporting at the national, state and local levels.

9. Because national and/or state data may not adequately collect small sample sizes needed to analyze specific subgroups, the Federal government must support data collection by ethnic subgroup, which may require small, community-based, localized efforts. The Federal government should fund and collaborate with community-based organizations, tribal governments, tribal and native epidemiology centers, Historically Black Colleges and Universities (HBCUs), Hispanic Serving Institutions (HSIs), Asian American and Pacific Islander serving institutions, Alaskan Native and other American Indians institutions. These entities should be engaged to collect, analyze and report data and to assure adequate dissemination and utilization as well as providing reports to the communities they represent.

10. Funding should be provided for oversampling and longitudinal studies of racial and ethnic subgroups in order to ensure "equal explanatory power," where sampling targets provide enough statistical power to make scientifically valid conclusions.

11. Funding should be provided to SSA to upgrade its database technology to ensure internal interconnectedness and external communication with

other agencies. For example, in some SSA field offices, primary language data are collected, but these data are not integrated into the SSA database that updates CMS' Medicare database.

12. Electronic health records and other health information technology (HIT) applications should have the capacity to support health care providers in collecting data on race, ethnicity, gender and primary language. To ensure that all communities have access to HIT, the Federal government should adequately fund local initiatives such as community-based Health Extension Centers (as defined in ARRA) and should provide "meaningful use" incentives to providers serving underserved populations. The Congress should provide for appropriate uses of HIT in the collection of race, ethnicity, gender and primary language data for public health initiatives.

13. Funding should be provided for educational campaigns directed to health care consumers about the need for collecting race, ethnicity, gender and primary language data and its utility in improving public health and health care access and quality of care. Multimedia educational campaigns should be conducted in a culturally and linguistically appropriate manner and in tandem with local community health organizations and private and public health insurance plans. DHHS and specifically CMS, HRSA, NCHS, AHRQ, CDC and IHS should be involved in these efforts.

14. Funding is needed for updating and standardizing data collection systems at the Federal, State and local levels. With the advent of HIT, linking public health and health care access and quality is essential for the development of an effective integrated system.

Strengthening Existing Infrastructure and Research:

Agencies involved in minority data collection and reporting must be strengthened and research using health data should be supported and expanded to ensure that communities of color and other historically underserved populations are making gains in health care access, quality and health outcomes under system reform. These priorities include, but are not limited to:

15. The National Center on Health Statistics (NCHS) should be given the importance and prominence it deserves within DHHS. It should be strengthened and be adequately funded at a minimum at $137.5 million base in FY 2010. In addition, because building state infrastructure is essential to the Federal efforts, NCHS should receive a one-time

investment of at least $15 million to support states as they update and modernize the vital birth records system.

16. The National Institutes of Health (NIH) should assure that an adequate percentage of funds allocated for evaluation should be used to collect data on race, ethnicity, gender and primary language. Research projects should reflect the diversity of the American public by deliberately integrating participation and/or involvement of researchers from a diverse range of racial and ethnic backgrounds.

17. The Center on Minority Health and Health Disparities at NIH should become an Institute with all of the attendant privileges, funding, authority and responsibility to expand current research efforts and engage a broad spectrum of organizations serving racial and ethnic minority populations as described in OMB standards.

18. The Office of Minority Health, DHHS should be authorized and sufficient funds appropriated to strengthen its capacity to engage and inform racial and ethnic minorities regarding the benefits of participation in data collection and reporting activities.

Signatories:
African American Health Alliance
'Ahahui o nā Kauka, Association of Native Hawaiian Physicians
American Association for International Aging
Asian and Pacific Islander American Health Forum
Association of Asian Pacific Community Health Organizations
California Pan-Ethnic Health Network
Department of Gerontology, Center on Aging, College of Health and Human Services, San Diego State University
Ke Ali`i Maka`ainana Hawaiian Civic Club
Khmer Health Advocates, Inc.
La Fe Policy Research and Education Center
Latino Caucus, American Public Health Association
National Association of Black County Officials
National Association of State Offices of Minority Health
National Black Nurses Association
National Council on Urban Indian Health
National Indian Project Center
National Health Law Center
National Hispanic Medical Association
Out of Many, One
Papa Ola Lokahi
Racial and Ethnic Health Disparities Coalition

Summit Health Institute for Research and Education, Inc.
The Cave Institute

May 2, 2009

Senate Committee on Finance
Attn: Edetorial & Document Section
Room SD-219
Dirksen Senate Office Bldg
Washington, DC 20510-6200

Gentlemen:

I'm aware you are working on the socialized health care plan and I am strongly opposed to this plan and hope Congress will oppose it. If passed, it will take the American economy and health care into the brink of despair. We do not deserve this and should be able to vote on this matter.

Sincerely,
Jean Scarr

Reforming America's Health Care Delivery System
April 21, 2009

Physicians for a National Health Program
29 E Madison St, Suite 602
Chicago IL 60602-4406

Mr Chairman, Members of the Committee,

It distresses us that no single-payer expert has testified before the Committee. We feel honest debate must include scrutiny of this important policy option.

In the Committee's most recent panel on "Reforming America's Health Care Delivery System", much testimony described the need to reform or eliminate the "fee-for-service" model, about the need to collect information on best practices and to alter treatments accordingly, and about the need to increase computerization of medical records.

The following publications are authored by members of our organization and offer criticism on these themes. Although we do not disagree that reforming America's health care delivery system is an important goal, we feel that this can best be achieved within the context of a single-payer financing mechanism. Failing to consider single-payer national health insurance denies an estimated savings of $400 billion annually that could be redirected to improve our health care delivery system, improve coordination of care, and cover all Americans.

We implore the Committee to consider the merits of a single-payer financing mechanism. Thank you.

Focusing on doctor pay misses point
Paul DeMarco, MD
The State, South Carolina, March 2009

I hate to disagree with my friend John Black, the president-elect of the S.C. Medical Association; he is a good man, a good clinician and a passionate advocate for primary care physicians. But his recent column, "Medicaid: a fair price must be paid," misses the point.

Doctors complaining about Medicaid rates in the current health-care climate are about as tone-deaf as the crew of a sinking ship complaining to the passengers about their low pay. Yes, Medicaid rates are too low and need to be addressed, but Black approaches the problem from the wrong direction. We must put patients first, not doctors.

The Medical Association must make access to decent health care for all South Carolinians its central focus. When I took the Hippocratic Oath, I took it to mean that I would care for any patient who made it to the threshold of my office, no

questions asked, and that my fellow physicians would do the same. The issue of how the patient was going to pay was only a secondary concern.

I don't deny the business aspect of medicine. Physicians endure rigorous training for years, sometimes incurring tremendous debt. When we finally begin practice, we have a right to make a good living. Most physicians realize the privilege we have in serving our patients and provide free or low-cost care to some. Black rightly points out that there is a limit to physicians' generosity; however, his comparison of physicians and car dealers is misplaced ("the car dealer is not expected to sell for a loss"). We chose medicine over selling cars for a reason. We wanted to take care of patients, to provide them healing and compassion impossible in the car business. And we knew that would involve taking all comers.

Unfortunately, some physicians look for ways to avoid taking care of the poor and uninsured. It is a discouraging fact that part of the unraveling of the medical safety net has been physicians' doing. Some physicians drop out of Medicaid and Medicare legitimately, but others do it to preserve a certain high salary expectation. This is an abdication of their duty to the medical profession and to their patients.

Black's warning that the situation is grave and that physicians "can no longer pay essential bills to keep our offices open" is an overstatement. First, there is no evidence that significant numbers of physician practices are closing because of payment issues.

Second, plenty of high-paying openings are available to physicians looking for jobs in South Carolina. I found more than 100 on MDsearch.com. One listing for a family practitioner in Clinton advertised "excellent income potential in excess of $250,000."

Third, it is not physicians who are most at risk in the current system; it is patients. Forty-six million have no coverage, and 25 million more are underinsured. According to one report, in 2001, medical expenses helped push an estimated 2 million Americans into bankruptcy.

As physicians, we must roll our sleeves up, but not in the service of padding our own pockets. We must work together to craft a system that covers all the patients that we care so deeply about. As we remake America's health care system, we'll ensure that its physicians are adequately compensated, but that must be a byproduct of our effort. The patient always, always, always comes first.

Is P4P about patients, or providers?
Don McCanne, MD
Quote-of-the-day, September 2006

Pay for performance (P4P); what a simple concept. When the providers (physicians and hospitals) demonstrate higher performance on quality and costs, reward them with extra payment. To maintain zero-sum budget neutrality, fund

those rewards with financial penalties against those with lower performance scores; that will motivate them to shape up.

But what have we learned from Premier? At the provider (hospital) level, there was only a minimal correlation between quality and cost. However, when assessed at the patient level, favorable correlations between quality, cost and outcomes were demonstrated. And isn't health care really about the patient?

Is rewarding physicians for better performance measures a good idea? The British experience suggests that any financial rewards should be very modest, or spending will increase since you can't bankrupt the portion of the system with lower scores. Physicians in difficult practice environments, facing chronic under-funding, poverty, poor patient compliance, and impaired access by patients, will have lower scores even though their actual performance may be superior. On the other hand, physicians in well-financed, uptown practices might well benefit from manipulations of their practice managers who develop expertise in making certain that the quality scores are optimal. P4P would shift funds from the former to the latter. Is that sound policy?

The field of medicine still stands apart. In the computer business, higher quality brings financial rewards. But in medicine, higher quality brings healthier patients. And penny ante rewards will never distract physicians from that sacrosanct obligation to try their very best to attain better health status for their patients.

Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, And Costs
Don McCanne, MD
Quote-of-the-day, March 2005

It is assumed to be a given that soon we are to have greater quality, greater efficiency, and a reduction in medical error through the fulfilled promise of an integrated information technology system using electronic medical records and computerized order entry systems. The RAND article speculates on the benefits and cost savings of that Utopian concept. The Himmelstein and Woolhandler commentary explains why this is no more than a pipedream at the present. They list many of the issues that have not been resolved.

As only one example, let's take the issue of privacy. Supporters contend that an encrypted electronic record is more secure than a paper record in a stack file. But doesn't that record have to be accessible? Wouldn't a system need to be in place to allow access to records of a comatose patient who is unable to give consent? If those providing immediate care would be able to gain access, then doesn't it seem likely that others could as well. Since the goal is a nationally integrated technology system, doesn't that mean that some patient records would require transfer through WAN rather than LAN technology, relying on the Internet? Once that record moves into a non-secure cache on the Internet, it is there forever for all the world to see. Are we really ready for that?

Who is developing this technology and for what purpose? A hint may be found in another article in this same issue of Health Affairs, reporting on use of electronic medical records in private physician offices. These offices used systems from private vendors, a process which represents another diversion of dollars from patient care to administrative intermediaries. Perhaps more alarming was the finding that the primary "benefit" of the electronic records is that they provided a means of increasing fees by upcoding, without a commensurate increase in the quality of the services provided. Is this what this technology is all about? Making more money? Private sector development and application of information technology will always hinge on the potential prospects for increasing profit.

Pete Stark has said that the technology for electronic medical records is "free" since it has already been developed and paid for by the VA system. A system developed in the public sector is designed for the simple reason to improve the care of patients. Before we could adopt a public sector system, we would need an administration that believes the government should do what it can do better.

Although the RAND HIT report is only speculative, it does threaten us with an unintended consequence (or more likely intended, considering the sponsors of the report). The political response to the concerns about escalating health care costs have been to dodge the real issues and to turn to support of information technology as the means to reduce costs by increasing efficiency. But adding an information technology system to our current fragmented system would only increase costs, and quite significantly so. Once again, we have been conned into using their rhetorical framework to debate health care reform.

Establishing efficiency is not about adding an expensive technology that wouldn't function well under our current system. Efficiency is about reducing the profound administrative waste by adopting a single, publicly administered insurance program. Efficiency is about budgeting capital improvements to reduce the waste of excess services that result from excess capacity. Efficiency is about negotiating fair prices so that we reduce the waste of worthless or detrimental expenditures such as the marketing excesses of the pharmaceutical firms.

In spite of the challenges, we should accelerate our efforts to develop a truly beneficial information technology system. Just imagine how well an integrated information technology system would function with an integrated health care delivery system: a single payer system.

PREMIER

Statement for the Record

Submitted by

The Premier healthcare alliance

U.S. Senate Finance Committee Roundtable
"Reforming America's health care delivery system"

April 21, 2009

On behalf of the Premier healthcare alliance, serving more than 2,100 leading not-for-profit hospitals and health systems, we appreciate the opportunity to provide a statement for the record of the Senate Finance Committee healthcare reform roundtable, entitled "Reforming America's health care delivery system."

Premier is a hospital quality and cost improvement alliance of 2,100 non-profit hospitals and health systems. The Premier alliance operates the nation's most comprehensive repository of hospital clinical, outcomes and financial information as well as one of the nation's leading group purchasing organizations. The hospitals united in the Premier healthcare alliance share the goal of providing safe, affordable, quality care through the sharing of knowledge, experience and tools. A world leader in helping deliver measurable improvements in care, Premier works with the Centers for Medicare & Medicaid Services (CMS) and the United Kingdom's National Health Service North West to improve hospital performance.

Overview of the CMS/Premier HQID Project
Since October 2003, Premier has partnered with CMS in the CMS/Premier Hospital Quality Incentive Demonstration Project (HQID). The CMS/Premier HQID project is designed to determine whether economic incentives are, in fact, effective at improving the quality of inpatient hospital care. The HQID, which has since been extended for an additional three years through 2009, is the first-ever national test of quality incentives across a broad array of acute care conditions in Medicare patients.

The first three years of the project included more than 250 hospitals located in 35 states, and provided incentives to hospitals that successfully used evidence-based, widely accepted clinical treatments and measures to care for patients with these conditions: heart attack, heart failure, coronary artery bypass graft (CABG), pneumonia and hip/knee replacement. Rewards were in

the form of public recognition and annual quality incentive payments from CMS to top performers.

Those hospitals that performed in the top 10 percent of a clinical area—heart bypass, for instance—received an incentive payment equivalent to two percent of their applicable Medicare base rates; those in the top 20 percent received a one percent payment. In the third year only, those hospitals that were low performers based on year one baseline results were financially penalized.

The HQID project was extended for an additional three years to test additional measures, including more than 30 new outcome measures, as well as new incentive models including the recognition of improvement, as suggested by the Medicare Payment Advisory Committee (MedPAC). In the extension, incentives have been expanded to include hospitals that achieve the greatest quality improvement, those that attain a defined level of quality, along with those that are in the top 20 percent of quality in each condition. In addition, the extension will allow for penalties for low performers, identified using targets set two years prior, on an annual basis. More than 240 hospitals, across 35 states, elected to continue in the project extension.

HQID Hospitals Have Achieved Rapid and Sustained Improvements and Are Closing the Performance Gaps in All Measurement Areas

The quality of care provided by HQID participating hospitals has significantly improved in all five clinical focus areas between the inception of the program in October 2003 and June 2008, the timeframe for which the most current preliminary data is available.

The greatest improvement was in heart failure, where the overall median Composite Quality Score rate increased 31.4 percent, from 64 percent to 95.4 percent.

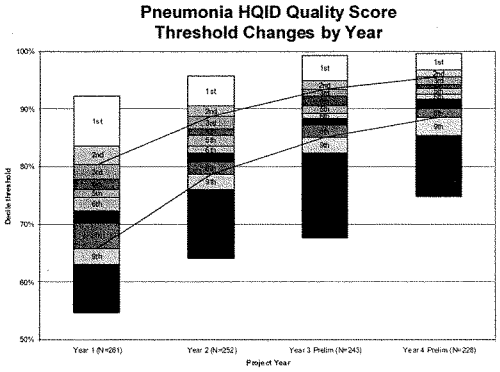
This was followed by pneumonia with an increase of 25.9 percent, from 70 percent to 95.9 percent; heart bypass with an increase of 14.1 percent, from 85.1 percent to 99.2 percent; and hip and knee replacement with an increase of 13 percent, from 85.1 percent to 98.1 percent.

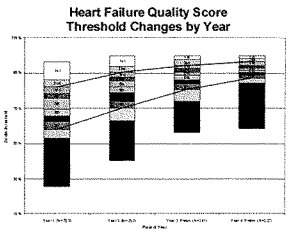
Significant increases were also identified in heart attack (8.9 percent, from 89.6 percent to 98.5 percent), which had the highest performance at the onset of the project. Improvements are also apparent in the recently added surgical care population, where the median performance improved three percent from 92.3 percent to 95.3 percent in just three quarters.

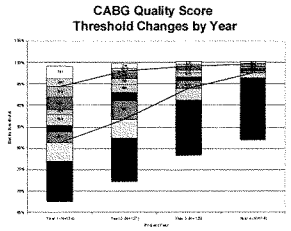
Notably, the range of variance among HQID participating hospitals is closing, as those hospitals in the lower deciles continue to improve their quality scores and close the gap between themselves and the demonstration's top performers.

In addition to the rising thresholds, the data shows a compression of the ranges, or a reduction in variation, across project participants. All hospitals, even the low performers, are making strides in quality improvement.

- **Quality improvement across all hospitals**
- **Variation in hospital performance decreased**







- In heart attack, the variance between the highest and lowest score was 40.68 percent in year one and has declined to 18.38 percent in year four[1].
- In heart failure, the variance between the highest and lowest score was 70.97 percent in year one and has declined to 41.24 percent in year four.
- In pneumonia, the variance between the highest and lowest score was 37.64 percent in year one and has declined to 24.85 percent in year four.
- In heart bypass, the variance between the highest and lowest score was 31.6 percent in year one and has declined to 18.29 percent in year four.
- In hip and knee replacement, the variance between the highest and lowest score was 27.97 percent in year one and has declined to 23.99 percent in year four

[1] Year 4 data reported is preliminary and will be finalized in spring 2009.

HQID Rewards and Penalties

Among the 242 providers in the third year, 206 incentive payments were distributed across 112 providers. In contrast, of the 1,028 potential areas where participants could receive a negative payment adjustment by falling below the payment adjustment threshold, only 11 total penalties occurred across nine total providers, or fewer than one percent of participants. This is a significant improvement considering that at the end of year one, by definition, 20 percent of participants were below the threshold.

The majority of penalties (six of the 11) were in the Hip and Knee Replacement clinical area. Poor performance penalties in this clinical area was predominately due to one clinical measure - prophylactic antibiotic discontinued within 24 hours. Other payment adjustments were in AMI/Heart Attack (3), Heart Failure (1), and CABG (1). In some instances, issues beyond hospital control had a detrimental affect on their efforts/results; for example, a merger/buy out/bankruptcy/administrative change or issues with physician compliance to measures.

Participants in HQID have continuously improved throughout the project, setting the bar higher and higher. For year four, hospital performance was evaluated against the 9^{th} and 10^{th} deciles set during the second year of the project. In some clinical areas there were little variation in high and low performers, and penalty thresholds were preliminarily set at nearly 90 percent in these clinical areas.

To avoid penalizing hospitals that are performing well, the penalty threshold to identify poor performance was capped at 85 percent, which was a natural baseline from the start of the demonstration. Capping the thresholds for clinical areas where performance is already high allows the bar to be set higher for other clinical areas with more opportunity for improvement. Only nine penalties, less than one percent of the possible penalties (978), are projected for year four.

HQID: A Powerful Stimulus to Accelerate Performance

HQID participating hospitals have shown performance gains that have outpaced those of hospitals involved in other national performance initiatives such as Hospital Compare, a consumer-oriented Web site that provides information reported by hospitals to CMS on how well they provide recommended care to their patients. In fact, analyses by Premier using the Hospital Compare calendar year 2007 dataset showed that demonstration participants scored on average 7.5 percent higher than non-participants (93.38 percent compared to 85.86 percent) when looking at a composite of 19 measures shared in common between HQID and Hospital Compare.

Although Hospital Compare data was not available at the inception of the HQID project, a comparison of participants to the Joint Commission national comparative data on a set of 14 measures shared in common with HQID showed that HQID participants did not start the project

outperforming other hospitals (77.88 percent compared to a national average of 78.96 percent).

A *New England Journal of Medicine* publication by Lindenauer et al.[2] confirms these results. This study compared two years of data on a set of 10 quality measures used in heart attack, heart failure and pneumonia for HQID participants and a control group obtained by matching hospitals on hospital characteristics of bed size, rural/urban, teach/non-teaching, geographic region and for-profit/not-for-profit status. The study determined that HQID hospitals achieved quality scores 2.6 to 4.1 percentage points above the control hospitals that were participating in public reporting due solely to the impact of quality improvement incentives. These differentials appear more impressive when the limited opportunity for improved performance is taken into account.

A separate study[3] published in *Health Affairs* last year about hospital performance and evidence-based quality measures and mortality rates found that hospitals in the top quartile of quality performance, compared with hospitals in the bottom quartile on quality performance, had 11 percent lower mortality for acute myocardial infarction, seven percent lower mortality for congestive heart failure and 15 percent lower mortality for patients with pneumonia.

HQID Hospitals Improve Care Beyond Core Measures, Across All Payers

Some have expressed concern that providing incentives based on a subset of the many aspects of patient care will cause hospitals to "teach to the test" or perform well on the processes that are measured while giving cursory attention to other aspects of care.

However, in a recent analysis[4] that evaluated the effectiveness of the HQID project by comparing performance to a group of hospitals involved in another program devoted to heart attack quality improvement, HQID hospitals performed noticeably better on the non-HQID measures (13.6 percent compared to 8.1 percent improvement in the composite score) and also achieved greater levels of improvement on all the HQID measures than the control group hospitals.

This would indicate that hospitals that are incentivized to do so adopt a more serious and comprehensive approach to performance improvement that extends beyond the areas measured in the project to overall patient care.

Although HQID is a demonstration through the Medicare program, analyses using Premier's Perspective database for the October 2003 through June 2006 timeframe indicated that improved and reliable delivery of evidence-based processes is associated with better outcomes across

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[2]Lindenauer PK, Remus D, Roman S et al. Public reporting and pay for performance in hospital quality improvement. *N Engl J Med* 2007 February 1;356(5):486-96.

[3]A. K. Jha, J. Orav, Z. H. Li, A. M. Epstein, The Inverse Relationship Between Mortality Rates and Performance in the Hospital Quality Alliance Measures, *Health Affairs* July/August 2007 26(4):1104–10

[4]Glickman SW, Ou FS, DeLong ER et al. Pay for performance, quality of care, and outcomes in acute myocardial infarction. *JAMA* 2007 June 6;297(21):2373-80.

multiple payor groups. This would indicate that a Medicare-sponsored demonstration can impact care throughout the facility.

Benefits of HQID to patients served by participating hospitals

Over the long term, we have learned that standardizing hospital processes brings about efficiencies in the delivery system. In fact, in an analysis released in 2008, Premier found that as hospital quality continued to improve, hospital costs declined among participants in the HQID project. According to the analysis of 1.1 million patient records, if all hospitals nationally were to achieve the three-year mortality improvements found among the project participants for pneumonia, heart bypass, heart failure, heart attack (acute myocardial infarction) and hip and knee replacement patient populations, they could reduce hospital costs by more than $4.5 billion annually. The 1.1 million patient records represented in this analysis encompass 8.5 percent of all patients nationally within the five noted clinical areas over the three-year timeline of this analysis.

The same Premier analysis also showed that, if all hospitals nationally were to achieve the HQID three-year mortality improvements across the project's five clinical areas, an estimated 70,000 lives per year could be saved.

Policy Recommendations and Lessons Learned From HQID

A program like HQID requires systemic changes that can be challenging for any hospital to implement. Therefore, Premier recommends any national hospital value-based purchasing policy addresses the following issues:

Quality reporting should be automated and based on medical records data. The current process for reporting of quality indicators is a dual process that relies heavily on manual clinical data abstraction of medical record review information and reconciliation of administrative data. This is both time consuming and costly to the organization. Moreover, because data is coming from medical records and billing information, this process can lead to errors and inaccuracies. Moving forward, we hope that many of these issues can be resolved as we work to implement more advanced health information technology (HIT) systems within our facilities, as supported through the American Reinvestment and Recovery Act. In doing so, our hope is to extract quality data directly from the electronic health record (EHR).

However, different EHR systems capture and organize data in unique and proprietary ways. To automate the process, the standard-format data captured in EHRs should be readily accessible to be transmitted to quality reporting systems. The government should develop the interoperability standards for the data needed for quality reporting and mandate that all EHR products provide a utility that can be certified to comply.

Mandated reporting programs should be based on open and fully transparent measures. There are many quality measures that exist or are being developed by private organizations. If these

measures are used in federal programs, healthcare providers would have to purchase the proprietary software and data systems in order to track their progress and report to CMS. In other words, the adoption of these privately owned quality measures by CMS would create monopolistic suppliers of these measures. In the HQID project, all measures used to assess hospital performance were open and transparent, allowing the hospitals to replicate methodologies and efficiently report progress. This transparency must be preserved in any program used to incentive quality.

All measures should be evidence-based, accepted as best care by the medical expert community and strongly linked to better patient outcomes. Serious harm to the credibility of the program is done when measures are not medically accepted or have significant unintended consequences. To assist the process of measure development and refinement, as well as to provide hospitals with experience in using the measures, measures should be extensively tested among a broad group of hospitals before they are included in a quality incentives program.

Efforts should be taken to ensure that the measures used do not institutionalize existing care disparities. The measures used to determine rewards should be crafted with appropriate representation of our increasingly diverse population and should be relevant to all patient populations. Care should be taken to avoid measures that may create unintended consequences, such as decreasing access to care for the uninsured or vulnerable populations.

Implementation should be gradual. Because certain types of hospitals may take longer to adjust, implementation of payment accountability should be gradual to allow these hospitals time to adjust.

Hospital, physician and other providers' incentives should be aligned. To be effective, programs that reward improvement must align hospital, physician and other providers' incentives, encouraging all to work together toward the same goals of improving quality and patient safety, providing both effective and appropriate care and creating better health outcomes.

Quality improvement and quality attainment both should be rewarded. The purpose of incentive-based payment approaches should be very focused on *improving quality and patient safety and providing effective care.* An effective program should provide incentives to providers for both attainment and improvement to reward a broad group of providers for their efforts.

Financial incentives matter and are more powerful change agents than recognition alone. The persistence of the public recognition gap in the face of the payment gap attenuation suggests that incentives matter, i.e. payment incentives can motivate hospital behavior when mere public recognition does not.

Conclusion

Based on the successes of the HQID project, we believe that quality incentives can and do improve patient outcomes across a wide variety of measures and payers. It is our belief that projects like HQID represent a model for implementing a range of health reforms. As we learned through HQID, if tested and piloted first to ensure appropriate incentives are in place and provider interests are aligned, we can achieve remarkable advances that improve safety, quality and affordability of care.

Premier is pleased by key policy makers' interest in the results and lessons learned from the HQID. On behalf of its alliance hospitals and health systems, Premier looks forward to continuing to work with Senators Baucus and Grassley and other members of the Finance Committee as healthcare reform progresses in Congress. Thank you again for the opportunity to submit a statement for the record.

APPENDIX

Widely Accepted Clinical Indicators Used in HQID

Measures added for Years 4&5 = underlined
Outcomes measures (7) = Bold italicized text
Composite score an average of all measures for each condition

Acute myocardial infarction (AMI)

1. Aspirin at arrival
2. Aspirin prescribed at discharge
3. ACEI/ARB for LVSD
4. Smoking cessation advice/counseling
5. Beta blocker prescribed at discharge
6. Beta blocker at arrival
7. Thrombolytic received within 30 minutes of hospital arrival
8. PCI received within 90 minutes of hospital arrival
9. ***Inpatient mortality rate***

Coronary artery bypass graft (CABG)

1. Aspirin prescribed at discharge
2. CABG using internal mammary artery (Test)
3. Prophylactic antibiotic received within one hour prior to surgical incision
4. Prophylactic antibiotic selection for surgical patients
5. Prophylactic antibiotics discontinued within 24/48 hours after surgery end
6. Patients with controlled 6 A.M. Postoperative Blood Glucose
7. ***Inpatient mortality rate***
8. ***Post operative hemorrhage or hematoma***
9. ***Post operative physiologic and metabolic derangement***

Hip and knee replacement

1. Prophylactic antibiotic received within one hour prior to surgical incision
2. Prophylactic antibiotic selection for surgical patients
3. Prophylactic antibiotics discontinued within 24 hours after surgery end time
4. ***Post operative hemorrhage or hematoma***
5. ***Post operative physiologic and metabolic derangement***
6. ***Readmission within 30 days to any acute care facility***
7. Surgery patients with recommended VTE prophylaxis ordered
8. Surgery patients who received appropriate VTE prophylaxis within 24 hours prior to surgery up to 24 hours after surgery end time

Heart failure (HF)

1. Left Ventricular Systolic (LVS) assessment
2. Detailed discharge instructions
3. ACEI or ARB for LVSD
4. Smoking cessation advice/counseling

Pneumonia (PN)

1. Percentage of patients who received an oxygenation assessment within 24 hours prior to or after hospital arrival
2. Initial antibiotic selection for Community Acquired Pneumonia
3. Blood culture collected prior to first antibiotic administration
4. Influenza screening/vaccination
5. Pneumococcal screening/vaccination
6. Antibiotic timing, percentage of pneumonia patients who received first dose of antibiotics within four/six hours after hospital arrival
7. Smoking cessation advice/counseling

Surgical Care Improvement Project (SCIP) (year 5 & 6)

1. Prophylactic antibiotic received within 1 hour prior to surgical incision
2. Prophylactic antibiotic selection for surgical patients
3. Prophylactic antibiotics discontinued within 24 hours after surgery end
4. Patients with controlled 6 A.M. Postoperative Blood Glucose
5. Surgical Patients with Hair Removal
6. Colorectal Surgery Patients with Normothermia
7. Surgery patients with recommended VTE prophylaxis ordered
8. Surgery patients who received appropriate VTE prophylaxis within 24 hours prior to surgery up to 24 hours after surgery end time
9. Surgery patients on Beta-Blocker Therapy who Receive Beta-Blocker during Perioperative Period

Measures Now Being Tested in HQID At CMS' Request

Outcomes measures (32) = Bold italicized text

Acute myocardial infarction (AMI)

- LDL Cholesterol Assessment
- Lipid lowering therapy at discharge
- ***HQID 30-day mortality rate (CMS admin. data)***
- ***Same hospital readmission within 30 days (all cause)***
- ***AHRQ patient safety composite***
- Appropriate care measure
- ***CMS 30-Day readmission rate (CMS admin. data)***
- ***CareScience complication measure***
- ***Risk-adjusted average length of inpatient hospital stay (yr 6)***

Coronary artery bypass graft (CABG)

- CABG using internal mammary artery (IMA)
- Isolated CABG patients on beta-blocker therapy who receive beta-blocker during perioperative period (yrs 4,5)
- ***Same hospital readmission within 30 days (all cause)***
- ***AHRQ patient safety composite***
- Appropriate care measure
- ***AHRQ inpatient quality indicators post-procedural mortality rate***
- ***CareScience complication measure (yrs 4,5)***
- ***Risk-adjusted average length of inpatient hospital stay (yr 6)***

Hip and knee replacement

- Hip/knee patients on beta-blocker therapy who receive beta-blocker during perioperative period
- ***AHRQ patient safety composite***
- Appropriate care measure
- ***AHRQ inpatient quality indicators post-procedural mortality rate***
- ***CareScience complication measure (yrs 5,6)***
- ***Risk-adjusted average length of inpatient hospital stay (yr 6)***

Heart failure (HF)

- ***Same hospital readmission within 30 days (all cause)***
- ***AHRQ patient safety composite***
- Appropriate care measure
- ***HQID 30-day mortality rate (CMS admin. data)***
- ***AHRQ inpatient quality indicators in-hospital mortality rate***
- ***CMS 30-Day readmission rate (CMS admin. data)***
- ***CareScience complication measure (yrs 5,6)***
- ***Risk-adjusted average length of inpatient hospital stay (yr 6)***

Pneumonia (PN)

- ***Same hospital readmission within 30 days (all cause)***
- ***AHRQ patient safety composite***
- Appropriate care measure
- ***HQID 30-day mortality rate (CMS admin. data)***
- ***AHRQ inpatient quality indicators in-hospital mortality rate***
- ***CMS 30-Day readmission rate (CMS admin. data)***
- ***CareScience complication measure (yrs 5,6)***
- ***Risk-adjusted average length of inpatient hospital stay (yr 6)***

Surgical Care Improvement Project (SCIP)

- Cardiac surgery patients with controlled 6 a.m. postoperative blood glucose
- Surgical patients with hair removal
- Colorectal surgery patients with normothermia
- Surgery patients on beta-blocker therapy who receive beta-blocker during perioperative period
- ***CareScience complication measure (yrs 5,6)***
- ***Risk-adjusted average length of inpatient hospital stay (yr 6)***

Ischemic Stroke (Yr 6 add)

- Deep vein thrombosis (DVT) prophylaxis
- Discharges on antithrombotic therapy
- Patients with atrial fibrillation receiving anticoagulation therapy
- Thrombolytic therapy administered
- Antithrombolytic therapy by end of hospital day two
- Dischargedon cholesterol reducing medication
- Dysphagia screening
- Smoking cessation advice/counseling
- ***Risk-adjusted average length of inpatient hospital stay***

Princeton Task Force on National Health Care

66 Witherspoon Street
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Princeton, NJ 08542

Statement for the Record

Harrison A. Moyer

Co-Chairman

Princeton Task Force on National Health Care

For the U.S. Senate

Committee on Finance

Roundtable on Health Care Coverage

May 5, 2009

MEDICARE for All

The United States is the only advanced country without universal health care.

"Where we are unique (among countries) is in leaving most of our health system to the tender mercies of profit-maximizing investor-owned businesses".
(Marcia Angell, M.D., senior lecturer, Harvard Medical School; former editor in chief, The New England Journal of Medicine. The New York Times, November 28, 2007)

O U R R E C O M A N D A T I O N

We recommend a new MEDICARE Part E, to be all-inclusive, to insure hospital costs, physician fees and medical needs, and prescription drugs---i.e. Parts A, B, and D of Medicare---to be offered to the 161 million under 65 who are now insured by private insurance companies, and for the 47 million who are uninsured.

Because of lowered administration costs alone, this has a minimum potential saving of $77 billion annually.

A working private/government partnership is already in for 44 million U.S. citizens in the year 2009---15% of our population---those most in need of medical care: the 36.7 million elderly and the 7.1 million disabled---MEDICARE.

MEDICARE has four components which recommend it: an administration cost of 4%; already negotiated fees for physicians and hospitals; a single, national risk pool; and it works, with a minimum of fraud.

A great advantage of this national, single risk pool of 44 million is that the oldest and sickest people are included equally, and their risks spread among a large pool of people, rather than excluded, and discriminated against by the private insurance companies, especially those with pre-existing conditions. Better yet, their coverage cannot be cancelled.

It also has the advantage of prompt payment of claims without delaying tactics, or refusing coverage and payment.

MEDICARE's administration cost of 4% handles 92 million people---the MEDICARE, Medicaid, and SCIP programs--- which is one third of our population.

We recommend mandatory health insurance for all. In practical terms, Hawaii has mandated health insurance for years, and has only reached the percentage of 93% of its citizens covered.

Holland has a success rate of 98% for its mandatory insurance.

Comments

"I am an advocate for a single-payer plan (Medicare for all). Let's hope that single payer gets at least a fair hearing before the American public, and that Pres. Obama and Congress 'get it.' I'm concerned that too many are still pushing a 'compromise' which keeps some form of private insurance in the game. That of course, will be the (loop)hole that sinks the ship."
-Dr. N.B., New Jersey psychiatrist, March 2009

"The 'mandate model' for reform rests on impeccable political logic: avoid challenging insurance firms' stranglehold on health care. But it is economic nonsense. The reliance on private insurers makes universal coverage unaffordable.

"An inconvenient truth: only a single-payer system of national health care can save what we estimate is the $350 billion wasted annually on medical bureaucracy".
(David U. Himmelstein and Steffie Woolhandler, Professors of Medicine at Harvard; The New York Times December 15, 2007)

"Most physicians now support single-payer, national health insurance" ("Medicare for all")
Professor Alan Meyers, Boston University Medical School, NYT 6/19/08

The American College of Physicians, the nation's largest physician group, has endorsed a single payer healthcare system.

"As a physician in private practice for 35 years, I do not fear a public plan as part of health care reform. I would welcome it.

"Medicare and private insurance fees are the same: most private insurers base their fees on those paid by Medicare. But it is much more difficult to collect these fees from private insurance companies than from Medicare.

"The H.M.O.'s require that I submit and resubmit claims several times. And then they even have the chutzpah to offer lower payment soon, rather than their contractually agreed-upon payment sometime in the future. I prefer Medicare , which mostly pays promptly and with far fewer hassles for me and my staff."
---Elizabeth Rosenthal, The New York Times March 30, 2009

Scott Serota, president of the Blue Cross Blue Shield Association, which insures 102 million Americans, or one out of three, stated that 29% of the nation's health costs are due to waste.
(The New York Times, October 18, 2008)

Dr. Thilo Weissflog wrote in The New York Times of November 20, 2007, "As a physician, I deal with insurance companies and their reluctance to pay for indicated procedures or tests on an almost daily basis.

"The difference between health care and other businesses is that it doesn't deal with widgets but human lives. Cutting your costs and increasing your profits, by denying people necessary care is unconscionable. Until profit is removed from the health insurance industry, we will unfortunately not see an end to these tragic stories."

The wife of another doctor wrote in The New York Times of November 6, 2007 "Before my husband and I moved to Denmark in August, we were increasingly frustrated with a system in which even people with 'good' insurance spend too much time begging for approval for medical treatments. As a physician, my husband felt he was in a daily fight with midlevel bureaucrats whose sole job was to deny care".

"The truth is that single-payer, government-run health care has been a panacea.

"In the 40 years that I've practiced family medicine, I've found Medicare, Medicaid, the Veterans Administration, all of them single-payer government administered health care programs, more predictable, uniform and reliable than the for-profit health care insurance companies.

"This is better for doctors and hospitals and certainly better for the patients.

"I like one form to file, one payer, one set of rules for everyone and the assurance that everyone has health care coverage when patients come to see me". Melvin H. Kirschner, M.D., The New York Times, November 28, 2007

Comments to the Task Force

"Natasha, we are not signing this because we believe we should institute a single payer plan, and get rid of the private, for-profit health insurance companies altogether. As long as we are dedicated to keeping them in the mix, the government will be subsidizing them to keep them "competitive", there will be endless nonsensical debates eating up our time (and that of Congress, of course), endless attempts at "end runs" around any new rules, and boundless confusion for the public. All of this will continue to cost time, money, energy

and lives, which we cannot afford any longer to lose! It's time to stop compromising, believing that it is necessary to be "realistic", and establish a new, sane Reality on the ground!"

Dr. N.B., New Jersey psychiatrist

One of our task force members asked his doctor relative, living in Florida, why he charged his patients a million dollars a year.

His answer: "It is the system."

"Yes, Health Costs are way too high, but the cause is probably multi factorial. Physician's costs are too high because of insurance premiums, and the fear of law suits. No doctor has ever been sued for doing too much, so with the threat of litigation hanging over our heads, the thing to do is 'cover every thing' (Lab. And Radiology) and that of course is very expensive.

"With the county clinics gone, the poor are streaming to the Emergency Rooms for basic, yet very expensive, care; Government medicine, though excellent in places like Walter Reed generally is not the best at VA Hospitals and county clinics."

"I do not believe in a socialist state and that is what we are trending to.

"It was only when the government removed the 2-tier system 'for fairness' that prices climbed and climbed …"

-Dr. H.W., California

"I know many doctors who are not fans of MEDICARE. Certainly speaking from someone who sees medi-cal (Medicaid) patients in an otherwise comprehensive care system, I am not a fan. They limit drug choices and getting a referral is impossible. Their mental health coverage is extremely poor. The only good thing is that at least they have some insurance and an assigned primary care provider. I far prefer at the moment the Kaiser system in which one premium can provide comprehensive care -- the labs, X-rays, specialists, eye doctor and mental health are all in one place -- 3 clicks on the computer and a little typing and it is done. And I don't have to worry about reimbursement because I am on salary, so I have no incentive to have patients obtain care that they don't need. Certainly I think the worst world is the current private payer system."

- Dr. K.S., California pediatrician

"…The status of our American Health Care system. There is no easy solution in correcting this system, but I am in agreement that we have to begin somewhere. I can tell you that observing how health care has changed over the past 22 years, the shift in mentality has made it nothing more than a business. I do realize that providing some type of revenue will enable us to have the funding to advance medicine.

However, the other side of this is that proper clinical judgement can be blurred by thinking of health care as a business.

"I know I am only skimming the surface of the complexities that currently exist; I do think that now is the time, but there must be due diligence in continuing to lay down the proper foundation.

"I do believe the change not only has to exist in Washington, but also with each individual. Much of what adults ail from could be avoided with prevention."

-K.G., R.N.

It's the Money Stupid

In Chaucer's "The Canterbury Tales: The Pardoner's Prologue and Tale", 1390 A.D. it reads:

Radix Malorum est cupiditas "Greed is the root of all evil"

Germany pays its doctors 2 ½ times that of its blue collar workers, i.e. $100,000

U.S. pays its doctors 13 times that of its blue collar workers, i.e. $520,000

German health care costs are 10% of its GDP
U.S. health care costs are 16% of our GDP

"Wall Street investment companies and private equity firms have bought many nursing homes.

"Drug companies spend billions of dollars wooing doctors--- more than they spend on research.

"Private insurance plans are often just one step ahead of the sheriff." Senator Sherrod Brown, Ohio

"Health insurers are accused of underpaying consumers by hundreds of millions of dollars. 'This is about outright fraud,' said Senator John D. Rockefeller IV, West Virginia

"Vehement Republican objections to the idea of a new government-run insurance plan, competing directly with private insurers.

"If you did a pure (honest) report, you'd be out on your ears and the insurers wouldn't pay for it. You have to give them what they want. That's the game" ---Dr. Hershel Samuels, New York City

[New York Times April-May, 2009]

"Forcing individuals to purchase insurance in the current market would be a disaster. Before we even have that discussion, we need to make health care more affordable and improve its quality."
(James P. Gelfand, U.S. Chamber of Commerce)
--- The New York Times February 20, 2009

U.S. Physicians

Physicians control the cost of health care through their own fees, their writing of prescriptions for drugs, for tests and lab work; their recommendations for hospital admittance and for surgery, physical therapy, etc; their referrals to other doctors.

Either we create a system that supports their decisions, or we continue with the current system of insurance companies questioning their professional judgment in order to avoid paying for needed care.

"Overutilization is driven by many factors. The most important factor, however, may be the perverse financial incentives of our current system.

"Doctors are usually reimbursed by whatever they bill. The culture in practice is to grab patients and generate volume. 'Medicine has become like everything else', a doctor told me recently. 'Everything moves because of money.'

Physicians accounted for $421.5 billion, for an average net income of $476,235 for the 884,974 doctors including inactive (AMA) in 2005.

[the 2009 World Almanac]

If MEDICARE were to offer individual policies to all under 65, because of its lower administrative costs of 4% as opposed to 20-30%; using a savings of 16% of $3000 per insured person for a family of 4,

the cost for this Part E policy would be $2,520, a savings of $480. For a family of 4, the savings would be $1,920.

There are five major components of health care costs---hospitals, physicians, prescription drugs, dental care, and long term nursing care; all naturals to be covered by insurance.

However, a drawback of a private insurance-financed system is the millions of dollars spent on lobbies---700 in Washington, D.C. alone---plus many more in each of the 50 state capitals---by these insurance companies, hospitals, doctors, nurses, drug companies, etc. to maintain the status quo.

In addition, all of the above are spending millions of dollars on marketing expenses---television, radio, newspapers, magazines, direct mail, billboards, you name it.

Neither this industry-wide lobbying nor marketing effort directly benefits the patients; it only benefits those promoting themselves.

These activities add at least 10-20% to the national health care bill.

Who Pays for these Health Care Costs ?

Of our 300 million population, 92 million are enrolled in Medicare, Medicaid and SCIP for $187 billion federal tax dollars.

47 million are not insured; meaning that the balance of 161 million are covered by private insurance companies.

Recommendation: a new MEDICARE Part E for Parts A, B, and D

For those under 65

It has been estimated that currently the average premium cost of these 161 million people covered by private insurance companies averages $3000 per year.

We recommend that those privately insured be offered a standard MEDICARE Part E benefit package covering hospital, physician and drug costs for a premium of $2,500. In as much as MEDICARE administrative costs are 4%, and private insurance administrative costs are at least 20%, this new Part E coverage would save $480 per person.

This has the potential of saving $77 billion annually.

It would also eliminate the denial of medical claims, as well as rejection of issuing an insurance policy. It would allow patients to choose any physician or hospital without referrals.

This would also create a nation-wide insurance risk pool of potentially 161 million persons, more than adequate to spread the risks. The 47 million uninsured would be eligible for this insurance, and thus be a part of this pool.

Social security insurance covers the entire national risk pool of 300 million people for disabilities and old age pensions.

The private health insurance companies are notorious in trying to avoid paying for needed medical services. For example, United-Healthcare, with 26 million members, leaves the decision to cover the drug propofol, used in the colonoscopy procedure, to its local carriers, most of whom have restrictive policies.

Aetna, with 16.6 million insureds, has "suspended" its policy of denying coverage for this drug.

Humana and Well-point are among the large carriers that have sought to curtail coverage.

(The New York Times 2/28/08)

Mandatory Insurance

At present those who have health insurance are paying a compulsory surcharge to pay for the costs of treating the uninsured. This is especially noticeable in the ridiculously high per diem hospital charges.

We do not question the necessity of requiring universal auto liability insurance, even though there the insured pay a surcharge for the uninsured through "uninsured" and "underinsured" coverages.

We recommend the adoption of John Edward's idea that when a person files their federal income tax return, they must submit proof that they have health insurance.

Similarly, when a person goes for medical care, they must show proof of insurance, or be enrolled on the spot in our proposed Medicare Part E.

For those who truly cannot afford to pay for health insurance, enroll them in Medicaid.

Racial and Ethnic Health Disparities Coalition (REHDC)

Statement for the Record

Senate Committee on Finance

Hearing

Roundtable to Discuss
Reforming America's Health Care Delivery System
April 21, 2009

Mr. Chairman, Ranking Member and other members of this distinguished Committee, I am Fredette West, Chair of the Racial and Ethnic Health Disparities Coalition (REHDC), a working group committed to the elimination of racial and ethnic disparities in health and health care. As all of us are keenly aware, communities of color are disproportionately burdened by acute and chronic diseases, and are subjected to disparities in the quality of care they receive. This occurs across the full spectrum of disease categories, and in medical and surgical procedures. The compilation of Federal government findings and scientific studies – from those outlined in the *1985 Report of the Secretary's Task Force on Black and Minority Health,* to the 2002 IOM Study entitled, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,* to those on HIV/AIDS, cancer, heart disease, oral health, diabetes, mental health, and all that fall in between – document a compelling case for a national Federal response.

Indeed, racial and ethnic disparities in health and health care are an ongoing national health crisis that must be addressed comprehensively. Health reform is absolutely essential to achieving this goal. Hence, we strongly believe that the elimination of racial and ethnic disparities in health and health care must be a vital element of enacted health care reform legislation. Therefore, I appreciate this special opportunity to present to you, on behalf of REHDC, our *Health Care Reform: Key Principles and Priority Legislative Areas of Focus document.* All of the principles and priorities that we have outlined therein were formulated to help further the elimination of these disparities. We urge that the principles help serve as a guide and be reflected in the legislation, and that the *priority legislative areas of focus*

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provisions be included in the health reform legislation that you draft, deliberate and report out. A reformed health care system that embodies the REHDC principles and provisions will help to ensure improved health for all. We envision health reform that guarantees, as a human and civil right, quality health care.

Please know that we appreciate the Committee's longstanding commitment to helping eliminate health disparities. The Racial and Ethnic Health Disparities Coalition looks forward to working with the Committee on these intertwined national priorities: Health Reform and the elimination of racial and ethnic disparities in health and health care. We are pleased to provide any additional information and/or assistance that is needed, do not hesitate to contact us at healthalliance@comcast.net .

Again, we thank you for your leadership, commitment and this opportunity to help ensure quality health care for all. The REHDC *Health Care Reform: Key Principles and Priority Legislative Areas of Focus* document follows.

Racial and Ethnic Health Disparities Coalition (REHDC)

Health Care Reform: Key Principles and Priority Legislative Areas of Focus

We envision health reform that guarantees, as a human and civil right, quality health care. The reform must make health care coverage comprehensive, accessible, affordable, and equitable. This includes creating a health care system that utilizes cultural competency, linguistic appropriateness, data, research, case management, wellness promotion, diseased prevention, and health information technology. A system that values, solicits and uses consumer/community input in decision-making, policies and programs development, and in monitoring and evaluating the system overall. Reform that ensures improvements in health outcomes expands knowledge and research, improves health- and nutrition- literacy, increases workforce diversity, and responds to environmental factors. This right to quality health care shall be afforded to all United States residents including the poor, homeless, disabled, incarcerated, wounded warriors, adolescents, young adults and veterans. Health care that is provided in an equitable manner to assure that no person will experience health disparities as the result of his or her race, ethnicity, age, gender, religion, disability, sexual orientation, pre-existing condition, genetic predisposition, immigration or refugee status, national origin or language of preference. A system that embodies the appropriate: authority, accountability, legal redress, and transparency. The sum of which

would be better health and quality health care for all that is consumer, government and business responsive and cost effective.

Key Principles

1. ***Eliminating racial and ethnic health disparities is a national imperative that must be a vital element of health care reform legislation.***

   Although gaps associated with income, education, geography, gender and other factors must be addressed, the persistence of racial and ethnic disparities in health clearly warrants priority action by government. Racial and ethnic health care disparities are an American atrocity. Race based health inequities are also costly across the life span, – in terms of increased mortality and morbidity, wasted human potential, lost productivity, tertiary care, expensive emergency and end-stage medical treatment. Strategies developed and implemented to eliminate health disparities must reflect the reality that racial and ethnic health gaps remain even after adjustments are made for socioeconomic differences and other health care access-related factors.

2. ***Partnerships with communities of color are essential to achieve health care reform goals.***

   Organizations and individuals from communities of color are essential partners in achieving health care reform. Legislative recommendations from communities of color must be solicited, considered and included in the development, implementation and evaluation of health reform and related policies and programs, including health promotion and disease prevention efforts, workforce development, research and education.

3. ***Improving health care requires focus on eliminating racial and ethnic disparities so that quality efforts do not exacerbate existing health gaps.***

   Both quantitative and quality measures must include the reducing and eliminating of racial and ethnic disparities, cultural and linguistic competence, rehabilitation and tertiary care, patient satisfaction, provider and consumer communications, and effective health education and literacy. Essential tools include using health information technology and collecting and using racial, ethnic and primary language data, as well as the reporting of disaggregated data.

4. ***Improvements in the health of racial and ethnic minorities require that the health paradigm shift from a strict medical model to one that includes health promotion, education and consumer/community empowerment.***

   Priority must be given to community-driven, neighborhood-based and developed wellness promotion, disease prevention, equitable service delivery, health education, and approaches that address the social determinants of health. These are indispensable mechanisms and tools for achieving health parity, and health care reform and quality. Federal resources are critical to the design, implementation and sustainability of a community "wellness" infrastructure. Such an infrastructure will help abolish the pervasive racial and ethnic health disparities.

Priority Legislative Areas of Focus

- **Provide for universal coverage, universal access and comprehensive benefits with services provided in a culturally competent and linguistically appropriate manner**

  Health care reform legislation must provide for universal coverage by a date certain and universal access to quality, affordable, culturally and linguistically responsive, non-discriminatory health care, that is portable and includes a comprehensive benefits package with pharmacy benefits, prevention services, and language services. Enabling services such as transportation, child care, health education and case management are essential components for equitable provision of "universal coverage" that is designed to help improve access for medically underserved communities. There must be periodic review of the benefits package and "community" input must be central to the review process; updating and evaluating the benefits package is essential. In addition to primary health care, the package must include provisions necessary to cover dental health, mental health, and behavioral health including tobacco, alcohol and substance use/abuse prevention, intervention and treatment. Also, research must be enhanced to improve knowledge on health-related behavior, behavioral interventions, decision-making and environmental influences. This would include research on how individuals use services and information to manage their health, access services, experience with medications, self-care, and change behaviors; and on how these are affected by environment and constraints on resources, including money, time, and other factors. The purpose of which would be to better develop strategies that cut across risk behaviors and that can be delivered with a high degree of cost effectiveness.

- **Include prevention and wellness services as a core component of the benefits package**

  Prevention is a critical component to health care reform. The nation will never be able to appropriately meet the humanitarian need of its residents if it does not focus on prevention immediately. Prevention is an important factor in controlling the onset and improving the management of chronic diseases, and reducing health care cost. Physical exams and screenings coupled with school-based and work-based wellness programs are prevention and critical to health care reform. These types of community-based prevention strategies should be provided by Community-Based Organizations. The nation must focus its policies and funding on building healthier communities and educating the public on disease prevention and control, and improving health literacy. It must also include nutrition literacy with attention also on nutritional specific guidance and equitable access to such nutrients.

  Systems change coupled with the behavioral components of health requires provisions that include establishing partnerships between local and state health departments, health care and educational institutions, business and industry, and work places to promote better nutrition, increased physical activity and rewarding healthier living habits. A technical working group needs to be a central component of the health care reform effort focused on developing specific responses to specific diseases that

disproportionately impact communities of color in urban and rural areas. This technical working group must include members with proven expertise in implementing effective responses that are culturally appropriate, and gender and age sensitive. Legislation must address the need for additional research on behavioral interventions designed to further prevention efforts and on enhancing translation of research to practice.

- **Require proper data collection on race, ethnicity and primary language, and utilization of such data to help improve health and delivery of care**
  Data collection is vital to measuring access, quality of health and health care, elements critical to reducing health disparities. Legislative provisions must be included that improve the quantity and quality of proper data collection on race, ethnicity and primary language by all federal agencies dealing with health and social determinants of health including but not limited to SSA, CDC, NCHS, CMS, DHHS, EPA, DoJ Departments of Education, Labor, Housing, and the U.S. Census Bureau. It must mandate expanded and uniform data collection at the State level and the U.S. territories by all health providers, health insurers, health plans and health care institutions in order to measure quality of care provided to people of color, the uninsured, the underinsured and the entire population. Report and utilize the data collected to improve quality of care, reduce health disparities and health care costs. The legislation must also include a set timetable and mechanisms so that all health care institutions receiving federal funds are mandated to collect and report data in a uniform manner on a selected set of health care quality indicators by patient race, ethnicity, primary language, and education level.

- **Expand workforce diversity and strengthen health care infrastructure**
  Health care reform legislation must assure a health care system with an infrastructure that sustains the nation's new "universal" paradigm. It must ensure an adequate contingent of health care providers including primary care, allied health professionals, and specialists competent to meet the needs of all U.S. residents. It is essential that these health care professionals be racially and ethnically diverse as well as culturally and linguistically appropriate. Also, resources must be targeted to developing a diverse health information technology workforce and on the proven effective and efficient, community health workers. Indigenous providers and institutions such as "safety net" public and community hospitals must be revitalized. Renewed investment, both human and fiscal, must be made in public health clinics, neighborhood and community health centers as well as community pharmacies. It must provide also for retraining of workers that want to enter the health care fields.

  There must also be increased support for leadership development programs for minority health care providers capitalizing on their direct participation via appointments to decision-making positions in the public health care agencies and private health care institutions. Leaders in health from minority communities tend to better understand the challenges and have the expertise needed to help shape effective strategies to reduce health care disparities. Historically Black Colleagues and Universities (HBCU), Hispanic Serving Institutions (HSI), Hispanic-Serving Health

Professional Schools (HSHPS), and Tribal Colleges and Universities, the predominant pipeline for health professionals of color, must be strengthened so that more of their graduates participate in the health and health care workforce. Given the enormous debt incurred by typical students of these institutions and the poor health status of residents of communities traditionally unserved or underserved practical incentives must be offered for the recruitment and retention of diverse competent providers.

- **Include strong quality assurance mechanisms that assure cultural and linguistic competence**
  Research has demonstrated, especially for people of color that patient satisfaction alone is not a good indicator of quality. The legislation must strengthen consumer protections through expanded and enhanced quality standards, measures and assurances. These must reflect proper measurable indicators of quality care which include access to culturally sensitive health care providers; removing language access barriers; utilizing health information technology; and assuring access to required prescription medications.

- **Facilitate implementation and application of health information technology to help improve quality and health outcomes**
  The legislation must include provisions that facilitate the implementation of and requires the evaluation of health information technology standards, policies and quality measures that enable providers and public health practitioners to improve the health and health care of all vulnerable populations. Confidentiality, accuracy and interoperability are critical issues associated with health information technology including electronic medical records and personal health records. Equitable access is vital and must be provided. Municipal resources must be leveraged for "universal" availability and convenience. Opportunities for trusted indigenous entities to be the suppliers of health information technology for vulnerable populations must be sought and provided. Health care reform legislation must ensure that no community is left behind or left out and it must prevent the creation of a "health information technology" divide.

- **Provide for a strong consumer and community role in the administration of the program and strong anti-discrimination protections**
  The legislation must provide for the ongoing participation of consumers/community in program administration. It must reflect the nation's commitment to civil rights and affirmative action. It must ensure that affirmative action provisions are federally mandated, and include federal authority for enforcement and oversight with regard to implementation of health care reform. Also, the legislation must ensure that communities of color have equitable representation on all health care governing bodies at the Federal, State and local levels. Representation is to reflect the number and percentage of individuals of communities of color in the region.

- **Ensure one-tier of health care services for all that allows free choice of provider**
  There must not be a two-tier health care system that provides a lower quality care for the poor. It should eliminate significant financial barriers to care, such as deductibles

and co-payments that limit choice of providers for those with little or no income and include patient-friendly medical referrals process that help to improve access to specialists and related health care services. Individuals must be able to choose their own doctors and health plans.

- **Empower communities and ensure a level playing field for employment and business opportunities for racial and ethnic underrepresented health providers, entrepreneurs and workers**
  The legislation must provide for the development and implementation of health empowerment and action zones for vulnerable communities to become healthy communities. Such must be especially targeted to areas of the country with densely populated minority communities including the U.S.-Mexico border and U.S. territories. It must ensure that business and economic opportunities are provided on a level playing field that facilitates and expands the participation of communities of color by providing access to entrepreneurial opportunities, and to the capital needed to implement them. It must ensure that targeted resources are provided and reflect the percentage of individuals of communities of color that exist in a region as opposed to in the country as a whole.

Dear Senate Committee,

I am writing in concern to the hearing held on April 21, 2009 concerning America's healthcare system.

I wanted my voice to be heard that I am <u>not</u> in favor of nationalizing healthcare in America. I have heard many people from other countries say that nationalized healthcare is not in the best interest of America. That when they are in need of serious healthcare, they are not able to get the medical attention that they need. This concerns me. I want to be able to seek the medical attention when I need and where I need it. I do not think that will be possible if you choose to Nationalize Healthcare.

Please consider my thoughts and do <u>NOT</u> Nationalize Healthcare.

Thank you,

Darcy Stringer
1212 N. Pfenning Rd
Ellensburg, WA 98926

urac

Statement of Alan P. Spielman, President and CEO, URAC
1220 L Street NW, Suite 400; Washington, D.C. 20005

Written Testimony Provided to the
U.S. Senate Committee on Finance

Roundtable to Discuss
Reforming America's Health Care Delivery System

April 21, 2009

Chairman Baucus and Members of the Committee:

URAC appreciates the opportunity to provide written comments to the Committee as it addresses reform of the health care delivery system. URAC, a nationally recognized health care accreditation organization, shares the Committee's objectives to improve health care quality and promote better care coordination. URAC works toward these goals by bringing diverse health care stakeholders together to develop voluntary accreditation standards that set the bar for health care organizations and encourage continuous quality improvement. Our clients span the breadth of the health care spectrum and include care management companies, health plans, pharmacy benefit managers, utilization review organizations, and other health vendors doing business both in the commercial sphere and through government programs like Medicare and Medicaid.

Regardless of the precise direction of legislative reform, sustained improvements in the health care delivery system will require the innovations, clinical expertise and service capabilities of health plans and other care management organizations working in collaboration with health care providers and consumers. For example, strategic approaches such as case management and disease management incorporate collaborative practice models to identify and engage patients with chronic illness or high cost conditions who will benefit from improved self-management (e.g., diet, exercise, and medication adherence) and evidence-based medical treatment. Collaborative programs such as these capitalize on patient data, the clinical expertise of health providers, and the coordination capabilities of

managed care working together to provide the most in-need patients with the best health information and the most medically appropriate interventions.

Private accreditation organizations such as URAC play a valuable role in our health care system by defining and synthesizing innovative practices such as those described above to drive improvements across the industry. Through the accreditation process, URAC galvanizes health care organizations to keep pace with health care advancements more readily than if undertaken by legislation or regulation. Companies undergo URAC reviews on a two or three year cycle to establish compliance with contemporary standards and encourage adoption of leading health management approaches. During the accreditation review, our team of clinical reviewers works with health organizations to share best practices and validate their quality improvement efforts.

URAC's educational approach to accreditation yields conclusive results; accredited companies regularly emerge ahead of the curve in adopting practices that protect and empower consumers and ensure clinical and organizational quality. For example, CVS Caremark was recently lauded at URAC's 2009 Best Practices Awards Conference for their strategy to reduce adverse drug events by promoting direct contact between patients and physicians. Participants were enrolled in the drug therapy management program through referrals from practitioners (e.g., case managers) and offered ongoing physician consultation availability featuring concrete medication utilization recommendations. By promoting similar evidence-based innovations at the management level, URAC drives health care organizations to voluntarily adopt improvements that promote coordination and ripple through the entire health care delivery system.

Accreditation by an external organization such as URAC promotes transparency and accountability within the health care delivery system. Companies seek accreditation under URAC standards to improve internal operations and demonstrate to consumers, participating providers, and clients that they have undergone a rigorous external review to validate the quality of their services. Moreover, purchasers in both the private and government sectors recognize URAC accreditation as a meaningful seal of approval as they evaluate bids and select vendors.

As Congress embarks on this important effort to improve the nation's health care system, we stand ready to provide resources about quality standards, measures, and operational review functions and to support public/private partnership solutions in the health care system, as we have for the past 19 years. It is our hope that you find the following description of URAC's role within the health care industry informative to your ongoing reform discussions.

Overview of URAC

URAC is an independent, nonprofit organization whose mission is to promote continuous improvement in the quality and efficiency of health care management through the processes of accreditation, education and measurement. Our strategic priorities are to:

- Enhance Continuity of Care;
- Encourage Transparency: Cost & Performance/Quality Data;
- Engage Consumers in their Health Care Management;
- Enhance Operational Management Effectiveness; and
- Engender Support for Evidence-Based Decision-Making

To support these goals, our Board of Directors represents the full spectrum of stakeholders interested in our health care system, including consumers, employers, health care providers, health insurers, purchasers, workers' compensation carriers and regulators.

Incorporated in 1990, URAC pioneered utilization management accreditation by creating a nationally recognized set of standards to ensure accountability in managed care determinations of medical necessity. As the health care industry evolves, URAC continues to address emerging issues: we now offer over 25 accreditation and certification programs across the health care spectrum:

- Case Management
- Claims Processing
- Consumer Education and Support
- Core Organizational Quality
- Credentialing Support
- Credential Verification Organization
- Disease Management
- Drug Therapy Management
- Health Call Center
- Health Content Provider
- Health Network
- Health Plan
- Health Provider Credentialing
- Health Utilization Management
- Health Web Site
- HIPAA Privacy
- HIPAA Security
- Independent Review Organization
- Mail Service Pharmacy
- Medicare Advantage Deeming
- Pharmacy Benefit Management
- Specialty Pharmacy
- Vendor Certification
- Wellness
- Workers' Compensation Pharmacy Benefit Management
- Workers' Compensation Utilization Management

Government Recognition of URAC Accreditation

Federal and state policymakers recognize the value of private accreditation to promote cost-efficiency and to ensure that their constituencies receive quality health care. At the federal level, four federal agencies recognize URAC accreditation. The Centers for Medicare and Medicaid Services recognize URAC Medicare Advantage Health Plan Accreditation for the Medicare Advantage (formerly Medicare+Choice) Program; the Office of Personnel Management recognizes all URAC accreditation programs under the Federal Employee Health Benefits Program; TRICARE/Military Health System recognizes URAC's Health Network Accreditation, Case Management, Disease Management, and Utilization Management Accreditations; and the Department of Veterans' Affairs recognizes URAC's Health Call Center Accreditation.

Many states have found URAC's accreditation standards helpful in meeting regulatory requirements for managed care plans and other health care organizations and functions. Thirty-nine states and the District of Columbia currently reference accreditation through statute, regulation, agency publication, Request for Proposal or contract language, making URAC the most recognized national managed care accreditation body at the state level.

URAC Standards: Establishing Quality Benchmarks

URAC accreditation serves as a symbol of excellence in the health care industry, promoting prevailing industry standards and consumer protections. In the rapidly evolving field of health care, URAC standards are developed through a dynamic process that identifies best practices and promotes high quality performance measurement. All stakeholders in the health care arena actively participate with URAC in developing these quality benchmarks through an inclusive process that incorporates an opportunity for public comment.

URAC's standards development process begins with a period of careful research, debate and discussion among stakeholders. An initial set of standards is then proposed and made available for a public comment and review. URAC's advisory committees review the submitted comments, make appropriate changes, and the draft standards are then beta tested with a discrete group of companies in order to ensure that they work in practice. After beta testing, the standards may be modified again, and then they are forwarded to URAC's Board of Directors for consideration and approval. URAC revises its standards through this process at least every three years.

URAC Accreditation Review Process

The URAC accreditation review process begins with applicants for accreditation submitting material through AccreditNet, URAC's secure online application system. When an application arrives, a reviewer is assigned to conduct an assessment of the submitted documentation for compliance with URAC standards. Any standard that appears non-compliant is noted and communicated to the client with a recommended course of action to meet the standard. Then an onsite review is conducted for each applicant.

URAC staff reviewers are clinical experts who provide application support through the entire accreditation process, including a sharing of best practices during the onsite review. The objective of the onsite review is to verify operational compliance with URAC standards. URAC reviewers, for example, interview the applicant's staff and review a statistically valid sampling of relevant documentation, including specific quality information. With respect to quality data, URAC accepts nationally recognized measures, such as HEDIS measures to evaluate plan performance and CAHPS data to evaluate consumer satisfaction. URAC may also consider other credible, CMS-recognized quality measures such as the Wisconsin MEDDIC-MS and MEDDIC-MS SSI Performance Measures.

The findings from an applicant's onsite review are anonymously presented to the URAC committees that make the accreditation determinations through an Executive Summary report. Committee members include industry peers and experts such as physician providers, plan physicians, quality management professionals, information technology experts, pharmacists and security/privacy officials. Levels of accreditation are awarded in accordance with corporate policy and URAC's accreditation scoring methodology. Applicants receive an official notification letter with their accreditation status and a certificate of accreditation.

URAC Accreditation Standards At-A-Glance

URAC accreditation programs are comprised of modules, or sets of standards. The Core Organizational Quality Standards serve as the foundation of URAC accreditation, and this module is part of each URAC accreditation program, with the exception of URAC's Health Information Technology accreditations. The Core standards address several key organization functions that are important for any health care organization:

URAC Core Organizational Quality Standards	
Organizational Structure Defined	Communication Practices Monitored
Policies and Procedures Articulated	Confidentiality Maintained
Clinical Oversight	Access to Services
Staff Qualifications Defined	Promotes Consumer Safety
Staff Credentialing Enforced	Promotes Consumer Satisfaction
Robust Staff Training	Rigorous Complaints and Appeals
Rigorous Information Management	Quality Management Program Defined
Rigorous Regulatory Compliance	
Delegation to Business Partners Monitored	Robust Quality Improvement Projects
HIT Business Continuity Plans (2009)	Health Literacy (2009)

URAC Health Utilization Management Accreditation is URAC's premier program. Pioneered in 1990, it presented the first-ever industry standards for utilization management and transformed the industry. URAC Health Utilization Management Standards serve as the basis for many states' laws and regulations and are the most widely recognized utilization management standards at the state and federal level. The standards address key issues in medical necessity decisions:

URAC Health Utilization Management Standards	
Review Criteria	Time Frames for Initial UM Decision
Accessibility of Review Services	Notice of Non-Certification Decisions
On-site Review Services	Notice of Certification Decisions
Initial Screening	UM Procedures
Initial Clinical Review	Information Upon Which UM is Conducted
Peer Clinical Review	
Peer-to-Peer Conversation	Appeals Considerations

URAC broke new ground in care coordination in 1999, and established the first of its kind guidelines and protocols for the evolving field of institutional Case Management in health, behavioral health and worker's compensation. URAC Case Management Accreditation, developed with the support of the Case Management Society of America, is the only program of its kind and specifically addresses this health care organization practice aimed at better meeting patients' needs and improving their treatment outcomes by coordinating the full continuum of care. URAC standards look at:

URAC Case Management Standards	
CM Policies and Procedures	Consumer Protection
Information Management	Collaboration with Physicians
Case Management Criteria	Case Management Qualifications
Case Management Disclosure	Case Management Training
Case Management Consent	Case Management Caseload
Case Management Tools	Ongoing Professional Training

Case Management Assessment	Case Management Complaints
Case Management Plan	Patient Empowerment
Case Management Dispute Resolution	Respect of the Patient

URAC continued to set quality benchmarks for care coordination in 2001, when it launched Disease Management Accreditation. These program standards contemplate coordinated health care interventions and communications for populations with conditions (e.g., diabetes) in which patient self-care efforts are significant. Disease Management supports the practitioner-patient relationship and plan of care, emphasizes prevention utilizing evidence-based practice guidelines and patient empowerment strategies, and evaluates outcomes with the goal of improving overall health. URAC standards address:

URAC Disease Management Standards	
Evidence Based Care	Coordination of Services
Personalized Care	Staffing for DM Programs
Patient Empowerment & Privacy	Clinical Decision Support Tools
DM Program Design	Telephonic Access
Collaboration with Physicians	Program Interventions
Shared Decision-making with Consumers	Performance Measurement/Reporting
Consumer Rights and Responsibilities	Methods for Managing Eligible Populations

In 2007, URAC once again set the bar in a new area of the health care sector, with the release of the first-ever national accreditation standards for pharmacy benefit management and drug therapy management. URAC worked with health care leaders and customers of pharmacy benefit management services for two years to develop quality indicators for the industry. URAC Pharmacy Benefit Management Accreditation and Drug Therapy Management Accreditation speak to the array of sophisticated administrative, clinical and financial management services provided by this sector. For example, the areas addressed by URAC standards include:

URAC Pharmacy Benefit Management Standards	
Concrete Consumer & Client Disclosure	Clinical Review Criteria
Robust Communication Safeguards	Scope of Drug Utilization Management Defined
Scope of Pharmacy Distribution Channels	Consumer Safety Process Requirements
Articulated Criteria for Access & Availability	Non-Formulary Exceptions
Articulated Criteria for Quality & Safety	Up-To-Date Formulary w/ Optimum Therapeutics
Network Access & Availability	Formulary Appeals Process, Includes Peer Clinical Review
Pharmacy Contracting & Subcontracting	Process To Promote Rational, Clinically Appropriate, Safe& Cost Effective Drug Therapy
Claims Processing Standardized	Formulary Decisions: Safety, Efficacy and Therapeutic Before Cost Factors
Coverage Decisions Based on Clinical Information	Expedited and Standard Appeals Review Defined

URAC has made similar achievements in setting quality benchmarks in other areas of health care management, health care operations, and health information technology and pharmacy quality management. We would be pleased to share copies of URAC accreditation standards and additional program overviews with the Committee as it moves forward with its deliberations on health care reform. Members and staff are also invited to URAC's educational programs and workshops, where the implementation of our quality standards are explored in detail.

Value of Accreditation

URAC's practice of bringing the entire scope of experts and stakeholders to the table ensures that URAC is creating contemporary accreditation standards that are both meaningful and achievable. Numerous jurisdictions have either "deemed" URAC accreditation to satisfy state or federal requirements or have modeled their requirements on URAC standards because they recognize the effectiveness of public/private partnership solutions in the health care system. In addition, the National Association of Insurance Commissioners (NAIC) and the National Conference of State Legislators (NCSL) have each acknowledged the benefits that accrue from "partnerships between state regulators and private accreditation entities." In a "LegisBrief" on managed health care accreditation, the NCSL identified some of these benefits:

- Multistate managed care organizations can meet different states' regulatory requirements though a single set of nationally recognized standards;
- States benefit because accreditation quality standards are updated regularly, keeping pace with health care advancements more readily than if undertaken by legislation;
- States are assured that health care quality standards reflect the national scope of experience; and
- Consumers are provided evidence that managed care organizations have made a commitment to quality measured against national standards of practice.

("LegisBrief," *Managed Health Care Accreditation* (Richard Cauchi, November/December 1998)

Accreditation standards are also valuable because they:

- Drive improvements in health care as a consequence of an impartial and rigorous evaluation process undergone by companies seeking to meet URAC standards;
- Support ongoing quality improvement by continually adjusting benchmarks to reflect best practices;
- Provide transparency and accountability through nationally recognized and publicly available standards; and
- Incorporate consumer perspectives into the standards development process.

Conclusion

URAC appreciates this opportunity to inform the Committee about URAC and our standards for quality assurance in health care. We hope that our accreditation standards and operational reviews will be helpful to your efforts to improve health care quality and promote better care coordination. Additional resources are available through the policy maker portal on the URAC website (http://www.urac.org/policyMakers/resources/).

Please do not hesitate to contact URAC Vice President for Government Relations, Product Development and Education John DuMoulin (jdumoulin@urac.org, 202/962-8836) and URAC Government Relations

Director Mara Osman (mosman@urac.org, 202/962-8838) for additional information and resources as the Committee continues to address issues related to health care reform.

Thank you for your time and consideration.

* * * * *

April 23, 2009

Senate Committee on Finance
Attn. Editorial and Document Section
Rm. SD-219
Dirksen Senate Office Bldg.
Washington, DC 20510-6200b

Dear Senate Committee Members:

Please do not nationalize the healthcare system of the United States of America.

(1) Nationalized healthcare would result in higher taxes for the citizens of the U.S. and/or result in spending cuts in the budget for defense, education, etc.
(2) Government-controlled healthcare would lead to a decrease in patient flexibility and limit patient options. For example, in Canada, patients must wait over 6 months for a routine pap smear. It is a known fact that many residents of Canada come to the U.S. for healthcare needs.
(3) Government-mandated procedures would reduce doctor flexibility and lead to poor patient care.
(4) Patient confidentiality is likely to be compromised, since centralized health information would have to be made available throughout the government.
(5) The costs for drugs and doctor visits would not be curbed but would most likely increase to several times what they are now. Profit motives, competition, and individual ingenuity have always led to greater cost control and effectiveness.
(6) Nationalized healthcare would result in the loss of private practice options and dissuade potential doctors from pursuing education and careers in the medical profession.
(7) Malpractice lawsuits would expose the government to legal liability, and the potential for excessive legal fees would be passed down to the American citizens in the form of more taxes.

Truly, the cons outweigh the benefits of a national healthcare system. It is important that measures be taken to keep our healthcare system independent from government control.

Sincerely,

Pamela Talbot-Henn

Pamela Talbot-Henn, Educator
B.S. Mathematics Education

Pamela Talbot-Henn
104 Longstreet Court
Greer, SC 29650-3818

Dear Senate Finance Committee: 5/5/09

I am writing to ask you to reconsider voting for the Socialized Health Care plan proposed by President Obama. If health care is socialized, it will be one more freedom taken away from Americans. They will no longer be allowed to choose their own doctors, treatments, etc. Also, once again, the business owner, small and big, will be footing the bill. The more expenses/taxes charged to the business owner, the less likely they will stay in business and therefore the higher the unemployement rate.

Therefore, I ask you to think it through and to please reconsider voting for the proposal to socialize medicine.

Sincerely,
Lisa Thomas

WILLIAM C. WATERS III, MD, MACP
6 Brookside Drive
Newnan, Georgia 30263
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KEY EXCERPTS FROM
TWO DAYS THAT RUINED YOUR HEALTH CARE
And How our Can Provide the Cure
(Full copies available on request)

1

SOURCE OF ALL ILLS

October 2, 1942, was a sparkling clear day in Washington, D. C., and, as the Senate convened, a slight breeze was coming off the Potomac. The lawmakers walked into the chamber to vote on the so-called Stabilization Act of 1942, which had already passed the House. They voted *yea.*

It was a perfectly well-intentioned move. After all, in the face of World War II, history's greatest conflict, it was reasonable that the bill should freeze wages to prevent too much inflation. But then big companies wanted to offer some attraction to a work force shrunk by war mobilization. So this bill allowed employers to deduct from taxable income all payments for employees' health premiums.

But it did not allow the same benefit if the employee paid. In this moment the workers lost management of their family's health care. And the employer, without a day of training, became their doctor.

This was the First Day.

It was a bright spring morning—April 10, 1965—when President Lyndon Baynes Johnson signed into law a bill to provide health care benefits for anyone who had passed his or her 65th birthday. It was the Mills Bill, HR 6675, popularly called Medicare. On this day the federal government, without any schooling, awarded itself an MD degree.

This was the Second Day.

As a result of these two days, individual patients lost much control over their medical care, and all control over the cost. Even today they are still deluded into thinking they are spending other people's money ($7,500 per person per year in 2007) when all along it is theirs. Now they don't care about their medical care costs, any more than they wash their rental car. So costs have zoomed. These spiraling expenditures have deprived many citizens of comprehensive care, including those whose own money caused the trouble in the first place. Despite the twin viruses imposed by the Two Days, the U. S. has somehow mounted the best health care system in the world. But problems exist and there are those who cry that the main issue is not having insurance. I will suggest that the problem, ironically, is insurance itself — public and private.

There is a way out, but it will require common sense and courage.

Yes, there are more days.

21

THE MAGIC BULLET

There may be a way out. Finally Congress, under the urging of the Bush administration, authorized Health Savings Accounts in 2004.

WHAT HSAs ARE. Under this plan, the individual first obtains high-deductible insurance (catastrophic policy) to cover major medical problems. Then he can set aside an annual fund — *pre-tax* — for ongoing medical expenses. Major events like heart attack, surgery, will be covered after a deductible up to millions. Week-to-week medical expenses can be paid direct out of the fund, using credit or debit card if desired. *And this fund does not have to be all spent.* Figures for allowable amounts in 2009 are now available, and the average American family could look like this:

***OLD* SYSTEM:**
AVERAGE "VISIBLE" FAMILY INCOME $47,000

PREVIOUS AMOUNT PAID BY EMPLOYER

FOR HEALTH INSURANCE (BUT NEVER SEEN BY EMPLOYEE)	7,000
TOTAL REAL COMPENSATION	54,000

***NEW* HSA SYSTEM 2009**

AVERAGE "VISIBLE" FAMILY INCOME	47,000
AMOUNT PAID FOR CATASTROPHIC	2,300*
AMOUNT FOR HSA FUND	4,700**
TOTAL REAL COMPENSATION	54,000

*Minimum under 2009 IRS rules

**Maximum under 2009 IRS rules for family will be 5,950

Now, then. With the same total commitment of money, the employee's family is completely covered. And they pay as they go out of their own fund.

JUST SUPPOSE

Suppose: you don't spend the whole amount in the year.
It remains in the account and is rolled over to the next year. And the next. And the next.

Suppose: a significant amount accumulates over the years and it's retirement time. What happens to the money?
It becomes part of your IRA, or 401 K. It's yours.

Suppose: You have a major medical calamity in the family, like an auto accident, time in ICU, or a kidney transplant, and the bill is $150,000. *This will use up your annual $4,750, of course, but will activate your major medical (high-deductible) account, and everything is paid.*

Suppose: Your doctor wants you to have an expensive test, like an CT scan or wants you to go into the hospital for evaluation.

You'll be paying for this, so you might ask, Is this CT ($1000) really necessary? Can we do the other tests as an outpatient? You want to keep as much of your fund as you can.

Suppose: Your doctor orders a new-fangled expensive antibiotic ($100) for your bronchitis.
You can ask about the old time-proven generic ($10). He strokes his chin and says, "It'll probably work just as well. By the way, we're not sure this is a bacterial infection anyway."

IS IT WORKING?

Here are the data so far:

YEAR	No. of HSA accounts
2005	1,031,000
2006	3,168,000
2007	4,532,000
2008	6,118,000

(If Health Resource Arrangements, a related plan, are included, the mid-2007 figure was 8,961,675)

Wait, you say — there are 300 million people in the country. Yes, but if you start with zero in 2004 and draw the ascending line — it may well reach 200,000 by 2015. Some reliable observers predict annual doubling through 2009.

WHAT ABOUT MEDICARE PATIENTS?

There is evolving a plan for the over-65 group. They too can obtain an HSA tax-free fund. So far this mechanism is a little complicated (the government web site is about 70 pages), but it should soon be a practical reality. Stay tuned.

WHAT ABOUT THE INDIGENT?

As many as 48% of the population pays no taxes, so a tax break would be meaningless to them. But a HSA voucher system to replace Medicaid would be a workable and a marvelous advance. About $5200 is already spent on each Medicaid patient — more than the $4500 for every private patient — and the care is substandard. It could be better spent. The

Medicaid patient can assign his voucher to a reputable health care system and be completely covered.

Let's create a plan.

THE BEST PLAN
An antidote to the TWO DAYS

1. **HSA.** Allow everybody to have an HSA account which they can use to pay medical bills. It can come from employer, employee, a combination, or can originate with the individual. It is permanent, rolls over from year to year, is tax-deductible for both employer and employee, and can become part of the retirement account. There will also be no minimum distribution at age 70½. *(This is already permitted by existing federal law.)* Use of this plan will require number 2.

2. **HDHP.** A high-deductible (or catastrophic) program must be in effect. This will cover all major medical expenses, such as prolonged hospitalization, surgery, and trauma. It will also serve as a "seat-belt" which protects society from paying huge bills from which uncovered patients are normally forgiven. *(This too is already existing federal law.)*

[The average American citizen is spending over $7000 yearly on health care, and $8000 is predicted for 2009 ($4,511 for under-65 citizens in 2004); the HSA/HDHP plan will cost much less]

3. **MEDICARE HSA.** The over-65 patient pays the usual Medicare premium and is given a tax-free account and a major-medical plan as above. At a certain ceiling, the fund can be converted to a retirement account. (Federal law is evolving on this plan, but is very complicated and the government needs your encouragement. See *End Notes.)*

[The Average Medicare patient accounts for about $15,000 expenditure each year ($14,797 in 2004). The Medicare HSA program will cost much less).

4. **MEDICAID HSA.** The Medicaid patient is given a voucher containing a major medical provision and a cost-defined fund which can be presented to any approved health provider, who can then withdraw payments based on a predetermined price list.

[The average Medicaid patient costs seem to be debated: the CMS says calculation is "inappropriate"; others say $3500. My arithmetic is $313 billion divided by 60 million equals $5200 (more than the private patient) annually. The Medicaid HSA program should cost much less.]

5. **HSA FOR UNINSURED PATIENT WHO PAYS NO TAXES**. This group will receive a voucher from the government. It will function like the Medicaid HSA.

[The uninsured patient, whether indigent or not, usually presents to the emergency room and hospital, receives care, and does not pay. The bill is usually not successfully pursued by the provider. The amount of this expenditure is unknown, but is thought to be enormous. The figure for 2006 which could be obtained was $31 billion. With the HSA plan, cost-accounting will be possible.]

6. There is no reason why consumers with HSA funds or vouchers cannot use the money to purchase health **insurance** or prepayment programs from companies who provide approved plans. The consumer can now bargain with the companies and the firms can compete.

7. Health insurance should be purchasable **across state lines**. The average premium in New Jersey is five times that of Nevada. This is because of "mandates," in which various merchants have persuaded the legislature to require insurers to pay for massages, aroma therapy, yoga, etc., etc.

[Items 1 and 2 are in force. Item 3 is in transition. Items 4, 5, 6, and 7 have not been authorized by Congress.]

The errors of the TWO DAYS will now be cancelled. The government, the employer, and the insurance company no longer

make the decisions — only the patient and the doctor. And the cost spiral is stopped and reversed.

WHAT ARE THE ADVANTAGES?

- *You are in charge of your medical expenses. You call the shots.*
- *The doctor now cares what you spend, because you do.*
- *You can bargain with your doctor.*
- *You can bargain with your hospital.*
- *You can bargain with the lab or the imaging center.*
- *You can bargain with the insurance company.*
- *You are likely to have left-over money each year, which accumulates for future medical costs or for retirement fund.*
- *Competition, that powerful force, enters the scene. So prices will go down, just like computers, not up, like present health care.*
- *No insurance clerk will tell you or your doctor what you can and can't do. No pre-certification. No denials of payment.*
- *The small business employee will benefit more than anyone.*
- *It will be a boon for the uninsured.*
- *Total national medical costs will fall (the Kaiser study found a one-third reduction in the first year). So your country will be spending less on health care and can devote those funds to other purposes — infrastructure, national security — or even reduce taxes.*

Testimony of

Ronald A. Williams

Chairman and Chief Executive Officer, Aetna Inc.

before the

United States Senate Committee on Finance

"Delivery System Reform"

Tuesday, April 21, 2009

[Written Submission]

Introduction

Good morning Chairman Baucus, Ranking Member Grassley and members of the committee. My name is Ronald A. Williams, and I am the Chairman and Chief Executive Officer of Aetna Inc. Headquartered in Hartford, Connecticut, Aetna is one of the nation's leaders in health care, dental, pharmacy, group life, disability insurance and employee benefits. We provide products and services in all 50 states, serving over 36.5 million unique individuals. Our customers include employer groups, individuals, college students, part-time and hourly workers, health plans, governmental units, government-sponsored plans, labor groups and expatriates.

Thank you for the opportunity to participate in today's roundtable and share with you my views on our top priorities for reforming our nation's health care delivery system.

While access to health care is deservedly much-discussed, the scope of comprehensive health care reform must be broader to ensure that the system successfully delivers high-quality health care. We need a health care system that can help Americans achieve their optimal health by delivering the right kind of care to everyone who needs it every single time. Today, we simply do not have such a delivery system in place.

I believe achieving the ideal delivery system requires us to focus on several key areas of reform:

1) We need to **harness the power of health information technology** so that we can turn complex health data into knowledge that physicians and patients can act on to improve health outcomes;
2) We need to **make wellness and prevention a priority in our health care system**. Our seat belt laws and anti-smoking efforts have achieved great results and we need this same type of commitment in the wellness challenges facing us in the areas of obesity and encouraging healthy behaviors; and
3) We must **reform our payment system**, utilizing public programs alongside private sector innovation, so that our focus rests on value and quality, rather than volume.

To a large degree, the value of these reforms is demonstrated in the positive outcomes we have achieved through programs for our customers and employees. It is clear that health care marketplace innovations can be utilized for the benefit of all Americans, and I want to highlight some of these experiences while discussing our priorities for delivery system reform.

Priorities for Reforming the Delivery System

1) Leverage the power of health information technology to enhance care coordination and improve outcomes

We need to change delivery paradigms by using health information technology (HIT) tools that enable providers and patients to make better use of the right data, at the right time to

make quality care decisions. HIT can facilitate vast improvements in individuals' health care experiences by offering them a clearer picture of their own health, a more coordinated interaction with multiple health care providers and better, safer health outcomes.

There is widespread recognition of the problems that could be partially solved through enhanced use of HIT – as many as 98,000 individuals die annually in U.S. hospitals as a result of medical errors[1] and at least 1.5 million Americans are injured every year because of medication errors, at a cost of at least $3 billion.[2] Yet, we have witnessed a very slow adoption curve among U.S. providers for tools such as Electronic Health Records (EHRs). The slow rate of EHR adoption among physicians has been documented, and a recent *New England Journal of Medicine* survey found a similar trend among hospitals; only 1.5 percent of U.S. hospitals have a comprehensive electronic records system.[3]

Aetna applauds the efforts of both Congress and the Administration for making the $22 billion down payment in the American Recovery and Reinvestment Act to incent providers to purchase and implement electronic record platforms. While absolutely necessary, Aetna believes that EHRs are only a partial solution if we are to fully realize the $80 billion in projected annual savings generated from the use of electronic record technologies. More important will be "smart" technologies that enable data exchange across providers as well as the companion services which deliver advanced, intuitive clinical decision support. These tools will ensure that providers are able to quickly rationalize the growing volume of data on their patients and to use that data to make the right treatment decisions. It is from these latter two areas – data exchange tools and clinical decision support tools – that the public will realize true value for its HIT investment, and I would encourage Congress and the Administration to make these investments.

Data Exchange Tools

We need continued focus and investment to develop the infrastructure needed to support data exchange tools. All Americans should have access to a secure, interoperable health system that provides administrative and confidential medical information. Health information technology, coupled with evidence-based medicine, translates into fewer errors, improved patient safety and better doctor-patient communication.

Aetna Experience

Aetna and its ActiveHealth Management division are working closely with regional health information organizations around the country to embed the value of evidence-based technologies and services to assist the clinical providers who are connected to the information exchange network. An exciting program is underway with the Brooklyn Health Information Exchange in New York City where ActiveHealth's clinical decision support technology and services are to be used to aggregate, analyze and connect otherwise disparate information

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[1] Linda T. Kohn, Janet M. Corrigan and Molla S. Donaldson, "To Err is Human: Building a Safer Health System," Institute of Medicine, November 1999.
[2] Philip Aspden, Julie Wolcott, J. Lyle Bootman and Linda R. Cronenwett, Eds., "Preventing Medication Errors," Institute of Medicine, July 2006.
[3] Ashish K. Jha, Catherine M. DesRoches, Eric G. Campbell, "Use of Electronic Health Records in Hospitals," *New England Journal of Medicine*, April 2009.

from lab results, pharmacy data, diagnostic and procedural claims data. This technology allows for identification of gaps in care, medical errors and quality of care concerns via evidence-based guidelines. ActiveHealth is also providing specialized Personal Health Records to Brooklyn patients that will be populated with patient-centric data drawn from the exchange. From this data, ActiveHealth will be able to generate care alerts to be sent to both patients and their providers to create a customized care plan for the patient. Our work with the health information exchange in Brooklyn has been an important milestone for ActiveHealth, and we are pleased to now be working with a number of other regional exchanges to implement similar programs.

Clinical Decision Support

Aetna believes the key to leveraging the power of health information technology is to ***make data actionable***. Giving providers greater visibility to patient data to make better decisions for their patients – and Aetna members – has been a central driver for much of the $1.8 billion Aetna has invested in HIT since 2005. This was the impetus for our acquisition and continued deployment of an interoperable clinical decision support service, ActiveHealth Management and its CareEngine® clinical decision support solution.

Aetna Experience

As envisioned in the collaboration now underway between ActiveHealth and the Brooklyn Health Information Exchange, advanced clinical decision support is a vital tool that enables providers to "meaningfully use" their electronic health record system. Many commercial payers already recognize the value of this technology, as it serves more than 19 million plan members and their physicians. ActiveHealth services generated more than 7 million care alerts in 2008. Most importantly, these alerts are having a measurable impact on both the quality and economic value of the care patients are receiving, especially in higher cost chronic disease areas where effective care coordination makes a tremendous difference. Some real world results include the following:

- Alerts calling for the right use of ACE inhibitors in the appropriate cardiovascular patient population delivered $510 per member per month reduction in submitted charges when compared to a matched control group that did not receive such alerts;
- Compliance improvements of 47 percent were achieved in ensuring chronic kidney disease patients received the standard of care to prevent bone disease;
- Use of alerts improved compliance with national osteoporosis guidelines by up to 23 percent; and
- There was an incremental 12.5 percent boost to overall patient compliance with their providers' care recommendations when patient alerting was used.

These and other examples underscore the vital role that advanced clinical decision support can, and should, play in ensuring providers maximize the value and potential of electronic health information.

Recommendations

While ActiveHealth Management's CareEngine® is a leading technology in the clinical decision support and care management category, this area as a whole is a rapidly emerging space for innovation and one which merits continued public policy focus and support for its ability to drive a measurable return on investment. Specifically, Congress and the Secretary of Health and Human Services should give additional consideration to how Medicare and Medicaid incentive payments to providers could be used to help providers acquire these services and tools as part of their effort to use EHRs, improve care coordination and enhance quality of care for patients. In the months ahead, as this committee and the Congress consider comprehensive health care reform, I encourage Members to become familiar with how these decision support tools function, how they provide a necessary complement to enable the "meaningful use" of EHR technology and how they can foster quality and value for providers, patients and payers. In addition, I believe we must invest in the infrastructure necessary to facilitate the establishment of a truly interoperable health information technology system.

2) Focus our system on prevention and lifelong wellness to get and keep Americans healthy

Today, our health care delivery system is largely oriented toward treating disease once it surfaces rather than preventing it before it has the chance to appear. Refocusing our system to prevent disease and promote wellness can shift the pendulum toward better health for all Americans, giving individuals the support and resources they need to lead longer, healthier lives.

Overall, we are simply not as healthy as we could be. More than half of Americans are living with at least one chronic disease.[4] Nearly one in five four-year-olds is obese, with significant disparities in prevalence among different racial and ethnic groups.[5] Unhealthy behaviors have severe human and economic consequences. Obese children face risk factors for cardiovascular disease (e.g., Type II Diabetes, high blood pressure) previously only seen in adults, and they are likely to be obese as adults, as well.[6] Smoking alone accounts for 400,000 annual deaths[7], and obesity is associated with more than 111,000 excess deaths each year.[8] The United States spent $217.6 billion on direct costs in treating non-institutionalized

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[4] Ross DeVol, Armen Bedroussian, Anita Charuworm, et al., "An Unhealthy America: The Economic Burden of Chronic Disease Charting a New Course to Save Lives and Increase Productivity and Economic Growth," Milken Institute, October 2007.

[5] Sarah E. Anderson and Robert C. Whitaker, "Prevalence of Obesity Among U.S. Preschool Children in Different Racial and Ethnic Groups," *Archives of Pediatrics and Adolescent Medicine*, 2009; 163(4):344-348.

[6] David S. Freedman, Zuquo Mei, Sathanur R. Srinivasan, Gerald S. Berenson and William H. Dietz, "Cardiovascular Risk Factors and Excess adiposity Among Overweight Children and Adolescents: the Bogalusa Heart Study," *The Journal of Pediatrics*, 2007, 150(1):12–17.

[7] National Committee for Quality Assurance, "State of Health Care Quality," 2007.

[8] Katherine M. Flegal, Barry I. Graubard, David F. Williamson and Mitchell H. Gail, "Excess Deaths Associated with Underweight, Overweight and Obesity," *JAMA*, April 20, 2005; 203(15): 1861-1867.

Americans for chronic disease in 2003, while experiencing an added $905 billion in losses associated with indirect costs.[9]

Our delivery system reform efforts must refocus our system on getting and keeping people healthy throughout their lives. I believe a number of strategies are critical to refocusing our system on wellness and prevention, including:

- *Developing an integrated, holistic approach to care management to allow for early intervention and education;*
- *Using consumer engagement and targeted incentives to encourage sustained healthy behavior and change unhealthy behaviors; and*
- *Promoting coverage policies and initiatives that encourage the use of high-value health care and address the needs of specific population segments.*

Integrated, Holistic Approach to Care Management

All too often, patients can find themselves in a maze of multiple physicians and providers, lacking a coordinated, holistic view of their total health and the range of needs they face. For health care to be as effective as possible for each individual, care must be integrated and coordinated among providers and with health plans to ensure the right kind of focus on all aspects of a patient's health and needs. I believe that a holistic approach to care can have a positive impact on quality while also reducing costs.

Aetna Experience

Aetna Health Connections Disease Management helps people with chronic conditions get the treatment and preventive care they need by taking a wider view of an individual's health, rather than focusing solely on a single disease. Aetna's nurses and clinicians help members understand and follow their doctor's treatment plan and better manage ongoing conditions with the goal of helping members achieve their optimal level of health. These programs include foundational care management capabilities; effective use of data that provides a 360° view of a member's health; and personalized, actionable information through pinpoint identification that can measure changes in engagement levels over time. Employers who invest in this program have seen a 2 to 1 return on their investment. Moreover, through disease management programs, we have seen reductions in emergency room visits and inpatient admissions, including a 7 percent reduction in ER visits for asthma, a 13 percent reduction in inpatient admissions for coronary artery disease and an 18 percent reduction in inpatient admissions for strokes.

Consumer Engagement and Behavior Change

Wellness and prevention require consumer engagement and sustained behavior change. The path to engagement and behavior change begins with involving people in programs that will set them on their way to improved health, while providing continuous support and interaction to keep them moving in the right direction. This can be achieved by providing education,

[9] Devol, Bedroussian, Charuworm, et al. Indirect costs include decline in worker productivity, presenteeism and overall reductions in the labor supply.

interactive and easy-to-use tools and access to a range of services. These should include health risk assessments, fitness programs, weight management, disease management, smoking cessation, employee assistance and incentive programs.

Aetna Experience

Wellness Works Programs. We believe so strongly in the value of wellness programs that we implement them widely for our own employees. The goals of our *Wellness Works* programs include promoting positive, healthy behaviors; offering prevention and early intervention services; promoting appropriate utilization through our expertise in evidence-based medicine; and supporting a healthy culture that gives employees "permission to be healthy." As a result, engaged Aetna employees are getting healthier and contributing to lower medical costs. In fact, the suite of Aetna wellness programs were a strong contributor to Aetna's maintenance of a just over 3 percent trend in growth of health care costs. Two examples among many include the *Get Active Aetna* program, a fitness action campaign through which 55 percent of employees logged 970,000 exercise hours in 2008, and the *Healthy Lifestyles* programs, through which employees can receive up to $600 in financial incentives for participating in the company's health assessment and for tracking individual physical activity and healthy eating.

Value-Based Insurance Design. Based on evidence in the medical literature that co-payments and/or coinsurance can create barriers to care, value-based insurance design eliminates or reduces co-payments or coinsurance for certain medications or types of care that are demonstrated to be crucial in preventing or managing disease. In other words, insurance is designed so that costs are not a deterrent to individuals in seeking out the right kind of care. One important example is the various types of care that are provided with first-dollar coverage, including preventive care, routine physicals, gynecological exams and medications for chronic care conditions. In addition to offering these products in the market, Aetna and the Aetna Foundation are supporting two clinical studies to evaluate the efficacy of value-based insurance design with researchers at Brigham and Women's Hospital and the University of Pennsylvania.

Coverage Policies and Initiatives to Address Critical Needs

Another important approach for improving health and wellness on a large scale involves identifying groups of people – based on health condition, ethnicity or another unifying characteristic – that can benefit from a specific intervention and then providing that intervention. Such interventions have the potential to improve the wellness of individuals who may have otherwise fallen through the cracks. Aetna has worked hard to identify areas where we can have an impact on individuals, quality improvement and the health care system at large.

Aetna Experience

Childhood Obesity Pilot. In 2009, Aetna launched a childhood obesity pilot in cooperation with the Alliance for a Healthier Generation (partnership between William J. Clinton Foundation and American Heart Association), Aetna's employer clients and the medical

community. The program, currently available to five large employer groups totaling 74,000 employees, includes coverage for obesity and nutritional counseling provided by physicians, access to clinically-based community resources, educational materials distributed at the worksite and educational resources for physicians. We believe the program is breaking new ground; currently there is no evidence-based protocol for treating childhood obesity with counseling absent a co-morbid condition (e.g., diabetes). By addressing childhood obesity *before* it leads to serious health complications, this program takes an important, proactive step in improving health and quality of life for children in need. Our program offers a uniquely comprehensive approach by combining proactive treatment of childhood obesity with collaboration among insurers, employers, the medical community and families.

Aetna Compassionate Care Pilot. Although 70 percent of Americans say it is their wish to die at home, just under 25 percent do so.[10] In the advanced stages of illness, individuals and families too often face the challenging all-or-nothing decision of choosing between curative care in a hospital setting and palliative care in a hospice or home setting. In 2004, Aetna introduced a pilot program to evaluate whether liberalized hospice benefits (i.e., offering access to curative care whether in a hospital, hospice or at home) and specialized nurse case management support could improve quality of care and quality of life for members in the final stages of life. Through a study comparing three groups of members,[11] we found that the proportion of members using hospice increased across the board (71 percent for commercial health plan members and 63 percent for Medicare members); outpatient days spent in hospice more than tripled; and members were rushed to the ER less and had fewer hospitalizations. Most importantly, in a member satisfaction survey Aetna conducted of family caregivers of members enrolled in the program, 96 percent said they believed the member's needs for pain management and symptom relief were met in the final months of life.

Breast Health Ethnic Disparities Initiative. Through the Breast Health Initiative, we aim to improve women's compliance with screening mammograms by identifying those African American and Latina members who have not had annual screening mammograms, identifying barriers to screening mammograms and conducting personalized, culturally competent outreach.

Recommendations

Investments should be made in programs that promote the health and wellness of our population and encourage the use of preventive care. The programs enumerated above are only a sample of the many specific initiatives being implemented nationwide, but they demonstrate the value and efficacy of engaging individuals in the pursuit to achieve and maintain better health and wellness. Importantly, the employer-based system provides a critical venue for implementation of wellness and prevention programs, as insurers can help employers target interventions to the needs of their employees and their families. Congress should consider providing tax incentives to employers for offering evidence-based wellness programs, while also considering vehicles for pre-tax purchase of wellness-promoting

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[10] Robert Wood Johnson Foundation, "Means to a Better End: A Report on Dying in America Today," November 2002.

[11] Three member groups were: those receiving hospice benefits and case management from trained nurses; those receiving case management support only; and Aetna Medicare members.

activities. Grants for community-based wellness and fitness programs should also be considered in order to reach a larger segment of the population. In addition, wellness and prevention initiatives should be implemented in public programs in order to improve the quality of care provided and reduce costs. In all cases, programs should: be implemented with an eye toward consumer engagement and behavior change; utilize new and existing tools (e.g., care management, HIT) to ensure care is integrated; and enact coverage policies that encourage (rather than discourage) people to access care that promotes wellness and prevents disease.

3) Reform our payment system to focus on value, rather than volume

Though we as a nation have the highest per-capita health care spending in the world, the quality of care delivered by our health care system falls far short of expectations. Incentives in our payment system that reward providers for quantity of care rather than quality of care are an important part of the problem. Improving our delivery system starts with reforming our payment system to focus on quality and value. Aetna supports transforming the payment system into one that aligns provider reimbursement incentives with achieving high quality outcomes for patients.

Various payment reform approaches linking payment to performance and aligning care across the continuum of providers are being piloted and tested across the country. I believe we must work together to test and identify those that achieve value and sustain robust health care systems, including the following:

- *Consider new payment models to align care and recognize performance;*
- *Expand pay-for-performance;*
- *Revitalize primary care and support the patient centered medical home*
- *Increase transparency*
- *Include public programs in payment reform*

New Payment Models and Pay-for-Performance

The goals of both new payment models and pay-for-performance are: (1) to recognize and reward physicians, hospitals, other health providers and health systems for delivering high value; and (2) to create incentives for improvements in performance, outcomes and quality of care (e.g., safety, effectiveness and efficiency).

New Payment Models to Align Care and Recognize Performance: Reform should focus on meeting consumers' needs as they try to successfully navigate through our health care system by paying for coordinated care driven by intelligent decision-support systems. Approaches that dominate the payment reform debate and need to be considered include bundled payment for an episode of care and gainsharing (rewards for greater efficiencies), recalibrating the current fee-for-service system, global payment through capitation and other mechanisms. The private sector has been and will continue to be a useful laboratory for testing these approaches.

Pay-for-Performance: Pay-for-performance initiatives that are evidence-based and focus on continuous improvement can help bridge the transition to more comprehensive payment reform. Our collective ability to differentiate and measure performance and performance improvement is a fundamental component of payment reform. Investment in this area must focus on measures that are credible to physicians, clinically important, transparent to all stakeholders and understandable and useful to consumers.

The following are some examples of Aetna's efforts to try new payment structures that are designed to promote a team approach to medicine and improve outcomes for the patient.

Aetna Experience

Aetna's Pathways to Excellence.[SM] Pathways to Excellence initiatives are focused on engaging providers to improve both the patient experience and outcomes of care. This set of innovative solutions advances value-driven healthcare purchasing by aligning recognition, incentives and/or payments to providers with the delivery of high quality, safe and efficient care. It includes such diverse initiatives as pay-for-performance with physicians and hospitals; our High Performance Provider Initiative health care improvement collaboratives; Aetna's Institutes[SM] Program for designating top performing facilities and providers for specific health services; and Aetna's Aexcel® Specialty Designation High Performance Network.

Currently, nearly 80,000 physicians and 350 hospitals participate in *Pathways to Excellence*. To ensure that our provider partners are actively engaged in achieving successful outcomes, we work with them to select mutually agreed-upon measures for improvement assessment. As part of this program, a multi-hospital, metropolitan system experienced significant improvement in antibiotic management along with a 10 percent reduction in length of stay over a two-year period. In our High Performance Provider Initiatives, we work with hospital and health plan data to identify variations in care and implement targeted interventions to reduce these variations. These collaborations have reduced hospital readmission rates, increased post-discharge physician visits, increased the use of generic drugs and decreased unnecessary high-cost radiology procedures.

Both our Aetna Institutes and Aexcel Programs identify high performing providers and designate High Performance Networks. In Aexcel, specialists who have met clinical quality and efficiency standards are recognized. Aetna's performance network is associated with high-quality care that saves up to 4 percent in medical costs annually. **Aetna Institutes™** facilities are publicly recognized, high-quality, high-value health care facilities. By identifying these providers in our provider search engines and, in some cases, providing incentives to members, we reward these facilities for their performance. Our Institutes for Bariatric Surgery have achieved exceptional outcome results for our members, resulting in medical costs in the year post surgery that are 15 percent lower than the year prior.

Revitalizing Primary Care and Supporting the Patient Centered Medical Homes

We need to build on the Patient Centered Medical Home models now being tested and refined in both the private and public sectors. Fundamental to these programs should be the establishment of methodologies for compensating primary care practices in a way that

recognizes the value of care coordination. Investment in formal evaluation of the impacts of the Medical Home on quality, cost and patient experience should be an integral component of all demonstrations undertaken in the public sector. Payment reform should also directly address practical methods to recognize the value of telemedicine, electronic visits and other technology-enabled approaches to delivering more effective care, especially for those patients with chronic medical conditions.

Aetna Experience

Primary Care Revitalization and Patient Centered Medical Home. Aetna is engaged in four Patient Centered Medical Home demonstrations and is planning several others. In each of these, payment structures can range from allowing payment for care coordination services and consultation within an interdisciplinary team to innovative gainsharing strategies. In our Medicare Advantage program we also are making nurse care coordinators available on-site at physician offices to support primary care. Our rigorous methods of measurement will help identify effective strategies for reaching our common goals among the diverse populations, communities and practice-types that must be supported through such initiatives.

Transparency

Health care consumers often lack quality and price information before they receive care, often leading them to pay too much for care without being assured of the standard of care they expect. Conventional wisdom might suggest that more expensive health care is better care, but researchers have found that neither quality of care nor patient satisfaction is correlated with costs. The system should demand transparency in health care quality, network membership and pricing to give consumers easy access to health care information to make good decisions. We believe that investments in transparency should be accompanied by rewards and other incentives for providers that efficiently deliver evidence-based care.

Aetna Experience

Healthcare Transparency Tools. Aetna has a leading suite of online health care transparency tools that provide our members, prior to receiving care, with clinical quality, cost and efficiency information. Online access to this information helps members choose health care providers, make informed health care decisions and better plan for their health care expenses. Ensuring transparency on all three levels – quality, cost and efficiency – makes certain that price information will not disproportionately drive health care decisions.

We have integrated transparency information directly at the point of member selection of providers through Aetna's DocFind search-engine. Today, members can learn which physicians are participating in the American Board of Internal Medicine Quality Improvement Program and the American Society of Clinical Oncology Practice Improvement Initiative, and which physicians are recognized by the National Committee for Quality Assurance (NCQA) or Bridges to Excellence.

Members can utilize our hospital comparison tool with direct links to the Leapfrog Group and hospitalcompare.gov to better understand hospital care and quality. We continue to expand

our partnerships for external recognition while also building our own internal recognition programs.

Include Public Programs in Payment Reform

Among all payers in our system, the government is the largest individual payer of health care costs. Public programs must be part of payment reform. Under Medicare's current fee-for-service payment structure, providers are paid on the basis of volume rather than value, often with suboptimal results. Moreover, lower payment rates paid by public programs result in cost shifting to those who are privately insured. In 2007, commercial payers paid physicians at much higher rates than public payers, with Medicare rates at 89 percent of the overall average rate, Medicaid rates at 60 percent of the average and commercial rates at 114 percent of the average. On an aggregate level, the cost shift from public programs to commercial plans is about $89 billion, leading the average privately insured family to spend an additional $1,788 annually.[12] By addressing the challenges within the public program payment systems, we can begin to tackle payment reform head-on, while also reducing some of the negative externalities associated with the payment structures within these programs.

In addition to payment reforms needed within Medicare to improve quality and reduce costs, and in light of budgetary needs for a down payment on health care reform efforts, we may also have to address the related issue of Medicare's operational structure and the Medicare Advantage bidding process. In particular, if we decide to follow a pathway to Competitive Bidding in Medicare Advantage, we should look at the development of a viable structure that exhibits the following guiding principles: (1) generates meaningful cost savings from the Medicare Advantage program; (2) maintains access for all beneficiaries and minimizes disruption; and (3) provides incentives to improve quality.

Recommendations

We must continue to test new payment models and pay-for-performance programs as we implement the most promising approaches in both private insurance and public programs. We should take steps to revitalize primary care, recognizing its importance to providing integrated, quality care at a lower cost. Beyond investigating new primary care models, such as the medical home, Congress should offer loan forgiveness to medical students choosing to practice primary care. Congress should push for greater transparency in public programs, in order to provide consumers with the critical price and quality information they need to make good choices when it comes to their own health care. For all interventions related to payment reform, I urge Congress to recognize and act on the importance of implementing payment reform in public programs, including Medicare, Medicaid, CHIP and the Indian Health Service, in order to expand the reach of effective approaches for the benefit of a broader segment of the population.

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[12] Will Fox and John Pickering, "Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid and Commercial Payers," Milliman, December 2008.

Conclusion

We cannot ensure a high standard of care for all Americans until we repair our health care delivery system. To repair our system, we must encourage the widespread adoption of the health information technology tools that can provide for better care coordination and better care. To repair our system, we must achieve a renewed focus on getting and keeping people healthy by maintaining a primary focus on wellness and preventive care. And finally, to repair our system, we must reform payment structures to facilitate provision of the highest possible quality of care.

Aetna has been at the forefront of bringing about innovations to improve the health and lives of our members and to enhance the functioning of the many parts and players in the health care system with whom we interact. I believe the competitive marketplace has played – and can continue to play – an important role in fostering the innovation necessary for our country to achieve true and widespread greatness in our health care system. I encourage Congress to accelerate the implementation of these innovations on a wider scale for the benefit of our entire population.

Thank you for the opportunity to share my thoughts with you today.

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