HEALTH REFORM IN THE 21ST CENTURY: PROPOSALS TO REFORM THE HEALTH SYSTEM

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HEALTH REFORM IN THE 21ST CENTURY: PROPOSALS TO REFORM THE HEALTH SYSTEM

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

JUNE 24, 2009

Serial No. 111–26

Printed for the use of the Committee on Ways and Means

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HEALTH REFORM IN THE 21ST CENTURY: PROPOSALS TO REFORM THE HEALTH SYSTEM

WEDNESDAY, JUNE 24, 2009

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The Committee met, pursuant to notice, at 9:09 a.m., in room 1100, Longworth House Office Building, Hon. Charles B. Rangel (Chairman of the Committee), presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
June 24, 2009

CONTACT: (202) 225–3625

Chairman Rangel Announces a Hearing on Health Reform in the 21st Century: Proposals To Reform the Health System

House Ways and Means Chairman Charles B. Rangel (D–NY) announced today that the Committee will hold a hearing to examine proposals to reform the health system. This is the sixth hearing in the series on health reform in the 111th Congress. **The hearing will take place at 9:00 a.m. on Wednesday, June 24, 2009, in the main Committee hearing room, 1100 Longworth House Office Building.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from the invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Rising health costs threaten access for the 250 million people with insurance and undermine the competitiveness of American companies. In addition, nearly 46 million people lack coverage today and millions more have coverage that fails to meet their needs. A reformed health system must build on what works in our current system to expand access, while minimizing disruption for people who have coverage and helping to slow the rise in health costs. Recent studies have indicated that half of all bankruptcies are the result of serious illness and medical debt, and many of these families have coverage.

The Committee has held five health reform hearings this year to examine the current state of various parts of the health system. These hearings build upon hearings and legislation that the Committee has undertaken in previous Congresses. Among other topics, these hearings have highlighted the need to improve the way care is delivered and the problems with the current insurance market. The hearings also stressed the importance of the employer-based system of health insurance and the need to improve and strengthen current programs like Medicare and Medicaid.

The Committee has worked with the Committee on Energy and Commerce and the Committee on Education and Labor to develop a proposal that reflects President Obama's health reform principles and will begin to rein in rising health care costs, protect current coverage, preserve choice of doctors, hospitals and health plans and ensure affordable, quality health care for all.

In the coming days, this discussion draft health reform proposal will be released. This hearing will focus on that proposal as well as other proposals to reform the health system.

"We have an historic opportunity to reform our Nation's health care system, building on what works and fixing what is broken to reduce health care costs, protect current coverage and preserve choice for patients to guarantee affordable, quality care for all," said Chairman Charles B. Rangel. **"Health reform is critical to America's economic recovery and I look forward to feedback from Members and witnesses so we can continue working to make this goal a reality."**

FOCUS OF THE HEARING:

The focus of the hearing will be on the forthcoming proposal developed by the Committees on Ways and Means, Energy and Commerce and Education and Labor and other proposals to reform the health system.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://democrats.waysandmeans.house.gov*, select "*Committee Hearings*." Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record*." Once you have followed the online instructions, complete all informational forms and click "submit" on the final page. ***ATTACH*** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **Wednesday, July 8, 2009**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://democrats.waysandmeans.house.gov*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TDD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman RANGEL. The Committee on Ways and Means will come to order as we begin, I guess, our ninth hearing on health reform. I want to thank the staffs, minority and majority, for bringing us to this point in our Nation's history where we do see light at the end of the tunnel for one of the most serious domestic problems our great Nation has faced.

It is abundantly clear that we have a serious financial problem as the cost of health care escalates far beyond our imagination, and continues in this upward spiral. We have a moral obligation in

terms of the number of people who have lost their homes, gone into bankruptcy as a result of the costs of providing health care. And of course, we have a crisis in terms of the waste and inefficiency and the misuse of our resources by health providers that find us in need of changing the entire system.

We hope at the end of the day that we are able to say that those people who find that their insurance meets their needs, that they should rest assured that we have enough problems without interfering with the relationship they have with private health insurers.

They will have to be able to understand, however, that in their search for profit, there has to be basic sound principles that health care providers would have to be involved and support. One thing for certain: The whole idea that insurance companies can pick and choose the healthiest of their clients is wrong, and it will be corrected as we make certain that those people that have preconditions will be acceptable.

We know that there are so many employers that want to provide health care for their employees because it is the right thing to do, and they just can't afford to do it. We have to give them assistance.

We know that there is nobody in the United States that is an adult and understands the problems we face that hasn't got a horror story, with or without insurance, as to what has happened to their families and, indeed, communities because the system is broken.

We also know that we just don't have enough primary care doctors and nurses and support system. And we have to encourage these people in order for us to be healthy and competitive with foreign countries to be out there, not just looking for profits but looking to fulfill their life's work in terms of taking care of our sick; and, more importantly or just as important, to make certain that we avoid these serious and expensive illnesses.

We have the support of the President of the United States. We sincerely wish that this could be a bipartisan effort. The book is not closed. We have before us a discussion draft, and we have had more discussion than we had thought we would have, which I think is healthy; so that at the end of the day, when we pass this, more and more Americans would understand that we have done the right thing.

And certainly the polls, for what it is worth, overwhelmingly believe that what we are doing in terms of having a competitive public option so that people can go to exchange and pick and choose, with a variety of private options just as we in the Congress have, and also a public option, we think at the end of the day it is going to be the American citizens that will be the beneficiary. The industry will be improved. America will be stronger and more competitive. And we all are privileged to be able to be participants in this effort.

Peter Stark is one of the—probably, with me, is historically the longest-serving Member of this great Committee that was cited in the Constitution, and the only one cited. And he has dedicated his entire legislative career to trying to get a handle on the ever-increasing problems that health care has caused our Nation to face.

I know that this era is one of the most proudest that he has enjoyed, and the Committee is grateful for the investment that he has

made in time and dedication to reach this point that during his stay here, he would be able to say, we finally have improved the system.

Pete, we are indebted to you, and I would like at this point in time to yield to you.

Mr. STARK. Thank you, Mr. Chairman. You and my colleagues and the President are committed to health reform, and I think we all understand this is the time to act. We have worked with our colleagues on the Energy and Commerce and the Education and Labor Committees to write a draft proposal that provides affordable, quality health care for all, expands choice, and slows the rate of growth in health care spending.

Some will be unhappy that we still don't have CBO numbers for provisions. We put this bill out last Friday in draft form so that all Members of Congress, the American public, and interested parties can read the discussion draft and provide us with input.

Today's hearing, we hope, will be long, and we will hear from three panels. The first will be our panel of policy experts with their thoughts; second, a panel consisting of those impacted by health reform—consumers, seniors, businesses both large and small, labor; third, we will hear from health care providers who will share with us their thoughts on our draft legislation.

As I said, it is in draft form. Today's hearing will give us guidance for meetings over the next couple of weeks as we work to convert this draft into a final bill.

So I want to thank all of our witnesses in advance for their testimony. They have had a lot to analyze in a short time, and we appreciate their willingness to enlighten us today. Thank you very much.

Chairman RANGEL. Thank you, Mr. Chairman.

Most of you know, and certainly the Committee Members know, that David Camp and I have tried with the most that we can to see whether or not we could work together in a bipartisan way. Many times this is impossible because of the differences, not of he and I, but certainly of the political direction in which the parties would want to go.

We know that this is not a Democratic problem. It is not a Republican problem. And the Nation is going to look at this as a problem that we hope that we can come together and work together and bring up a bipartisan bill.

As Peter Stark has indicated, this is a discussion draft bill that will help us to try to perfect our ideas. And I yield to my friend David Camp for whatever purposes he would want to state.

Mr. CAMP. Well, thank you, Mr. Chairman. And thank you for holding this hearing. And I want to thank all of the witnesses and the panels that have taken time out to be here today.

Mr. Chairman, I am not sure quite what to focus on this morning, all we know about the bill or all that we don't know about the bill. But in either sense, it is very disturbing. And let me begin with what we don't know.

We don't know how much CBO says it will cost or how it will be paid for. And hopefully everybody can see page 162 of the bill on the TV screens. Now, I know a picture is worth a thousand

words, but I think that picture may be worth well over a trillion dollars.

The bill says other revenue raisers are to be provided. When will these tax increases be provided? When will the American public get to know how much this trip to the doctor will cost them? Those details aren't unimportant.

If you are shopping for a car, even I have to admit that a Ferrari looks pretty good next to a Ford until you see the pricetag. A six-bedroom mansion on the waterfront looks pretty good next to a modest three-bedroom ranch until you see the pricetag. We need to know the pricetag of this bill if we are to do our jobs properly, and that is to write a bill our country can afford that will guarantee every American has access to affordable quality health care.

Just this morning I received an independent, nonpartisan analysis of the bill. I know I said this picture was well over a trillion dollars, but this report makes it clear that I really don't have much future in appraising because this bill is actually worth $3.5 trillion.

And let me repeat that for everyone here, especially the Members who have not been given any information on the cost. An independent, nonpartisan analysis says this bill costs $3.5 trillion. And I ask that a copy of this report by HIS Network be included in the record.

Now, that is a staggering figure, even in Washington. Equally staggering are some of the ideas we have heard floating around about how to pay for this bill, such as new taxes on employer-sponsored health benefits, new taxes on sugared soft drinks, additional taxes on alcohol that will turn Joe Sixpack into Joe Fourpack, a new national sales tax, new taxes on American businesses competing worldwide, and higher Medicare taxes.

Those are pretty darned scary in and of themselves. But what has me in shock is the fact that those taxes won't even come close to covering $3.5 trillion in new Federal Government spending. And it is clear that if we move forward with this $3.5 trillion bill and with any of those taxes, whatever hope remained that the President would keep his word not to tax families earning less than $250,000 will be quickly erased.

The President has also promised repeatedly that Americans who have and like their insurance will be able to keep it. Now, I know he is getting pressured to back off that statement. I would hope both Republicans and Democrats on this Committee would help him keep that pledge.

But the analysis we received this morning says this bill would cause 64 million Americans to lose their coverage. Sixty-four million. That means one out of every three Americans under the age of 65 would lose their current private health coverage. We need to strengthen and improve our health care system, not destroy it.

No matter what comes out of this hearing, unanswered will be several critical questions. How much will you tax and who pays those "other revenues"? What will be the impact on family budgets? What will be the impact on employees and employers and on those looking for work? What about the economy as a whole? I am disappointed that this information isn't before us since it is impossible to make a thorough evaluation of the bill without it.

Now to what we do know. It creates a government-run plan that reimburses at Medicare rates, which will force millions of Americans to lose their current health care plan. There are absolutely no prohibitions on new government-run plan or government programs like Medicare or Medicaid from using cost-effectiveness research to impose delays or denials of access to life-saving treatments for patients. And just the new taxes and penalties on employers that we have already seen will force 4.7 million Americans to lose their job.

Now, those aren't my numbers or my analysis. That is what you get when you plus the taxes associated with an employer mandate into the economic models developed by Dr. Christina Romer, the Chair of the President's Council of Economic Advisers, and Jared Bernstein, who is in the Office of the Vice President.

What does this leave us with? In short, a bill in which the solution costs more than the problem, and health care reform in which millions of Americans lose their insurance, lose access to treatment, and maybe even their job.

This is what happens when legislation of this nature is written in secret by a few behind closed doors without the input of Members on both sides of the aisle, not to mention the families and businesses it will affect. I have heard even Members of this Committee have raised their concerns about the way this bill was written. So have Blue Dogs in a written letter, and so have House Republicans.

This painfully reminds me of the stimulus bill. But as important as it was, we were just talking about money then. This time we are talking about people's health, about their lives. We cannot get it wrong again.

The President was right when he said health care reform should not be a Democrat issue or a Republican issue, but an American issue. And as you know, last week Republicans outlined a summary of what we believe successful health care reform should focus on—affordability, accessibility, and availability of quality health care for all Americans.

There are a number of areas where we could reach bipartisan agreement. I and the Republican Members of this Committee stand ready to meet and work with you to get this bill right, and I hope we can do that soon.

And with that, I yield back the balance of my time.

Chairman RANGEL. Thank you. I ask you to share with me at some point in time the firm that did the analysis for you that estimated the $3.5 trillion cost because it may be helpful for us to be able to make up numbers since Republicans and Democrats are stuck with the Congressional Budget Office. And as you know, they have not been very friendly in their estimates in terms of costs. But if someone can create just $3.5 trillion, I can share with you that I will walk away from any bill that has this type of cost.

The whole idea of cost, however, should not be an issue because we are going to pay for this not by raising taxes, but even in this walk-through that we have. Five hundred billion dollars is reform in the system that we have.

And whatever we do to raise the other revenue, at the end of the day we will be able to say that the bill is a reform bill and will not be additional cost. So we have to try to read from the same

page. And I know you won't object to reading from the pages given to both of us by the Congressional Budget Office.

And yes, we all would want Ferraris. I was settling for a Cadillac since it is made in the United States. But after we look at the cost of the options that are there, then we will know what we can afford. And so it really doesn't make that much difference as to what we hope for. We will only do what we can afford and what will be acceptable to the American people.

I am glad to hear you say that your minds are open. At any point during the testimony of your witnesses or ours that you believe we can sit down and work together, we will go into recess, go into the library, take advantage of that, and then move forward.

So let today be the beginning of a new start. And as Chairman Stark has said, we have an extraordinary panel here. The first panel we have is Karen Pollitz, who is the Policy Director of the Health Policy Institute from Georgetown Public Policy Institute, Georgetown University; John Holahan, Dr. Holahan, who is the Director of the Health Policy Research Center in The Urban Institute; Quentin Young, Dr. Quentin Young, National Coordinator for Physicians for a National Health Program, from Chicago; and David Gratzer, Dr. David Gratzer, a Fellow, Manhattan Institute for Policy Research, from my hometown and my city, New York, New York.

We thank you for taking the time to come here to share your views with us so that we can make a more perfect piece of legislation. We have—by unanimous consent, all of the documents that you have will be submitted in our record.

Restrict it this morning to 5 minutes for each witness, which is indicated by the red light coming on. And the Republicans and Democrats welcome your appearance here before the Congress and the Committee.

So we will start off with Dr. Karen Pollitz.

STATEMENT OF KAREN POLLITZ, POLICY DIRECTOR, HEALTH POLICY INSTITUTE, GEORGETOWN PUBLIC POLICY INSTITUTE, GEORGETOWN UNIVERSITY

Ms. POLLITZ. Thank you. I am not a doctor. Just call me Karen.

Chairman RANGEL. Thank you, Karen.

Ms. POLLITZ. And good morning, Mr. Chairman, Members of the Committee. I want to congratulate you on the tri-committee draft proposal for health care reform. It contains the key elements needed to achieve universal coverage and introduce cost discipline into our health care system. It reflects both wisdom and practicality. And this time I believe you will get the job done.

The tri-committee proposal defines a minimum health benefit standard. It requires all Americans to have at least that minimum coverage, with shared financing responsibility by employers. It creates tax credits for small businesses, expands the Medicaid safety net, and creates new premium and cost-sharing subsidies for private health insurance coverage to help other Americans of modest means.

The proposal also establishes a set of strong new market reforms for private health insurance, with important consumer protections. It creates a new health insurance exchange, an organized health

insurance market, with greater consumer protections and support than individuals and small employers have today.

It will provide competitive information on plan choices, help with enrollment, appeals, application for subsidies. It will have a health insurance ombudsman to help individuals and small businesses navigate the coverage system and make good choices. And on their behalf, the exchange will negotiate with insurers over premiums in order to get the best possible bargain. And importantly, consumers and employers who buy coverage in the exchange will also have the choice of a new public plan option.

A recent national poll indicates Americans strongly favor the establishment of a public plan option to compete with private health insurers. Such an option can address failures of competitive health insurance markets today.

First, it offers consumers an alternative to private plans that for years have competed on the basis of discriminating against people when they are sick. Just last week your colleagues on the Energy and Commerce Committee held a hearing on health insurance rescissions.

There, a woman battling breast cancer testified that her health insurance was revoked for failure to disclose a visit to a dermatologist for acne. When consumers are required to buy coverage, having a public option that doesn't have a track record of behaving that way will give many peace of mind.

Second, a public plan option will promote cost containment. Research shows that health insurance markets today do not compete to hold down costs. Rather, insurers and providers negotiate to pass costs through to policyholders while maintaining and growing profits.

For the first few years, the public plan option will be allowed to base its payment to doctors and hospitals and most other providers on the Medicare fee schedule—actually, increases above those fee levels—but over time it will develop innovative payment methodologies that hold down costs and promote quality.

Mr. Chairman, clearly, as this bill moves through the legislative process, there will be opportunities to improve and modify it. And in my written statement, I offer several recommendations in this regard, and would briefly describe just three of those for you now.

First, with respect to the essential benefits package, I think there are opportunities to strengthen the package and add specificity. The essential benefits package in particular does not include a limit on cost-sharing for care received by non-network-plan physicians. That is an important protection to add. And the essential benefits package doesn't have a specific reference to a benchmark plan, the Blue Cross Blue Shield standard option plan that so many Members of Congress have, and that has been discussed as a reasonable benchmark for coverage adequacy.

It is not clear whether the essential benefits package outlined in the draft proposal meets that standard, but it should. And if it doesn't, then the standard should be improved. And if that requires adding more money to the bill, then you should add it.

Second, with regard to rules governing health insurance, new rules won't be meaningful unless there are resources for oversight and enforcement. The Department of Health and Human Services

today has four employees who work part-time on private health insurance oversight. At the Department of Labor, there has been testimony indicating that there are resources to review each employer-sponsored health plan under that Department's jurisdiction once every 300 years. And State insurance departments are also strapped for resources.

Your colleague on the Appropriations Committee, Congresswoman DeLauro, has introduced legislation to provide resources for health insurance oversight and enforcement, and I hope you will work with her.

And finally, with regard to subsidies, the bill, the draft bill, creates sliding scale assistance so that middle-income Americans with incomes up to 400 percent of the poverty level would not have to pay more than 10 percent of income toward their premiums.

But after that level, the subsidies stop, and as the charts in my written statement indicate, some consumers, including self-employed individuals, who have incomes above that level might still face significant affordability problems. That is essentially likely for people who buy family coverage and for baby boomers who would face much higher premiums under the age rating adjustments that are provided for under the bill.

So I hope the Committee will consider making additional adjustments to your subsidy to protect all Americans so that they don't have to spend more than 10 percent of their income on health insurance.

Thank you very much.

[The prepared statement of Ms. Pollitz follows:]

GEORGETOWN UNIVERSITY
HEALTH POLICY INSTITUTE

Statement of

Karen Pollitz, Research Professor
Georgetown University Health Policy Institute

Hearing on
The Tri-Committee Draft Proposal for Health Care Reform

Committee on Ways and Means

June 24, 2009

Good morning, Mr. Chairman and Members of the Committee.

I am Karen Pollitz, a Research Professor at the Georgetown University Health Policy Institute, where I study the regulation of private health insurance.

I commend the Members of the three House Committees, including this one, for the Tri-Committee Draft Proposal for Health Care Reform. Your hard work, wisdom, and practicality are evident in this proposal. It contains the key elements necessary for effective health care reform that will achieve universal coverage and introduce cost discipline into the health care system. I congratulate you on this effort, and as a citizen, I thank you for it. This time, you will get the job done.

In my remarks today, I will comment on some of the central health care reform provisions contained primarily in the first five titles of the draft legislation and offer several suggestions that I hope you will find helpful and constructive as you work toward enactment later this year.

For health care reform to provide all Americans with secure coverage, changes must be adopted and enforced to ensure that health insurance is always available, affordable, and adequate. Key elements of the Tri-Committee proposal will address these critical needs.

Individual responsibility

The legislation requires all Americans to have health insurance coverage. More importantly, it makes other changes to our coverage system to enable people to comply with this requirement.

Essential benefit standard

A most basic component of health care reform is to define what constitutes health insurance. Far too many policies that provide inadequate coverage are on the market today, and as a result, almost as many Americans are under-insured as uninsured. Recent studies find that 57 million Americans are burdened with medical debt, and 75 percent of them have health insurance.[1] Medical bills continue to be a leading contributor to personal bankruptcy and most medical bankruptcies also occur among people who are insured.[2] This spring, *Consumer Reports* magazine reported on a host of health insurance products that nonetheless left policyholders on their own to pay tens of thousands of dollars (or more) in medical bills.[3] Studies show the under-insured, similar to the uninsured, have difficulty accessing timely and quality health care.[4]

A fundamental purpose of health care reform must be to put an end to medical debt and medical bankruptcy and to ensure that health coverage is, indeed, a ticket to health care. The Tri-Committee draft proposal sets national standards for an essential health benefits package that includes hospital care, inpatient and outpatient medical care, prescription drugs, mental health and substance abuse treatment, rehab services, preventive care services, and maternity care. Enhanced benefits for children are also covered. Cost

sharing for covered services provided in-network cannot exceed $5,000 per year for an individual, $10,000 for a family. The annual limit on cost sharing is a comprehensive limit that applies to all forms of cost sharing, similar to that required for tax preferred HSA-eligible health plans today.

All qualified health benefit plans will be required to cover the essential benefits package. Three levels of plan options can be offered. The Basic Plan level must set cost sharing to achieve an actuarial value of 70 percent of the essential benefits package. Enhanced and Premium Plan options must have actuarial values of 85 and 95 percent, respectively, of the essential benefits package.

A Health Benefits Advisory Committee chaired by the Surgeon General will fill in other important details on plan features, such as the annual deductible(s) and update the benefit package over time.

Recommendation – The essential benefit package must include a maximum out-of-pocket limit whether people receive care in or out of network. Though the bill provides for the establishment of network adequacy standards, patients nonetheless need protection against unlimited cost sharing when they must seek care out of network. The sickest patients are most likely to need care from sub-specialists who may not participate in their plan network. And any patient who is hospitalized may inadvertently receive costly care from non-network doctors whom they do not choose (for example, anesthesiologists, radiologists, pathologists, emergency physicians.)

In addition, an often mentioned benchmark standard for coverage adequacy is the Standard Option plan offered by Blue Cross Blue Shield under the Federal Employees Health Benefits Program (FEHBP) - coverage that most federal employees and many Members of Congress have today. The essential benefits package outlined in the draft proposal appears to provide less coverage than this FEHBP standard. If that is the case, additional resources should be added to the bill to raise the minimum benefit standard. Over the next decade, our economy will generate more than $187 trillion in gross domestic product and we will spend a projected $33 trillion on medical care. Investment in health care reform that guarantees an adequate level of protection for individuals and families is worthwhile.

Whatever benefit standard is ultimately adopted, the Health Benefits Advisory Committee should be required to regularly report on medical bills that individuals and families incur in order to monitor and strengthen coverage adequacy.

Finally, the draft proposal continues to permit the sale of certain so-called "excepted benefits" in traditional health insurance markets. These include cancer policies and other dread disease and limited benefit policies. Consumers are vulnerable to abusive marketing practices when it comes to these policies and state regulators have long warned they are a poor value.[5] At a minimum, such policies should contain warning labels that they do not constitute qualified health benefit plans and that coverage is duplicative of that provided under qualified health benefit plans.

Subsidies and Medicaid expansion

Today most uninsured people have low incomes and lack coverage chiefly because they cannot afford it. The Tri-Committee proposal addresses affordability in two ways.

First, it expands Medicaid coverage to all Americans with family incomes up to 133-1/3 percent of the federal poverty level (FPL). This is an important departure from the current Medicaid program, which only provides coverage for certain categories of individuals – children and their parents, and other adults only if they are elderly or disabled. In addition, current Medicaid income eligibility standards for adults vary significantly by state but often are set at levels far below the FPL.

To make this expansion affordable for states, the draft legislation provides that the federal government will pay the full cost of covering new expansion populations – childless adults and other adults for whom current income eligibility levels are below 133-1/3 percent FPL. Further, to ensure individual choice, Medicaid-eligible individuals will have the choice between enrolling in Medicaid or seeking other subsidized private health insurance coverage

Second, the discussion draft provides for sliding scale financial assistance for individuals and families to purchase private health insurance. Premium subsidies would be offered on a sliding scale for people with income up to 400 percent of FPL. Subsidies at this level will be absolutely necessary, and, as discussed below, may well need strengthening.

Importantly, the discussion draft also provides subsidies for cost sharing under private health insurance. This is also critically important. Deductibles, co-pays, and coinsurance are additional payments required of insured individuals at the point when they seek health care. Decades of research shows that cost sharing deters the use of care, including medically necessary care, particularly by people with limited income. Further, research shows that when out-of-pocket spending for medical bills (not including premiums) exceeds just 2.5 percent of family income, patients become burdened by medical debt, face barriers to accessing care, and have problems paying other bills.[6] Cost sharing subsidies are necessary to ensure that people can afford to access covered benefits.

Recommendation – Depending on what premiums are charged for qualified health benefit plans, subsidies capped at 400 percent of FPL may prove to be insufficient to ensure affordable health care for all Americans. At last count, ten percent of the uninsured, or some 5 million Americans, had incomes at or above 400 percent FPL. This is due to the fact that our measure of poverty level income is very low, while the cost of good health coverage is relatively expensive. For example, an income of 400% of FPL for a family of three is $73,240. For that family to enroll in the FEHBP Blue Cross Blue Shield Standard Option plan would cost $13,446, or 18 percent of gross family income.

The Massachusetts health care reform experience is instructive. In that state, subsidies are limited to residents with incomes to 300 percent of FPL, and as a result, the state waives the individual mandate on grounds of affordability for approximately 2 percent of residents.[7] Because people with incomes above the subsidy levels provided in this bill

may find quality health insurance coverage costs more than they can afford, you should consider improvements to the premium subsidy schedule.

The Committee might consider instead a rule that no individual or family will have to pay more than 10 percent of income on health insurance premiums (with lower limits set for low-income individuals, as the Tri-Committee draft does.) Cutting subsidies off entirely at an arbitrary income level can leave families vulnerable.

As shown in Figures 1 and 2, if the intent of the Committees is to assure that no families or individuals will have to pay more than 10 percent of income for health insurance premiums, and if the FEHBP Blue Cross plan is used as a benchmark premium, then people will need help beyond that provided for in the draft proposal. The cost of good coverage is will be sizeable compared to what many working families earn. (See Figure 3) A subsidy system that caps people's liability for premiums at no more than 10 percent of income would be more protective and subsidies would taper off gradually, avoiding a cliff. Some assistance would reach people at higher income levels, though help provided to higher earners would be modest.

Figure 1. Comparison of Single Premium for FEHBP BCBS Standard Option to Various Income Levels, 2009

% FPL	Annual Income	BCBS FEHBP Annual Premium	Premium / Income	Sliding Scale Income Cap on Premium Liability	Individual Pays	Amount Help Needed	(%) Help Needed
100%	$10,830	$5,872	54%	0	0	$5,872	100%
200%	$21,660	$5,872	27%	2%	$433	$5,439	93%
300%	$32,490	$5,872	18%	6%	$1,949	$3,923	67%
400%	$43,320	$5,872	14%	8%	$3,466	$2,406	41%
500%	$54,150	$5,872	11%	10%	$5,415	$ 457	8%
600%	$64,980	$5,872	9%	10%	$5,872	0	0
1,600%	$174,000	$5,872	3%	10%	$5,872	0	0

Figure 2. Comparison of Family Premium for FEHBP BCBS Standard Option to Various Income Levels, 2009

% FPL	Annual Income	BCBS FEHBP Annual Premium	Premium / Income	Sliding Scale Income Cap on Premium Liability	Family Pays	Amount Help Needed	(%) Help Needed
100%	$18,310	$13,446	73%	0	0	$13,446	100%
200%	$36,620	$13,446	37%	2%	$732	$12,714	95%
300%	$54,930	$13,446	24%	6%	$3,296	$10,150	75%
400%	$73,240	$13,446	18%	8%	$5,860	$7,586	56%
500%	$91,550	$13,446	15%	10%	$9,155	$4,291	32%
600%	$109,860	$13,446	12%	10%	$10,986	$2,460	18%
700%	$128,170	$13,446	11%	10%	$12,817	$629	5%
735%	$134,460	$13,446	10%	10%	$13,446	0	0
950%	$174,000	$13,446	8%	10%	$13,446	0	0

Figure 3. What do people earn?

Individual			Family of 3		
% FPL	Annual Income	Example occupations*	% FPL	Annual Income	Example occupations*
100%	$10,830		100%	$18,310	
150%	$16,245	Fast food worker	150%	$27,465	Dishwasher + part time laundry worker
200%	$21,660	Home health aide	200%	$36,620	Cafeteria attendant + shampooer
250%	$27,075	School bus driver	250%	$45,775	Restaurant cook + stock clerk
300%	$32,490	Travel agent	300%	$54,930	Receptionist + secretary
400%	$43,320	Social worker	400%	$73,240	Police officer + child care worker
500%	$54,150	High school teacher	500%	$91,550	Legal secretary + electrician
600%	$64,980	Nurse (RN)	600%	$109,860	Real estate agent + librarian
1,600%	$174,000	U.S. Congressman	950%	$174,000	Administrative law judge + aerospace engineer

* Source: Bureau of Labor Statistics

Private health insurance market reforms

The Tri-Committee proposal prohibits the use of common insurance industry practices today that have the effect of discriminating against people based on health status. Under reform, health insurance would have to be offered on a guaranteed issue basis. No longer could individuals or employer groups be denied coverage based on health status or health history, although insurers would be allowed to surcharge premiums by as much as 100 percent based on age – a strong proxy for health status. The discussion draft also provides for guaranteed renewability of coverage – a requirement of current law – with clarification that the rescission of health insurance is also prohibited. In other words, insurers will be explicitly prohibited from a common practice today of taking back coverage from individuals and employer groups after claims are made. The draft legislation also prohibits the imposition of pre-existing condition exclusion periods and prohibits insurers from varying premiums based on health status. These market rules will promote the spreading of risk, instead of today's industry practices of segregating risk. And they are essential in a world where people are required to have health insurance.

Other new market rules will ensure that coverage works well and efficiently for consumers. Standards for network adequacy and the timely payment of claims are provided for under the bill. In addition, insurers will be required to meet minimum loss ratios of 85 percent, so that no more than 15 percent of premium dollars can be spent on marketing, administrative costs, and profits.

Recommendation – Consideration should be given to tighter limits on age adjustments to premiums, or for elimination of such adjustments altogether. Particularly if premium subsidies are capped at 400 percent FPL, affordability problems may be substantial for members of the "Baby Boom" generation. Premiums for coverage sold today in Massachusetts, where age rating of 2:1 is also permitted, illustrate the affordability problem for people as we age. See Figure 4.

Figure 4. Monthly age-rated premiums (2:1), family of 3, Massachusetts

Plan-type	Age 24	Age 64
Bronze	$626 - $1,020	$1,144 - $1,759
Silver	$834 - $1,466	$1,648 - $2,483
Gold	$1,091 - $1,878	$2,183 - $3,172

Finally, for market reforms to be meaningful, Congress must authorize and appropriate resources for oversight and enforcement, both at the federal and state level. The Tri-Committee proposal wisely requires extensive data disclosure by health plans so that regulators can monitor compliance with market rules. But regulators will need expert staff to review and analyze data, as well as to conduct compliance audits and respond to consumer problems and complaints.

Resources at the federal level are particularly lacking and must be increased. At a hearing last summer of the House Committee on Oversight and Government Reform, a representative of the Bush Administration testified that the Centers for Medicare and Medicaid Services (CMS), which is responsible for oversight of HIPAA private health insurance protections, then dedicated only four part-time staff to HIPAA health insurance issues. Further, despite press reports alleging abusive rescission practices, the agency did not investigate or even make inquiries as to whether federal law guaranteed renewability protections were being adequately enforced.[8]

Additional resources will also be needed at the U.S. Department of Labor (DOL). After the enactment of HIPAA, a witness for DOL testified the Department had resources to review each employer-sponsored health plan under its jurisdiction once every 300 years.[9]

At the state level, limited regulatory resources are also an issue. In addition to health coverage, state commissioners oversee all other lines of insurance. In several states the Insurance Commissioner also regulates banking, commerce, securities, or real estate. In four states, the Insurance Commissioner is also the fire marshal. State insurance departments collectively experienced an 11 percent staffing reduction in 2007 while the premium volume they oversaw increased 12 percent.[10] State regulators necessarily focus primarily on licensing and solvency. Dedicated staff to oversee health insurance – and in particular, insurer compliance with HIPAA rules – are limited. Enforcement of consumer protections is often triggered by complaints.

In order for new promised consumer protections to be real, strong oversight and enforcement will be essential. Your colleague, Congresswoman Rosa DeLauro, has wisely introduced legislation (HR 2427) to strengthen oversight and enforcement capacity at the federal and state level.

Establishment of a national health insurance Exchange

The Tri-Committee proposal also provides for the establishment of a national health insurance Exchange. An Exchange is a more organized health insurance market than

what individuals, employers, and insurers are used to today. For purchasers in the Exchange, there will be subsidies to make premiums affordable. There will also be considerable new sources and types of assistance – for example, the provision of comparative information about plan choices, as well as assistance with enrollment, appeals, determination of eligibility for subsidies, and so on. Many of these services will be provided by a new Health Insurance Ombudsman, created solely to help consumers navigate the coverage system and make choices that are best for them.

For sellers of health insurance, the Exchange will accept bids and negotiate with insurers over the premiums they charge. The Exchange will also exercise much closer oversight of health insurance. Insurers will be required to report data on their products and practices in order to make more transparent the black box that is private health insurance today. These data will be used to establish risk adjustments to premiums and to monitor compliance with market rules and consumer protections.

Initially, the Exchange will serve those consumers who are most in need of these added protections – individuals and the smallest employers (with fewer than 20 employees) who lack market clout and the resources to hire human resources experts of their own. Authority to permit other employers to participate in the Exchange is delegated to a Commissioner starting in the fourth year of implementation.

The Commissioner is also authorized to require that certain consumer protections – such as network adequacy protections, transparency standards, and external appeals – apply to all qualified health benefit plans, including those outside the Exchange. However, the Commissioner might not require parallel protections. Further, the legislation does not require that insurers offer the same plan options at the same prices both inside and outside the Exchange.

Recommendation – In order to protect against risk selection, it is important for requirements to be identical for all qualified health benefit plans, no matter where they are sold, in or outside of the Exchange. Insurers who sell coverage to employers inside the Exchange should be required to offer identical policies outside of the Exchange and for the same price. If insurers can vary the plan options and prices they offer in different markets, they will be more able to steer risk, and small employers will be vulnerable to distorted prices when somebody in their group gets sick. The legislation should clarify that sanctions for violation of market rules will be the same for insurers who sell coverage outside of the Exchange. In addition, the Tri-Committee plan includes special sanctions for employers if they are caught steering plan participants into the Exchange when they get sick. Similar "anti-dumping" sanctions should be applied to insurers who operate outside of the Exchange.

A public plan option

Within the health insurance Exchange, consumers will have a choice of private health insurance plans and carriers, as well as a public plan option. This key provision in the draft reform bill will promote both choice and cost containment. Under the Tri-

Committee proposal, the public plan option must meet the requirements of other qualified health benefit plans offered by private insurers.

A recent national poll indicates Americans are strongly behind the establishment of a public plan option to compete with private health insurers.[11] By introducing this option into the marketplace, a public plan option can address failures of competitive health insurance markets today.

First, it offers consumers an alternative to private health plans that, for years, have competed on the basis of discriminating against people when they are sick. At a hearing of the House Energy and Commerce Committee just last week, patients testified about having their health insurance policies rescinded soon after making claims for serious health conditions. One woman who is currently battling breast cancer testified that her coverage was revoked for failure to disclose a visit to a dermatologist for acne. At this hearing, when asked whether they would cease the practice of rescission except in cases of fraud, executives of leading private health insurance companies testified that they would not.[12] Experiences like these make some consumers distrust private insurers.[13] If consumers are required to buy health insurance, having a public coverage option that does not have to compete on the basis of profits will give many peace of mind.

Second, a public plan option will promote cost containment. Research shows that health insurance markets today do not compete to hold down costs. Rather, insurers and providers negotiate to pass cost increases through to policyholders while maintaining and even growing corporate profits.[14] Under the Tri-Committee proposal, the public plan option will initially be allowed to base its payments to doctors, hospitals, and most other providers on the fee schedules used by Medicare, albeit at a higher level than Medicare pays today. The public plan will negotiate new payment rates for prescription drugs with pharmaceutical companies. And it will be able to offer bonus payments for providers that participate in both Medicare and the public plan. The public plan option is further tasked with development of innovative payment methodologies that hold down cost and promote quality. This will help move the market in the direction of competition based on the efficient delivery of health care services.

Shared responsibility

Finally, the Tri-Committee draft proposal provides for a continued role by employers in the provision of health benefits. Most insured Americans today get health coverage at work and a stated goal of health care reform is to let people keep current coverage if they are satisfied with it. A requirement for employers to provide health benefits ("play") or contribute toward the cost of other public subsidies for coverage ("pay") is consistent with this goal and will help keep employer resources in the financing system.

Conclusion

Mr. Chairman, the Tri-Committee draft proposal for health care reform is an impressive accomplishment, worthy of the challenges we face to make health coverage available, affordable, and adequate for all Americans. Your proposal defines a minimum health

benefits standard, requires it for all Americans, and institutes reforms to ensure affordable coverage in reformed and better organized markets with added, important consumer protections. You also make available a new public plan option that will add to consumer choice and prompt insurance companies to compete on the basis of quality and cost efficiency, not risk selection.

No doubt, others will recommend modifications as I have today. The legislative process was intended to consider all points of view and then act in the best interests of the public you represent. I could not be more pleased to see this legislative process at work. I thank you for your courage and commitment to health care reform that secures good, affordable health coverage for all Americans, and will be happy to provide you any additional information or assistance that I can.

Notes

[1] Peter Cunningham, "Tradeoffs Getting Tougher: Problems Paying Medical Bills Increase for US Families, 2003-2007," Center for Studying Health System Change, Tracking Report No. 21, September 2008.
[2] David Himmelstein, et.al., "Medical Bankruptcy in the United States, 2007: Results of a National Study," *The American Journal of Medicine*, June 8, 2009.
[3] "Hazardous health plans: Coverage gaps can leave you in big trouble," *Consumer Reports*, May 2009.
[4] Cathy Schoen, et al., "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," The Commonwealth Fund, June 10, 2008
[5] See, for example, http://www.ncdoi.com/consumer/consumer_publications/health%
[6] Peter Cunningham, "Living on the Edge: Health Care Expenses Strain Family Budgets," Center for Studying Health System Change Tracking Research Brief No. 10, December 2008.
[7] Health Care Reform Facts and Figures, Commonwealth Connector, June 2009.
[8] Testimony of Abby Block, Hearing on Business Practices in the Individual Health Insurance Market: Termination of Coverage, Committee on Oversight and Government Reform, U.S. House of Representatives, July 17, 2008.
[9] Testimony of Olena Berg, Assistant Secretary of Labor, Pension and Welfare Benefits Administration, Senate Labor and Human Resources Committee, October 1, 1997.
[10] National Association of Insurance Commissioners, *2007Insurance Department Resources Report*, 2008.
[11] Kevin Sack and Marjorie Connelly, "In Poll, Wide Support for Government-Run Health" *New York Times*, June 21, 2009.
[12] Lisa Girion, "Health insurers refuse to limit rescission of coverage," *Los Angeles Times*, June 17, 2009.
[13] Gallup poll, June 17, 2009, available at http://www.gallup.com/poll/120890/Healthcare-Americans-Trust-Physicians-Politicians.aspx
[14] James Robinson, "Consolidation and the Transformation of Competition in Health Insurance," *Health Affairs*, November/December 2004.

Chairman RANGEL. Thank you so much.

We will now entertain the statement from Dr. John Holahan, director of the Health Policy Research Center. Thank you for coming.

STATEMENT OF JOHN F. HOLAHAN, PH.D., DIRECTOR, THE HEALTH POLICY RESEARCH CENTER, THE URBAN INSTITUTE

Mr. HOLAHAN. Thank you. Mr. Chairman and distinguished Members of the Committee, thank you for inviting me to share my views on the discussion draft. The views I express are mine alone and should not be attributed to The Urban Institute, its trustees, or its funders.

I believe this plan has many excellent features, and I commend the Committee for its efforts. The plan builds upon the successful health reform enacted in the State of Massachusetts, provides for Medicaid expansion, a set of income-related subsidies up to 400 percent of the Federal poverty line, a national health exchange, and extensive insurance market reforms.

It contains an individual mandate which is essential to providing for universal coverage. It provides a cap on total out-of-pocket spending for individuals, and higher payment rates for primary care doctors.

I want to spend a few minutes on the public insurance option. A public plan competing with private plans will provide more choice and place substantial cost-containment pressure on the health care system. The argument is often made that competition between public and private plans could never be fair and that it will lead to a single payer system.

This argument ignores the fact that many health insurance markets, as well as provider markets, are simply not competitive and efficient. An extraordinary amount of concentration in the insurance and hospital industries has taken place over the last several years, and this concentration has been a significant contributor to health care cost growth.

No one can be in favor of controlling health care costs and ignore this reality. Several studies have documented the increase in concentration and the effect on insurer profitability and hospital revenues. For example, a number of studies have shown that hospital rates are higher in more highly concentrated markets by as much as 40 percent.

The public plan can help with the problem of cost containment. First, it is likely to have somewhat lower administrative costs. Second, the public plan can also establish and negotiate provider payment rates at lower levels than private payers are able or willing to negotiate today.

Today commercial payment rates are 35 percent above Medicare for hospitals and 23 percent for physicians. The plan will likely need to pay higher rates than Medicare does today to assure access to a sufficient number of providers. Where these rates are set is critically important. I think there should be a key role for MedPAC in advising the Congress on this.

There are a number of aspects of the public plan that are important to assure fair competition. The public plan should be legally and administratively separate from exchanges. It should abide by the same insurance market rules that private plans do. It should

offer the same benefit packages, have the same levels of cost-sharing, and the same caps on out-of-pocket liabilities. The income-related subsidies should apply in the same way to all plans. The plans should be required to maintain adequate reserves.

On the other hand, the public plan may well get a disproportionate share of high-risk enrollees. A level playing field also means that a public plan should be compensated if it does end up with a less healthy population.

The public plan can reduce the costs of reform significantly. In a paper being released this week by The Urban Institute, we estimate that subsidy costs would be lower by $200 to $400 billion relative to a plan with only private insurance options.

We also believe that the public plan will not destroy the private insurance market, in part because the private market will respond to competition from the public plan, and in itself become more efficient.

In the same paper, we have estimated that the net loss in private coverage will be relatively small. While a large number of those currently in the non-group and small group market will purchase coverage through the exchange and many will choose to join the public plan, there are close to 50 million uninsured who will now obtain coverage. Some will enroll in Medicaid or the public plan, but many will end up in private plans.

On balance, we estimate that the number of people with private coverage will fall from about 177 million to 161 million. In the end, the number with private insurance will not be too different than it is today, and the savings to the government in lower subsidy costs will be substantial.

I would like to close by saying that while there is not a cost estimate for this bill, the CBO estimates for one of the Senate bills last week was $1.6 trillion over 10 years. This may seem an alarming number, but it should be viewed in context.

Over the 10-year period, 2010 to 2019, the amount of gross domestic product projected for the U.S. economy will be $187 trillion. Even a number as high as 1.6 trillion is less than 1 percent of the amount of GDP being produced over this period. The Nation will also spend $33 trillion in health care over this period, even without reform.

We clearly need to gain control over this spending, and there are many proposals for doing this. But these proposals will require difficult choices. It is important that a good plan be passed and be fully paid for, but the design should not be driven by a budget goal, whether it is $1.6 or $1.2 or $1.0. There are many other key design features, and this is affordable, and there are plenty of ways to pay for it.

Thank you.

[The prepared statement of Mr. Holahan follows:]

Statement of

John Holahan, Director, Health Policy Center
The Urban Institute

Hearing on
Health Reform in the 21st Century:
Proposals to Reform the Health System

Committee on Ways and Means
United States House of Representatives

June 24, 2009

Mr. Chairman and distinguished members of the committee, thank you for inviting me to share my views on the Tri-Committee's health reform draft proposal. The views I express are mine alone and should not be attributed to the Urban Institute, its trustees, or its funders.

The proposal has many strengths and I applaud the committee for the thoroughness with which it approached its development. In many respects, it builds upon the successful health reform enacted in the state of Massachusetts. It provides for a Medicaid expansion to 133 percent of the federal poverty level (FPL), a set of income-related subsidies between 133 percent FPL and 400 percent FPL, a national health exchange, and extensive insurance market reforms. It contains an individual mandate, which is essential to providing universal coverage. It provides for a competitive framework within the exchange by requiring individuals to pay more if they want more comprehensive coverage. The plan improves access to primary care, including increasing payment rates to primary care physicians in the Medicaid program. It also provides for a cap on total out-of-pocket spending, an essential protection for those with high medical expenses in a given year. Finally, it includes a public option, which I think is essential for several reasons that I will discuss below.

I want to focus my testimony on a few specifics of the plan: the individual mandate, the public plan option, the Medicaid reforms, and the employer pay or plan mandate. First, an individual mandate is essential for providing universal coverage. Numerous studies and the leading microsimulation models have shown that voluntary efforts, even with generous subsidies, will fall well short of universal coverage.[1] An

[1] Linda J. Blumberg, John Holahan, Alan Weil, "Toward Universal Coverage in Massachusetts." *Inquiry* 43 (2006): 102–21; Danielle Holahan, Elise Hubert, and Cathy Schoen, "A Blueprint for Universal Health

individual mandate with subsidies that make coverage affordable is a fair way to get to universal coverage. Voluntary efforts will tend to extend coverage to those with the most serious health conditions. As a consequence, adverse selection into a new guaranteed source of insurance coverage would likely lead to unstable insurance pools. A requirement for everyone to participate eliminates this critical problem. Also, the government's cost of extending coverage via an individual mandate to those who would not voluntarily enroll is relatively small because this group tends to be healthier and, therefore, lower cost. Further, without an individual mandate and universal coverage, it is impossible to reallocate dollars now being used to support safety net providers that care for the uninsured. This is an important source of financing that is only possible with an individual mandate.

Second, I think it is important that the committee has included a public insurance option in the plan because having a competitor to private plans, under a fair set of market rules, will provide more choice and place substantial cost containment pressure on the health care system. The arguments made in the public plan debate too often ignore the fact that a public competitor would not be introduced into a well-functioning health marketplace. Many health insurance markets, as well as provider markets, are simply not competitive today. As a result, the markets are not providing the benefits one would expect from competition, including efficiency and control over the growth in health care costs. An extraordinary amount of concentration in the insurance and hospital industries has taken place over the past several years. This concentration has been a significant contributor to cost growth.

Insurance Coverage in New York" (New York: The United Hospital Fund and the Commonwealth Fund, 2006).

According to a 2003 study, 34 states have had values of the Herfindahl-Hirschman Index, a measure of market concentration, that exceed guidelines set by the Department of Justice and the Federal Trade Commission and should trigger antitrust concern.[2] Another study has shown 94 percent of 314 large metropolitan statistical areas (MSAs) were highly concentrated.[3]

Provider markets, particularly hospital markets, have also become increasingly concentrated in recent years. According to a 2006 study, 88 percent of large metropolitan areas were considered to have highly concentrated hospital markets.[4] Studies have shown that hospital rates are as much as 40 percent higher in more highly concentrated markets.[5] While much of the hospital sector is not-for-profit, the lack of competition often means increased revenue that can be devoted to the purchase and diffusion of new and higher-cost technologies and procedures.

The impact of consolidation on health care spending depends on the particular market. In markets where there is little concentration among insurers but a concentrated

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[2] James C. Robinson, "Consolidation and the Transformation of Competition in Health Insurance," *Health Affairs* 23, no. 6 (2004): 11–24; The Federal Trade Commission and U.S. Department of Justice, Horizontal Merger Guidelines, issued April 2, 1992, and revised April 8, 1997, www.ftc.gov/bc/docs/hmg080617.pdf. The Herfindahl-Hirschman Index is calculated by summing the squared market shares of each competitor in a given market.

[3] American Medical Association, "Competition in Health Insurance: A Comprehensive Study of U.S. Markets" (Chicago) American Medical Association Division of Economic and Health Policy Research, 2008).

[4] William B. Vogt and Robert Town, *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?* (Robert Wood Johnson Foundation Research Synthesis Report 9, 2006); see also Federal Trade Commission and Department of Justice, *Improving Health Care: A Dose of Competition* (Washington, DC: Federal Trade Commission and Department of Justice, 2004), http://www.usdoj.gov/atr/public/health_care/204694.htm.

[5] Alison Evans Cueller and Paul J. Gertler, "How the Expansion of Hospital Systems Has Affected Consumers," *Health Affairs* 24, no 1 (2005): 213–19; C. Capps and D. Dranove, "Hospital Consolidation and Negotiated PPO Prices," *Health Affairs* 23, no. 2 (2004): 175–81; Cory Capps and David Dranove, "Competition and Market Power in Option Demand Markets," *RAND Journal of Economics* 34, no.4 (2003); Emmett B. Keeler, Glenn Melnick, and Jack Zwanziger, "The Changing Effects of Competition on Non-Profit and For-Profit Hospital Pricing Behavior," *Journal of Health Economics* 18, no. 1 (1999); R. Krishan, "Marketing Restructuring and Pricing Behavior, " *Journal of Health Economics* 20, no 2 (2001); L. Dafny, "Estimation and Identification of Merger Effects: An Application to Hospital Mergers," Mimeo, Northwestern University, 2005.

hospital market, there is little ability to negotiate. Where there is a dominant insurer, it is possible to do better and obtain discounts from hospitals, but they still have little negotiating power with dominant hospital systems. In some markets, dominant insurers have no real incentive to be tough negotiators because they have no real competitors. Small insurers lack bargaining power with providers and thus cannot significantly compete with larger insurers on premiums. Finally, there is no real competition in many hospital markets because smaller hospitals have no ability to challenge the dominant system.

The public plan can help with the problem of cost containment in the United States. First, it is likely to have somewhat lower administrative costs, though not as much as some have argued.[6] The public plan can also establish and negotiate provider payment rates at lower levels than private payers are able or willing to negotiate today. The plan can pay lower rates than do commercial plans but higher than current Medicare rates. It may be necessary to require providers who participate in Medicare to participate in the public plan, at least in the short term. But participating in the public plan is not a requirement to see large numbers of patients. Much more important is that the program makes participating economically worthwhile. A program that pays higher rates than Medicare does today should result in many providers being willing to participate voluntarily. MedPAC should have a role in advising the Congress on the payment rates to ensure access to sufficient numbers of providers and to avoid adverse effects on the financial viability of institutions.

[6] Merrill Matthews, "Medicare's Hidden Administrative Costs: A Comparison of Medicare in the Private Sector" (Alexandria, VA: Council for Affordable Health Insurance, 2006).

A number of aspects of the public plan are important to ensure fair competition. The public plan should be legally and administratively separate from exchanges. It should abide by the same insurance market rules as private plans. It should offer the same benefit packages and have the same levels of cost sharing and caps on out-of-pocket liabilities. The income-related subsidies should apply in the same way to all plans within the exchange. The plan should operate on a level playing field with regard to maintaining reserves. Initial start-up capital will be needed. The public plan should be required to set premiums high enough to build up adequate reserves and to pay back the government over time for the initial start-up funds.

On the other hand, the public plan may well get a disproportionate share of high-risk enrollees. A level playing field means that a public plan should be compensated if it ends up with populations with higher medical needs. But risk adjustment is not perfect, and the public plan could have somewhat higher premiums as a result.

However, the presence of the public plan should have a significant cost containment impact both directly by providing a lower cost option and indirectly by creating incentives for private insurers to become more efficient. The House proposal calls for individuals to have a choice among plans within the exchange and for subsidies tied to a mix of the lowest-cost plans in the area. If the public plan is one of the lower cost plans in an area, as we expect, it will bring down subsidy costs significantly. In a paper being released this week, we estimate that subsidy costs would be lower by $200–400 billion relative to a plan with only private insurance options.[7]

[7] John Holahan and Linda Blumberg, "Is the Public Plan Option a Necessary Part of Health Reform?" (Washington, DC: The Urban Institute, forthcoming).

We also believe that the public plan will not destroy the private insurance market. In the same paper, we have estimated that the number of people losing private coverage will be relatively small. While a number of those currently in the nongroup and small-group market will purchase coverage through the exchange and many will choose to join the public plan, there are close to 50 million uninsured who will newly obtain coverage. Many of these will take up employer coverage outside the exchange; others will purchase coverage within the exchange and will choose both public and private options. On balance, we estimate that the number of people with private coverage will fall from about 177 million to 163 million.[8]

One issue ignored by many in this debate is that the private market will respond to the presence of a public option. There are many insurers that do an excellent job of managing care. This is particularly true of integrated health systems. But it is also true that Blue Cross plans and others that have substantial market share can reduce costs. Plans with limited leverage are likely to be at risk, but private plans that can develop strong management systems and negotiate effectively with providers will remain active and successful competitors in the new market place.

Thus, we conclude that the public option will help lower the costs within the exchange, and even with possible spillover effects to plans offered outside the exchange. Private insurers will respond to this competition, and health care costs will be lowered as a result. The number with private insurance will not be too different than it is today due to the expansion of coverage overall, and the savings to the government in lower subsidy costs will be substantial.

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[8]Holahan and Blumberg, "Is the Public Plan Option a Necessary Part of Health Reform?"

Third, I applaud the committee for the Medicaid provisions in the bill, particularly the proposal to increase payment rates for primary care physicians. I would encourage the committee to consider increasing payment rates for specialists as well. However, I also believe that the provision that pays 100 percent of the cost of new enrollees should be reconsidered. Such a policy would provide a large amount of money to states with low levels of coverage today and provide no relief to states that have already covered populations to these levels. Now is an opportunity to restructure parts of Medicaid financing to make it more equitable among states. The legislation could have the federal government pick up state responsibility for Medicare premiums and cost sharing and eliminate the prescription drug claw-back. It could increase matching rates on acute care services. This would provide some fiscal relief to all states and help address some longstanding Medicaid financing issues. This would not fully address all the needs of lower-income states. The remaining gap in their funding for new enrollees could be met with a short-term matching rate increase that would be phased out over time.

Fourth, the provision for an employer mandate with a payroll tax of 8 percent of payroll should be reconsidered. It is true that some believe an employer mandate is necessary to keep employers from dropping coverage. However, there is considerable research evidence, as well as actual experience in Massachusetts, that employers are unlikely to drop coverage.[9] Most employers in the United States offer coverage to their workers without a mandate; they do so to compete for workers. The current tax exclusion of employer contributions to health insurance provides a strong incentive to provide some

[9] Sharon K. Long and Paul B. Masi, "How Have Employers Responded to Health Reform in Massachusetts? Employees' Views at the End of One Year," *Health Affairs* 27, no. 6 (2008): 576–83; Jon R. Gabel, Heidi Whitmore, Jeremy Pickreign, Will Sellheim, Shova KC, and Valerie Bassett, "After the Mandates: Massachusetts Employers Continue to Support Health Reform as More Firms Offer Coverage," *Health Affairs* 27, no. 6 (2008): 566–75.

form of compensation in the form of health benefits. There is nothing in this legislation that would change these fundamental incentives. The Massachusetts experience has shown that, despite the very small penalty on employers, employer coverage has actually increased. This is because in order to comply with an individual mandate, workers are more likely to take up employer offers of coverage. Further, employers in competition for workers find it advantageous to offer coverage to help their workers satisfy the mandate. One possibility is to assess a tax rate that varies with worker wages: 2 percent on those whose wages are less than $20,000, 4 percent for those with wages between $20,000 and $60,000, and 6 percent for others, up to a cap.

Finally, while there is not a cost estimate for this bill, the CBO estimates for one of the Senate bills last week was $1.6 trillion over 10 years. This may seem an alarming number but it should be viewed in context. Over the ten-year period, 2010–2019, the amount of gross domestic product produced in the U.S. economy will be $187 trillion dollars.[10] Even a number as high as $1.6 trillion is less than 1 percent of the amount of GDP being produced over this period. The $1.6 trillion does not account for the savings to business and individuals because of subsidies and new coverage options, and states and localities because of less uncompensated care. The new societal cost, net of these savings, is closer to $1.0 trillion. We will spend $33 trillion on health care over this period, even without reform. We clearly need to gain control over this spending. It is important to pass a good plan—not one that is meant to achieve an arbitrary budget goal. It is important that health reform be fully paid for. There are many ways to achieve this.

[10] Congressional Budget Office, "A Preliminary Analysis of the President's Budget and an Update of CBO's Budget and Economic Outlook" (Washington, DC: CBO, 2009), http://www.cbo.gov/ftpdocs/100xx/doc10014/03-20-PresidentBudget.pdf.

Chairman RANGEL. Thank you, Doctor.

The Committee would now invite Dr. Young, the National Coordinator for Physicians for a National Health Program, from Chicago.

STATEMENT OF QUENTIN YOUNG, M.D., MACP, NATIONAL COORDINATOR, PHYSICIANS FOR A NATIONAL HEALTH PROGRAM, CHICAGO, ILLINOIS

Dr. YOUNG. Mr. Chairman, Members of the Committee, I thank you for giving me the opportunity to comment on the proposal that has emerged from the three key House Committees, and to articulate the single payer alternative. Thank you.

I am the National Coordinator of Physicians for a National Health Program, an organization of some 16,000 American physicians who support single payer national health insurance. Our organization represents the views of the majority of the U.S. physicians now, 59 percent of whom support national health insurance in a recent survey. I wish to make two points to the Members of this Committee.

The first is that the best health policy, science, literature, and experience indicate that the tri-committee proposal will fail miserably in its purported goal of providing comprehensive, sustainable health coverage to all Americans. And it will fail whether or not it includes the so-called public option health plan.

The second point I wish to make is that the single payer national health insurance is not just the only path to universal coverage, it is the most politically feasible to health care for all because it pays for itself, requiring no new sources of revenue.

The difference between single payer and the tri-committee proposal could not be more stark. Single payor has at its core the elimination of U.S.-style private insurance, using huge administrative savings and inherent cost control mechanisms to provide comprehensive, sustainable, universal coverage.

The tri-committee discussion draft preserves all of the systemic defects inherent in relying on a patchwork of private insurance companies to finance health care, a system which has been a terrible failure both in providing health coverage and controlling costs heretofore.

Elimination of the U.S.-style private insurance has been a prerequisite to the achievement of universal health care in every other industrialized country in the world. In contrast, public program expansions, coupled with mandates like those in the tri-committee proposal, have failed everywhere they have been tried, both domestically and internationally.

First, because the discussion draft is built around the retention of private insurance companies, it is unable, in contrast to single payer, to recapture the 400 billion in administrative waste that private insurers currently generate in their drive to fight claims, issue denials, and screen out the sick. A single payer system would redirect these huge savings back into the system, requiring no net increase in health spending, and covering those uncovered today.

Second, because the discussion draft fails to contain the cost control mechanisms inherent in single payer, such as global budgeting, bulk purchasing, negotiated fees, and planned capital expenditures,

any gains in coverage will quickly be erased as costs skyrocket and government is forced to choose between raising revenue and cutting benefits, something we face today.

Third, because of this inability to control costs or realize administrative savings, the coverage and benefits that can be offered under the discussion draft will be of the same type currently offered by private carriers, which cause millions of insured Americans to go without needed care due to the cost and have led to an epidemic of medical bankruptcies, 1 million annually presently.

Virtually all of the reforms contained in the discussion draft have been tried, and have failed repeatedly. Plans that combined mandates to purchase coverage with Medicaid expansions fell apart in Massachusetts in 1988, Oregon in 1992, and Washington State in 1993. The latest iteration, Massachusetts 2006, is already stumbling with uninsured rates again rising and costs soaring. Tennessee's experiment with a massive Medicaid expansion and a public plan option worked for 1 year, until rising costs sank it.

The inclusion of a so-called public option cannot salvage this structurally defective reform package. A public plan option does not lead toward the single payer but toward the segregation of patients, with profitable ones in private plans and unprofitable ones in the public plan.

A quarter-century experience with public/private competition in the Medicare program demonstrates that the private plans will not allow a level playing field. Despite strict regulation, private insurers have successfully cherry-picked healthier seniors and have exploited regional health spending differences to their advantage.

They have progressively undermined the public plan, which started as a single payer system for seniors but now has become a funding mechanism for private HMOs and a place to dump the unprofitable ill.

The potential $1 trillion pricetag on the tri-committee proposal already threatens to capsize our new President's flagship initiative. In contrast, single payer avoids these hazardous political waters entirely because it requires no new sources of funding.

In tumultuous economic times, single payer is the only fiscally responsible option. Two-thirds of the American people support it. The majority of physicians are in favor of it, as are the U.S. Conference of Mayors, 39 State labor federations, and hundreds of local unions across the country. Millions of Americans are mobilized to struggle for single payer, but your leadership is crucial. I hope this Committee will see fit to provide it.

[The prepared statement of Dr. Young follows:]

Quentin D. Young, M.D., M.A.C.P.
National Coordinator
Physicians for a National Health Program
312-782-6006 | info@pnhp.org

Testimony to
U.S. House Committee on Ways and Means
June 24, 2009

Mr. Chairman, members of the Committee, thank you for giving me the opportunity to comment on the proposal that has emerged from the three key House committees and to articulate the single-payer alternative. I am national coordinator of Physicians for a National Health Program, an organization of 16,000 American physicians who support single-payer national health insurance. Our organization represents the views of the majority of U.S. physicians, 59 percent of whom support national health insurance.

I wish to make two points to the Members of this Committee. The first is that the best health policy science, literature, and experience indicate that the Tri-Committee proposal will fail miserably in its purported goal of providing comprehensive, sustainable health coverage to all Americans. And it will fail whether or not it includes a so-called "public option" health plan.

The second point I wish to make is that single-payer national health insurance is not just the only path to universal coverage, it is the most politically feasible path to health care for all, because it pays for itself, requiring no new sources of revenue.

The difference between single payer and the Tri-Committee proposal could not be more stark: single-payer has at its core the elimination of U.S.-style private insurance, using huge administrative savings and inherent cost control mechanisms to provide comprehensive, sustainable universal coverage. The Tri-Committee discussion draft preserves all of the systemic defects inherent in reliance on a patchwork of private insurance companies to finance health care, a system which has been a miserable failure both in providing health coverage and controlling costs. Elimination of U.S.-style private insurance has been a prerequisite to the achievement of universal health care in every other industrialized country in the world. In contrast, public program expansions coupled with mandates, like those in the Tri-Committee proposal, have failed everywhere they've been tried, both domestically and internationally.

First, because the discussion draft is built around the retention of private insurance companies, it is unable – in contrast to single payer – to recapture the $400 billion in administrative waste that private insurers currently generate in their drive to fight claims, issue denials and screen out the sick. A single-payer system would redirect these huge savings back into the system, requiring no net increase in health spending.

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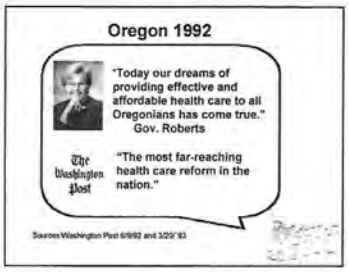
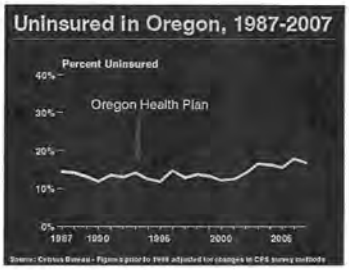
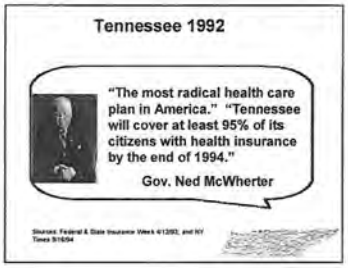
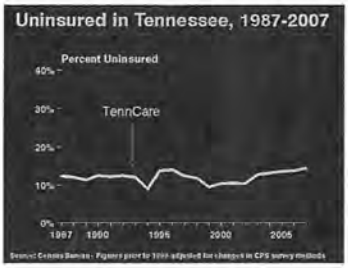
Thank you.

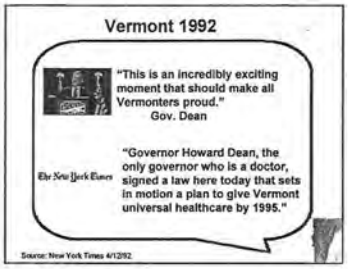
Mandates and Subsides: A History of Failure to Provide Universal Care

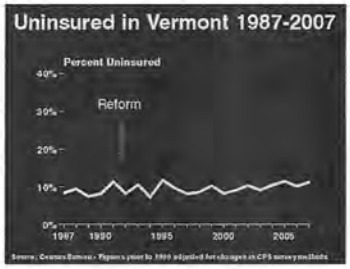




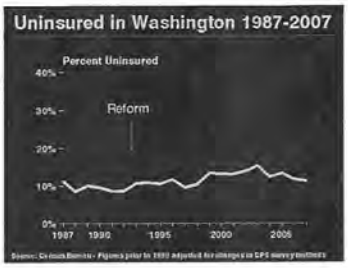


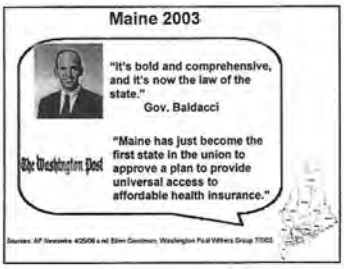


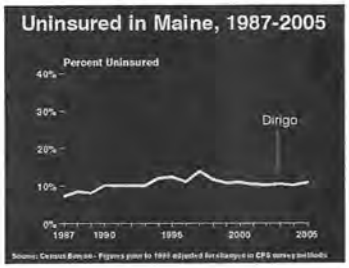




Mandates and Subsides: A History of Failure to Provide Universal Care







Chairman RANGEL. Dr. Young, the Chair has been advised that one of our most distinguished Members in the House and the Chairman of the Judiciary Committee has arrived and is here with us, and that is Chairman John Conyers. If he is here, I want to pause and recognize the fight that he has had over the decades in support of the single payer.

And I want you to understand, Dr. Young, that our President has decided that he wants to make every effort to have a bipartisan bill. And I think there are over 83 Members of Congress that have supported the single payer. But I don't think too many of them belong to the other party.

And so in an effort to launch this in a way that we could accommodate each other, we have the public program that we hope would compete with the private sector. But having said that, Members will have questions later. And I hope that if Chairman Conyers is in the audience, he would stand so that we would recognize the service he has provided over the years.

John Conyers, we thank you.

[Applause]

Chairman RANGEL. We thank you for your great contribution, and we would not be where we are today had it not been for your great efforts here.

The Chair would like to call on Dr. David Gratzer. He is from Manhattan Institute for Policy Research from the great town of New York, New York.

Thank you.

STATEMENT OF DAVID GRATZER, M.D., SENIOR FELLOW, MANHATTAN INSTITUTE FOR POLICY RESEARCH, NEW YORK, NEW YORK

Dr. GRATZER. Thank you, Mr. Chairman. Thank you, Members of the Committee.

Mr. Chairman, as you gave me that warm introduction, I was reminded of a comment a colleague of mine had said a few years ago when he suggested that on paper, I seemed like a remarkable individual.

Chairman RANGEL. Let's hope so at the end of your testimony.

Dr. GRATZER. Mr. Chairman, I made a similar comment when I testified a couple of weeks ago before a Subcommittee of the Committee on Education and Labor. People also laughed then, and I am not sure why. Pause for a moment just to soak this up.

I am a kid from the prairie, and it is an enormously humbling experience to speak before this august body. And I appreciate the work that you are doing. And we may agree to disagree on some things, but I am honored to be able to testify today.

I am going to speak in a few moments about the draft legislation before us. But I want to pause for a moment and talk about some personal experiences. You know, health care is ultimately very personal. And it is important as we discuss policy details, as we discuss statistics and figures, not to leave out the human aspects of this.

A few years ago my wife hurt her back. We had gone on a ski trip in the Rockies. Actually, I had been invited out to a conference,

and they had generously even agreed to pay for my wife's plane ticket. All I had to do was buy the lift tickets, and off we went.

My wife is no athlete. She is an emergency doctor, and she hurt her back. I want to emphasize for the sake of our marriage that she tells the story a little bit differently than I do. Her version of events involves gale-like winds of 60 miles an hour or so, a tall mountain rivaling, perhaps, Everest, and a small mammal that had crossed her path that needed to be saved. My version of events is a little less august, involving a small ski slope, the bunny hill, and a lot of falls on her rear.

But whether or not you accept her version of events or mine, at the end of the day she ended up seriously hurting her back. And my wife, who likes to log long hours in the emergency department, ended up lying on her couch in pain, numbness in her foot, largely unable to work.

We were uninsured at the time, and interested in getting her some help. Forty years ago there would have been no help to be had. She just would have lived her life like that. Twenty-five years ago there would have been a surgical procedure to help her out that would have had a long convalescence, a risky procedure that may not have worked.

My wife ended up getting a procedure that lasted less than 28 minutes, involved a scar that she wears on her back that is less than a half-inch long, and within a few weeks, she was able to rise up from that couch and go back to life.

It was in its own ways something of a miracle, something we see every day in American health care. I would emphasize that there are so many problems with American health care—and we are going to talk about that today, in the coming days and the coming weeks. But we should not forget what is good about this system, that American medicine is second to none.

I have talked about my wife's back, but certainly we could cite other examples. Death by cardiovascular disease has dropped by two-thirds in the last 60 years. Polio is confined to the history books. Childhood leukemia, once a death sentence, is eminently treatable for people under the age of 11.

You know, in my other life I am a doctor, and I have seen miracles there, too. I had a patient who came in covered in his own urine who was completely psychotic. We gave him an anti-psychotic, a new one, developed right here in the United States, and he went back to being a college student and living out his life. Let us not forget the successes when we talk about the failures.

Of course, there are problems. It was difficult to find a neurosurgeon for my wife because quality is so uneven and they are such a black box. We actually Yahoo'ed "Neurosurgery, west New York," and got a bunch of porn sites. Costs are uneven and at times inexplicable. We got a bill that lasted about 3½ feet and was unanswerable.

People look at these problems and they say, it is time now for Washington to take a larger role, a more robust role. And I see that Members of the Committee are entertaining that. I understand that temptation.

I understand the belief that government expansion will be compassionate and will increase quality. I understand that because I

used to believe it. I was born and raised in Canada. I, too, believed in some level of socialized medicine. Then I got mugged by reality, and I have seen the waiting lists and the queues for care and how unsatisfying it is.

You have a choice to make, and down one path is the government temptation. But there is also, my friends, the low road less traveled of individual choice and true competition. And that is why I think we need policy reform and regulatory reform and tax reform to build on what is good with this system, and not to end up with a system far worse like you see in Canada or Britain or right across the western world.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Gratzer follows:]

Prepared Statement of David Gratzer, M.D., Senior Fellow, Manhattan Institute for Policy Research, New York, New York

Thank you for this opportunity to testify at this important time. My testimony is drawn from personal experience—as a physician born and trained in Canada, as the author of two books (and the editor of a third) on comparative health care policy, and as a senior fellow at the Manhattan Institute. (For the record, the views I present are my own and do not necessarily represent those of the Manhattan Institute.)

The choices Congress will make on this issue are critical both for the United States and for patients around the world who benefit from American advances in diagnostic technology, pharmaceuticals, biotechnology, surgical techniques, and medical device design.

It is not a coincidence that the United States is so productive in medical science. America's health care system is unique in its capacity to mobilize private investment. Many critics of the system look at its rising share of GDP and see only cost. But we must remember in these discussions that American medicine is second to none. The achievements of the last 60 years have been amazing: Polio is confined to the history books; death by cardiovascular disease has fallen by two-thirds; childhood leukemia, once a death sentence, is now treatable.

The U.S. system needs reform, yes. Costs continue to rise. Quality is uneven. Too many lack insurance. But in our effort to make a system with better coverage and access, we must not lose what is right and what is good.

1. BUILDING ON WHAT WORKS

U.S. lawmakers should be cautious about borrowing reforms from other countries; Congress must reform the health care system with made-in-America solutions.

Congressional leaders would be wise to focus on simple, practical reforms that build on what works in this system.

- We must recognize the forgotten role of health in health care (*policy reform*);
- We should foster insurance competition in a larger marketplace (*regulatory reform*); and
- We must level the tax playing field for individuals seeking insurance outside the workplace (*tax reform*).

Supporters of a single payer model repeatedly point to America's lower life expectancy as evidence of a systemic failure. As a physician, let me assure you that life expectancy is about much more than what happens in the doctor's office. Indeed, some of the biggest problems we face are due to choices and not (health) care. Americans live unhealthily—smoking, drinking, and eating more than their neighbors to the north, or their Western European cousins. Consider that the percentage of obese Americans has doubled in the last quarter century.

The failure to prevent common illnesses like diabetes and lung cancer carries significant financial consequences for the health care system. Both Democrats and Republicans can agree with this point. Significant government and private actions are needed—we must do more to promote wellness, provide incentives for prevention, and encourage Americans to take greater responsibility for their own health.

Market competition can contain the high cost of insurance—if Congress and the States would only allow it to take place. Efforts at creating equity and fairness in the health insurance market—done with the best of intentions—have created dramatic differences in price across the country. For example, a health-insurance plan

for a family of four in New York can cost more than $12,000 a year, but a similar is about $3,000 in Wisconsin.

The Federal Government can promote regulatory strategies that will increase interstate insurance competition. Proposals to create a true national market for health insurance is on the right track, but Congress must go farther to level the tax and regulatory playing field for non-group insurance. Once the marketplace of individuals can compete fairly with employer-provided plans, they can serve as an ideal vehicle for broadening coverage to the uninsured.

2. THE SOCIAL RISKS OF GOVERNMENT–MANAGED CARE

Single payer advocates and their allies insist that only government health insurance can solve America's problems. For example, when it comes to wellness, some claim—without evidence—that preventive care will be strengthened in a single payer system.

In reality, preventive care has suffered in many single payer systems because it is not urgent care. Governments in single payer systems have tended to see "elective" and preventative care as a safer target for rationing, in much the same way that governments worldwide habitually underbudget for infrastructure maintenance.

For example, it's a common mantra that Canadians can choose their own family doctor in Canada's socialized health system. But as many as one-sixth of Canadians cannot find a family doctor. Canada has two-thirds as many doctors as the OECD average, with severe shortages in several areas of specialty (for example, gynaecology). When there are no doctors to choose from, the "freedom to choose" is a limited benefit. The doctor shortage is a direct result of government rationing, since provinces intervened to restrict class sizes in major Canadian medical schools in the 1990s.

To further inform Congress about the challenges of government-managed care, I cite Canadian-sourced data.

(1) CIHI Reports on Provincial Wait-Times "Progress"

The Canadian Institute for Health Information (CIHI), a government-funded body, is the designated agency responsible for collecting provincial wait-times data. Their reports[1] paint a disturbing picture. Advocates for the Canadian system often cherry-pick broad averages or median wait time figures, but CIHI's most recent (2008) data gives a fuller picture of what service is like at the "back of the line." Consider just a few examples:

- In Alberta, Canada's wealthiest province, 50% of outpatients waited 41 days or more for an MRI scan. Ten percent of those patients waited 4½ months or longer.
- In Saskatchewan, 10% of knee replacement patients waited 616 days or more for surgery.
- In Nova Scotia, 25% of patients waited 199 days or more for cataract removal.

All of these and other figures reflect wait times after referral by a general practitioner. As noted earlier, millions of Canadians do not have access to a family doctor.

(2) Canadian Wait Times Alliance: Annual Reports, 2004–2009

Canada's *Wait Times Alliance* offers a counterpoint to CIHI's reports. The Alliance consists exclusively of Canadian medical professional associations like the Canadian Medical Association. Their 2009 report, *Unfinished Business*, opens with the observation that "Canadians are used to waiting." The report[2] notes that provincial "progress" toward wait times targets often represents progress toward "minimum wait-times standards, rather than desired wait-times standards."

***(3) Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35**

This recent decision[3] by the Supreme Court of Canada serves as a wake-up call to those who see the Canadian system as a utopian mix of public funding and private choice. The case centred on a patient who chose to sue for the right to use his own money to secure timely medical treatment, a right that was denied Canadians until the *Chaoulli* decision.

Writing for the majority, Justice Marie Deschamps concluded that:

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[1] The latest CIHI reports on provincially-reported wait times are available at www.cihi.ca.

[2] The 2009 Report is available, as are previous years' reports, at www.waittimealliance.ca.

[3] The *Chaoulli* decision is online at http://csc.lexum.umontreal.ca/en/2005/2005scc35/2005scc35.html.

> "[T]he evidence in this case shows that delays in the public health care system are widespread, and that, in some serious cases, patients die as a result of waiting lists for public health care. The evidence also demonstrates that the prohibition against private health insurance and its consequence of denying people vital health care result in physical and psychological suffering that meets a threshold test of seriousness."
>
> *Chaoulli v. Quebec (Attorney-General) 2005*

(4) [Quebec] Taskforce on the Funding of the Health System, 2008

Finally, consider the most recent report from Quebec, a comprehensive review of a government-managed system in peril. The government-appointed Chair of the Taskforce was M. Claude Castonguay, widely considered "the father of Quebec medicare," as he co-authored a report in the late 1960s that created Quebec's earliest single payer model. Almost 40 years later, this report[4] concluded that "there is no ideal system," called for an increase in private sector involvement and cited crippling cost inflation and poorly rationed care as major flaws in Quebec's single payer model.

3. THE FISCAL RISKS OF GOVERNMENT–MANAGED CARE

These challenges are not unique to Canada. Around the world, the more public the system, the greater the challenge in managing it. For example, the United Kingdom recently increased the annual budget of the National Health Service (NHS) by tens of billions of pounds in an effort to bring wait times below their own targets. The effort succeeded, but only if you believe that the NHS guarantee of care no later than 18 weeks after a referral represents timely service. Recessionary budget reductions are likely to limit further progress as the Brown government has ordered the NHS to prepare for increases below core inflation (1.6%) in fiscal year 2010–2011.

The White House is alarmed by private-sector health inflation, but it must also acknowledge the same trend in government-managed systems. Even with pharmaceutical price controls, technology rationing, and limited capital investments, almost all Canadian provinces carry substantial debts fuelled mostly by persistent health care inflation. Ontario's health budget is projected to grow by 7% for each of the next 3 years. The 2008 Taskforce calculated Quebec's annual health inflation rate at almost 6%. In Britain, the NHS admits to a 60 year *average* increase of 3% over inflation. Ireland's single payer system has experienced constant price turbulence. Despite 3.5% *de*flation this May, Irish health costs still grew at an annualized rate of 4.5%.

What causes inflation in public health insurance programs? As government's role as the primary funder grows, the greater the political contradiction between demands for fiscal restraint and demand for service. The pattern is consistent across national boundaries: If governments provide the insurance, benefits come cheap and easy in the early years. When the cost of treating older citizens, serving new patients or providing new treatments climbs, policymakers face a devil's choice between rationed care or tax-funded cost inflation. Most often, they try to balance the two bad options, restraining inflation slightly below U.S. levels with ever-more painful restraints on capital investment, human resources, technology, and drug access. Waiting lists for treatment are the inevitable consequence.

4. A PUBLIC PLAN OPTION *IS* GOVERNMENT–MANAGED CARE

The Administration insists that support for a "public plan option" is not intended to serve as a "Trojan horse" for a single payer health care system. I can only reply with the time-honoured scientific observation that "if it walks like a duck, if it quacks like a duck . . ."

The historic reality is that even if the Administration sincerely does not want public insurance to serve as a Trojan horse for a single payer system, the public plan option is certain to deliver exactly that result, just as more limited public insurance schemes in Canada, Britain, and other countries, came to dominate their own health sectors:

- As a government program rather than a state-regulated insurance plan, the public plan option has competitive advantages;
- If those advantages are removed, then there is no point in introducing the public plan when the proposed "Health Insurance Exchange" will increase competition anyhow;

[4] The full report is online in English at http://www.financementsante.gouv.qc.ca/en/rapport/index.asp.

- If the advantages are left intact, the United States will undermine its private-sector health care, as have other western countries.

The Administration believes a public option is needed to, in the President's words, "keep the insurance industry honest." If this argument is carried to its logical conclusion, the public plan must also be "honest."

Will the public plan be financed on a pay-as-you-go basis as many entitlement programs have been, or will it be properly financed to future insurance costs?

Will the public option pay market costs for capital, just as private insurers must?

Will the public plan comply with costly State mandates just as private insurers do, or will the Federal Government override them?

If the public plan has any built-in government advantages, it will build market share—not because it is necessarily better insurance, but because it is subsidized and legally privileged. As the plan grows in size, Federal taxpayers will foot an ever-larger share of the system's increasing costs, and governments will be under ever-more pressure to ration care to contain them.

Further, if the goal of public competition is to reduce the impact of public health care costs on the U.S. Treasury, then the best policy choices are those which extend coverage and improve affordability without significant damage to the U.S. tax base. Will the public plan pay taxes to simulate the tax costs of a private insurer? If not, then every dollar attracted to the public plan is a dollar taken from the taxable private sector, reducing the economy's ability to carry the costs of public health programs in future.

Let's be clear: American health care is in need of reform. But as any good doctor knows, it's not enough to get the diagnosis right, we need a treatment that makes sense. A massive expansion of Washington's role is not that treatment. Rather, Congress should look to alternatives:

Prioritize regulatory reforms that will open up true competition between existing, fully-funded insurers.

Target direct government aid to individuals who really need it, with incentives for individuals to become a powerful competitive force in the insurance marketplace.

Promote rapid improvement in the personal health of Americans to reduce demand on the system's most costly health care services.

These ideas would bring greater choice to American health care; they would also help instill in the system the oldest of American virtues: Personal responsibility. While they may not be as catchy as promising Medicare for those who want it, these ideas have the benefit of pushing the system toward a sustainable future, not a government bureaucracy.

Chairman RANGEL. Thank you so much for your testimony. I can see why our Republican friends have selected you. You are very persuasive. And I want to make it abundantly clear: Anybody supporting this concept certainly cannot disregard the great advancements that have been made in American medicine, and the great contributions that the private sector have and continue to give.

And I only wish that you can help us to understand that we cannot find acceptable 48 million people without health care. And I know you agree with that. Over half of that amount are underinsured. And the whole idea that this genius of the private sector cannot compete with a government operator, or better than that, that the American people will not seek out the best that they can find, certainly is a far cry from what you describe as socialized medicine or whatever derogatory term that you want to call it.

We are not competing for a French plan or a Canadian plan or a foreign plan. This is an American problem, and it has to be an American solution to it.

And so I just ask you, Doctor, if indeed we are talking about competition, don't you believe that the government can learn from the private sector and that the private sector can learn from the gov-

ernment? We as Americans, and certainly the medical profession, have never run away from the challenge of competition. Why won't you give us a chance?

Dr. GRATZER. Mr. Chairman, let me agree with you that there are significant problems here. And certainly I don't wish to walk—or don't wish for you to walk away from my testimony today thinking that I am glossing over these problems. There are too many uninsured Americans.

I am not quite sure that we should be so concerned with that large number, but within them there is a core group, maybe 8 or 9 million, who really do fall through the cracks. And it is up to this body in these deliberations to find a way of reaching out.

But be careful. Be careful what we end up doing because as any good doctor knows, it is not enough to come up with the right diagnosis. You have to come up with the right treatment. And sometimes when you don't do that, the patient gets worse.

As you know, I am pretty libertarian in my thinking. Milton Friedman wrote the foreword to my last book. He was a mentor for me.

Chairman RANGEL. What was the name of your book? We might as well get that in now.

Dr. GRATZER. Well, Mr. Chairman, "The Cure: How Capitalization Can Save American Health Care," available on Amazon.com at a very reasonable price, Mr. Chairman.

[Laughter.]

Dr. GRATZER. But today, I will offer you a book at no charge. But Mr. Chairman, I think one should be very careful about the language we use. Yes, you and I believe in competition. Yes, you and I believe in individual choice. But a public plan option as is being discussed is not true competition, and it is not true choice.

As you know, the discussions underway are to have Medicare pricing. In other words, we would build a public plan option basically modeled after Medicare. Medicare is not really an insurance. I know you and I throw that term out. And when you have public plans in other countries, we talk about social insurance, but they are not true insurance.

Medicare is a Federal program. Medicare is a Federal program with price controls, one that is opted out of State regulations, that doesn't require any of the capitalization required of private insurances, that doesn't account as private insurances do.

So yes, I believe in competition. But it has to be fair competition. I think a better——

Chairman RANGEL. Pause there. Tell me, please, what is unfair about the option? Because I have more respect for the ingenuity of the private sector. Why would anyone that enjoys the genius of the private sector walk away from that to a crumbling, failing, government, irresponsible program?

Dr. GRATZER. Can I quote you on that?

Chairman RANGEL. Well, this is your language. And I am saying that why would anyone walk away from what you are describing? The key word that separates you and I is that you already said the program, the public option program, is unfair.

Well, hell, I am sorry, but if I was losing a lot of money to a competitor, I would try to find that word, saying, this competitor is

coming in, reducing my profits. I am in business to make money. That is what my job would be in the private sector.

And if anyone came in with any idea about just providing health care, I wouldn't call that unfair. Tell me what is unfair about the system since we are searching to give confidence that we want an even playing field?

What could we possibly do to provide that competition, which I am certain you are not afraid of, as long as it is, what, fair? Tell me what we could do to perfect this so you can say, well, at least that is fair, and we can match you patient for patient, and in your case, dollar for dollar.

Dr. GRATZER. Sure. Three words: Scrap price controls.

Chairman RANGEL. Where would the price control be?

Dr. GRATZER. Well, Medicare price controls. As you know, there is a committee of——

Chairman RANGEL. We are paying for the private sector with Medicare. That is how they make their money. It is government money that goes into these programs. The doctors are reimbursed with Federal dollars.

Dr. GRATZER. But they are being reimbursed at a fraction of what they would make in the private sector. And as you know, there is good evidence that there is cost-shifting going on whereby private plans end up picking up the weight, the dropped weight, from the public system.

Chairman RANGEL. Doctor, we have so many programs that the patients and the clients are supported by Federal dollars and Medicare where they are doing so well and making profits, if you will, by cutting a lot of procedures that are truly found to be unnecessary.

And I might say that a lot of doctors would share with you the lack of satisfaction that they get with the payment system, which forces them in many cases to find services that are not necessary to be funded by the government because they don't believe that the reimbursement is adequate. We are trying to take care of that. I don't think we——

Dr. GRATZER. Hold on, Mr. Chairman. I think you have persuaded me that Medicare is in need of reform. I am not sure you have persuaded me——

Chairman RANGEL. You bet your sweet life it is.

Dr. GRATZER. But you have not persuaded me that——

Chairman RANGEL. The whole system is broken.

Dr. GRATZER. The whole system is——

Chairman RANGEL. But we don't expect the private sector to come forward and fix it. We need a partnership. We need a fair relationship. And the only difference that separates you and I is that I think you are suggesting that you are not afraid of fair competition.

Dr. GRATZER. Then let's agree on what fair competition might be for this public option.

Chairman RANGEL. Exactly.

Dr. GRATZER. No price controls. Reimbursement set by the private sector. Capitalization required.

Chairman RANGEL. Reimbursement set by the private sector, did you say?

Dr. GRATZER. Yes. Doctors ought to make a fair wage, don't you think?

Chairman RANGEL. A fair wage? Okay. Okay. All right.

Dr. GRATZER. I believe in competition. But we are not talking about competition between insurances.

Chairman RANGEL. Let's talk in New York.

Dr. GRATZER. We are talking about competition between——

Chairman RANGEL. It is all a question of what is fair. And I would like to yield to the Ranking Member because we have reduced our differences to price.

Mr. CAMP. Well, thank you, Mr. Chairman. We have had a number of hearings either in the Committee or Subcommittee—I think six this year—on various aspects of health reform, seven if you look at the Income Security Subcommittee's hearing on a new entitlement program that was incorporated into this draft, and really nearly two dozen in the last Congress.

So I really want to focus on the specific aspects of this legislation before us, not necessarily in general what health reform—what might be right and wrong in the health reform system.

And so Dr. Gratzer, you mentioned the difference often between the public and private plans. And I believe in section 1401(b) of the bill, there is a new tax on all non-government health insurance policies, which would be another way that competition isn't really fair between the public plan and the private plans. It would be a $370 million tax to fund the competitive effectiveness research trust fund.

Would this tax, in your opinion, fall on people at all income levels? Is it based only on who has a non-government health insurance policy or private health insurance?

Dr. GRATZER. I thank you for the question. I will be honest with you: I am not as up on perhaps the specifics of the bill as I should be. It is an 825-page bill, and I have only had since Friday to review it.

But my suspicion is besides the structural differences between a Federal program and insurance, you have hit the nail on the head that even this bill will exaggerate these differences from a tax point of view.

Again, I believe in competition, but it ought to be fair competition. And if really what we are going to do is take this public plan option and make it just like every other insurance except it is not for profit, we already have the blues, sir.

Mr. CAMP. All right. Thank you.

And Ms. Pollitz, I am a little confused about whether insurance policies offered through the exchange would have to adhere to State benefit mandates. I believe in section 203, which starts on page 55 of the bill, that the new health choices commissioner could override State mandates with their authority. Is that your read of the bill?

Ms. POLLITZ. I don't remember. I am sorry.

Mr. CAMP. Okay. I believe on page 59 you would find that is the case.

I also have a question for Dr. Holahan. It appears that there will be, for an employer who does not offer health insurance, an 8 percent tax on total wages. Is that your understanding?

Mr. HOLAHAN. Yes.

Mr. CAMP. And if there was an employee who had a spouse who had an insurance plan with another company, and that employee decided to go on their spouse's insurance for some reason—it may have better benefits; it may be cheaper for their family—and that policy was in the exchange, would the employer still have to pay the 8 percent tax on that employee who was not covered by insurance?

Mr. HOLAHAN. So you are saying the employee is covered, the spouse is not?

Mr. CAMP. The spouse is covered by another plan that is in an exchange. This employee decides, I will go on my spouse's plan. I am not going to use my employer's plan. Because it might be cheaper. It might have different benefit levels.

Mr. HOLAHAN. There are a lot of difficult design issues in——

Mr. CAMP. My view——

Mr. HOLAHAN. I don't know how they dealt with that, to be honest. I didn't see that.

Mr. CAMP. My read of the bill is that that employer would still have to pay an 8 percent tax. So if the employee made $100,000, the employer would still be on the hook for $8,000——

Ms. POLLITZ. Mr. Camp.

Mr. CAMP [continuing]. Even though that employee was covered.

Ms. POLLITZ. I believe there was a general provision in the bill that allowed for a delegated authority to the Secretary to arrange for accounting rules to take care of problems like that. I don't know that it is specified in the bill, but it is acknowledged that there would need to be accounting rules about how families are covered when there is more than one source of coverage, and that those will need to be addressed.

Mr. CAMP. Yes. The bill, as written now, would indicate that that tax by the employer has to be paid. It wouldn't necessarily change anything. The family doesn't pay that; it is the employer's payment.

I also have a question, Dr. Holahan. The health choices commissioner who would run the exchange, what protections are there in the bill to ensure that there is the necessary independence from the President and the Health and Human Services Secretary, given that this person would be running the health care—the government plan? What protections in the bill are to ensure that that is an independent position?

Mr. HOLAHAN. I don't think I can answer that. I didn't read that part of it.

Mr. CAMP. Okay. It is my understanding there aren't any such protections in the bill, and I think that is one of the concerns that we would have.

Mr. HOLAHAN. As I said in my opening remarks, I would agree with that. There has to be separation.

Mr. CAMP. Thank you.

I see my time is expired, Mr. Chairman. Thank you very much.

Chairman RANGEL. Well, I have talked with staff. And as we told you yesterday, we think the bill is clear that an employer that offers insurance will not be penalized merely because one of the employees would want to enjoy the benefits under another plan.

But in an effort to show the direction in which we want to go, we are prepared to accept Republican language to make it abundantly clear that if he is offering the insurance, it doesn't mean that the employee has to accept it. So there is no penalty involved.

I would like to yield to the Chairman of the Health Committee.

Mr. STARK. Thank you, Mr. Chairman. And thank my colleagues for their patience. I think it is important to note that in this draft proposal, there are still many issues that are undecided.

But I did feel that it is important to note that the—well, there has been a good bit of discussion about a Canadian system, which the public plan, I would suggest, is not. There is basically nothing in the public option that would create a Canadian-style system. Dr. Gratzer indicates that it would be important to have preventive health. I believe that we have eliminated copays for preventive procedures, which should increase preventive health.

Canadians don't get their health care via their employer. Private insurers do not exist in Canada offering comprehensive health benefits. There are province-wide caps on spending in Canada. And these are four major elements of the Canadian system that are not at least in this discussion draft.

So that I would just like to make crystal clear that this is an attempt to save money, as they say, bend the curve, and also a question to make sure that everybody contributes. Beneficiaries will contribute. Employers will contribute. Taxpayers will probably end up contributing. And providers certainly will.

Dr. Gratzer has suggested that physicians ought to set their own prices. They are currently the highest-paid group of people in America, averaging substantially over $250,000 a year, many making $6 or $700,000 a year. And I have repeatedly said I fail to extend much sympathy to the $600,000-plus physicians who are back here looking for more, particularly in this time when so many Americans are just looking for a job.

So that I think we have to move ahead. One of the things that was in this—whoever wrote this silly $3 trillion analysis managed to miss 500 pages of the text, and I wonder what else they missed, because they didn't talk about the savings in the bill.

And also, I must say, in the analysis they said that in contrast to the Senate version, our version is more fiscally prudent and effective. Now, given that CBO has scored the Senate version at around 1 to 1.6, this certainly indicates that we are doing a lot better.

So I hope we can continue to analyze the bill, and try and keep our analysis of it somewhat close to reality, and come up with a bill that will end up having more than 95 percent of the American public with an affordable quality access to medical care.

Thank you, Mr. Chairman.

Chairman RANGEL. Thank you, Chairman Stark.

I would like to recognize Mr. Herger, who has spent quite a bit of his legislative career working on health reform.

Mr. HERGER. Thank you, Mr. Chairman.

Dr. Gratzer, advocates of a government-run care program often point to Canada as a model for the U.S. to follow. However, your experience shows that many Canadians can't find a family physician, and those that do often face long waits if they need followup

care. In fact, some patients even die while waiting to receive treatment.

Could you please elaborate?

Dr. GRATZER. I thank the Member for the question. There is such a severe physician shortage in Canada that there are small towns where if you win the local lottery, you don't get money to pay off your mortgage. You don't get a boat. You don't get a new house. You get a trip to the family doctor.

One in six Canadians, according to the government's own statistics, are actively looking for a family doctor and can't find one, the shortage is so severe.

Even the Supreme Court of Canada—arguably, by the way, one of the most liberal supreme courts in the western world—wrote in a decision, writing for the majority, according to the chief justice, that access to wait lists is not access to health care.

The Canadian system rations. The British system rations. The Swedish system rations. Right across the board, you see the same thing—not according to my statistics or right-wing think tank statistics; according to even their government statistics.

Now, the question is, is any of this relevant today? And Mr. Stark has suggested that it is irrelevant because we are just talking about a public plan. But a public plan would inevitably lead to a government plan, and inevitably lead to a further skewing of the field, 120 million Americans taking up public insurance, and ultimately you are well on your way to a Canadian-style system. That is the danger.

Look north of the 49th parallel, and you don't find a compassionate system. You find people waiting, and to use your words, in some cases dying.

Mr. HERGER. Thank you. On a different issue, competitive effectiveness research, if done right, can be an important source of trustworthy information for patients and doctors. I am concerned, however, that if it is done wrong, it could take us down the path of countries like the U.K., where government agencies get in the middle of the doctor-patient relationship and decide whether or not to cover a medical treatment based solely on its cost.

I have introduced bipartisan legislation that would prohibit the Federal Government from using competitive effectiveness research to make cost-based coverage determinations, while also ensuring that research is conducted transparently and with adequate opportunity for public comment.

Dr. Gratzer, do you believe it is important for health reform legislation to include these kinds of safeguards to protect the doctor-patient relationship?

Dr. GRATZER. Absolutely. I am a huge believer in studying what is effective and what isn't. You know, in my other life I am a practicing physician. As a psychiatrist, I tap the CATIE study funded by the NIMH all the time. It was a direct head-to-head comparison of different anti-psychotics. It literally influences my practice every day. That is funding that worked and helped people.

On the other hand, one must be enormously careful not to follow the examples of countries like Britain, where you have a committee of really smart, well-meaning people who end up making decisions that they ought not to. There is a right way of doing this and a

wrong way of doing this. I fear in the stimulus bill we took the wrong tack. But I applaud your efforts and the bipartisanship it has enjoyed. That is the right way we ought to do it.

Health care is a black box. We are power consumers. No matter whether you agree with a single payer system or a government-run system or, as you and I do, a more private system, we need to inform individuals more correctly—not through government rationing committees, but through better information to consumers.

Mr. HERGER. Dr. Gratzer, again, thank you very much. I believe we all agree—Republican, Democrat, whoever we are—that the system needs to be fixed. But it needs to be repaired and fixed in a way that is going to make it better, not make it worse. So thank you very much for your testimony.

Thank you, Mr. Chairman.

Chairman RANGEL. I would like to recognize a senior Member of our Committee, Sandy Levin.

Mr. LEVIN. Well, we are having, I guess, a grand debate. So let's continue it.

Dr. Gratzer, in your testimony you say—I think you mean it humorously—the honored scientific observation that if it walks like a duck and it quacks like a duck, it is a duck. We are not talking about a duck. It is a straw man.

I live next to Windsor. We are not proposing a Canadian system, and there is no way we are going to allow the opponents of reform to mischaracterize what we are proposing.

You talk about the rationing of health care in Canada or in Britain. One of the problems is, and we have a strong health care system in some respects, but the present American system rations health care. There is a horrible difference in the availability of health care for Americans in this country. And we have a system that needs reform.

I think you said you are a libertarian. You say it straight. Essentially, you talk about the American system. That includes Medicare. You essentially would dismantle Medicare. I think you would.

You talk about price controls. We instituted some control of reimbursement costs for hospitals in Medicare. You would turn that over to, essentially, competition without any government role. At least that alternative is said essentially straight. But America has essentially rejected it. They don't think Medicare is a Canadian system of health care.

So if there is any hope for a bipartisan approach, and I hope there is, to reform our health care system, it will not be possible if the main effort of those who oppose what we are proposing is caricature. This is not a duck. That is a straw man.

And I want to say to Mr. Camp, it is true we do not at this point indicate how we will pay for it. And you bring out a study—I don't know, really, its origin—about 3½ trillion. We will see what CBO says. But I don't think that kind of a study should scare us into inaction.

And you also mentioned the problem of where both the couples, both work. You know, from Michigan, we should be sensitive to that because we have had a system where both people work. Essentially, one employer is paying all the costs for both people. And in 1993–1994, a plan that did not succeed attempted to address that.

And I think it is important that we face up to the issue, but without caricaturing what it is all about.

So Dr. Gratzer, you say that there can't be fair competition with government involvement. We will see. The reason that we have proposed focusing on reform and then focusing on how we pay for it is because the system needs to be revised.

The reimbursement structure today that we have in Medicare and beyond for physicians is totally unworkable. It is totally unworkable. And what our proposal does is attempt to begin to address an unworkable system and an unfair system of physician reimbursement.

And those of us on the majority side want us to examine how we go even further. And I think to say that a public plan is socialism or is Canadian misses the point. We want a public plan in part so that there will be more competition to address issues of reform. That is one of the strengths of a proposal that includes an option for a public plan.

Mr. CAMP. Mr. Levin, would you yield briefly? You used the words characterizing your plan. I am just trying to find out what it says.

Mr. LEVIN. I said caricature.

Mr. CAMP. Caricature. On page 115, it says, "The employer shall make a timely contribution to the health insurance exchange if an employee declines such offer but obtains coverage in an exchange."

So my read of the plain language of the bill is that an employer will be required to make that 8 percent. We can debate whether that is the right thing to do. I think at this hearing we are just trying to find out what does the bill do.

Mr. LEVIN. Okay. Let me take back my time. Let's talk about that issue without caricaturing the plan.

It is a problem where both work, and one employer is paying insurance for both. That is a problem. Let's discuss this on a bipartisan basis, whether the present proposal adequately addresses it or not. But don't caricature that provision or any other provision.

For you to come here and essentially say what we are proposing is a Canadian system is dead wrong.

Chairman RANGEL. The Chair would like to recognize a continuous service hero, Sam Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman.

Ms. Pollitz, you state in your testimony, "Defining a national standard for health insurance is crucial," and that, "an essential benefit package is necessary."

I was wondering if you think the benefit package should include acupuncture like they do in California?

Ms. POLLITZ. No. I think we could get by without that.

Mr. JOHNSON. No? Should it be required to cover the cost of prosthetic devices, as it is in New Jersey and California?

Ms. POLLITZ. Yes. I think prosthetic devices are very important for people with disabilities and would be needed.

Mr. JOHNSON. How about covering in vitro fertilization costs?

Ms. POLLITZ. I am not sure I have an opinion on that.

Mr. JOHNSON. Well, you know, a health insurance policy in New Jersey costs significantly more than a policy in the Midwest mainly because of excessive mandates. And I am concerned that

our government bureaucrats in D.C., who in this bill are tasked with making decisions on what to include in an essential benefits package, will include too many mandates.

Dr. Gratzer, isn't it likely, by giving all this power to one individual, they will succumb to the same pressures that landed New Jersey into their high cost health coverage situation?

Dr. GRATZER. Or New York or so many States. You know, I walk out of the think tank in New York City, and if I wanted to buy a policy out of the individual market, I would pay three times more for a policy, as you know, than I would if I took the Metro north 45 minutes to Connecticut. Three times more for a policy that covers basically the same stuff for me.

So absolutely, these mandates, built with the best of intentions, drive up costs. And we see them right across the United States. And the danger with a health insurance exchange with some czar of regulation is that we just keep adding and adding and adding until we get to the point, like New York State, where you have the most fair and equitable policy available. Just no one can afford it.

Mr. JOHNSON. Yes. You are right. But, you know, we could have a health czar that could solve all those problems. Right?

Ms. POLLITZ. Mr. Johnson.

Mr. JOHNSON. Yes.

Ms. POLLITZ. I just wanted to correct one thing for the record. Health insurance in New York and New Jersey is more expensive than in most other States because those two States require health insurance companies to sell coverage to people and to leave coverage with people when they are sick. And in all other States in the individual market, that is not the case. The pool excludes people who are sick.

I live in the State of Maryland, which is recognized as being the champion State of health insurance mandates. I believe we have more in Maryland than any other State. And yet individual policies are much cheaper in Maryland than they are in New Jersey, again for that very same reason——

Mr. JOHNSON. Private insurance.

Ms. POLLITZ [continuing]. That sick people can't buy the coverage.

Mr. JOHNSON. Private insurance, though.

Ms. POLLITZ. Yes. Private insurance.

Mr. JOHNSON. Oh, okay. But we are about to overturn that, are we not?

Ms. POLLITZ. Yes. I hope you are.

Mr. JOHNSON. Dr. Gratzer, your experience in the Canadian health care system seems to suggest reform that focuses on guaranteeing coverage. And it won't necessarily produce a quality health care delivery system. And your testimony also speaks to the fact that Canadians can't find a family physician, and those that do often face long waits if they need followup care. And I am told also that in Canada, some lottery winner accesses a physician.

You know, I am not sure that this type of system, and I think we are having trouble in this country, too, finding primary care physicians. Would you comment?

Dr. GRATZER. Well, undoubtedly there are problems with primary care access in the United States. Emergency room care also

is problematic in terms of overcrowding. But in our efforts to achieve better reform, we should be careful not to end up worsening the system.

There is no plan right now put forward by Congress for single payer option before this Committee. And yet when you are going to suck up 120 million people out of private plans and put them into a government system, I fear that is the road we are going down.

I know that your colleague is very concerned that I would take apart Medicare were I to be elected President. And for the record, because of constitutional limitations, I will not be running in 2012. But it doesn't matter what I am going to do because who cares what I really want to do? The question is what you guys are going to do because you are in this important, august Committee and before Congress.

And what you should be careful of is looking at this temptation of government and expanding Washington's reach because inevitably, you get to systems like you see in Canada or Britain or across western Europe.

Canada, incidentally, didn't start with a single payer system. Canada started with hospital construction grants in the 1950s, and then hospital insurance in the 1960s, built, by the way, to compete against private plans; and then physician reimbursement in the 1970s. And then finally, in 1984 because costs kept rising and so many people were in the public system anyway, they just went out and banned private coverage altogether.

That is the path that I fear Congress is starting to walk down with this draft legislation, sir.

Mr. JOHNSON. I agree with you.

Thank you, Mr. Chairman.

Chairman RANGEL. It is amazing how the language in opposition to this bill is basically the same language that was heard with Medicaid and Medicare: Keep government out of it. And now it has proven to be one of the most efficient delivery of services.

No one understands this problem better in the Congress than Dr. Jim McDermott. And I thank him for the great contribution he has made over the years, and I know he is thankful that the moment has come to change the inequities. Dr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

The President has said that cost is the real problem here. Access is much easier to deal with than controlling costs. And I want to talk to you, Dr. Quentin Young, who I have known for not the whole 61 years you have practiced medicine in Chicago, but certainly a whole lot of them.

And one of the things you said was that you thought that this plan that we have before us would put the sick people in the government option and leave the healthy ones for the private insurance industry.

Now, we built in guaranteed access so anybody can get into both a private plan or the public option. We said there can be no exclusion for preexisting conditions in either the public plan or the private plan.

How do you think the insurance companies will push the sick ones, as they do presently—how are they going to get around this

bill and push the sick ones into the government plan and leave the healthy ones who pay premiums but don't get any benefits?

Dr. YOUNG. Well, the recent history, I mean, the last 20 or 30——

Mr. MCDERMOTT. Hit your button.

Dr. YOUNG. Thank you very much. The recent history of our national experience with private insurance is the answer to your question. Private insurance has legendary skills in turning any system to their selective advantage. Speaking of Medicare, a superb achievement and still the brightest star on the insurance horizon in this country, nevertheless it has been compromised by the insurance skill, sometimes aided with congressional bills.

They have such things as Medicare Advantage. As you are probably aware, the President has said he wants to end that scam, which briefly creates a separate pool with a 12 percent subsidy per capita. And the insurance companies have dramatically been able to attract people who are under the Medicare average as incoming patients, and people when they leave the plan remarkably are much higher than average and they go to the public side.

I would describe Medicare Part D, the so-called drug benefit, which is a catastrophe for people who need to buy a lot of drugs, as an example of the big PhRMA creating its tentacles around a much-needed program. It was tragic that Medicare enacted in 1965 was a spectacular breakthrough, but remarkably it had no drug benefit. And I think that was an industry that was able to influence the legislation at the time.

So my answer, Congressman, is that they are good at that and they will continue to do it. And I want to expand a little bit in answer to your question. The problem in this country is not government medicine. It is private insurance. And private insurance isn't health. It is a business. And it is remarkably skilled. Everybody knows we are talking about one-sixth of the whole gross domestic product.

And let me give another figure that doesn't seem to be coming up here. We are spending twice per capita, something in the neighborhood of 8,000 per person in this country, for our health system, despite the fact that we have, as we all know, 45 going on 50 million uninsured.

And I hasten to add, before somebody adds for me, that that doesn't mean they don't get any care. Indeed, they frequently get very expensive care in the ER. But the point is they are not covered. And 50 million more are underinsured.

And we have—the other nations of the world, which I am not their representative but I have to defend them, the achievements of everyone in the countries that have been revolved for government medicine are spectacular and much more popular with their nation.

The Canadians, for example, when polled, 96 percent prefer their system to the American system, which they know. The border is very porous. As Congressman Levin would point out, they know what they have and they know what we have, and they like theirs 96 to 4. People have pointed out 4 percent is the same percentage of Canadians who think Elvis Presley is alive, but that is not——

Mr. MCDERMOTT. Can I get you to focus on one other issue?

Dr. YOUNG. Please.

Mr. MCDERMOTT. And that is how does a single payer system control costs? Dr. Gratzer says that the Canadian system ultimately was—the costs were getting out of control, and so ultimately they passed the umbrella law in Canada to control costs.

Dr. YOUNG. Well, I think single payer is the only arrangement for payment that allows you to control costs. As is well known, there are great variations in activities of doctors, good faith and not in good faith—too many operations, not enough operations, depending on the incentive.

The single payer system, because everything is paid for through a single payer, identifies doctors' practice patterns. And that is used as a guide to best practices, not Big Brother standing over you repeatedly saying, you can or cannot do this. Usually that is ascribed to the British system, erroneously or dishonestly.

But when you have control of all the transactions, which is by definition what a single payer system does, you can see abnormalities. And there are, Congressman, huge variations in this country that can't be explained rationally by the various public health areas of this country. I think there are 11 of them.

There are variations in, for example, hysterectomy, as three is to one. Now, some may be doing too many; some may be doing too little. But best medical practice has to be sought. The single payer system allows you to identify these patterns.

And the great tradition of medicine, going all the way back, of using experience to define behavior can be implemented because you have the knowledge. In a multi-payer system with the variety of inhibitions and other distortions of utilizations, you don't know.

And as a result, we American people don't—despite the fact that yes, ours is the best in the world when you can get it, there are tens of millions of people that can't get near that best. And that is why we are here and you are here.

But I want to, if I may, as an extension of my answer, end the myth that private is good and public is bad. It ill behooves the Congress, who enacted it, to neglect the superiority of the NIH, for example, the best system in the world for stimulating research, and is the reason for America's primacy in biomedicine.

And indeed, the VA system, which now sets the standards for quality for the whole world, and I would add military medicine, with its mission defined, it is fantastic the achievements they have been able—these are all government medicine. For the naysayers, I would like them to find whether they want to abolish VA and Medicare.

And so my experience, those 61 years you were talking about, by and large the private control of finances is bad. I can't name a single improvement that is a result of putting health insurance in the hands of the private sector.

So I would plead that this Committee have an orientation that seeks to bring health care to all the American people at the best price, and even if it means bucking against right-wing criticism of government medicine. Thank you.

Mr. MCDERMOTT. The Chairman is being more than generous.

Dr. YOUNG. I know. And I have been generous, but I have been outnumbered.

Chairman RANGEL. Thank you. Thank you so much for your contribution.

The Chair would like to recognize Mr. Ryan, who has authored a bill to attempt to deal with this problem.

Mr. RYAN. Thank you, Chairman.

A couple of points I think we ought to dig into in this Committee. And hopefully we can have some more hearings on this because this is obviously probably the most important subject we are going to tackle here this year.

The one point is, we oversee Medicare in this Committee, and the trustees have just told us that Medicare right now has a $38 trillion unfunded liability. So we can talk about how efficient that system is. The system is going broke in just a few short years. And if we want it to be there for the generations alive today, we would have to literally set aside $38 trillion invested at Treasury rates in order to pay the bills for Medicare.

And the question we ought to be asking ourselves is: Are we creating a new program, a new entitlement program, that will rival the size and liabilities of Medicare? And what is unfortunate about this debate is we are not going to get scores outside of the 10-year window.

Yes, we will probably in a number of days get scores from CBO and Joint Tax showing us what this thing will cost in 10 years. But they are not going to give us—and we have already been asking for them—they are not going to give us scores of what it will cost in the out years.

So I think it is just a point worth making because we ought to know what kind of liabilities we are creating here and what kind of new entitlement this will be in its size.

The second point, and I would like to get into something with you, Dr. Gratzer, is I will take my colleagues at their word that their goal here is not to create a Canadian-style or a British-style system. Unfortunately, just looking at this bill from an actuarial standpoint, from a mathematical standpoint, I believe it is impossible to conclude that this does not create such a system. And here is why we believe this point.

No. 1, a public plan as designed in this bill has such a stacked deck, has such a huge competitive advantage over the private sector, it is impossible to conclude that the private sector won't buckle under this kind of a confrontation.

What are the advantages? Well, the public plan doesn't have to pay taxes. The private sector does. The public plan gets to dictate the prices it pays to providers. We are going to cut Medicare by, I don't know, $4 or $500 billion, and then pay 5 percent above that for 5 years, and then Medicare after that. The private sector doesn't get to dictate its prices it pays to providers.

And the other issue is the private sector does have to have capital reserves set aside. The public plan doesn't have to do that. The private sector does have to pay for and account for its employees and their benefit and wage costs. The public plan does not have to do that.

So there are enormous, enormous advantages. It is kind of like my 7-year-old daughter's lemonade stand competing against McDonald's. It is an impossible stacked deck whereby actuarial

firm after actuarial firm, expert after expert, are telling us what is going to end up happening here is the private sector will not be able to compete with the public plan.

And remember, the people who decide for the most part who gets health insurance in this country are the employers. Individuals don't choose this. Employers choose this. And most people in this country like their employer-sponsored care. Most people would like to keep what they have.

But the talking point, that if you like what you have, you can keep it, just doesn't add up when all these actuaries are telling us, an employer faced in a situation of ever-higher-growing prices for their private insurance, because of the overwhelming advantage of the public plan, will be faced with.

Pay the 8 percent payroll tax that is indexed at inflation, which is predictable—they can budget for that—or pay this unpredictable, ever-higher-growing private health cost. And what are all the employers telling us? They are going to dump their people on the public plan. And that is what the actuaries are telling us. All of the actuaries are telling us this.

So it is not a number. It is not a measure of whether it is going to be 120 million people or 64 million people or 23 million people. What it is is people are going to get dumped onto the public plan, and we will have a new program which will rival the size and liabilities of Medicare.

And my question, Dr. Gratzer, is this: If the intention of this thing is not to have Canadian-style health care today, the clear trajectory of this plan is that it will be Canadian-style health care tomorrow. And the authors of this claim that this is better to get our hands on health care costs.

So in the out years, we are worried. Medicaid, Medicare, and then this new entitlement which I don't think we have a name for this yet, will be so expensive we are going to have to contain costs in order to, you know, make sure that the next generation doesn't get swallowed up in debt and high taxes.

And my question is this: Under those models, do they contain the costs? I mean, we know rationing is the method of containing costs. But even with all of this rationing, even with all of these waiting lines, do they actually achieve the cost containment that these goals are intended to achieve?

Dr. GRATZER. Congressman Ryan, you ask a great question. Undoubtedly we are concerned about cost inflation of the private system in the United States, but also the public system in the United States.

I would point out, though, when you look across western Europe and you look across Canada and their experiences with public health care, one finds cost containment isn't as great as one would assume. I will throw out some numbers, and you will find them also in my written statement.

Ontario's health budget is growing by 7 percent over the next 3 years, Quebec 6 percent. In Britain, I will say 60 years of data where health inflation has outstripped real inflation by 3 percent, on average, every year. In Ireland, my last statistic, one finds that they actually had de-inflation this May of—they had 3.5 percent

de-inflation this May, and yet health costs are growing at an annualized rate of 4.5 percent.

My friend Shakira Delmia has done 30 years' worth of analysis, and suggested at best a mixed picture on public containment of costs. But you still have the rationing, the waiting lists, and the lack of availability of modern care.

Mr. RYAN. Medicare is at 6½, Medicaid is at 7½. Thank you.

Chairman RANGEL. Well, I think all of you have done a pretty good job of trashing the health care system in Canada and in Ireland and in Europe generally. But by unanimous consent, I would like, Mr. Ryan, to introduce a solution for the record because one of the things that we need is to find out, if not this bill, what?

I would like to recognize Mr. Neal. But before I do, I want to make it clear that we have a vote on the floor, and the Ranking Member and I agreed that to the best we can, we will keep the Committee going and rotate. And since this is a single vote, those who want to go and come back, this would be the right time to do it.

And Mr. Ryan, would you like to start your testimony or vote or whatever?

Mr. NEAL. We share a similar background, Mr. Chairman, but—Mr. Neal and Mr. Ryan. You called me Mr. Ryan.

Chairman RANGEL. I am so sorry.

Mr. NEAL. I was just about to give him a bad time, and he left. [Laughter.]

Mr. NEAL. Thanks, Mr. Chairman. I find it ironic that our friends on the other side all of a sudden profess this newfound interest in adding to the deficit. Their Medicare legislation in 2003 added $500 billion to the deficit. Two point three trillion dollars of their tax breaks for wealthy people were added to the deficit.

The war in Iraq is headed toward a trillion dollars added to the deficit, much of it borrowed money. And for them to complain today all of a sudden with this newfound conscience of debt spending I think falls by the wayside under the magnifying glass of critical analysis.

Let me, if I can—because a couple of you have mentioned Massachusetts—let me give you the framework, as an architect might. The Massachusetts plan was proposed by a Republican Governor who launched a campaign for President in some measure based upon that plan; a legislature that is—I think there are four or five Republicans in the State Senate. There are 19 in the House of Representatives out of 160. But the Governor did it with a Democratic legislature.

The plan was blessed by Senator Kennedy, whose credentials on that I think are unrivaled in the Congress. And there have been some bumps. I don't think anybody would argue with that notion. However, it has been well met by business, labor, and advocates across the State. And in fact, the argument might be made, I think with accuracy, that the uninsured part of the population has decreased dramatically, the suggestion being that there is some skin in the game for everybody.

So with that, Ms. Pollitz, could you perhaps give us some thoughts about that plan based on your knowledge?

Ms. POLLITZ. Well, John and his colleagues have studied it far more closely than I.

Mr. NEAL. Let me go back to Dr. Holahan, then.

Ms. POLLITZ. But it is a terrific success, what has been accomplished in Massachusetts. It is 3 years in the making. There are certainly still some growing pains. Not every problem has been worked out, but the State has achieved a coverage rate now of 98 percent.

Employer-sponsored coverage has increased. Individual responsibility, individual purchase of coverage, has increased. They have expanded public programs and created new subsidies for private coverage similar to what is in the draft bill today. People are overwhelmingly supportive of the program and are willing to do their part, and have really kind of stepped up to make it work as well as it has, which is most impressive.

Mr. NEAL. About 97 percent of the people of Massachusetts are covered right now.

Dr. Holahan, would you comment, please?

Mr. HOLAHAN. I think Karen covered the most important things. I think there is a set of surveys that have been done annually that have tracked what has happened, and they continue to show reductions in out-of-pocket costs and burdens that families are facing and improvements in access on almost all measures.

And so I think in addition to gaining coverage, I think on other things that you care about in terms of measuring the success of a program, Massachusetts has done quite well.

In the early years, there was a jump in costs that was alarming to a lot of people. But a lot of that was explained by the fact that sicker-than-average people were the first to join; that the people who were fully subsidized as opposed to partially subsidized were the first to join; and they miscounted the number of uninsured low-income people they are dealing with because of survey issues.

But I think that has generally slowed down. I think the State does face long-run cost issues that they are going to have to wrestle with. But, you know, on balance it has been a big, big success.

Mr. NEAL. Thank you.

Dr. Gratzer, would you list Medicare as one of the maybe top 20 legislative accomplishments in American history?

Dr. GRATZER. I think Medicare did an enormous amount to help elderly Americans.

Mr. NEAL. Would you say that it was successful?

Dr. GRATZER. I would say that aspects of it have been enormously successful, though there are cost problems today and there are cost problems around reimbursement and other aspects.

Mr. NEAL. During your medical training, did you receive any reimbursement under graduate medical education from Medicare?

Dr. GRATZER. I actually did my training in another country, sir, so the answer would be no. But many of my colleagues did, absolutely.

Mr. NEAL. Would most of your colleagues professionally have received some benefit under Medicare under GME?

Dr. GRATZER. I would suspect all of them did.

Mr. NEAL. I didn't say that. I said would most of them.

Dr. GRATZER. I suspect all of them, yes. I agree.

Mr. NEAL. Okay. How would you handle the GME portion of Medicare now?

Dr. GRATZER. I think that is a topic for another day. And I am, to be blunt, not a Medicare expert. But I would suggest that both in the public system and the private system, we have enormous difficulties.

We see costs rise in both systems, costs that are unsustainable.

Mr. NEAL. I acknowledge that. My point is that Medicare has been transformative. It has changed the way tens of millions of people have lived their lives.

Dr. GRATZER. Absolutely.

Mr. NEAL. Overwhelmingly for the better, I think you might acknowledge.

Dr. GRATZER. Absolutely.

Mr. NEAL. Thank you, Mr. Chairman.

Chairman RANGEL. I would like to leave on that positive note, but Doctor, you have made it clear that we haven't impressed you with our health reform plan. Has there been any Republican plan offered to you to study that you would think could do a better job?

Dr. GRATZER. I think there are a few proposals out there that I like. And I don't think that there is one plan that necessarily excites me. I think plans, particularly bipartisan plans, that look at prevention and wellness excite me.

Chairman RANGEL. Could you tell me the author? Is the Republican leadership supporting any one of these plans that you find to your liking?

Mr. NEAL. There are aspects of different plans I like. I mean, Congressman Ryan's plan about a tax credit I think has some worth in it. I think on the Senate side, Senators Bennett and Wyden have some exciting ideas that they are conveying.

Chairman RANGEL. Well, with all due respect to the Senate, I really was trying to think of the House of Representatives because right now we don't have much competing in terms of a health program before us, even though we are getting more than our share of criticism.

So since you and I are from New York, if in the course of your thinking that you think there is something that we could improve upon, I look forward to meeting with you in New York and see what we could do.

Dr. GRATZER. I would be excited to draft something with you. But as I suggested before, I think we need some policy reform around health, not just health care. I think we need some regulatory reform to increase competition on insurance companies. And I also think we need some tax reform that doesn't—a system that won't discriminate against the self-employed and the unemployed.

Chairman RANGEL. That goes unchallenged. The thing is, how do we get together and do it?

Mr. Linder, thank you so much for your patience, and I welcome the opportunity to allow you to ask questions.

Mr. LINDER. Thank you, Mr. Chairman.

Ms. Pollitz, you referred to the Massachusetts model being quite a success. Still have some problems to be worked out. The States' overall costs on health programs have increased 42 percent since

2006. For an individual earning $31,213, the cheapest plan in Massachusetts can be $9,800 in premiums and out-of-pocket costs.

The longest wait times in Boston to see a physician, almost 50 days. Double the costs of—double the time of Philadelphia. The government-run Medicaid plan, MassHealth, denied the highest share of medical claims in the State, four times more than the private plans denied.

It has not reduced the rate of adults seeking non-emergency care in an emergency room. Both before and after reform, 15 percent of adults and 23 percent of low-income adults sought care in an emergency department.

Is that a success story?

Ms. POLLITZ. I think, Congressman, Massachusetts has been a success story and they clearly have not solved all the problems. Massachusetts is unique, I think, from most other States. They have always had, even prior to reform, very, very high costs.

They have always had a particular shortage, I think, of primary care physicians. Many of the best medical schools in the country are located in Massachusetts, in Boston, and many of the best medical schools around the country don't even have a department of family medicine. They are just kind of too good to train primary care physicians.

So there have been some structural problems that are throughout the Nation that have been particularly intense in the State of Massachusetts for a long time, even leading up to reform. And they still have not all been addressed.

I was on a panel yesterday with someone from the Commonwealth Connector, who talked about how tackling the cost problem is particularly difficult in that State, that the Boston area in particular is one where there has been not only a high concentration of insurers but also a very high concentration of providers.

And the competition between, you know, concentrated providers and insurers you would think would be kind of, you know, King Kong vs. Godzilla and someone would be lying on the ground at the end, but that is not the case.

Instead, the high prices are demanded by the providers and just passed through by the insurers. And they haven't yet been able to get a handle on that. And what she testified yield was that if there were a public plan option that were available in addition to the mix of private plan options that they have made available, that that might begin to change.

Mr. LINDER. Let me comment just briefly. But first of all, Dr. Gratzer, do you have a comment on that?

Dr. GRATZER. I just want to add, you know, if you are suggesting that costs haven't been contained in Massachusetts, even she has acknowledged that. I will just throw out a few figures in terms of the rise in health insurance premiums between 2007 and 2009.

In Massachusetts, 7.4 percent, 2007; 8 to 12 percent, 2008; and 9 percent is forecasted for this year. Outside of Massachusetts, 6.1 percent, 4.7 percent, 6.4 percent for those same years.

I would point out for a family of four in Massachusetts, a health insurance plan now costs almost $17,000. Nationally, it is closer to

$12,500. Massachusetts has in no way, shape, or form contained costs.

There are successes there, particularly, I think, for the self-employed and those in the small business coverage pool. But yes, costs have just continued to rise.

Mr. LINDER. Thank you. I want to comment on the public plans. We have had testimony before this Committee in the past that the typical small business spends about 12 percent of their payroll on health care costs. Some of the bigger companies with Cadillac plans spend as much as 14 to 18 percent of their payroll.

We hear a lot of talk about choice, options. And the President says, if you like your program today, you know you will have to give it up. But we don't have—our citizens don't make these choices. Their employers do. And if the employer can pay 8 percent instead of 14 percent, my guess is he is going to put the people on—in fact, that is what they tell us. They will move their people to the public plan, and there will be no choices left at all.

I don't know why this is considered such a good option. Dr. Gratzer.

Dr. GRATZER. I agree.

Mr. LINDER. Thank you all. Thank you, Mr. Chairman.

Chairman RANGEL. Thank you.

The Chair recognizes Mr. Becerra for 5 minutes.

Mr. BECERRA. Thank you, Mr. Chairman. And I don't know if these charts are ready or not, Mr. Chairman, so I think I will just quickly run through them.

But in something Dr. Gratzer said earlier, I wanted to just give him some food for thought. I am sure he is aware of this already because he mentioned Canada and Great Britain.

I am looking at a chart of the infant mortality rates of the leading industrialized countries of the world. And as I look at this chart—I don't know if we have it available, but this, CRS–54, if it could be put up if we happen to have it; I don't know if we do—the industrialized country with the highest infant mortality rate of those industrialized rates, Turkey.

After Turkey, Mexico. After Mexico and Turkey is the United States. Well above Canada, well above the United Kingdom in terms of the rates of infant mortality, in other words, children, babies, who die early. So our infant mortality rate is still very high compared to the two countries you rail against, Canada and Great Britain.

When you take a look at the deaths from medical errors per 100,000 people in the country, the countries with the worst record of having people die from medical errors are Greece, Australia, and in third place, the United States, well above, once again, the United Kingdom and Canada.

And so once again, we seem to be doing worse than Canada and Great Britain when it comes to the deaths that occur in this country simply as a result of medical errors.

When you take a look at mortality rates, how long do people in our countries, respective countries, live, once again comparing these industrialized countries, you take a look at the worst mortality rate—or, excuse me, life expectancy rate of people.

Turkey is least, has the lowest rate. So their average life expectancy at birth is 71 years. There you see the United States at 77½ years. Guess what? Once again, the United Kingdom does better in letting people live longer than we do. And guess what? So does Canada. And so—way up here. Canada is way up here. The U.S. is way down here. And so perhaps there are reasons to rail against what Canada and Great Britain do.

But I have to tell you, if you want to live longer, you want to have a better chance of living when you first are born, or you want to make sure you don't die from some basic medical error, you may be better off living in some of these other countries.

That is why, rather than come with a Canadian model or a Great Britain model for American health care, we are coming up with a uniquely American solution to that, which offers choice.

To the issue of choice, I guess it is in the terms of the private for-profit health insurance companies because you seem to be saying it is good to have competition so long as it is only on the terms that the private insurance companies wish to have, but not to have it on an equal basis business.

Because we talk about the fact that there are price controls. Medicare, you said, Dr. Gratzer, is price control. I would tell you that anybody who has a private health insurance company insurance policy cannot go in and negotiate with that insurance company on what they wish to pay for a doctor or hospital. There are controls that are put in place by those insurance companies that doctors have to accept, hospitals have to accept, and certainly the consumers who asked to have those insurance policies.

So I guess it is all in the definition, as I think the Chairman tried to say with regard to the definition of what is fair. I think most of us are going to try to make it so that it is not you. It is not me. It is certainly not a private health insurance company that is there for profit. And it shouldn't be the government who determines your choice as a consumer. It should be the consumer's choice.

So if you have a lot of different options where the consumer chooses which plan to select, then it makes no difference. If you have an overly burdensome government plan, as you would like to describe it, or if you have a very abusive private health insurance plan, consumers won't have to go in that direction. They can go anywhere they want.

And so no one need fear being dumped, as some would say, into any particular plan because it is not anyone's choice where to send that consumer but the consumer's. That is hopefully what this unique American solution to health care will provide us.

But Dr. Holahan, I wanted to see if I could ask you one question. With regard to this choice, can you have real choice when you have a private sector insurance system where in most geographical areas of the country there is very little choice for consumers because most areas of the country only have one or two health insurance providers to begin with that offer coverage to Americans.

And can you really have choice if you shackle, as I think Dr. Gratzer would do to the public health insurance plan, the opportunity to compete on a level basis, no advantage to the public health insurance option?

Mr. HOLAHAN. I think that is a good point. In many parts of this country, there really is only one choice.

Chairman RANGEL. Doctor, I hope you might be able to submit your answer in writing to the Committee. The gentleman from California's time has expired, and we have a very long, long day ahead of us.

The Chair would like to recognize Ms. Brown-Waite from Florida for 5 minutes.

Ms. BROWN-WAITE. Thank you very much, Mr. Chairman, and I thank the panelists for being here.

When we look at the Ways and Means Committee, you would think that we would be looking at ways and means to pay for this, but when subtitle D says, "to be provided," I just wanted to list some of the suggestions thus far and get your reaction to them, if anyone on the panel wants to jump in. One is tax your employer for providing health insurance; two, tax your employer for not providing health insurance, tax you for owning health insurance, tax you for not owning health insurance, tax you for spending your money on health, tax you for saving your money for future health-related expenditures, tax you for drinking soda and other sweetened beverages, tax you for having an alcoholic beverage, tax you for making charitable contributions, tax mortgage interest payments, increase personal income taxes, energy, pollution tax as a part of the cap and trade taxes, increase taxes on American companies doing business overseas, increase taxes on domestic oil and gas production, raise taxes on oil or natural gas obtained from the Gulf of Mexico, raise taxes on domestic oil refineries, raise taxes on drilling equipment, raise taxes on prescription drugs, increase taxes on dividend income, and just last night I put—I have about eight more. I will not go through them, but I can just tell you that Americans right now in this economy are very concerned. Businesses in most of our districts are having their lines of credit called, and when you are talking about this kind of additional tax to cover this kind of health care when estimates are that if this bill is passed, about 120 million Americans will lose their health care, I do not see where this is a win/win situation.

I would ask—and I apologize, I do not—Ms. Pollitz, I will just go from one end of the panel to the other end because I obviously will run out of time, I would like to have your reaction to this?

Ms. POLLITZ. Actually, if you would not mind, Congresswoman, I would defer to Dr. Holahan. I know they are doing some research on options for funding health care.

Ms. BROWN-WAITE. Okay.

Mr. HOLAHAN. Well, that was a pretty amazing list. I think some of those things have to be on the table. I think that what we call sin taxes, I think a cap probably starting at least at a high level on the employer exclusion and some of the other things that you mentioned. And certainly we should exploit all the possibilities for savings that we can, including trying to reform the way we deal with chronic illness.

I just want to make a point because the issue of the cost of reform has come up several times. There is a huge cost if you do nothing. We published a paper about a month ago called, "Health Reform: The Cost of Failure." If there is nothing—no reform, the

number of uninsured could go up into the mid-60's, 65 million roughly in the worst case. The employer-sponsored coverage will drop quite a bit. The number of people going on Medicaid will expand, that is a cost to government. The number of uninsured will mean more uncompensated care that will have to be financed.

Ms. BROWN-WAITE. Sir, did you miss the part about 120 million will lose their coverage under the proposed plan?

Mr. HOLAHAN. No, that is not possibly right. That is ridiculous.

Ms. BROWN-WAITE. That is not possibly right?

Mr. HOLAHAN. No, it is ridiculous.

Ms. BROWN-WAITE. You think it is ridiculous? Well, sir, I really think that employers will be dropping their plan because the 8 percent may be——

Mr. HOLAHAN. But they offer it now and they pay no penalty, right?

Ms. BROWN-WAITE. If they offer it now, there is still a question about if someone is covered by the spouse's plan and also the percent that they cover of the employee's plan. So I think we need to be very careful where we go with this.

Dr. Gratzer, I would like to hear your comments?

Dr. GRATZER. With the 120 million figure, by the way, that you just quoted is not something, as you know, out of a right-wing think tank or plucked out of thin air but was a Lewin Group analysis.

I would also point out that Professor Jacob Hacker, who really came up with this idea of a public plan auction, he called it Medicare Plus, as you will recall, in fact had worked with the Lewin Group about 10 years or so ago as he designed this specifically to pluck more than 100 million people out of the private insurance market. So to suggest that that estimate is wrong, it is designed to compete with and overshadow eventually the private system.

Now, as for your list of taxes, I would simply say that we are all concerned about health costs. It is curious how much more we need to spend and how much more we need to tax to get those costs under control. Needless to say, I share your bias, we need a more focused plan, a plan that directly helps the uninsured who need help, and a more innovative plan, for instance with uncompensated care, trying to get over to the States to let them innovate. But certainly spending so much money that even Paul Klugman says, "Well, it is not as much money as the Bush tax cuts," is hardly a great plan for us to endorse.

Ms. BROWN-WAITE. Thank you. I see my time has elapsed. With that, I yield back my time.

Chairman RANGEL. The Chair recognizes Lloyd Doggett of Texas to inquire.

Mr. DOGGETT. Thank you, Mr. Chairman. Just picking up right there, we are spending over $2 trillion on a health care system now that leaves many Americans out, and we are proposing to add, in order to ensure more Americans are covered, another $100 billion a year to that system and to finance much of that by squeezing some of the inefficiencies out of the existing system. That is hardly spending gone wild.

The notion that compassion is a distinguishing characteristic of the American health care system is a fantasy. For those people who

lack insurance, they do not find much compassion in our current system. There is an estimate that 22,000 people died in America last year because they did not have health insurance. The notion that delay would be a feature of our system because of the changes we propose in this legislation ignores the fact that delay is a major characteristic of the current system.

The American Cancer Society has estimated that an individual who has cancer and no insurance has a 60 percent greater chance of dying in America today because of the "compassion" that is in the American health care system.

And, of course, one of the hopes that we have with a public plan is to squeeze some of the inefficiency out of that system, which has more people in the American health care system today who are not providing health care themselves directly than those who are providing health care and a significant number of people who spend every waking hour of their day trying to find a way to deny health care to someone else.

Recently, we had testimony here in Congress that three major insurance companies continue to engage in the practice of recision, a practice where people who are paying their health insurance premiums incur substantial bills and find out that their insurance company has dropped them. That is "compassion" in the American system.

As far as independence is concerned, I am reminded of a conversation I had out in south Austin with my constituent, Laura Stager, who said, "My husband is entrepreneurial and wants to own a business, but he tells me it would be irresponsible for him to form his own company because we would lose our health insurance." That is the independence of forcing people to stay where they have insurance even though that may not be the most productive use of their resources and their talents.

I had another constituent, Mark Seefgan, talk to me about what is happening to his small business and the difficulty of dealing with a huge bureaucracy within the insurance industry that seems to be bigger than anyone could imagine in Canada or anywhere else in terms of the challenges to a small business and how it is hard to explain to his employees that they just got a $200 increase in their pay but Blue Cross took all of it in increased health insurance premiums.

Are these problems, Ms. Pollitz, that my constituents face in Austin, Texas and in other parts, do you find the same kind of problems in other parts of the country?

Ms. POLLITZ. Yes, sir, and that is how the private insurance market competes. That is not compassion, that is competition in the private insurance market. I was at that hearing on rescission last week, and just yesterday, the Governor of Connecticut vetoed a bill that was passed in her State legislature to limit the rescission practice. And the reason she vetoed it was she said that would raise premiums, and so we need to let that practice continue because that is what keeps health insurance cheap.

Clearly, we cannot continue to let health insurance compete in that way. There has been a lot of talk about a level playing field, we do not want to be on that playing field anymore. In that playing field, the house wins every time. And we need to compete on the

basis of compassion. We need to put a plan in place that is oriented toward patients and not profits and stimulate the market to compete in that direction.

Mr. DOGGETT. Dr. Holahan, if we just pour more money into the system that we have now, that permits rescission and this kind of activity, and do not have an effective, meaningful public plan, will we really have any reform of our health care system at all?

Mr. HOLAHAN. I think you could have some but the kind of insurance reforms that this bill calls for, it would improve things a great deal. I think the bigger problem is what I talk about in my testimony, the lack of true competition. And if you go back to the Massachusetts problem, the costs are growing at levels that they are not going to be able to sustain but it is because of a very dominant hospital system, a very dominant insurer, and the way they negotiate with each other. And that problem exists around this country.

Mr. DOGGETT. Well, what is it with all these people who are always here telling us in the rhetoric, "Government cannot do anything efficiently, government is broken," that they fear something like a Medicare plan that does not pay Medicare rates as one alternative to compete with these private insurance companies?

Mr. HOLAHAN. I think it fails typically to recognize what really goes on in the market. And the idea that we should not have price controls because the private system can negotiate all this, that is what we have today. If you are in one market and you are a strong insurer, and there are a lot of hospitals with very little leverage, you get one outcome from those negotiations. If the opposite is true, that you have a strong hospital and many insurers or an insurer without enough leverage, you get a very different outcome. Negotiations simply are not working unfortunately. As an economist, I would prefer to have the market work. No one can say that these markets meet the conditions that you expect to get, the efficiency that you would expect to get out of competitive markets. It just does not exist.

Mr. DOGGETT. Thank you.

Chairman RANGEL. Thank you. The Chair recognizes Mr. Davis of Kentucky.

Mr. DAVIS OF KENTUCKY. Thank you, Mr. Chairman. Just one comment that Dr. Young made before going on with the questions, he made the statement that the only way to control cost is a single payer system, well, the mathematics simply do not work on that. We have proven that in defense contracting here in the United States, that the single contractor will ultimately drive costs and overhead and likewise the former—our former opponents of the Cold War learned that single State systems did not tend to deliver quality, they ended up limiting capacity.

I am very concerned, and what I think many of us are really struggling with here today is that we do not have the facts on this bill, and we have been told this will be likely our only hearing. And we are talking about entirely changing the framework of health care in America with no debate of any substance other than we think this is great.

This appears to be reform in name only because the actual delivery cost drivers are not being touched at all. We are not going to

reform the CMS process and dramatically compress it, which we could do to improve quality. We are not touching true insurance reform on the process for how pooling is controlled. And liability is not on the table at all, which drives a huge portion of costs.

Do any of you have any idea how much this could cost, even an approximate number, a range? Ultimately, we have to pay for this, nothing is free, and since you are not going to actually tamper with the system because you are convinced that the CMS is to make Medicare basically the dominant market player here, how are we going to control costs? We are mandating increases in taxes, and we are mandating reduction in payment to providers without dealing with the core engine. How much will it cost?

Mr. HOLAHAN. Are you asking us to make a cost prediction?

Mr. DAVIS OF KENTUCKY. Yes, just as a group. You all have advocated this, I am just kind of curious how you actually pay for it? I think the talk of compassion also has to be done with realism. In Greek it means to "suffer with." And I think that if we are going to suffer with and come alongside the thousands of people, who many of us help in our offices, we have to get down to a legitimate understanding of the nature of the cost.

Dr. YOUNG. Well, I will take a percent at that. Presently, we have about a 38 to 40 percent add-on by the bureaucratic practices of the private insurance that add nothing to the health care of the people, and indeed I think aggravates their problem. Recovering that money in the single payer system would be a giant step forward for cutting costs.

I would like to add to the list the Congressmen and women have made, that we have two big increases in health care needs and costs in the form of aging of the population and increasing bio-technical skills, which are costly.

Mr. DAVIS OF KENTUCKY. Okay, I would like to reclaim my time, Doctor, just because it is limited today. Still nobody has actually answered the question with a number, and I believe the reason we cannot answer the question with a number is there are no true metrics that are framed. All of this at core has been wrapped around the existing government system. Do any of you know how many more Americans will be covered under this bill when you actually factor in the millions estimated to lose employer-sponsored coverage? Are there any numbers there?

Ms. POLLITZ. Mr. Davis, I am sorry, I am not a budget estimator and I cannot answer those questions, but I would suggest that there are very specific metrics in this bill and that those should be—when the CBO finishes its work, they should be able to give you——

Mr. DAVIS OF KENTUCKY. The initial CBO scoring on a sister piece of legislation was well over $1 trillion for about the first quarter of the bill. I am just concerned that you all were propounding the benefits of this without laying out a true cost before the American people. And I know many in my district that would either lose coverage or not be covered in the language that this is written.

Without the basic facts, how can you come here today to support a bill and tell us it is going to lower costs and increase access when those fundamental answers are not there? That would be unacceptable in a business system. It would be unacceptable from any type

of appropriation from a contracting standpoint too because of the precision that is required in those areas.

Dr. Gratzer, do you have any thoughts on this?

Dr. GRATZER. Well, if you are advocating a CBO scoring before you vote on it, I am on your side. I think we have to be very cautious about this. I think that we can all agree there are problems with American health care. On the other hand, (a) I have significant issues with the way they are going about reforming it. It is not just that the government plan would be price controlled, but I do not see government's role as providing competition in general to the private sector. I don't particularly like my cell phone, but I do not think that the goal then should be or the proposal should be that the Federal Government create a new cell phone company to compete with existing providers.

But, second, I think cost is a huge factor. And if you look at some of the preliminary scoring, we are talking about well over $1 trillion and still we would have uninsured and still Medicare and Medicaid remain fundamentally the same.

Mr. DAVIS OF KENTUCKY. My fear, Mr. Chairman, is that this legislation is actually going to hurt the most those who it is designed to help based on the economic realities of this. And with that, I yield back my time.

Chairman RANGEL. Thank you. But I would just like to make it clear, and I think everyone is in accord, you cannot say how much it is going to take to pay for it until we have the Congressional Budget Office give us the numbers. And then we will have to determine how we are going to pay for it, and we are not prepared to do it for now. We are not going to ask you to vote for a bill unless it is fully paid for.

Mr. DAVIS OF KENTUCKY. Mr. Chairman, may I respond?

Chairman RANGEL. Yes.

Mr. DAVIS OF KENTUCKY. Just respectfully I do not understand how we can do a capital plan for the country without actually understanding the magnitude of the capital required before we begin to set priorities by effectively approving legislation and then determining how to pay for it afterwards.

Chairman RANGEL. Your questions are right on point, but there is no bill before us to mark up. And we will have answers for you when we ask for your vote. Right now, we are just trying to make certain that we perfect this. We would not dare ask you to support something without knowing how we are going to pay for it but this is not the forum.

The Chair recognizes the gentlemen from Dakota, Earl Pomeroy—North Dakota.

Mr. POMEROY. Thank you, Mr. Chairman. The difficulty of conducting even this hearing in the middle of all these delayed votes I think is reflective of the fact that the minority participation in trying to build a health reform package is more focused on delay and disruption rather than making some meaningful contribution. I am still frustrated that our meeting last week was canceled, the joint bipartisan meeting to discuss the architecture of the plan, because we were on the floor with procedural votes.

Mr. BOUSTANY. Will the gentleman yield?

Mr. POMEROY. No, I will not yield. I have 5 minutes, and I have all kinds of votes going on, I have to run and vote, so I have to get my question in.

I think there is a contribution, I would say this to the good doctor who was just seeking time, we want to make this thing work. And we believe that the status quo has gotten out of control cost inflation that is wrecking our health care system and threatening our Federal budget. So especially I would be interested in ideas, referenced for example by my friend, Congressman Davis, in his questions, he alluded briefly to CMS payment reform. So if you have ideas about cost containment you want to put on the table, whether or not you are for the final bill, I think these are legitimate ideas we need to study carefully and include where they have merit. And that would be a much better way to proceed than simply throwing the usual lines of attack that this is on the one hand going to cost too much, on the other hand, it is going to do too little, and we are going to have rationing somewhere in between. This is not helpful. Let's work together and build a good deal, and let's focus, among other things, on system reform that contains costs. I believe that that is absolutely critical.

Now, another thing my friend Mr. Davis said was he thinks this bill is going to do too little to help those who need the help the worst. On this one, I believe that he is completely mistaken. The strength of the bill is going to be getting coverage to those who do not have coverage, 45 million there, and assisting at least as many, and maybe even more, that are struggling mightily to keep their present coverage in place in the face of rapidly rising costs.

One of the strategies by which premiums have been paid is to shrink basically the coverage you are buying. And so it is interesting that recent bankruptcy statistics show the high number of bankruptcies caused by medical costs and the high number of people in that bankrupt situation that had insurance but the co-pays, the deductibles, the out-of-pockets in the end proved too much to handle.

And so as a former insurance commissioner myself, I have seen you paying more and more for less and less, more and more for less and less and the health security of everybody, those with insurance and without insurance, has been placed squarely at risk.

Now, one of the things I believe Congress has done when talking about health reform over the years is we focus on the intermediary, the insurance layer, and we do not get right down to cost drivers. And I believe we need to spend a lot of time dealing with cost drivers.

Dr. Holahan, if I understand your testimony, it is that the public plan option is a new competitive element in the marketplace, not just to offer another insurance alternative, but maybe they will be able to try some things that more effectively give value to the consumers than the conventional options. I think those that are opposing a public plan option have to explain to taxpayers why we are going to put a major investment into the system, a system that has out-of-control cost inflation, and essentially not do anything relative to trying to structurally add some opportunities for innovation.

Would you respond on that point?

Mr. HOLAHAN. Well, I think I could not say it any better than you did, I totally agree with that. I think it is an opportunity not only to gain control over the costs of care, but to innovate, through a lot of payment and delivery system reform, the development of medical homes.

Mr. POMEROY. There is a final point I want to get in before my time elapses. I will ask Ms. Pollitz this one. There has been some discussion about the level of delegation between Congress and the executive branch relative to running, for example, a Medicare program relative to payment reforms. So when my friend on the other side of the aisle talks about CMS payment reforms, possibly he is contemplating the idea that there ought to be delegation of authority to the executive branch, to CMS, relative to being able to initiate payment reforms. What are your thoughts on that one?

Ms. POLLITZ. I'm sorry, sir, I cannot really comment on that.

Mr. POMEROY. You are a long-term health expert with experience in the executive branch yourself. I am surprised that you cannot comment.

Ms. POLLITZ. I know there is interest in trying to remove from the political process some of these important decisions so that they are made on a more scientific basis, and I think there may be some value in trying to accomplish that.

Mr. POMEROY. Thank you.

Chairman RANGEL. Mr. Boustany.

Mr. BOUSTANY. Thank you, Mr. Chairman. Dr. Gratzer, I am a cardiac-thoracic surgeon who has 20 years experience, clinical experience dealing with patients before coming to Congress, and I appreciate your comments earlier about quality and innovation, which have been really unique in medical history worldwide. What we have seen in this country has been tremendous development. The question is how do we most efficiently use all that.

I think there are a couple of things missing in this debate. First of all, the basic things we ought to be talking about are access to a physician, a doctor/patient relationship that is actually meaningful, that focuses on prevention and screening built on trust. And, second, the cost issue. But what has been missing in this debate are the real drivers of cost, and it is at the level of the doctor/patient relationship because you have physician behavior and you have patient behavior. And this bill does not do much at all to address either one of those. And, in fact, I would submit that the bill, there are elements of this bill that will make that worse.

Would you like to comment?

Dr. GRATZER. So you were a surgeon?

Mr. BOUSTANY. Yes.

Dr. GRATZER. I am a psychiatrist. We have nothing in common. Look, I could not agree more with you.

Mr. BOUSTANY. Compassion.

Dr. GRATZER. Look, there are certain things we can agree on no matter whether you are a Republican or Democrat or what your political affiliation. One is that the doctor/patient relationship should always be preserved, that it is the building block of the modern health care system and should always be preserved within any reform package. But I also think you would agree that we spend in America and do not always get results.

Again, I am not arguing that some of the medical technology has not been extraordinary. You mention cardiac-thoracic, as you know, death by cardiovascular disease has plummeted by two-thirds in the last 60 years. And we have seen innovation time and time and time again. But just because you go to a doctor and there are new drugs do not necessarily mean that they are better drugs. Just because you get a procedure does not mean you needed it or it was well done. I think that goes back to some of the things that Peter Orszag and others in the White House are talking about that I agree with, that we need better value. There is a smart way of doing that and a bad way of doing it.

Mr. BOUSTANY. I agree and that is what is missing in the debate.

Dr. GRATZER. Absolutely.

Mr. BOUSTANY. Because I think we are still at the 30,000 foot level. If I can reclaim my time for a moment, I was listening to the testimony very carefully and, Ms. Pollitz, you talked about a government controlling costs. Does Medicare control cost?

Ms. POLLITZ. To some extent, yes.

Mr. BOUSTANY. It does not do a very good job, does it?

Ms. POLLITZ. Well, I think Medicare cost growth in most years has been at or below that of the growth of private insurance.

Mr. BOUSTANY. As my colleague from Wisconsin, Mr. Ryan, pointed out, the looming insolvency of the Medicare Trust Fund. We have serious Medicare problems that we need to address. And so I think to pose a government option at a time when we are dealing with existing government programs is at the very least problematic.

A question, let's see, for Dr. Holahan. You mentioned Medicare rates in the government plan. Do you believe that the Medicare rate structure has caused distortions in the entire reimbursement structure given that Medicare rates most of the time do not cover cost of basic goods and services? And do you advocate price controls extending beyond the provider side to the suppliers of medical technology and devices?

Mr. HOLAHAN. Well, that is what we do today and the government sets them, but by and large there——

Mr. BOUSTANY. So you do agree with price controls and you want to see it extended into the——

Mr. HOLAHAN. Yes, I do not think you really have much alternative in the current market so it will be some——

Mr. BOUSTANY. Thank you.

Mr. HOLAHAN. But if you had——

Mr. BOUSTANY. I appreciate your answer, thank you. Thank you, sir. I have a question now for Dr. Young. Dr. Young, you talked about a single payer using "inherent cost control measures."

Dr. YOUNG. Yes.

Mr. BOUSTANY. Explain what that means?

Dr. YOUNG. Well, I tried to dialogue on that when I described the single payer giving you a complete record of the pattern of behavior of doctors.

Mr. BOUSTANY. So, in other words, you are having a bureaucrat make a medical decision and in fact rationing care?

Dr. YOUNG. I don't think that is what I said. I described the fact that you have the data that allow you to see patterns of excess or under service, and that we certainly need oversight. That is the great tradition of medicine.

Mr. BOUSTANY. Has Medicare done a very good job of that because we have Medicare data?

Dr. YOUNG. I think it has done a terrific job. I think it is the far best of the insurers in this country.

Mr. BOUSTANY. Could you comment on the use of the Society of Thoracic Surgeon's database in cardiovascular disease?

Dr. YOUNG. I cannot help you, I am not acquainted with that.

Mr. BOUSTANY. I would think as someone who is interested in data and using best practices, this database has been outstanding. It was developed in 1989 and has gone a long way toward the improvement in care in cardiovascular disease. I suggest you look at it.

I see that my time is up. I thank the Chairman.

Mr. STARK [Presiding]. Mr. Thompson, would you like to inquire?

Mr. THOMPSON. Thank you, Mr. Chairman. And thanks for holding today's hearing and for your effort to make sure that this process has been open, and that we are able to work through this to address all these issues. I just hope that the ongoing procedural votes that we are taking do not further disrupt our efforts here.

I want to first point out there has been a lot of talk about this independent, nonpartisan study that associates some pretty high prices with doing what most Americans believe we need to do, and that is reform health care. And I think it is important to note for the record that this HSI Network that is supposed to be nonpartisan and independent is actually a group that is—one of the participants is the modeler for Senator McCain's health care and his work. And it has been pointed out in the press that some of what they said had not always been based in fact. There was one quote that I found interesting, "Every candidate should say that these numbers were produced by my experts, and they are my best estimates but they are not exact."

And if you look at what this same group, this HSI, did in regard to modeling the health bill over in the Senate. They were four times higher than what the CBO came in with. So I think we need to know where these numbers are coming from.

And as they relate to our tri-committee effort, I think it is important also to note that they said that the analysis has no offsets, their analysis, there are no offsets in this discussion draft. And that is just patently false. We know that to be the case. And so if they miss that, it is hard telling what else they missed.

Mr. CAMP. Would the gentleman yield for just a moment?

Mr. THOMPSON. On a positive note——

Mr. CAMP. Would the gentleman yield for just 30 seconds?

Mr. THOMPSON. I want to finish my thought here, then I will get back to my other issues there. On a positive note, they did say one thing that was interesting, and I will quote. They said, "In contrast to the Senate version of this bill, the House version is more fiscally prudent and effective." Yes, for 30—for 15 seconds.

Mr. CAMP. Just to say that CBO did not score the full Kennedy bill, so the $1 trillion is really not the final number. I just wanted to clarify the record on that. We are not comparing apples to apples here.

Mr. THOMPSON. Reclaiming my time, and the numbers that we are being told are nonpartisan and independent are not real numbers at all, so it is a very, very biased study.

I want to get some policy changes that I believe will lead us to better health care and at the same time drive down prices. I would like to get the experts' opinion on this. I am one who believes that an expansion of technology can really be beneficial in all this and think that there is a lot more in the area of telehealth that we could be doing that would provide better outcomes and drive down the cost. And there are a couple of examples that I have seen in my district alone. UC–Davis does a virtual tumor board, and they have just example after example of cases where they have helped people and driven down the cost. They talk about one where they were able to confer with a local team and diagnose a patient and a treatment plan for a patient who was in an underserved area, doing this through telemedicine. And they were able to treat it in a non-invasive way at a much lower cost. And, ironically, that work is not reimburseable under the Medicare provisions that we have now.

I have another case, I could just go on and on and on with examples of this, but I think it is an area where we can really pick up some costs and do better health care. And I would like to hear your impression of that and if you think that we should really expand the provisions for telehealth in this bill? We can start with Ms. Pollitz.

Ms. POLLITZ. I am not an expert on this area, but I don't believe a lot of private insurance health insurance would pay for that either. And this kind of consulting between physicians, whether it is face to face or on the phone or telehealth, I think is very important in patient coordination of care. And that we do need to find ways to support that and reimburse it.

Mr. THOMPSON. Anyone else care to?

Mr. HOLAHAN. It seems to me that it is a very good idea, but you really—you need payment reforms that bundle payments that can include that kind of contact.

Mr. THOMPSON. Well, these are not even included in many, many cases. And in underserved areas, there is some expansion in rural but urban underserved areas do not get the attention. And underserved is underserved, it does not matter where they are. And these are people who are going without health care or were provided at a much higher price.

Mr. HOLAHAN. I agree with you.

Dr. GRATZER. Look, there is a role for other things as well. I do not think necessarily everyone needs to see a doctor. There is a greater role for nurses and nurse practitioners. I really think in the United States we have done ourselves an enormous disservice by not tapping more in terms of information technology.

You know, in Denmark—Denmark, everyone's health record who wants it is put online. You can look up your own cholesterol and track it over time. I think if that is good enough for the Danes, it

ought to be good enough for the Americans. I think it also would address to a small extent Mr. Becerra's comment about the high level of medical errors we have in the United States. So much technology if you go to Wal-Mart and you buy your kid a plastic lawnmower but so little technology in terms of your health records. You can see your doctor right across the street from a hospital, and go to the hospital because you are feeling worse, the ER, and no one would know any blood test that had been done. It is just absurd. So I agree with your point.

Mr. THOMPSON. Thank you.

Mr. STARK. Mr. Nunes, would you like to inquire?

Mr. NUNES. Yes, thank you, Mr. Chairman. I want to thank the panel for being here today. Ms. Pollitz, Dr. Holahan and Dr. Young, the three of you support the underlying bill, right, even though——

Dr. YOUNG. No.

Mr. NUNES. Oh, you do not? Dr. Young, you do not support the bill?

Dr. YOUNG. That is right.

Mr. NUNES. Okay, but the first two of you, you do support the bill?

Ms. POLLITZ. I think it is a very good bill and it could use some additional improvements.

Mr. NUNES. Okay, like finishing the bill, you guys have seen this, one of the parts not finished yet? I am wondering if that is—is that the strategy is to get 50 votes in the Senate and then let the Administration fill in the bill, do you guys know?

Ms. POLLITZ. I cannot comment on that.

Mr. NUNES. Well, for the two of you that support the underlying bill or the basics of the bill, I do not think there is any argument that under this bill more people would be eligible for Medicaid and more people would be pushed on to Medicaid, do you agree with that?

Ms. POLLITZ. More people would definitely be made eligible for Medicaid, which is a very important reform, but the bill also provides that people who are in Medicaid can have the choice of enrolling in a private plan through the exchange.

Mr. NUNES. Can you—go ahead.

Mr. HOLAHAN. I think the answer is basically yes, but I think there are people that are above the level, the income level that they talk about who might eventually move off of Medicaid into the exchanges. So there will be some moving around.

Mr. NUNES. I have trouble understanding, maybe the two of you can help me understand, why would we want to put more American citizens on to Medicaid? I have a lot of people on Medicaid in my district, and for the life of me, I cannot understand why we would want to make more people eligible for Medicaid and why we would want to shove more people on to Medicaid, can you guys answer that question, why that is a good idea?

Mr. HOLAHAN. It is a program that is big, it has a lot of history, a lot of law and regulation around it. And we are taking on a lot in reform in terms of putting even more people potentially into these exchanges and potentially into the public plan. I think it would make the job harder if you did not build on to some extent on what we already have. And I think down the road, you might

want to revisit whether Medicaid should stay distinct or how it gets incorporated within the exchange, but I think that for the moment that would make the whole job harder.

Mr. NUNES. Right, unless you are on Medicaid right now. I do not have anyone that I know of, and maybe you guys could help me dig some folks up, that like being on Medicaid and that want to be on Medicaid.

Ms. POLLITZ. I do.

Mr. NUNES. You know people who like Medicaid?

Ms. POLLITZ. Yes.

Mr. NUNES. Well, I would love to meet these people.

Ms. POLLITZ. I would be happy to introduce you.

Mr. NUNES. Because I have a whole bunch of people on Medicaid in my district, and the doctors do not want to see them, the people that I know are embarrassed to even admit that they are on Medicaid. They do not want to be on Medicaid. If that is the case, why don't we just make—why do we need this big plan, why don't we just put everybody on Medicaid?

Ms. POLLITZ. Congressman, I think there is no question that the Medicaid program has suffered from underfunding over the years and that there has been a stigma attached to a poverty program, but the Medicaid program has incredibly important protections that it offers people, very comprehensive coverage, no cost sharing, coverage for all kinds of additional services that are important and that people with limited means need in order to get the health care, transportation care services.

Mr. NUNES. But you know someone, you said that you know people that are on Medicaid that like it?

Ms. POLLITZ. Yes.

Mr. NUNES. And they would prefer to stay on Medicaid?

Ms. POLLITZ. I have a friend—yes, her—a friend of my daughter, a 14-year-old young lady, her mother just passed away, she had been on private insurance.

Mr. NUNES. She likes Medicaid better than private insurance?

Ms. POLLITZ. It was a pretty good plan but it has a $500 deductible and 20 percent call insurance, and she had to go to the emergency room earlier this year because she was very sick and her aunt took her and a great big bill generated. My husband and I ended up paying it for them.

Mr. NUNES. So if the hypothesis is——

Ms. POLLITZ. She just got on Medicaid and now——

Mr. NUNES. The hypothesis is though, your hypothesis that Medicaid is insurance from what I just heard?

Ms. POLLITZ. No, I am just saying that Medicaid has a lot of advantages and offers a lot of extra protections for people and it is important.

Mr. STARK. Would the gentleman yield?

Mr. NUNES. Well, my time is running out. My time is running out, Mr. Chairman.

Mr. STARK. I will extend it. Just if I could suggest——

Mr. NUNES. Just for 10 seconds here because I do not want to lose my time.

Mr. STARK. After 5 years, people could choose in the exchange.

Mr. NUNES. The public option?

Mr. STARK. They could choose private or public and not take Medicaid if they did not want to. In other words, after the first 5 years with the exchanges that are running, the bill, the draft would suggest that at that point people would not have to go into Medicaid, they could choose an exchange. And we would welcome other options, but once the bill—it is not the intent of this draft to force people into Medicaid. That is all I am saying.

Mr. NUNES. But I think there is no question though that it would make—it would put people into Medicaid, which I have—Mr. Chairman, I have a fundamental problem with. I think Medicaid is broke now, it has a $20 trillion unfunded mandate, and the more people we throw on to them, how are we going to pay for this?

Mr. STARK. In California, you have a real problem.

Mr. NUNES. That is our problem I guess to deal with too, Mr. Chairman.

But in finishing up, I would just say that I really do not understand a plan that we would put out there that would put more people into Medicaid even in the short term. I think if we are going to revamp health care, we ought to look at Medicaid and try to get as many people off of Medicaid as possible today, not tomorrow.

And I will yield back. Thanks, Mr. Chairman.

Mr. HOLAHAN. One point to make is that one of the things that I think that you were concerned about is access to primary care physicians, and there is a provision in this bill that would increase those rates.

Mr. STARK. I thank the gentleman. Mr. Blumenauer, would you like to inquire?

Mr. BLUMENAUER. Thank you, Mr. Chairman. I appreciate the opportunity for us to start focusing in on some of these items. And I appreciate in particular Dr. Holahan talking about the cost of doing nothing. And I think that is one of the things that is so critical that gets lost. If we float along for another year or two or three or four, we are going to find more uninsured. We are going to find fewer people who are insured by their employers. And those that are, are going to be facing higher costs and less comprehensive coverage.

I hope that we as a Committee will be able as we go forward to look at getting more value out of the existing system. There is some in the draft that I like. There are things that I have in terms of end of life transitional benefits. There are a whole series of things that I am excited about, some of which are in the draft. We can do more. I do not think we have gone far enough in terms of dealing with radical disparities of Medicare reimbursement around the country. I am particularly concerned that what is in the bill for Medicare Advantage will hurt efficient areas and will have virtually no effect on very high cost States. But this is a process that I hope we can work on together.

The notion of how we are going to pay for this is part of the cost containment. We have 3 or 4 years before this kicks in, so we will have a chance to refine the getting more value out. And I do not think any of us feel that when the other areas where there will be some costs associated, and the polls show the American public is in favor of paying a little bit more if they get security and 50 million, more or less, get health insurance, they think that is a good

deal. But it is not going to kick in this year or next year. We will have a chance for the economy to regain its footing.

I am a little concerned about the language here about somehow forcing people on to the public plan because people will go into the exchange where the public plan is one of their choices, and that sort of gets lost in the discussion.

And I want to pose my question because, Dr. Holahan, you referenced it in your testimony, but as I read it, it is a little esoteric, with all due respect, about where the Department of Justice thinks it is noncompetitive and there might be antitrust. My reading of the data is that there are 25 States where one insurance company has 50 percent or more of the market. If you could perhaps discuss a little bit in practical terms about the lack of competition that most Americans face now with meaningful choices of health insurance. And my read of this is that the insurance companies themselves are going to be advantaged because we are going to streamline some of this process and squeeze out some of the goofy stuff that goes on. Right now, trying to deny people coverage, we are not going to have preexisting conditions, that is going to be a level playing field that is going to make I assume a very big difference.

And if you want to also comment for a second about the sound bite that you got trapped into saying about cost controls and then cut off, if time permits to elaborate. But I would like you to talk for a moment about meaningful competition that we are going to be providing under the framework that has been offered.

Mr. HOLAHAN. Yes, a few months back, we had some executives from a big Blue Cross plan in the Midwest visit us to get advice on how they could control costs. And the first thing I asked was how well do you pay relative to Medicare. And the answer was they paid 79 percent above Medicare rates to hospitals and 68 percent above Medicare to physicians. And so like why are you here? They did this because they can. They have no competition. And they can pass on, to the extent this means higher premiums, they are able to pass that on. And I think that is a role that this public plan would have to—I think could help with, help in those markets and help in others where there are more insurers but one that is really dominant and still not able to deal with dominant hospital systems or single specialty groups that essentially bargain as monopolists.

Mr. BLUMENAUER. Thank you. I appreciate that. I would just close by noting it would be interesting to take a test of the people on this Committee who have health insurance, I assume most of us probably do, and find out how many of us made the decision based on what was the cheapest plan? It would be interesting to find out if we could figure out what was the cheapest plan. I get my insurance through my wife's company because I think she has greater contact with their Department of Human Resources to try and decipher stuff that I cannot, but I think the record is rather clear that there are lots of people, including in the Federal system, and I will bet people on this Committee, who make lots of choices that are not the cheapest as it appears on that chart. And so I think the fear somehow that all competition would stampede to a public plan if it appeared a little more affordable is at least near-fetched.

Thank you.

Mr. STARK. Thank you. Mr. Roskam, would you like to inquire?

Mr. ROSKAM. Thank you, Mr. Chairman. First of all, thanks for your time and your attention today. I think all of us have been enlightened by the nature of your comments. And you have been fairly transparent, when you have not known what is in the bill, I appreciate someone saying, "I have no idea what is in the bill." I do think this time, this season that we are in is absolutely incredible. There is momentum here, right, and there is an opportunity I think transformational, but it has struck me as strange that here we started this hearing at 9 o'clock, I was out for a couple of minutes for some of the procedural stuff that is happening on the floor but we are well into this hearing, and we have not had much of a conversation about Medicare fraud, about fraud within the system and abuse within the system.

I have been briefed by experts, and I do not think these are folks that are pulling punches one way or the other in terms of donkeys and elephants, but have come to the conclusion that as much as 13 percent of current Medicare outlays are fraudulent. I have a quote from the chief counsel to the Health and Human Services Inspector General who said, "Building a Medicare fraud scam is far safer than dealing in crack or dealing in stolen cars and it is far more lucrative." And here we are on the verge of something that is absolutely enormous in terms of costs. Frankly, when costs come up, the Majority kind of loses high contact and gets a little bit defensive, with all due respect, about, well, who is putting these estimates out and so forth. But as we are sitting here today, no real number in terms of a cost estimate.

And, yet, here we have this opportunity to recast resources and put it in the proper direction that I think ultimately can have a huge impact. So I would like to shift the conversation a little bit. Dr. Holahan, something that you said concerned me, and I want to give you a chance to clean it up. But when you were having a conversation I think it was with Mr. Nunes a minute ago, in sort of defense of Medicaid, you said, and I jotted it down because it really got my attention, and "these were attributes that I interpreted as positive attributes," right? You said that, "It is big, it has a history and it has lots of law and regulation around it," meaning sort of this case law around it. And I would suggest that I think that is one of the real weaknesses of the current system, that it has become hidebound, an inability to recognize fraud within the system and an inability to recognize abuse within the system, an inability to recognize overutilization and so forth. And I just wanted to first of all give you an opportunity to—surely those three adjectives of big, rich history and lots of law and regulation is not an attribute, those are not characteristics that you are lauding, are they?

Mr. HOLAHAN. Well, what I meant was—to be more specific, I think this is a really big deal to reform our health system. To the extent you have something that you can build upon that works reasonably well, despite some problems, I think that is a good thing when we are taking on so much.

A few years back, I did a study with a colleague of mine to look at whether Medicaid is really high cost relative to private insurers, so we compared Medicaid to people with private coverage, all low-income people, and looked at whether medical benefits, when you controlled for health status and income and education and other

characteristics, controlled statistically for that, and Medicaid it turns out is less costly. And that is not to say there is not fraud in Medicaid and Medicare, but despite that, it is less expensive than private insurance by some margin. And we certainly should go after fraud wherever we can. I guess the thing I would be curious about is whether the same study that you were referring to had anything to say about fraud in Aetna or Blue Cross plans or anything like that. I do not know whether it did or not, but I can't believe it is totally absent.

Mr. ROSKAM. There is no question about it, but I think here we are 3 hours into a hearing that by the proponents' own adjective is going to transform the system and yet we really have not had much of a conversation as it relates to driving, just rampant abuse out of the system.

Thank you for being transparent about that. The people that I have interacted with as it relates to Medicaid feel underserved by it, feel discouraged by it, and it has taken the joy of the medical practice from physicians.

My time has expired, and I yield back.

Mr. STARK. Thank you. Mr. Kind, would you like to inquire?

Mr. KIND. Thank you, Mr. Chairman. I too want to thank our witnesses today for your patience and also the task of trying to absorb an 840-page piece of legislation in a short period of time, and I think you have been doing a good job today.

But I think my friend, the gentleman from Illinois, Mr. Roskam, raises a very important issue and that is what is contained in this health care reform that can really help crack down on fraud within the Medicare system? And with that, I would just reference Title 6 of the legislation and go through those specific provisions.

We are trying to not only enhance resources to the agencies in charge of detecting fraud and bringing greater accountability but also enhancing the penalties when it is ultimately—and that whole section is devoted to cracking down on fraud and the waste that exists in the system today. And if the gentleman or others have more ideas on what we can do to beef this up, we are all ears.

But I think the sweet spot we have to hit here is the ability to distinguish between unintentional error and intentional fraud, and I think that does concern a lot of the providers out there, especially in submitting their billing claims, that if something was inputted wrong, are they going to be subject to the full weight of investigation and fraudulent penalties due to a harmless human error in the system.

But, listen, I want to take my time to direct your attention to Title 4 of the draft discussion piece. That is titled, "Quality," and I think this is the key to how successful we are at the end of the day, of whether or not we can enhance the quality of care and finding cost savings at the same time. That section is devoted entirely to the comparative effectiveness research. And that is what I want to get your response on, if you had a chance to review that provision.

Let me preface my question by saying I come from western Wisconsin, which has been recognized as a high-quality, low-cost area. We have Mayo in there, Marshville Clinic, Gundersen, even the President has recognized that the health care models that have

been developed in our region, as examples of what we need to incent in reform in order to achieve the type of cost savings without jeopardizing quality at the end of the day. This is coordinated, integrated care practices, more emphasis on primary, prevent, wellness programs, things that have proven very effective in helping drive down cost while enhancing care. And I think that is the key to doing comparative effectiveness research the right way and not the wrong way and establishing the center in the legislation for comparative effectiveness research, establishing an independent commission comprised of independent, both public and private stakeholders as part of the commission, to review the research, the data, making recommendations to the center. And then I think this is the key distinction, empowering our doctors and patients with the information so they know what works and what does not work. And we are placing a huge bet on that, that with doctors and patients armed with this information, that they are going to make the right decisions which is going to not only improve patient care but help drive down costs. And it is tough to ignore a study of a reputable organization like McKenzie Institute that claims based on their research that $650 billion of health care spending every year goes to care and treatment that does not improve the quality of results at the end of the day. And that is going to be the key I think to comparative effectiveness.

I see Mr. Herger has joined us because he raised a very important issue when it came time for him to question the panel, and that is how the information is ultimately going to be used. And I would reference, and he is involved in a conversation, but on page 446 of the discussion draft, lines three through six, the construction on the use of comparative effectiveness. And let me just read that real quick. This is an important point. It states that, "Nothing in this section shall be construed to permit the Commission or the Center on Comparative Effectiveness Research to mandate coverage, reimbursement or other policies for any public or private player." And I think that is a hugely important provision in this legislation, basically saying we are not going to ration, we are not going to be making those type of cost decisions based on CER research. And I think that is going to be important that we recognize that as we move forward.

So, Ms. Pollitz, let me first give you a chance to respond as far as the role you see CER research playing and how important or vital that is going to be for the health care reform that we are trying to offer here today?

Ms. POLLITZ. I think it is very important, Congressman. I had the pleasure of attending a conference a couple of weeks ago where the director of the agency in Australia that heads this up was just talking about how this research gets brought to bear in decisions in that country and people were left breathless, like why don't we do that here? So I think it is a very important investment, and I commend you for including that.

Mr. KIND. It is interesting a lot of providers are doing that. In fact, Cleveland Clinic has been doing this for a long time, and the CEO of Cleveland Clinic just indicated they had 70 countries contact them to find out what they are doing and how well it has worked, 70 countries. So even countries outside of the United

States are recognizing the type of model of care that is being provided and the cost savings that comes with it.

Dr. GRATZER. I note as well that there are some private sector innovations that are also useful. Think about Safeway, which has actually brought health inflation to a stalemate in the last 3 years. Some of the information is its comparative effectiveness, it is transparency of prices. If you are in certain regions in the country and you are a Safeway employee, they will actually list out your options for say CAT scan and the prices and soon they are hoping to put quality on board. So it is not just a role for government, I think. I am a little bit more hesitant on comparative effectiveness perhaps than you are, but there is a role for government undoubtedly, but I think there is also a role for the private sector as well and ultimately culturally as people demand more and should be required to shop around and gain more information, just as they do for much mundaneness things like food, clothing and shelter.

Mr. KIND. Thank you, Mr. Chairman. I see my time has expired.

Mr. STARK. Thank you. Mr. Pascrell, would you like to inquire?

Mr. PASCRELL. Thank you, Mr. Chairman. Chairman, I want to clear up some things that were mentioned before about New Jersey.

[Laughter.]

Mr. PASCRELL. New Jersey is more expensive because insurance companies are required to cover all comers. Without an individual mandate, healthier people drop coverage, leaving behind the sickest people. That drives up the cost, doesn't it, Ms. Pollitz?

Ms. POLLITZ. Yes, it does.

Mr. PASCRELL. If anything New Jersey is a case study in why we need universal coverage, just the opposite of our proponents—or opponents, whichever you decide, are talking about. State mandates are designed to protect people. And I would argue that if everyone were in the pool, folks in New Jersey would be better off because they would be guaranteed access to the services they need, like childhood immunizations. Let's not mandate that. What is the consequences of not mandating that? Aren't we talking about preventing diseases and in that way lowering costs?

How about my favorite chronic diseases, diabetes care. When we look at the cost of health care, who is seeking aid later in life because of situations that occurred much earlier, which they were not able to get hold of? How about prostrate cancer screening, do you want to mandate that? Do you want to bring down the cost of health care? Let's mandate it. Would anyone on the other side say, "No, we should not mandate that"? How about mammograms? We thought we had that battle a few years ago, but that continues to come up. Maternity care, treatment for alcoholism? Now, why in the world should we mandate that? Look, the patient is the center of what we are talking about here, not insurance companies, not Congressmen, the patient therefore is the main priority of putting a system together built around that patient. And that is what I have on my mind.

Now, Mr. Gratzer, in your testimony you said that, "We must reform our health care system with 'made in America' solutions." Well, that goes with a lot of other rhetoric I have heard. I could not agree more. The discussion draft that we are considering is a

"made in America" solution. It builds on lessons that we have learned right here in the United States. It brings competition and choice and a system of checks and balances, we do not have checks and balances now. We do not even have checks and balances with regard to ferreting out those who abuse the system, who actually purvey fraud on the system. In fact, we slap them on the wrist and say, "Sin no more," but we do not prosecute them.

I take issue with your focus on a single payer system, which despite your arguments is not the issue at hand. Even Dr. Young has told us that our plan is not a path to single payer. Unfortunately, you make fundamentally different underlying assumptions about a public health insurance option that most of the individuals on the panel, and many of the questions you pose about a level playing field can be answered with a resounding yes. In fact, we have gone to great pains to make sure that this public health insurance option is indeed on a level field with its private competitors.

And I would like you to comment on some of the arguments made by Dr. Holahan. Specifically, in the absence of a public health option, how would you propose bringing real competition to health insurance markets that currently have none?

Dr. GRATZER. I think we have regulated ourselves into a situation where in many States, too many States, you——

Mr. KIND. Who is "we," who is "we" regulated?

Dr. GRATZER. It is between Congress and State legislatures.

Mr. KIND. What have we done, what regulations have we put forth that have resulted in the consequences which you say exist? What is the regulation. Tell me one regulation, two regulations, three?

Dr. GRATZER. Well, in some States community rating.

Mr. KIND. "We," we said the Federal Government, you said the Congress, do not go back to the States. What did the Congress do?

Dr. GRATZER. Right, I said both, sir. And I would emphasize that it is a collective problem, and I think that these mandates end up driving out insurance companies and reducing choice. But, look, I agree with you, there is not enough competition in some States. In some States, in the small group market, you are down to literally one option or two options, but I think the way around that is through deregulation and allowing more competition amongst insurance companies rather than the Federal Government creating an insurance company, which by the way, as you know, would not be covered by those regulations, would not pay the tax, would not——

Mr. KIND. Dr. Gratzer, what would you deregulate right now?

Dr. GRATZER. Why would I deregulate?

Mr. KIND. Yes.

Dr. GRATZER. I would allow people to purchase insurance plans across State lines.

Mr. KIND. That is your deregulation moment?

Dr. GRATZER. Well, that would be one of the things I would do for sure. And then for the people who, as you point out, are chronically ill, I would——

Mr. KIND. I'm sorry, go ahead.

Dr. GRATZER [continuing]. Put them in high-risk pools and the like. I am not going to argue today that some people cannot afford

a private insurance plan, of course, but I think we have to be focused on our aid.

Mr. KIND. What do you do with those people? What do you do with those people, Dr. Gratzer, the people that cannot afford——

Mr. STARK. We will have to come back to this later, Mr. Pascrell, and let Mr. Reichert find out what Dr. Gratzer wants.

Mr. REICHERT. Well, thank you, Mr. Chairman. I want to at least first of all make a statement on I think Mr. Pascrell is absolutely correct, the patient really is the focus here, and I think all of us here today who have had a chance and opportunity to question and hear some of the answers to the questions are all in agreement that we are trying to do the best thing for the people of America, for those people who, all of us at some time or another, who need health care. And so that is why we are here today.

To fight over one system over another is counterproductive because I think we all can agree that the patient is the center of our attention and should be, that there are not enough checks and balances, I agree with that. There is a lot of fraud, waste and abuse, I agree with that. We are not doing anything with that. And we all agree that we would like Americans today to have better access to health care, better quality health care. We would like this health care to be cost-effective. We would like people to have a free choice. And I think that people, I know myself personally, would like to have some control over the treatment and the medication that is prescribed to me for my health care. Those things we all agree on.

The question, I think the major overarching question is how do we really overcome this fear of a lot of the American people today regarding this discussion we are having today about a government takeover of the health care plan, especially when you throw in the considerations that Mr. Ryan has expressed today and one other Member here, and the trillions of dollars of unfunded mandates. And so the fear of the cost and the fear of the lack of control and the reduction of your access to health care and the reduction of the quality of health care.

Dr. Gratzer, I would ask you first maybe to respond to that?

Dr. GRATZER. I want my colleagues to answer first.

Mr. REICHERT. Okay, anyone else, anyone on the panel?

Ms. POLLITZ. Congressman, I think public opinion polls show that the public overwhelmingly favor having the choice of a public plan. I think it is also true, and it was in The Washington Post this morning, that people are always nervous about change. I was here in this room, sitting in that row 15 years ago, the last time health reform care was considered and the Harry and Louise ads were all over the airwaves, and I think there is no question that the greatest vulnerability of the reform effort this time is to frighten people into thinking that they will be worse off.

Mr. REICHERT. I am just going to interrupt you for a second. I stepped out in the hallway and met with some representatives of a union who said we want a public health plan, we want to make sure that those people who are not insured get health care, we all want that. But the other thing they said to me was we do not want our health plan to go away and on top of that, I do not want my health plan taxed. So we have a problem here. How do you address those concerns, people who—and I am one of them, and I think as

I said most people here, we all want people without health care to get health care, but I like the plan that I am in. Others in this room I am sure do, 75 percent of Americans it said do like their health care plan. They do not want to be taxed on it. So the question here again goes back to cost. How much is this going to cost us and how are we going to pay for it?

And one of the issues around this is the waste, fraud and abuse. Some estimates place Medicare fraud at $13 billion per year. The GAO found that Medicare has paid at least $92 million to Part B for providers who are deceased. How can we reduce the staggering amount of fraud in the Medicare system? And what is to prevent this fraud, waste and abuse from happening in the government takeover of other parts of this system? Anyone want to respond?

Mr. HOLAHAN. I just was talking to the question about choice. I think that the way I understand this plan, there would be more choices. And I think sometimes the way——

Mr. REICHERT. What about the fear though that the private sector will not be able to compete with——

Mr. HOLAHAN. Well, I do not agree with that. I think there are some insurers——

Mr. REICHERT. But some people do——

Mr. HOLAHAN. I understand.

Mr. REICHERT [continuing]. How do you explain that?

Mr. HOLAHAN. I think the best insurance companies in this country are very, very good. They will be able to compete with the public plan. The weaker ones that have competed by just going after good risks and not being effective managers of care delivery could be at risk, but I think it will, at the end of the day, be an effective and healthy competition between the public plan and good insurers.

Mr. REICHERT. I appreciate your answer. Thank you, Mr. Chairman.

Mr. STARK. Ms. Berkley, would you like to inquire?

Ms. BERKLEY. Yes, thank you very much, Chairman Stark. And thank you all for being here and sharing your expertise with us. I am strongly in support of passing comprehensive health reform legislation this year. A third of the people I represent, and I represent the urban core of Las Vegas, have no health insurance. So it is imperative for the people that I represent, that they have some access to health care through insurance.

It is not as if people that do not have health insurance do not get sick. They get sick, and the additional cost is borne by the rest of us. I would say statistically speaking, $1,000 for each of us that is insured, there is an extra $1,000 attached to the cost of our health insurance in order to subsidize others.

In an effort to give full disclosure, my husband is a nephrologist, my stepdaughter is a primary care physician, we need more doctors, and we need to incentivize the opportunity for people to go to medical school, which is not only multiple years of their lives but also a great deal of expense. When my stepdaughter graduated—not graduated, but when she graduated, she had $190,000 debt. I am a tremendous advocate of loan forgiveness and also an advocate of increase GMEs. I think it is very important, and they need to

be spread out around the country a little bit more proportionately than they are now.

I do not think—look, this is a work in progress. I am not willing to sign off on the legislation. A draft proposal that was dropped on Friday is the beginning of an important and comprehensive discussion among all the stakeholders and those of us that are going to be voting for it. That is why your being here is so important today. Hopefully, this will be the first of many hearings in order to improve our expertise and knowledge so we can do the right thing and fine tune this.

Cost is definitely a factor. There is no doubt about it. But right now we have the most costly health care system on the planet. We are not getting a bang for our buck. Doctors do not like the system. The hospitals do not. The patients do not. And we need to change the paradigm so that we are investing our money wisely and having a far better outcome than we have now.

One of the things I am a great advocate of is preventative medicine, and I am the original sponsor of the DXA bill. Medicare cuts payments to people that need bone density by 60 percent, which means that the doctors are not administering them anymore. Nineteen billion dollars it costs this country in order to pay bone-related osteoporosis fractures every year. Let us take that money and put in the front end. It is going to cost us less. We are going to have a whole lot less bone fractures and statistically speaking, if you are over 70 and you break your hip, you are going to be dead within 10 months. It seems that we will improve the quality of life, we will enhance life, and we are going to save billions of taxpayers' dollars by using our dollars wisely in the front end of the process rather than in end of life care.

And if any of you care to discuss any of those, I would love to hear your point of view.

Ms. Pollitz.

Ms. POLLITZ. That was a lot and all excellent. I think just on the prevention, an important feature in the required essential health benefits package is that preventative services would be covered without any cost sharing so that people can have access to those services and not face those barriers. That is an important component.

Ms. BERKLEY. May I say one thing, and it just gets my goat, I am not the defender of every doctor on the planet, and I know we have a lot of real stinkers, but I will tell you something the doctors I know work like dogs and this fraud and abuse thing as if every doctor is out to scam the system is highly offensive to me as a spouse. I just want to get that on the record.

Dr. GRATZER. I would add, it is not just about prevention, though I fully agree with your comments on this. There is also some element of people taking more responsibility for their actions.

Ms. BERKLEY. What do you do with a patient, doctor, and I know you are a psychiatrist, but my husband does all the dialysis in Las Vegas, so that we know that smoking, obesity, lack of exercise——

Dr. GRATZER. Sure, incredible.

Ms. BERKLEY [continuing]. So patients are on the machine for 3 hours. They get up, they light up a smoke and they go grab

McDonald's. Now, how responsible should that doctor be because the patient is being irresponsible?

Dr. GRATZER. Well, it is a heartbreaker certainly in your husband's field of work but so many health costs are in some ways avoidable. Again, we have to be very clear. There are people who are genetically endowed to develop certain diseases, there are people who are just unlucky. On the other hand, smoking is 100 percent avoidable. We are seeing in America an obesity crisis, doubling of obesity rates over 25 years. And the best evidence, it seems to me, it is just we are taking in too many calories. I think part of that is a government solution in terms of like school lunch programs, funding better school lunches. I think part of that comes from the corporate community. I am excited with Safeway and what they have managed to do to better people's health. But part of it is also culturally people have to take more responsibility. It should not be societally acceptable to smoke and yet in a lot of ways, it still remains somewhat glamorous.

Dr. YOUNG. I would like to compliment your summary. I am in complete accord with several points you made, but to make the point from our purpose being here, I think your goals would be much more readily achieved in a single payer system with improved access and for that reason, I commend you to consider that option.

Ms. BERKLEY. Thank you.

Mr. STARK. Thank you. Ms. Schwartz, would you like to inquire?

Ms. SCHWARTZ. Yes, thank you. Thank you, Mr. Chairman, and thank you panelists for your patience and your willingness to be here for a number of hours.

I think we have covered some ground here but on some of the things—we get lost a little bit in some of the various specific details we have been discussing and forget our larger goals and how we are going to accomplish them. We are really very committed, as the President has asked us, to contain the rate of growth costs in health coverage and in health care, both through the government and for businesses and for families. And we know we can do that by some of the delivery system reforms we have, some of the payment reforms we are intending to—will be created in this way.

And we are also really clear about the fact that we want to deal with access to health coverage. I do not know that you would all agree that all Americans ought to have health insurance. I think at least three of you would. I think one of you would say, "Well, they are on their own, good luck. We will give you some tax credits and go and see what you can find."

But one of the things that this draft bill does do very, very clearly is to say that we are going to create a way to help all Americans purchase affordable, meaningful health insurance coverage. And there can be disputes about how we are going to do that, but the idea here is that there are numbers of Americans who have insurance that is not very meaningful. I think, Ms. Pollitz, I would want you to speak about this. We find particularly for small groups and for individuals buying meaningful health insurance that is affordable, if you have a preexisting condition now, if you are a small group that buys insurance and I just talked to one businessowner

who said their rates just went up 40 percent from one year to the next. We have all in this country seen our insurance premiums double in the last 9 years. That is unsustainable for families. It is unsustainable for businesses. And it is unsustainable for government. So we believe we have to take action.

Now, one of the things we are going to do, in spite of what the Republicans say, is to put a whole lot more Americans, almost 50 million of them, out there purchasing health insurance, private health insurance by and large. So I think that insurers should step up to the plate and offer some meaningful coverage. But we are going to change some of the market rules because if we are going to help Americans buy private health insurance, and we are, then we want to make sure that they meet some rules.

And I would like you, Ms. Pollitz, if you would start with some of the rules that we are going to change, preexisting condition exclusions, you cannot do that anymore. You cannot rate people based on gender. You cannot rate them based on their health status. We will make some changes in age. We are going to make it more affordable but also mean something. Now, you had mentioned in your testimony initially, way back when, earlier this morning, that one of the ways that you think we could strengthen the legislation, even though there is language in there now, is to make sure that a consumer, individual or small business or bigger business, knows what they are buying. When they are buying insurance, they know what they are buying. And right now, that is also very, very difficult.

There was a report recently about a woman who thought cancer care was covered. It turns out that the cancer care she was getting was outpatient and what was covered was inpatient. Now, there was no way of her knowing that when she read the policy. So, unfortunately, she got cancer, she had health insurance and it did not cover her care in the least expensive way possible.

I will just give you one statistic, 61 percent of the 72 million working age adults who had problems paying medical bills or paying off medical debt in 2007 were insured at the time the care was provided. That is again unsustainable. We know 50 percent of bankruptcies are due to medical debt.

So we are going to help people to be able to buy private insurance. Could you start by telling me what else you think we ought to be doing? I do have a bill with Congresswoman DeLauro that we are advocating putting some of that language in this bill that would make Americans feel more secure that when they are buying private insurance or public insurance, that they actually know what they are buying, they get what they are paying for, and that we reduce the cost of administration of private insurance companies now, just spending literally millions and tens of millions of dollars to screen records to make sure that they do not pay coverage. So could you just—I know I went on probably more than my allowed but if you would answer that and give us some information about what else you are doing, how important you think it might be to be doing this?

Ms. POLLITZ. I am happy to, and I will talk very fast. I think it is definitely the case that health insurance today is very complicated. Industry studies show that people do not understand over-

whelmingly how their coverage works and that most would prefer to do anything, including work on their income taxes, rather than try to read the insurance policy and figure it out.

I think you can make health insurance more predictable and more understandable for people by making it more standardized. If there is coverage for hospitalization, it should cover the whole hospital stay, not leave out the first 2 days. If there is a deductible, that should mean a deductible. If there is an out-of-pocket limit, that should actually limit your out-of-pocket costs. You could have more standardization of terms.

Also, we have suggested a new kind of labeling system for health insurance that I believe is included in the bill that you referenced.

Ms. SCHWARTZ. It is a little bit like the way when you buy a food product?

Ms. POLLITZ. Exactly.

Ms. SCHWARTZ. It is consistent.

Ms. POLLITZ. A coverage fact label, we would suggest that, our methodology was to simulate what it costs and what the claims are to have different illnesses and then have insurance companies process those claims and show you exactly what would be covered and what you would have to pay for the whole episode of illness so that people could synthesize and see that.

Ms. SCHWARTZ. We will continue to work together. I thank the Chairman for his indulgence.

Mr. TANNER [Presiding]. Thank you.

Mr. Davis.

Mr. DAVIS OF ILLINOIS. Thank you very much, Mr. Chairman. Listening to some of my colleagues would lead us to believe that the only relevant part of this discussion is not to have a public option included with our private system. I have heard a great deal this morning about costs. I have not heard much about service or quality of care. I have not heard much about accountability, responsibility or the need for access for the millions of individuals in our country who have no insurance at all. And in many instances no place to go if they get sick.

Dr. Young, I want to commend you and my colleague, Congressman Conyers, for your many years of long struggle and sometimes suffering to try and push our country toward understanding of what a single payer system would do. Sometimes, I did not know whether you were pushing or leading, but either way, you helped to get us where we are.

You have already told us that we have fallen short of the goal with this tri-committee draft that I think has been a tremendous effort led by our Chairman, Representative Rangel. Given that we have this document that we have put together, and I know that you are good at dual diagnoses and things like that, what would you say were the part that you like best or might be its strongest features?

Dr. YOUNG. Okay.

Mr. DAVIS OF ILLINOIS. And what would you say might be its weakest features?

Dr. YOUNG. Well, I naturally am pleased with those parts of the bill that extend coverage to people now not getting it, that is truism. The part I do not like is that it finds it necessary to retain

the private insurance system, which is the heart of our present dilemma. I am well aware of the awesome, real power the industry has, and I think I understand the legislative process. But having said that, my criticism or opposition to these other forms is not the purist point of view, I do not have that. I have had too many life experiences to have that view. It is that it will not work. And that I feel that all of—both sides of the aisle with their criticisms and suggestions have the same goal, but what is emerging is not a practical arrangement. And it has already been said, and I will echo it, the cost will sink not only the health economy but the national economy.

And I am happy, you suggested and I will emphasize, that the American people are increasingly aware of the desirability of a national health insurance, treating health care as a human right by society, emulate the achievements of other countries with much lower costs. I mean not a little lower, starting the highest competitor for cost, France, Switzerland and Germany, spend one half per capita. So with all that money and our American ingenuity and eliminating the unnecessary waste associated with the private insurance system, we could have a fabulous system and the country's mood, solidarity, confidence in government would go up tremendously.

Mr. DAVIS OF ILLINOIS. Thank you very much. Ms. Pollitz, let me ask you if I could, in some of our districts, 400 percent of the Federal poverty level seems like pretty high income. Yet, you propose that subsidies be set at an even higher level. Why would Congress need to subsidize health care for a family earning $88,000 a year?

Ms. POLLITZ. Well, if the cost of that coverage is $12,000 or $13,000 a year, that takes a big bite out of the paycheck of that family. And if the family head is my age, in their 50's, the cost will be much higher than that because age rating is provided for in this bill. So I think when you watch and set your policy about affordability, you need to step away a little bit from the optics that associate with this measure of the poverty level. It is in many ways an artificial measure and way too low for measuring the needs of families to pay for anything. And really look at what is the cost of good health care coverage and how much do you want families to have to pay out-of-pocket for that if they do not have other subsidies?

Mr. DAVIS OF ILLINOIS. Thank you very much. Mr. Chairman, I see that my time has expired but with your indulgence, could I just ask Dr. Gratzer, when we talk about costs, do you have any idea of how much of that cost is plowed back into the economy? Let's say if we spend a dollar for health care, how much of that goes back into the economy?

Dr. GRATZER. Well, you have asked a physician whether or not he likes health spending, you are going to get a pretty predictable response. And I think what you are hitting on is the right question, which we cannot just look at costs, we have to look at effect on lives. My wife's life has infinitely improved by a procedure. People suffering from cancer are infinitely improved by the technology we have available. It is also true that to some extent it is good for an economy. One must be careful though that we probably do waste

money within the system, and that is I think we would all agree getting better value for our dollar is worthwhile.

But to turn around and say we spend 16 percent, we would be economically better off spending 12 percent, I think is just very simplistic and unfortunately too many economists seem to fall in that trap.

Mr. DAVIS OF ILLINOIS. Thank you very much. Thank you, Mr. Chairman.

Mr. TANNER. Mr. Heller, you are recognized.

Mr. HELLER. Thank you, Mr. Chairman. And I want to thank the panel for your patience. Running back and forth between the forth, at least I get some exercise. Anyway, thank you very much for being here, and I appreciate your comments.

One of the things that intrigues me as we go through this conversation and one of the things that I would like to raise is a question that I am constantly asked by my constituency back in Nevada and that is what would happen if Members of Congress had to live with the same health care system that everybody else has to live by?

And I will assure you there is a great divide on this side here, of us sitting in front of you and everybody else out here in this room. There are people here in this room and in this audience that do not have the health care options that Members of Congress, whether it is the House or the Senate, have, and I believe that if we are going to go forward with this exercise, regardless of what plan ends up at the end of the day, that we ought to, if we are intellectually honest, ought to require Congress to live by those same provisions. Is there anybody on this panel that disagrees with this?

[No response.]

Mr. HELLER. Having said that, and again I think that is critical as we move forward in this debate is to make sure that Members of Congress, as they move forward on this, understand what their constituents have to live with.

Now, I want to go to you, Dr. Gratzer. In fact, I had a question for Secretary Sebelius, who was sitting right where you were a month or so ago, and I was talking about my district. And this could be rural America as much as rural Nevada, I have a very large district and talked about access to health care and the cost, and my question to her is would a public health care plan solve access and cost? Her response to it was, "I do not think anyone is talking about a government-run program." She also went on to say that, "I think the goal with this legislation is to have most Americans without health coverage in a health insurance exchange run by the private market to stabilize the current private market."

So, doctor, based on the draft we have in front of us today, I am pretty sure someone in Washington has a government-run health care in mind. Do you think this bill reflects a respect for the power of the private market as Secretary Sebelius envisioned?

Dr. GRATZER. No. Would you like me to elaborate?

Mr. HELLER. Would you, please?

Dr. GRATZER. I was going to rest on the eloquence of my response.

[Laughter.]

Dr. GRATZER. Again, I believe in competition, and I think that we should be very mindful of the fact that the system works well when we do have competition. The Federal Employee's Health Benefit Plan has actually kept costs relative to other types of health insurance down. I think most Members of Congress are very pleased with the literally hundreds of options they have available.

I belong to a think tank in New York, we have a choice of exactly one plan. So I think there are things to learn from that approach, but I also think we must be very cautious about this concept of enhancing competition with a government plan. The government plan is in fact price controlled. It will offer substantially lower premiums than anyone else can offer because it is paying a fraction of the amount, as Medicare presently does.

Mr. HELLER. Sure, similar to what we have in Congress now as Members?

Dr. GRATZER. And I think it will suck away from the private sector. So I think one must be very cautious about a public plan option. But I do think one can learn from what Members of Congress have, that you have many options available and that is useful, and the question is how do you get that to Americans who are too often available—have available just one choice of plans?

Mr. HELLER. Doctor, I know that you have looked at health care systems around the world, could you touch on survival rates, point out some of the statistics that might help this Committee, survival rates of patients in America and other nations?

Dr. GRATZER. Sure, look, comparing one system to another is enormously challenging and crude. Mr. Becerra, your colleague for instance, infant mortality rates. Unfortunately, as you know, a lot of health has to do with things other than health care. Infant mortality statistics would be a wonderful example of that. It turns out that in America the group with the best health infant mortality rates are Hispanic Americans. They also have the least access to health insurance and in fact are most likely to birth outside of a hospital. I am not advocating births outside of hospitals. What I am advocating and suggesting is that one must be cautious. Other factors, drug use, family structure, and so on has enormous weight.

So what are better ways of comparing systems than just saying infant mortality statistics? I would suggest looking at how people fair with different diseases, like cancer survival rates. Lancet Oncology as an example, compared American survival rates to European survival rates. Sixty-six percent versus 44 percent survival rates over 5 years. American medicine is second to none. We have problems here but do not lose the good.

Mr. HELLER. Thank you very much. I know my time has run out, but I just want to reiterate that I think it is critically important that we make sure Members of Congress live by whatever plan comes out of here. And I would challenge the leadership on this Committee to see fit that the necessary provisions are put into this bill so that Members of Congress and our constituents live with the same health care programs across this country.

Thank you, Mr. Chairman. I yield back.

Mr. STARK [Presiding]. Thank you. Mr. Etheridge, would you like to inquire?

Mr. ETHERIDGE. Thank you, Mr. Chairman. Let me join the others in thanking you for being willing to stay this long and stay in your seats. I know it has been tough, so we appreciate it.

There has been talk here about all the issues that we have to deal with, and it is a complicated issue. Whether people want to call it waste, fraud and abuse, whatever you want to call it, it is savings within the system, and we have to get it out because that will provide for more care, more quality care. I cannot imagine any person sitting on this panel, or hopefully not any Member of Congress, would be opposed to doing that. So I hope this bill is a start in that direction.

It is a draft, it is not perfect. It probably will not be perfect after it gets through the House and through the Senate, but I happen to remember something that Confucius said, he said, "The longest journey starts with the first step," and if you are always fussing about where you can go, you will never get anywhere, so you have to get started. And so at least the process has started and the dialogue is in place.

And I think the President is right saying that this is the time to talk about it. He said that if you like the plan you got, you keep it, you choose your own doctor, you do that and that the timing is right. I think the quality of care is a critical issue and you only worry about that if you get sick. If you are not sick, you do not need a hospital, do not need an insurance plan and that is why young people a lot of times do not get one. They choose not to. And the quality care, access to care and certain affordability, and these are some of the issues we are talking about.

Let me just tell you a quick little situation I bumped into Saturday with a friend. I went up to pick up some posts, I was doing some work on the farm, and this guy was selling them. And I looked at him and I said—he said, "Well, I don't feel well." And I said, "What is your problem?" He said, "I really need to go and have some medical attention. Number one, I don't have insurance." He owned his farm, but he did not make enough money to afford health insurance, he could not afford to have the kind of care he needed. So as any other Member of Congress would do, he happened to be in my district, we called, we tried to find care, and tried to link him up with people who do it, but a lot of that happens. The point is that ought not be the way people have to get care. So my question is that if you have care in a lot of cases, and in some places depending on where you are, if you live in a rural area, you are less likely to have access as you have already heard because primary care is very difficult, people have figured out the way we reimburse, and we have to change that, and I hope we do it in this legislation.

But let me ask a question to you, Ms. Pollitz, because, as you know, insurers, and you mentioned this earlier in your testimony or in answer to a question, rescinding health insurance policies if the policyholder has lied or concealed information from his or her—on his or her application. Okay, we understand that, that makes sense. But in a number of cases, in testimony even before this—not before this Committee but before other Committees, on June 17th, it was reported that three major insurance groups went before a Committee and admitted and said they were going to keep

doing it for people because they were sick. It reminds me if I have fire insurance and my house burns down, I expect the insurance company to pay it unless I set it on fire myself. And what they are saying is if you have a fire, you can pay your fire insurance as long as you do not have a fire. But if you have a fire, you are out of luck because we are going to cancel your plan or you are going to court. Well, we are saying the same thing with insurance, aren't we? Isn't that the same kind of thing we are talking about, if you get sick and you are really in bad shape, you have a policy, where you have a condition that stretches out, you have cancer, you have liver disease, you have a number of things, that bothers me. I don't know if we can fix it all but certainly—if you are going to be in the business of insuring, if you only choose people that are healthy, you are going to make money and you are not going to pay much out.

I would be interested in—I know these people are smart, I want them to make money, but at the same time I don't want them to discriminate against sick people, especially if they are people I represent.

Ms. POLLITZ. You are absolutely right, Congressman, and I was at the hearing, at the table with the executives when they said they would not cease to practice. And Mr. Barton, the Republican leader, said to them, "You do not have a friend in this room." One of the witnesses was a constituent of his who was a nurse, she had purchased a policy, she had paid her premiums, she was diagnosed with cancer, and at one point investigated, re-investigated—everything that they had investigated previously when she applied, they investigated again with a fine-tooth comb and they found that she had failed to disclose a visit to a dermatologist for what turned out to be acne and on that basis they took her policy away. And Mr. Barton fought them until they put it back. And there were other witnesses with similar stories and it is a common practice.

The executives testified that they maintain lists of as many as 1,000 to 2,000 different conditions and as soon as a claim comes in on one of those conditions for a new policyholder, that will trigger the post-claims underwriting process.

And I think it is important that the draft legislation makes extra clear, I think it is already illegal under current legal, but makes extra clear that policy rescission would not be permitted any longer.

Mr. ETHERIDGE. Thank you. Thank you, Mr. Chairman. I yield back.

Mr. STARK. Mr. Yarmuth.

Mr. YARMUTH. Thank you, Mr. Chairman. I hate to spend any of my time on this subject but we now have had four votes since we convened this hearing this morning. All four were motions by the Minority to adjourn the House in a dilatory effort to just gum up the works so that we cannot accomplish what we are trying to do for the American people. I was not here when we were in the Minority, maybe my party did the same thing, but I consider it, and I know many of my colleagues and the Republicans consider it disrespectful to the American people. So I hope who is watching would take the opportunity to call their Representative and urge

the Republican leadership to let us get about the business of the American people.

Now, with that being said, Dr. Gratzer, how many countries are there in the world?

Dr. GRATZER. Oh, if you looked at my geography marks back in high school, you would know I am not——

Mr. YARMUTH. About 190, give or take one or two. How many of those countries have some kind of a health plan, do you know? They said you studied these.

Dr. GRATZER. Well, I have studied Western Europe and the United States and Canada, I could not comment on Africa and Asia.

Mr. YARMUTH. Okay, well, let's just limit our discussion to the industrialized nations. How many of the industrialized nations in the world have some form of government single payer health care?

Dr. GRATZER. Many.

Mr. YARMUTH. Most, if not all but this country, is that correct? Are you aware of any that do not?

Dr. GRATZER. Well, it depends on what you mean by single payer. I mean if you think if you take it more broadly to include social insurance, all except the United States.

Mr. YARMUTH. Thank you, that was the answer I was looking for.

Dr. GRATZER. There you go.

Mr. YARMUTH. Are there instances in which government single payer health care co-exists with private insurance?

Dr. GRATZER. Yes, in most countries. Canada would be exceptional.

Mr. YARMUTH. Canada is the exception, so what you and other opponents of the public option have chose to do is single out Canada as the one example, even though it is an outlier of the supposed plans that we are trying to model. Is there anything else that we have modeled other than hockey that we have tried to take from the Canadians?

Dr. GRATZER. I would point out that while you have tried to model hockey——

Mr. YARMUTH. We have tried to model hockey.

Dr. GRATZER [continuing]. Canadians still have the advantage.

Mr. YARMUTH. I concede that.

Dr. GRATZER. Well, I was going to——

Mr. YARMUTH. No——

Dr. GRATZER [continuing]. But hold on a second, sir. I think it is important to draw lessons, and I see your point that Canada is a bit of an outlier. I would point out though if you look at countries like Britain or Sweden, while they have the option of private insurance, those markets remain incredibly small because they got crowded out and the problems——

Mr. YARMUTH. What about Germany?

Dr. GRATZER. Germany has a social insurance policy that is tightly regulated by the government. As you know, France has a similar one.

Mr. YARMUTH. But there is also a private insurance market, health insurance market in Germany, isn't there?

Dr. GRATZER. And in Canada, I should point out, you can opt out as well. You cannot buy private insurance but you can opt out and buy private service.

Mr. YARMUTH. So the point is we have the opportunity to follow any number of models, to do none of them, to create something that is distinctly and uniquely American, don't we?

Dr. GRATZER. I think that that would be a good thing, but I would be cautious about——

Mr. YARMUTH. I am glad you——

Dr. GRATZER [continuing]. In Washington given the way government expansion has gone in other countries.

Mr. YARMUTH. I am glad you applaud our effort. Now, I want to get to this issue of 120 million people who would move from a private plan to a public option supposedly, the Lewin Report. Was the Lewin Report based on an analysis of the discussion draft that we have before us now? Does anybody want to comment, Dr. Holahan?

Mr. HOLAHAN. Yes, I would. No, it was done before this draft came out obviously, but there were a lot of assumptions in there that got them that high a number. There were no exchanges. They made a big assumption about the difference in administrative costs. They assumed that the plan would pay Medicare rates as opposed to Medicare plus something.

And there were some other issues that I cannot recall, but it was—oh, one of the things that I think was very important is that they assumed the private system would not respond at all to competition from the public.

Mr. YARMUTH. Right, so it is fair to say that that analysis and that projection has nothing to do with the document that is before us?

Mr. HOLAHAN. It does not.

Mr. YARMUTH. When the representative from the Lewin Group was here, he mentioned the same thing, he said 70 something percent of the American people are happy with their insurance, and they prefer to get it from their employer. And yet he also said that 120 million people would move. And I asked the question of him, "Well, if they love their plans so much, why would they move?" And he said, "Because it would be cheaper." Is that your assessment, Dr. Gratzer, that that is why they would move because it would be cheaper?

Dr. GRATZER. That is the way it was designed. That is Jacob Hacker's original analysis, sure.

Mr. YARMUTH. Is it your contention or is the implication of that that all insurance companies do is compete on the basis of cost, this was a point that was actually made by Mr. Blumenauer and others?

Dr. GRATZER. Of course not.

Mr. YARMUTH. Of course not?

Dr. GRATZER. Of course, there are also quality issues for sure.

Mr. YARMUTH. Right. And if it were just a matter of cost, then the implication would be that the insurance companies are basically overcharging. If the government could create a plan that would provide the same service for less money, then the implication

would have to be the inference that the insurance companies were overcharging.

Dr. GRATZER. No, the implication is that the Federal Government does not play fair in price controls.

Mr. YARMUTH. How would the government be able to price control? There is nothing in this bill that forces a doctor to participate, is there?

Dr. GRATZER. As with Medicare, one sees that price controls can have an enormous impact and you can provide cheaper insurance. Be careful what you wish for.

Mr. YARMUTH. My time is up, Mr. Chairman. Thank you.

Mr. STARK. I know the panel does not believe this, but I think we have concluded. And I cannot thank you enough for your patience and discomfort of sitting so long as we have leaned on you for help and information and it is helpful. I know that many people, so I can excuse the panel.

I just would summarize that there will be lots of changes between now and the middle of July when we start to mark up and know more about the costs than we do now, but I appreciate your indulgence and your help.

And if the second panel has not escaped, I would ask them to come forward if they are still here. Mr. Kirsch, who is the National Campaign Manager of Health Care for America NOW; Mr. Mike Draper, who is the owner of SMASH from Des Moines, Iowa; Peter Lee, the Executive Director for National Health Policy, Pacific Business Group on Health from San Francisco; Mr. Gerald Shea, who is the Special Assistant to the President of the AFL–CIO; Ms. Jennie Chin Hansen, who is President of AARP; and Mr. Randel K. Johnson, who is the Senior Vice President for Labor, Immigration and Employee Benefits for the U.S. Chamber of Commerce.

Get a nice soft seat. I would also as you are getting settled suggest that we may have interruptions from time to time for votes, but I know that all of the Members have received your prepared testimony, and I know that they have prepared questions from that. And while they will be interested in hearing a summary of that, it is obvious that many of them are not here. I hope you will forgive our formalized procedures. We will ask you to summarize your testimony, and we will get through that. We will start to give the Members a chance to inquire, which will I think elicit a lot of information that will help us as we move ahead with this proposal.

I am looking to say with us and so we are missing Mr. Shea. He will be back, okay. Mr. Kirsch, would you like to proceed since you are first on the list?

STATEMENT OF RICHARD KIRSCH, NATIONAL CAMPAIGN MANAGER, HEALTH CARE FOR AMERICA NOW!

Mr. KIRSCH. Yes, I would. Thank you very much, Chairman Stark and Members of the Committee for your patience this morning as well as ours.

My name is Richard Kirsch. I am the National Campaign Manager of Health Care for America NOW, which is a coalition of more than 1,000 organizations in 46 States that are committed to specific principles to provide a guarantee of quality, affordable health care for all. Those principles have been endorsed in writing by the

President of the United States and 196 Members of Congress, including 176 Members of the House of Representatives from both parties.

I am so pleased to join you this morning because the legislation you have drafted meets those principles; it would deliver on the promise of quality, affordable health care for all in a health care system that is retooled to deliver better quality at lower cost. You have done so in this unique, tri-committee process that recognizes the urgency and historic imperative of this issue.

Our current health care system is a huge stumbling block to the American dream. No matter how hard we work, or make responsible choices for ourselves and our families, our health care system often gets in the way. For too many families, one serious illness can mean financial disaster, as medical costs contributed to more than three out of five personal bankruptcies, and most of those were people with insurance. And even those with good insurance have limited choices and dreams deferred in our system because if you want to look for a new job, start that new business, retire at 59, you are trapped because you will not be able to get affordable coverage—if you can get coverage at all.

And of course, so many working families cannot get coverage at all. Neither can many small businesses—that other engine of the American dream—who want to do the right thing for their employees, but cannot as health care premiums skyrocket every year.

The good news is that we can fix what is wrong with the system with a uniquely American solution. For those who say we cannot do this, it is too complicated, it is too much to take on, it's too much at once, your legislation is proof positive that yes we can.

As Americans begin to pay attention to the health care debate, they are asking what does this mean to me? Here is how I would explain to people how this works and how your legislation will make their lives better.

First, if you have good health coverage at work, you can keep it. But there will be two important changes. Under your legislation, you will no longer have to worry about your coverage at work getting skimpier every year, or your employer taking a bigger chunk each year out of your paycheck. Your employer coverage will not be barebones. It will cover most of your health care. It will not stop paying if you get seriously ill. Your job will pay for a good share of coverage for you and your family. One more thing, whatever job you take, you will have good health care. That is because all employers will either provide coverage or help pay for it.

Now, if you do not get health coverage at work, you work several part-time jobs, you are self-employed, an early retiree, or simply out of work, you will now be able to get good, affordable coverage. You will not be turned down because of a preexisting condition or charged more because you have been sick or you are a woman of childbearing age. You can still be charged more if you are older, but only so much.

And how much will it cost you? That will depend on your earnings, the size of your family, the assistance for low-, moderate-, and middle-income families.

You will go to get insurance in a new marketplace, called an exchange. In the exchange, all plans will have a decent level of bene-

fits and play by the same rules. And no matter which plan you choose, your out-of-pocket costs will be limited; no more catastrophic medical bills.

You will have a choice of the new public health insurance plan too, so you will not be limited to the same private insurance companies that have a record of denying and delaying care while they raise premiums three or four or five times as much as wages.

As the President says, there are two reasons for the choice of a public health insurance plan. The first is to lower costs from a plan that does not pay the average CEO $12 million a year, or have sky-high administrative costs. The mission of the public health insurance plan will deliver the kind of delivery system changes we need to innovate, provide better value and invest in our communities and make real progress in eliminating the barriers and disparities and access to services we experience today.

The second reason the President says we need a public option is to keep the insurance companies honest. The 93 percent of Americans who do not trust private insurance companies know that no matter how much we regulate them, their first order of business, actually their legal fiduciary responsibility to the shareholders is to make a buck. When they pay for someone's costly care, their profits go down.

This legislation also answers the crying needs of small businesses for affordable coverage. By offering tax credits and allowing small businesses to enter the exchange, it gives them the advantage of a large pool and lower costs.

Your legislation does a great deal more for the poorest through Medicaid and for seniors on Medicare to address the lack of primary care providers and disparities in access to health care.

Are there ways we would improve on this draft? There are, although not a great number. And we will detail them in our written testimony and I can suggest some today if you would like.

I would like to conclude by asking you to keep in mind one question over the coming weeks, as you hear from a myriad of interest groups complaining about this and that. It's the question your constituents will ask at the end of the day: Will I have a guarantee of good coverage that I can afford?

The draft legislation you have presented answers with a resounding yes. And if the answer remains yes, next fall when you send a bill to the President for his signature, you will have done your jobs. And in doing so, made history.

Thank you.

[The prepared statement of Mr. Kirsch follows:]

Prepared Statement of Richard Kirsch,
National Campaign Manager, Health Care for America NOW!

Good morning, Chairman Rangel, Chairman Stark and Members of the Committee. My name is Richard Kirsch. I'm the National Campaign Manager of Health Care for America NOW, a coalition of more than 1,000 organizations in 46 States that are committed to specific principles to provide a guarantee of quality, affordable health care for all. Those principles have been endorsed in writing by the President of the United States and 196 Members of Congress, including 176 Members of the House of Representatives from both parties.

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cost. You have done so in this unique, tri-committee process that recognizes the urgency and historic imperative of this issue.

Our current health care system is a huge stumbling block to the American dream. No matter how hard we work, or make responsible choices for ourselves and our families, our health care system often gets in the way. For too many families, one serious illness can mean financial disaster, as medical costs contributed to more than three out of five personal bankruptcies, and the great majority of those are people who are insured. Even having good insurance limits choices and defers dreams. Want to look for a new job, start that new business, retire at 59? Trapped because you won't be able to get affordable coverage—if you can get coverage at all.

And of course, so many working families can't afford coverage at all.

Neither can many small businesses—that other engine of the American dream—who want to do the right thing for their employees, but can't as health care premiums skyrocket every year.

The good news is that we can fix what is wrong with the system with a uniquely American solution. For those who say we can't do this, it's too complicated, it's too much to take on, it's too much at once, your legislation is proof positive that yes we can.

As Americans begin to pay attention to the health care debate they are asking what does this mean to me? Here's how I would explain to people how this works and why it will make their lives better.

If you have good health coverage at work you can keep it. But there will be two important changes. Under your legislation, you will no longer have to worry about your coverage at work getting skimpier every year, or your employer taking a bigger chunk each year out of your paycheck. Your employer coverage will not be barebones. It will cover most of your health care. It won't stop paying if you get seriously ill. Your job will pay for a good share of coverage for you and your family.

One more thing, whatever job you take, you'll have good health care. That's because all employers will either provide coverage or help pay for it.

If you don't get health coverage at work, you work several part-time jobs, are self-employed, an early retiree, or simply out of work—you'll now be able to get good, affordable coverage. You won't be turned down because of a preexisting condition or charged more because you've been sick or you're a woman of childbearing age. You can still be charged more if you are older, but only so much.

How much will it cost? The amount you pay will be based on your earnings and the size of your family, with assistance for low-, moderate- and middle-income families.

To get insurance you'll go to a new marketplace, called an exchange, one-stop shopping for health coverage. All plans will have a decent level of benefits and play by the same rules. No matter which plan you choose, your out-of-pocket costs will be limited; no more catastrophic medical bills.

You'll have a choice of a new public health insurance plan too, so you won't be limited to the same private insurance companies that have a record of denying and delaying care while they raise premiums three or four or five times more than wages.

As the President says, there are two reasons for offering the choice of a public health insurance plan. The first is to lower costs from a plan that doesn't pay the average CEO $12 million a year, or have sky-high administrative costs. The mission of the public health insurance plan will be to drive the kind of delivery system changes we need to innovate, provide better value and invest in our communities' health. A plan that will inject competition into the 94% of markets in this country that are anti-competitive under Department of Justice standards.

The second reason the President says we need a public option is to keep insurance companies honest. The 93% of Americans who don't trust private insurance companies know that no matter how much we regulate them their first order of business—actually their legal, fiduciary responsibility to their shareholders—is to make a buck; when they pay for someone's costly care, their profits go down.

An additional reason for the public health insurance plan is to ensure that we make real progress in eliminating the barriers and disparities in access to needed services that are too often experienced today.

Poll after poll shows strong support for the choice of a public health insurance plan. This Sunday the New York Times/CBS poll found that 72% of those polled support "offering everyone the choice of a government-administered health insurance plan—somewhat like the Medicare coverage that people 65 and older get—that would compete with private health insurance plans," including half of the Republicans, three-fourths of the independents and nine out of ten Democrats.

This legislation also answers the crying needs of small business for affordable coverage. By offering tax credits and allowing small businesses to enter the exchange, it gives them the advantage of a large pool and lower costs.

To the question of how we will pay for this, you have said with shared responsibility: Individuals responsible for what they can afford, employers responsible for paying for more affordable coverage. Government will fulfill its responsibility by achieving savings in the system and by raising new revenues that you will soon detail. In doing so, we would urge you to raise revenues from those who can most afford it and by closing Wall Street and corporate loopholes. Not by taxing the health care benefits of those who still are fortunate enough to have good insurance.

Your legislation does a great deal more, for the poor through Medicaid, for seniors on Medicare, to address the lack of primary care providers and the disparities in access to health care.

Are there ways we would improve on this draft? There are, although not a great number. We will detail them in our written testimony and I'd be glad to discuss some suggestions during the question period.

I'd like to conclude by asking you to keep in mind one question over the coming weeks, as you hear from a myriad of interest groups complaining about this and that. It's the question that your constituents will ask at the end of the day: Will I have a guarantee of good coverage I can afford?

The draft legislation you've presented answers with a resounding yes. And if the answer remains yes next fall when you send a bill to the President for his signature, you'll have done your jobs. And in doing so, made history. Thank you.

Mr. STARK. Thank you. And, Mike Draper, the owner of SMASH from Des Moines, would you like to proceed? Is your microphone on?

Mr. DRAPER. Yes.

Mr. STARK. Okay.

STATEMENT OF MIKE DRAPER, OWNER, SMASH, DES MOINES, IOWA

Mr. DRAPER. I may be a little nervous. This is my first time speaking to so many empty leather chairs.

[Laughter.]

Mr. DRAPER. As I look through this list, I am probably the only person who is not recognizable with the organization I am from, and so I thought maybe I would start with explaining exactly who I am and how I got to be here.

I own a store called SMASH. I am 26 and SMASH is a clothing store and screen printing shop located in beautiful downtown Des Moines. So essentially I am the token Main Street guy, the "Mike Six Pack," if you will.

I grew up in a small town in Iowa, studied history at the University of Pennsylvania, then moved to the United Kingdom where I married a girl from London, who was more than surprised when I decided to move back to Iowa and start a screen printing retail store, not just for the fact that she had to move from London to Des Moines but for the fact that I had no experience in retail, design or screen printing. And the closest I had come at Penn to a formal business education was a macroeconomics class, which I dropped after getting 42 percent on the supply and demand test.

I started the company at the bottom, printing shirts and selling them out of a bag on the street or on college campuses. While I was selling shirts on the street in Union Square with other vendors, I thought to myself, "Well, it is true. You really cannot do anything with a history degree." But I worked constantly and set up a

website in 2004 and then opened SMASH in 2005 as an 1,100 square foot retail store by myself and grossed $90,000 the first year. Now, 4 years later, the store has 4,200 square feet, 12 employees, and we will gross over $1 million this year, having been featured in the New York Times twice, NPR twice and several other national publications.

Along the way, I got the business education I needed. I have had to figure out business strategy, management, bookkeeping but health care has proved probably the most frustrating. In 2007, after 2 years of being uninsured, I bought an individual policy and felt like I was one of the "chosen few." And my insurance epiphany probably came when I had a minor surgery and weeks later was sent a bill for $347 for miscellaneous hospital charges. I started to wonder what would happen if I started sending out customers $347 miscellaneous T-shirt charge bills after I got done. But that is kind of the introduction of the system does not work on a market and it did not make sense.

And you guys probably know most of the problems as well as I do but the solution is a lot trickier. I think the bill that everyone has come up with here is a pretty good start. I think the exchange addresses a lot of those problems with general regulation, better pricing, transparency and coverage rules. But in my opinion competition is always more effective than just regulation and the public option is the only option strong enough to compete with the private sector.

Now, when I hear "public option," I do not hear "free option." I am not here asking for free health care, a government handout. I am asking for rational health care. As a businessowner, I would gladly pay 8 percent of my payroll into a public option since that would give me two things: One, peace of mind that my employees would be covered by something backed by the government; and, two, more importantly, an ability to accurately budget per year my company's health care expenses. Right now, my premiums and bills will fluctuate between 6 percent and 22 percent of payroll in any given year. An expense that large and unpredictable is what drives companies out of business, not a tax that they know they have to pay at the beginning of the year.

Now, it may sound strange that I would be willing to pay a new tax but rest assured I am not a socialist. I am not here trying to undermine capitalism. Rather, the small mountain of money I send to you guys several times a year does not make me clamor for more government, but the unsustainable cost of my current health cost, the one thing that could probably ruin the company, makes me clamor for an actual option.

The public option is less intrusive to me since I would have the option. I could take the public plan or I could take the private plan. With simply doing the exchange or by simply regulating the market, it seems like bigger government. You could have new rules, possibly required health care, some subsidized by the government, meaning that my tax money would go to subsidize some people's money going to the private insurance industry. On the other hand, my private money has to go to that same private insurance industry. Now, even somebody who has dropped out of macroeconomics says that that is a kind of frustrating thing to deal with.

I understand that the issues are complex. Insurance blends technical problems with ideological differences and many of the details of the plan really can only emerge when it is functioning, making these details impossible to know now, such as how many people will take the public plan, if rates will actually go down.

But not knowing every detail of the future should not stop us in the present from working for a better one. And something needs to be done for the future of small business health care. We should not lose sight of the fact that this is one of the few countries where somebody like me can start a business with no business knowledge and succeed. And while you guys cannot legislate entrepreneurial spirit, you can help to take down some of the hurdles impeding entrepreneurs from starting companies. Right now, health care is one of the biggest hurdles to either entrepreneurs trying to start companies or existing companies staying in business. And I think the public option is our best option for taking care of that.

Thank you.

[The prepared statement of Mr. Draper follows:]

Prepared Statement of Mike Draper, Owner, SMASH, Des Moines, Iowa

Chairman Rangel, Ranking Member Camp and Members of the Committee, thank you for inviting me to be here today and to testify on behalf of my business and small businesses across Iowa.

My name is Mike Draper. I am 26 and own and operate SMASH, a clothing store and screen printing/design shop in beautiful downtown Des Moines, Iowa.

Although I grew up in a small town outside of Des Moines, even the 21-year-old me never would have guessed that the 26-year-old me would be back in Iowa living and working. I left the State for the east coast at 17 to study history at UPenn in Philadelphia, I spent a year and a half living in the UK and Germany, and in the UK I met a girl from London who I would convince to marry me.

And let's just say that of all the people who were surprised I was moving back to Iowa, she and her parents were definitely in the top 5.

More surprising was that I wanted to run a clothing store and screen printing shop. I had no experience in design, in printing, or in retail clothing, but I always say that if I had ever actually stopped to analyze my situation, I never would have started the business I started.

After I graduated, I lived with friends while I traveled around selling shirts out of a bag on college campuses and busy street corners. One day selling shirts in Union Square I began to worry that what I had heard from so many people was true: You really can't do much with a history degree.

But I worked constantly. I built a website to sell shirts. I bought screen printing equipment. And I realized that my home State of Iowa offered the affordable space and the niche market I needed to succeed.

So in 2005 I moved back and opened a 1,100 square foot retail and printing space by myself and I grossed about $90,000 in sales. Now, 4 years later, SMASH has 4,200 square feet, a dozen employees, and will gross over $1 million in sales this year.

Like many businessowners, I have realized that business is often less about the idea, and more about finding solutions to the constant problems that come from dealing with other humans. The closest I ever came to a formal business education was a macroeconomics class that I dropped after getting a 42% on my first test that only covered supply and demand. But even without business training I have successfully maneuvered my way through small business taxes, building codes, trademark law, even immigration issues for a web designer from Denmark who went to college in Des Moines and now works at SMASH.

But health care has always confounded me.

SMASH and the Challenges of Health Care

Right after college, while I traveled and sold t-shirts, I went without health insurance. When I bought an individual policy in 2007, after 2 years of being uninsured, I thought I had become part of the chosen few, the insured. But my "insurance epiphany," when I realized how odd our system is, came weeks after a minor surgery, when I got an unannounced $347 bill for "miscellaneous hospital charges."

I laughed when I opened it, imagining what would happen if I started mailing out bills that said, "miscellaneous t-shirt charges" to customers weeks later.

It dawned on me how little my individual policy covered: High deductible, high drug costs, no free doctor's exams. But there was nothing else I could afford.

As SMASH added more employees, there were now more people inheriting my situation. As young moderns, none of us want to be tied to a corporate policy—we would rather have a flexible plan we can travel with. And so all of the employees at SMASH have individual policies that the company pays for.

This most basic coverage makes up 8% of our gross payroll.

What alarms me is that this is the most elementary coverage offered by our provider, Wellmark, and is really only intended to provide the most basic coverage in case of catastrophic accidents.

If SMASH were to try and provide our employees with full family coverage, our costs would balloon to about 22% of our gross payroll, and still we would have plans inferior to those plans of larger companies.

I can't run away from the cost of health care, either for myself, my family, or my employees. The way we do things now, where responsible employers offer coverage and others don't, creates an incredibly uneven playing field. I'd much rather be part of a system where all employers are contributing a fair share, instead of this game of shifting costs that we're playing today. Small businessowners like me are willing to contribute—73% said so in the *Taking the Pulse of Main Street* survey conducted by the Main Street Alliance last year.

Once my wife took a job as a nurse, I moved my insurance to her family plan, but with our family growing, it becomes more likely that my family plan will soon go through SMASH. And as the SMASH employees age and add families, the 22% cost becomes more and more likely.

I have seen being uninsured, being underinsured, now being "fully" insured under my wife's plan, and I've spent over a year living under the UK's national health. I'm as aware of the problems in each as everyone here is.

Big Steps in the Right Direction

The solution is much trickier, but I think the draft bill released by this Committee last week is a great start. The "Exchange" seems to address the need for basic regulation, transparent pricing, and coverage rules. It points out the major holes in our current system and gets to the heart of the matter: That we need competition. The Exchange will provide a more competitive, transparent marketplace that will offer real choices for individuals and small businesses. In the Exchange, we will actually be able to compare the insurance plans being offered because the benefit packages will be standardized and the differences in the plans will be disclosed.

I'm also happy to see the provisions in the draft legislation to reform insurance practices to prohibit discriminatory coverage and rating policies. These changes are long overdue—I wish it wasn't necessary for the Federal Government to step in and pass laws to get insurers to stop these unfair practices, but if that's what it takes then I support you taking action as quickly as you can to put them in place. Reforms that prohibit exclusions based on preexisting conditions and discrimination in benefits, require plans to meet minimum medical loss ratios, do away with annual and lifetime limits on coverage and cost-sharing for preventive care, limit unfair rating practices, provide for guaranteed issuance and renewal of policies, and assure the adequacy of provider networks will go a very long way to creating a sane marketplace where policies are worth their premiums and where individuals and small businesses can be smart shoppers for the health care coverage they need.

By creating a Health Insurance Exchange, the bill makes it possible for small businesses to have the affordable option necessary for employers and individuals to share the responsibility of providing quality health care coverage. I like the idea of the "Exchange," but in my opinion, real competition is always more effective than regulation alone. The public option set forth in the bill will do more than anything to ensure competition, and is therefore the most important component to me. Having a public plan that will compete toe-to-toe on a fair basis with private plans will guarantee that even in local insurance markets dominated by one or two private insurers, we'll have real choices and the leverage that comes from being able to vote with your feet and take your business elsewhere if you can't get the insurance coverage you need.

I'm convinced that by encouraging real competition and restoring vitality to the market, a public health insurance option will really drive broad-based positive change in the private sector health insurance industry. According to the Commonwealth Fund, health reform that includes a public option has been estimated to save employers $231 billion over 2010–2020, and $3 trillion for the Nation. Without the public plan option, those savings shrink from $3 trillion to less than $800 billion:

We lose three-quarters of the savings. I don't know much about budget scorekeeping in Congress, but it seems to me like these are savings we can't afford to pass up.

A public plan is also essential to encourage innovation in coverage and affordability in a competitive market. Our business has to be constantly looking for ways to serve customers better, more efficiently, at lower prices, and we are definitely driven by competition from other businesses. As a purchaser of health insurance coverage, I want my insurer to have to compete for my business the same way that I have to compete for my customers.

I understand that the insurance issue is not only technically complicated, but also invites ideological differences on government involvement. But it seems to me that some of those differences are obscuring the real agreement on the need for a public health insurance plan. A number of recent polls suggest that somewhere around 70% of the public supports the creation of a public health insurance option and from what I've seen most of the small businessowners I know agree. In the survey I mentioned earlier conducted by the Main Street Alliance, 70% of the responding businesses said they believe government should play a stronger role in guaranteeing access to quality, affordable health care. When asked to choose between a reform proposal with a public insurance option and one with expanded private market options, 59% of the responding businesses chose the plan with a public option, compared to 26% that preferred a proposal with more private market options.

The bill also includes a phase-in of eligibility for small employers to secure coverage through the Exchange and to gain access to the public health insurance option, with firms employing 10 or fewer workers eligible in year one and firms up to 20 employees eligible in year two. I realize that this phase-in is intended to be cautious and not create unintended consequences by moving too quickly. But from my viewpoint, we can't make access to the public plan option and the other private plan options available too soon. I would encourage the Committee to consider accelerating the phase-in for employers to gain access to the Exchange.

Now I don't read "public option" as "free option." I'm not here asking for free health care, all I'm asking for is rational health care.

I and other small businesses in my neighborhood are not tired of health care premiums. We're tired of health care premiums going to companies whose sole goal is to turn a profit, with little or no regard for the impact of their policies and practices on small businesses like ours. With SMASH's insurer, Wellmark, I know that I am a minute number on a long balance sheet that can be dropped or dragged through court.

With a public health insurance plan option offered through the Federal Government, I would have an independent Federal agency accountable to Congress—you all—on my side, and a system whose goal is not to maximize profits at all costs, but to actually provide real health coverage that meets the needs of my business. Which means at this point, apples to apples, if I had to choose between paying my premiums to the Federal Government or Wellmark, I'd rather send my premiums to the government.

It may sound strange to hear a small businessowner like me say I'd rather send my premium dollars to the Federal Government than to a private insurer. When it comes to economic issues, the pile of money I send to Washington, DC makes me fairly conservative. But it is this conservative streak in me that wants the competition that a public option will bring.

First of all, I understand that there may be additional taxes involved, but I don't mind paying taxes that are well spent. Right now, however, I see my tax money going to pay for high-cost health care that county hospital ERs are forced to provide for the uninsured, while 8% of my payroll already goes toward providing only the most basic, catastrophic coverage for a group of employees who are all single and in their 20s.

That means I'm paying for two separate yet equally inefficient systems, and even someone who dropped macroeconomics can see that isn't rational.

Second, I support the idea of shared responsibilities in the bill that require individuals and employers to play their part in assuring that everyone has health care coverage. I agree with the approach of giving employers an option of providing coverage for their workers or contributing funds on our worker's behalf. In my own case, I think paying 8% of my payroll to provide health insurance for my employees is fair, and the benefits package is likely to actually cover our health care costs with no preexisting condition exclusions.

For a business, taxes are easy to take into account because they are a fairly static expense. What are not static are health care bills that cannot be budgeted each year. I have never met a business that went under because of their tax burden, but I meet small businesses and entrepreneurs all the time that can't make it because of their health insurance burden. If extra taxes will help to stabilize the insurance

market and make it something I can actually depend on for care and realistically budget for, I am in full support.

While 8% would not be any issue for SMASH, I'm glad to see provisions in the bill to establish a tax credit to help small employers bear the cost of providing coverage for their workers. A 50% credit will give a big boost to businesses with 10 or fewer employees with average compensation of $20,000. This, too, offers a great deal of help in improving the health insurance options currently available to small businesses.

I also understand that requiring employers to provide health insurance puts another responsibility on me, but it's nothing new for small business. I already take care of withholding tax and unemployment tax for employees. If one of you came in to shop, I'd make sure the government got the sales tax you owed. These are the responsibilities that come with being at the top of the ladder. Right now, I have the unpleasant responsibility of knowing that the only health coverage we have is insufficient coverage, that one catastrophic illness could not only ruin one of my employees, but could put the entire company in serious trouble. When compared to that, I would gladly accept the responsibility of providing insurance coverage that I wouldn't have to worry about.

Representatives of the Main Street Alliance look forward to continuing to work with you to assess the interaction of the various small business related provisions in the bill to ensure there is affordability across the range of small businesses, whether they directly provide coverage for their workers or contribute to helping workers buy their own coverage through an Exchange.

An American Solution

I understand this is a complicated issue, but I think the U.S. is in a unique situation. We could now create a public-private hybrid that could work better than any system in the world, one that blends the stability of a government-backed system with the self-regulation of a market system.

As we step back, we shouldn't lose sight of the fact that this is one of the few nations where people like me can jump into business and succeed with hard work. We should recognize that it is not just a free market that makes this possible, it is also our country's ability to provide things like affordable public education to give people the tools they need to succeed in business.

Health care is currently a huge hurdle that is often too high for would-be entrepreneurs to surmount, and this creates a serious drag on a major part of our economic engine.

While you can't legislate the entrepreneurial spirit, it is possible for you, Congress, to tackle the hurdles holding back many small businesses and the economy at large. This model of creating choice and competition is an opportunity to do just that.

Adding a public option to health care would not only ensure care for the uninsured, it would provide a much needed injection of energy at the front lines of our market economy, making it easier for young people like me to strike out on their own and start their own business like millions of Americans before them and keep our country leading and prospering in the century to come.

Thank you.

Mr. STARK. Thank you, Mike Draper. Next, Mr. Peter Lee, who is the Executive Director for National Health Policy of the Pacific Business Group on Health from San Francisco, California. Welcome and please proceed as you would like.

STATEMENT OF PETER LEE, EXECUTIVE DIRECTOR FOR NATIONAL HEALTH POLICY, PACIFIC BUSINESS GROUP ON HEALTH, SAN FRANCISCO, CALIFORNIA

Mr. LEE. Chairman Stark, Ranking Member Camp, Members of the Committee, thank you very much for having me here today. I represent the Pacific Business Group on Health, which is a nonprofit coalition of some of America's largest employers that buy health care.

America's employers recognize that we need to dramatically overhaul the health care system. The recognition comes from the fact that they face challenges on a daily basis providing coverage to over 160 million Americans.

We appreciate what this Committee is wrestling with, what Congress is wrestling with, and what the Administration is seeking to do to craft reform that will change health care and make it more affordable.

There is not a single employer perspective on health reform, no more than there is a single American perspective on health reform. There are, however, some core beliefs that employers share in common. And I have detailed those in more detail in my written testimony, but I want to go through some of those beliefs and highlight how they relate to the discussion draft that we are discussing today.

First, employers believe that we must ensure that all Americans have health insurance, and we should do that by building on the current employer-sponsored individual and public program system. In many ways, the discussion draft does recognize the important role the employer-sponsored coverage plays in America and builds on that system. Having coverage for individuals for small businesses through exchanges across the country is going to be an important tool. With expanded coverage, employers are hopeful that the cost shift from the uninsured will be greatly reduced.

Employers believe that we must address health care costs, which are driving individual Americans to bankruptcy, making our companies less competitive internationally, creating long-term structural deficits that our children will have to bear.

The discussion draft supports many of the delivery system reforms that we believe are essential to reign in out of control health care cost while fostering quality. Among the proposals that we think are important are building and supporting national rules for a more competitive, affordable insurance marketplace for individuals and small business, developing better performance measurements for providers, changing payment and outlining incentives for higher quality, and expanding investments for wellness and prevention.

In particular, the discussion draft clearly recognizes the critical role that payment reform must play in creating better value for Americans. I applaud in the inclusion of the draft a range of payment reforms, including bolstering payments for primary care and changing the way we pay for care to move from volume to value.

Part of changing payment though should include changing how payment decisions are made. Current payment policies for Medicare are too inflexible and quite honestly susceptible to focused interest of the recipients of payment. Congress should consider creation of a new entity with independent authority to implement broad direction that Congress provides.

The discussion draft also recognizes that measuring the performance of health care is the foundation for quality improvement, giving consumers better tools and payment reform. Employers are part of a broad coalition called Stand for Quality, which makes a number of recommendations, many of which are in the discussion draft. We encourage the Committee to consider building those rec-

ommendations to make sure there is enough resources to develop new measures and to support consultative processes so when measures are put into use, consumers, purchasers and others are at the table.

Employers strongly support the discussion draft proposals to expand our national commitment to comparative effectiveness research. Patients and consumers need better information to make decisions about what is right for the patient.

The discussion draft also recognizes the need to promote wellness and prevention. Few issues are as close to the heart of the employer community; we support those significantly.

I would note that nationally there is a lot of discussion about the 10-year bill for expending coverage of being $1 trillion or $1.5 trillion. I would point out that those are big numbers and big issues, but over the next 10 years, we will spend $45 trillion on health care. The President is right that the real number we need to look at is how do we reduce health care costs across the board by $2 to $3 trillion. Your proposal includes many building blocks to put us on a path for reigning in costs, but we need to have mechanisms to measure our progress and hold both the public and private sectors accountable for reducing costs. We truly are on an unsustainable track in terms of health care costs.

Part of reducing costs and promoting efficiency is aligning public and private programs. When we looked at the proposal to have a public plan, many employers were deeply concerned that that public plan would shift cost to the private sector. What we need to have is options that align payment models across public and private purchasers to ensure that providers are rewarded consistently but do not shift costs from one sector to the other.

Health reform must be about making high-quality health care affordable for patients, employers and government. We look forward to working with this Committee and so many other Americans who share that goal.

Thank you very much.

[The prepared statement of Mr. Lee follows:]

Prepared Statement of Peter Lee, Executive Director for National Health Policy, Pacific Business Group on Health, San Francisco, California

Chairman Rangel and Members of the Committee, thank you for the opportunity to be with you today. America's employers recognize the need to dramatically overhaul our Nations' health care system. That recognition comes from the challenges we face on a daily basis providing health care coverage to over 160 million Americans. We greatly appreciate that this Committee, Congress and the Administration are seeking to craft reforms that will change how health care is delivered and make it more affordable.

The Pacific Business Group on Health makes these comments as 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. The Pacific Business Group on Health represents large and small employers in efforts to improve the value of health care. We help our large purchaser members "buy smarter," and for many years we operated one of the largest small employer purchasing pools in the Nation.

There is no more a single "employer perspective" on health reform than there is a single "American perspective" on reform. Employers hold a variety of positions on the big issues of financing and payment, as well as on issues such as the "public plan" and the role of government. There are, however, some core beliefs about health reform shared by virtually all businesses that we believe should guide the

Committee on Ways and Means and reform discussions in general. Those core beliefs include:

- We must ensure that all Americans have health insurance by building on the current system of employer-sponsored, individual and public programs;
- We must address health care costs which are driving individual Americans to bankruptcy, making our companies less competitive internationally, creating long-term structural deficits that are breaking the banks of States across the country, and imposing unacceptable liabilities on our children;
- We must address the persistent differences between how public and private systems measure performance and pay for care. These differences lead to confusion for consumers and providers, create unacceptable price pressures on employers and engender disconnected incentives between public and private payers;
- Health care reform must support and encourage clinicians and hospitals in delivering better quality, more "patient-centered" care—which will entail doing a better job measuring what works, changing how we pay for health care and making better use of information technologies;
- We need to promote wellness and prevention, instead of focusing only on intervening after the fact; and
- All Americans—as engaged patients, caregivers and consumers—need to be given better tools and incentives to participate in getting the right care at the right time.

Americans believe in value—we seek to get the best quality possible for our 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 which are not. Consumers lack information to make the choices that are right for them. Health reform must address these underlying issues and we are heartened that the proposals in the Discussion Draft recognize and address many of these problems.

Core Employer Belief: We must ensure that all Americans have health insurance by building on the current system of employer-sponsored, individual and public programs.

The vast majority of employers continue to believe that reform should build on the employer-based system that works for millions of Americans. Employers see health benefits as a crucial tool that fosters a more productive workforce. The Discussion Draft affirms the role of employer-sponsored coverage by building on the existing system and seeking to expand coverage through small business in Exchanges across the country. Employers that offer coverage believe that the costs of insurance for their employees is substantially higher than it should be because of cost-shifting from hospitals and doctors seeking to recoup costs of caring for the uninsured and receiving underpayment by public programs (both Medicare and Medicaid). With expanded coverage, employers are hopeful that the cost-shift from the uninsured will be greatly reduced.

Particular elements of reform—especially the possibility of employer mandates—will have support or opposition from the employer community in direct relation to whether the broader package of reforms promote meaningful improvements in the cost and quality of care.[1] As well articulated in the *Position of the HR Policy Association Regarding Reform of the U.S. Health Care System* (April 2009), large employers support the voluntary nature of the Nation's employer-based system and would consider the potential employer play-or-pay mandate only insofar as it is well-crafted, part of a wide array of other reforms and fully considers "the interplay of all elements of the package necessary for reform."

Core Employer Belief: We must address health care costs—which are driving individual Americans to bankruptcy, making our companies less competitive internationally, creating long-term structural deficits that are

[1] A recent survey of senior health benefits executives for large companies identified strong support for government playing a role in making insurance products available for individuals and small businesses (with over 55% supporting this role). At the same time, those surveyed held a range of views, but with more than two times as many having a negative view of the "play or pay" requirement for employers (38% strongly negative; 19% strongly positive) and establishing a "public plan" (40% strongly negative; 21% strongly positive). *Corporate Health Care Policy Forecast Survey*, Miller & Chevalier/American Benefits Council, June 2009.

breaking the banks of States across the country, and imposing unacceptable liabilities on our children.

There is broad recognition that we must slow the rise of health care costs. In the Discussion Draft, several proposals have the potential of reining in out of control health care costs while simultaneously fostering higher quality care. Among the reforms proposed that are essential to reining in costs and fostering quality and access are those that support national rules to create a more competitive and affordable insurance marketplace for individuals and small businesses; developing better performance measurement; changing payment and aligning incentives for higher quality; and expanding investments in wellness and prevention.

President Obama has repeatedly underscored that health reform that does not control costs is not health reform. Similarly, Peter Orszag has been eloquent in articulating that "health care costs are the key to our fiscal future." There is much discussion in Washington today about whether the 10-year "bill" for reform is $1 trillion or $1.5 trillion. These are indeed big numbers. But these costs need to be considered in the context of the projected national health expenditures for the next 10 years are expected to total $45.2 trillion which will be borne by taxpayers, employers, and individual patients.

America's business community is looking at the scoring done by the Congressional Budget Office and shares the concern that we have not yet achieved the bottom-line savings needed. As I have noted, the Discussion Draft has in it many elements that can reform the delivery of care and make it more affordable. We believe costs are driven by inadequate prevention, poor chronic care coordination, and overuse of supply-sensitive care. To achieve sustainable cost control, the health system needs to overhaul how care is delivered and the incentives that today reward more not better care. Also, compared to many other countries one of the key reasons for our higher costs is that in America we pay more for the same services. While addressing many of these elements are part of the reform proposals, employers share the concern evidenced by the CBO's scoring that not only are we coming up short on paying for expanded coverage, we are not seeing how the reforms will achieve the $2 trillion to $3 trillion in savings from trend that are needed to create a sustainable health care system.

We need to be serious about reducing costs while recognizing that we cannot restructure almost one-fifth of the Nation's economy overnight. As we put in place the reforms that will change how we deliver care, to be credible not just to the Congressional Budget Office but to the American people, we need to chart out the steps we will take in the coming years if—through private and public sector actions—we fail to bend the cost curve. As the Committee for a Responsible Federal Budget recently said, *"we believe that given the emphasis on crafting a plan designed to generate longer-term health care savings, the final bill should include a commitment to a certain level of longer-term health care savings with an enforceable budget mechanism to ensure the savings are realized. Such a mechanism could include automatic reductions in Medicare and/or new taxes if projected savings are not realized. A similar type of Medicare trigger has been ignored in the past, and a new budget mechanism would have to include real teeth and have the support of Congress to be effective."*[2] Any budget mechanism, however, needs to consider not "just" Federal spending, but the total health care expenditures of the Nation. Congress must recognize that its actions to reduce costs cannot merely shift costs to the private sector. If we cannot reduce current cost trends, the Nation must be ready to discuss solutions such as all-payer pricing or global budgeting.

Core Employer Belief: We must address the persistent differences between how public and private systems measure performance and pay for care. These differences lead to confusion for consumers and providers, create unacceptable price pressures on employers and engender disconnected incentives between public and private payers.

There is a need to align public and private programs on multiple fronts. The same measures of health care performance should be used to send consistent signals to providers and consumers to guide improvement, assist consumer decisionmaking and incent high quality and efficient care. The Discussion Draft recognizes the need to align public and private programs in a range of ways, including the efforts to

[2] Committee for a Responsible Federal Budget, June 1, 2009. The concept of a budget mechanism was also recently supported by Health CEOs for Health Reform, a group of leaders representing providers and payers who made a series of proposals in "Realigning U.S. Health Care Incentives to Better Serve Patients and Taxpayers" and in "Crossing Our Lines: Working Together to Reform the U.S. Health System," by Senators Baker, Daschle and Dole.

align Medicare's measurement and payment practices with those of the plans in the Exchange.

Public payers such as Medicare and Medicaid tend to pay significantly less for health care services than do private payers. Sometimes referred to as "cost-shifting," the actual dynamics are more complicated, as evidenced by innovative research undertaken by MedPAC. From the perspective of many employers and purchasers of health care, they face bargaining situations with hospitals and doctors that are stacked against them: Medicare and Medicaid, with their below-market fixed prices, result in providers seeking additional above-market prices from private purchasers. In addition, the payment models used by Medicare have, historically, incented volume over value. Private purchasers then face the dual challenge of managing not only the value of the services they pay for, but also need to overcome the deeply-embedded incentives offered by public programs' use of the fee-for-service system and lack of volume controls.

Over time, we must redress this imbalance of payment models and payment levels. Our physicians and hospitals face a bewildering array of conflicting quality incentives, payment strategies, and oversight mechanisms. As large employers evaluate proposals for a "public plan," they are deeply concerned that such a plan could lead to cost-shifting or increased misalignment between public and private payments to providers. While policy options are complex and fraught with hazards in this space, our priority should be to align the payment models across public and private purchasers to ensure that providers are rewarded consistently for safe, high quality, and efficient care.

Core Employer Belief: Health care reform must support and encourage clinicians and hospitals in delivering better quality care—which will entail doing a better job measuring what works, changing how we pay for health care and making better use of information technologies.

As noted earlier, the Discussion Draft includes an array of proposals to improve the delivery system such as better performance measurement; changing payment and aligning incentives for higher quality; and expanding investments in wellness and prevention. Employers view these as essential building blocks of reforming our health care system.

Promoting Measurement and Quality Improvement

In the past months there have been many collaborative proposals developed to reform health care. Two groups, in particular, have come together to advocate for concrete ways that quality and value can be built into reform efforts.

First, over 200 groups under the name "Stand for Quality"—representing an array of consumers, employers, clinicians and other providers, hospitals, health plans and more—have come together to call 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 (see 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.

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. I want to acknowledge and note my appreciation for the fact that the Discussion Draft embraces many of the Stand for Quality recommendations, including developing processes for setting national health care priorities, supporting the development of performance measures and funding quality improvement efforts at the point of care.

I would encourage the Committee to build on its initial proposals by looking at the agreement reached by this diverse range of stakeholders. Additional actions should include increasing the level of support for developing measures in key areas such as functional status and resource use; promoting the use of standardized measures; and supporting consultative processes that assure that consumers, employers and providers can provide meaningful input to CMS in how measures are used for public reporting and payment.

Beyond the common support for expanded measurement, employers strongly support the Discussion Draft's proposal to expand our national commitment to comparative effectiveness research so that patients can have better information to use with their doctors when deciding which treatment is right for them. We need 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.

Your Discussion Draft also recognizes the importance of releasing Medicare data—referring to the new Assistant Secretary for Health Information being charged with making available Medicare datasets. Beyond that action, CMS should be directed to 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 which will ultimately lead to lower premiums and higher quality of care.

Reforming Payment

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 does not reward better quality, care coordination or prevention nor encourage patients to get the right care at the right time. As Dr. Abraham Verghese said so well in a recent Wall Street Journal article, we have "a skewed reimbursement scheme set up by Medicare, . . . that pays generously when you do something to a patient, but is stingy when you do something *for* a patient."[3] A second broad collaborative—the Center for Payment Reform (www.CenterforPaymentReform.org)—has identified 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.

Your Discussion Draft clearly recognizes the critical role that payment reform must play in creating better value for Americans and reflects many of these principles. In particular, I applaud the inclusion in the Discussion Draft of an array of payment reforms, many of which seek to bridge Medicare and Medicaid and promote alignment with private plans. These include:

- Increasing payments for primary care in a range of ways. Fee-for-service payments do indeed need to 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.
- Extending the Physician Quality Reporting Initiative and calling on that program to better integrate clinical reporting of performance through electronic health records;
- Establishing a robust set of pilot programs for accountable care organizations;
- Establishing a program to reduce payments for avoidable hospital readmissions;
- Moving away from today's quality-blind fee-for-service and "pay for quantity" approach toward support for accountable care organizations, bundled payments for post-acute care and medical homes.

As these models are implemented, however, I urge you to build in accountability mechanisms to provide a check against providers' potential financial incentives to either seek to serve only healthier individuals ("cherry-picking") or skimp on care, particularly for the most vulnerable, at-risk beneficiaries. It is critical that we build in the means to assess whether these models are enabling us to achieve better quality, more efficient, and more patient-centered care.

Revaluing Services—Considering Patient and Societal Value

The Discussion Draft recognizes that CMS should be directed to assess and fix how payments may be misvalued. Getting valuation of services right is important for Medicare and because these values are often applied by private health insurance plans. The current relative undervaluing of primary care and care coordination functions bodes ill for the aging population that will need more support.

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[3] The Myth of Prevention, Dr. Abraham Verghese, Wall Street Journal, June 20, 2009, W1.

Beyond the assessment called for in the Discussion Draft, CMS should be directed to establish a mechanism to develop and implement a multi-year, multi-sectoral payment policy review and approval process. This mechanism would be charged with developing an integrated approach to updating existing and emerging payment models to assure aligned incentives across providers, and in the context of any State-driven and/or private sector-driven trends and initiatives.

This new mechanism should solicit input from external stakeholders through a formal multi-stakeholder advisory process that addresses all provider segments, including post-acute providers, through an annual notice and comment process. Under the current CMS processes, the overwhelming majority of comments are submitted by affected providers. While patients and their advocates and third-party payers can and do comment, the highly technical nature of the rules and policies, coupled with the limited impact of payment policies on any single patient or payer has inadvertently resulted in an unlevel playing field. As a result, CMS staff, in reviewing comments, often lack meaningful input from stakeholders outside of the provider community.[4]

A means to ensure meaningful input from other stakeholders is urgently needed. As a discrete complement to CMS' regulatory decisionmaking process, we recommend establishing a federally chartered body that includes patients, third-party payers and provider representatives to inform CMS' annual update processes. A standing Consumer and Health Care Purchaser and Provider Update Committee (CHUC) would be charged with providing independent input to CMS in its decisionmaking role with respect to Medicare payment levels, across all provider sectors. The new advisory group should include patients, purchasers, providers and payers—with majority representation by those who receive and pay for care—and serve as a forum for broader multi-stakeholder input, as well as collection and analysis of relevant information. This new group would be advisory only, but it could provide a needed and fresh perspective for CMS and for Congress.

Changing Payment Decisionmaking

Current payment policies—beyond the regulatory process are also too inflexible and susceptible to the focused interests of the recipients of payment. Congress should consider creation of a new entity with independent authority to implement broad direction provided by Congress. Regardless of the specific structure adopted, new processes need to be put in place to assure that flexibility, transparency, and meaningful stakeholder input are in place to assure that changes to payment policies are considered in the context of their impact on patients, providers, and health care purchasers.

- Congress should set the broad goals and targets for Federal health care payments, but the specific decisions about payment should be made through independent processes that are guided by what serves the patient and helps society as a whole. The decisionmaking body should be structurally independent, with mechanisms in place to insulate it as much as possible from political influence in order to ensure evidence-based decisions and to engender stakeholder trust.
- Payment decisions should be guided by evidence and should balance the perspectives of consumers, purchasers, payers and physicians and other health care providers—but the perspective of those who receive and pay for care should have majority control instead of those who receive payments.

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[4] While this phenomenon is present in all payment systems, it is most apparent in the area of CMS' annual efforts to update the Physician Fee Schedule and resource-based relative value scale (RBRVS). The relative values of the services are determined by CMS using its rulemaking authority. In practice, CMS relies heavily on recommendations (provided through the notice and comment rulemaking process) by an outside committee housed by the American Medical Association (AMA): the Relative Value Scale Update Committee or the RUC. The RUC is made up of physicians that represent nearly every specialty. Many of the RUC's recommendations are based on expert panels and qualitative, subjective assessments of the physician work and practice expense components of the RVU value. In response to CMS' request for comments, the RUC offers its recommendations on values for new services, and recommends adjustments to values for existing services on a periodic basis.

Given the cost of analyzing and proposing new or revised RVU values, great weight is given to the RUC's recommendations. (In March 2006, the Medicare Payment Advisory Commission (MedPAC) noted that CMS' 5-year review "does not do a good job of identifying services that may be overvalued." They further stated, "CMS has relied too heavily on physician specialty societies to identify services that are mis-valued." Five-year reviews have led to "substantially more increases in RVUs than decreases, even though many services are likely to become overvalued over time." (MedPAC, *Medicare Physician Payment*, March 2006.) All too often the perspectives of other health care stakeholders are notably absent and the broadly dispersed "public good" of assuring valuation for physician services that meets patient-centeredness and affordability goals is not a business priority for any one interest group.

- Processes and rules for making payment decisions should be simple, standardized and align value (to the extent possible) across physician, hospital and other types of health care payments.
- Payment decisions should promote consistency across private and public payers.

Assuring Competition While Promoting Payment Reform

While employers support payment reforms that encourage coordinated and integrated care delivery, we also recognize the need for policies that assure there are functioning markets—where informed patients and purchasers can fairly negotiate terms with independent providers. Health reform needs to assure there is an appropriate balance between coordination and competition.

Aligning incentives across providers and sites of care is essential to the appropriate focus on "end-to-end" quality, affordable care. In many markets, providers have formed multi-provider organizations, ostensibly to advance their clinical and financial goals, forming multi-hospital systems, multi-physician organizations, and combined hospital-physician entities. In some cases, these collaborations have resulted in higher quality and lower costs for payers and patients by focusing on generating clinical and financial efficiencies. In some instances, however, these new organizations have leveraged their market power in ways that may increase costs to patients, payers, employers and other health plan sponsors, with ambiguous impacts on quality.

Because of the concerns about potentially anti-competitive impacts of some forms of integration and coordination, there are a broad array of laws and regulations governing competition, anti-kickback, self-referral, and related issues. Some argue that portions of existing law and regulations need to be "loosened," as they inhibit providers' ability to coordinate care effectively. However, many others suggest that loosening existing laws and regulations is unnecessary to deliver more efficient care and could result in both higher costs and reduced choice for consumers.

Given the complex interrelationship between competition and coordination, we support the recommendation of the Center for Payment Reform that there be established a framework that will assure that both goals are promoted. The Secretary of Health and Human Services should be directed to produce or commission a report to Congress that shall examine how policies and payment can best balance the need to both promote coordination and competition. In doing so, the Secretary should engage representatives of the Attorney General, the Federal Trade Commission, the Comptroller General, CMS' Office of Inspector General and the Agency for Healthcare Research and Quality as well as representatives of consumers, private purchasers and providers. The report should be provided within 12 months and should address, at a minimum, the following:

- Are new laws or regulations needed to guard against the provider-based entities having or exercising market power to the detriment of consumers' interest in higher quality, less costly health care?
- Do existing anti-trust laws and pro-competitive regulations need to be revised or amended?
- Are there existing State or Federal laws that have the affect of creating inappropriate barriers to healthy competition that need to be examined?
- What is the empirical research on health care markets and market competition that should inform policy development?
- What is the role of promoting transparency with respect to quality and price in fostering better market functioning?
- How can the regulatory and legal oversight promoting competition best be structured?

Core Employer Belief: We need to move to promoting wellness and prevention, instead of focusing only on intervening after the fact.

There are few areas around which there is as much agreement in the employer community as in the importance of investing in wellness and prevention. The majority of America's employers are making these investments, with over 90% of large employers supporting wellness and chronic care programs. The importance of moving from a sick-care system to one that promotes wellness and prevention is clearly articulated in the Discussion Draft, which includes proposals for a Public Health Investment Fund and for the Secretary to develop a National Plan for Prevention. As a Nation, we need to get beyond the fragmentation that results in separate planning and strategies for health care delivery, public health, community prevention and planning, worksite wellness and other programs. As we move beyond this fragmentation, employers and consumers need to be at the table as priorities are shaped and strategies developed.

Core Employer Belief: All Americans—as engaged patients, caregivers and consumers—need to be given better tools and incentives to participate in making sure that they get the right care at the right time.

Health care consumers must be able to 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 and incentives to help them make good health care decisions. Some of the routes that your Discussion Draft supports in this area includes bolstering the Federal role of making 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.

The Discussion Draft recognizes the importance of considering the role consumer incentives play by proposing that Medicare remove cost-sharing provisions for Medicare beneficiaries. Medicare should join the private sector in going further. For example, Medicare should provide 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, perhaps by requiring that restructuring the standard Medicare Supplement plans offer information and tools to facilitate patient choice.

Similarly, Medicare should learn from the cutting-edge work of providers and private sector groups that are making sure that patients can fully participate in their own health care. One way that we can be sure that care is indeed patient-centered is for Medicare to support shared decisionmaking processes. This support can take the form of providing incentives to patients to get coaching and/or 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 decisionmaking.

Conclusion

Health reform must be about making high quality care more affordable. The employer community will work with you to develop a coherent package of reforms that foster cost control, and improves health through health promotion, prevention of illness, and effective treatment of disease and injury. We look forward to working with this Committee and with so many other Americans who share this goal.

Mr. STARK. Thank you, Mr. Lee. And next we have Mr. Gerald Shea, who is Special Assistant to the President, AFL–CIO. Proceed.

STATEMENT OF GERALD M. SHEA, SPECIAL ASSISTANT TO THE PRESIDENT, AFL–CIO

Mr. SHEA. Good afternoon, Mr. Chairman and Members of the Committee. We appreciate this invitation to talk to you about the experience of the AFL–CIO unions in bargaining health care. And I am going to restrict my remarks to the interplay between employment-based coverage, which, as you know, is the backbone of both coverage and financing for health care in this country, and the reform proposal before you because you have chosen a proposal that continues that role for employer-sponsored insurance.

And my main message to you today is that going down this road I believe requires that you first and foremost look at how you stabilize employment-based coverage. Employment-based coverage has been remarkably resilient despite enormous cost pressures and it is testimony to how much employers want to provide benefits and how much employees value those benefits. But, frankly, it is in a pretty fragile situation. We have lost 5 points percentage of people 18 to 64 who have health care. We have lost 5 percentage points

from 2000 and 2007. The number of underinsured people in a 4-year span from 2003 to 2007 went up from 16 percent to 25 percent. This is a system that has done very well in providing health coverage but today, frankly, is eroding pretty rapidly. And so we judge the proposals in terms of how well they support and strengthen the employment-based coverage if we are going to continue that.

And I want to congratulate you and your colleagues and other Committees of the House for having produced this bill. We think it is an excellent start. And, frankly, we think it really responds to the desires and the interests of the American people. And so we give you our hats off for that.

In order to stabilize employment-based coverage, we need to do three things in our opinion. First and foremost, control costs. If we do not do that, we are not going to do anything else. Second, we think everybody needs to be included in coverage, included in financing responsibilities, and included in health status responsibilities. And, third, we think it is essential that we reform the health delivery system so that we really make it a more efficient—much more efficient structure than it is today.

On the point of full participation, you have a proposal that has both an individual requirement and an employer requirement, we think that is appropriate. We think both are appropriate. And I want to make just a couple of comments on the employer requirement because I know that is controversial.

I think there are a number of advantages to doing this, to requiring employers to participate. One is that you reduce the burden on the Federal Treasury for providing coverage. If you are going to get universal coverage, the more employer coverage that is available, the less you will have to fund in terms of support for the currently uninsured.

Firms that opt to pay instead of play, using the common parlance here, will be putting money into the fund to pay for coverage and so you get money that way too. We think this is an important financing area. And, of course, it would also level the playing field among businesses because it would eliminate the free riders.

A corollary to this requirement is that we think you should look, as you have looked at, providing some relief for those employers who in the midst of great industrial change have tried to do the right thing by their workers and maintain retiree benefits for those who are pre-Medicare. We think that is extremely important, and we appreciate the fact that it is included.

In terms of the cost issue, the number one challenge, there is no question that the long-term answer to this is to change the delivery system and make it more efficient. My panel colleague just talked about saving $2 or $3 trillion over the next 10 years. That is a figure that comes from numerous studies as something that is in the realm of possibility depending on the design element.

But those are long-term changes and in the short-term, we believe strongly that you need a public insurance option to introduce competition into the marketplace. A lot has been said about that. I will not elaborate on it further.

But going to delivery system reform issues, your draft emphasizes and invests in quality and improvement methodologies. We

think this is very important, and we think your draft could be strengthened frankly in this area along the lines that Mr. Lee has just talked about.

And we also support the investment you make in the draft in the expansion of the health care workforce in primary care, and we would suggest that you look at the importance not only of the supply of the health workforce but the quality of the work we are asking them to do. Unfortunately, we have taken some of the great care professions like nursing, and we turned them in many places into lousy jobs. That can be corrected, and you have a perfect vehicle to do that because you have following examples that already exist in the health care system, the opportunity to promote the notion that all health care workers ought to be involved in producing quality care and break down some of these silos which make these jobs less than totally desirable.

Finally, I wanted to talk about—more broadly about financing. I believe it is true what people say, that we ought to be able to finance health reform out of the money in the health system now. There is so much of it. But obviously that is not something we can do overnight, and I think that if we set our goal, as some people have, of saying we have to restrict our financing to the health system, we get ourselves into trouble very quickly. And the danger of this you see in the Senate Finance Committee deliberations today where taxing health benefits is being planned. You do not have to go any further than the front page of today's Washington Post to get yet more evidence of how strongly people oppose the idea of taxing health benefits. They already pay a lot of money in deferred wages or outright out of their pocket. They do not want to be taxed on top of that.

But beyond the issue of payments and equity, there are tremendous problems with doing this in a fair fashion because you can have, and we have examples of this, similar workforces in similar kinds of health plans or health funds with very, very different annual cost based on health status, on geography, on age. Unless you can correct for those, you are going to wind up discriminating against those people who happen to be in a workforce that has a higher claims experience. And so we think it is extremely difficult for that.

Just in conclusion, I will say that we look forward to working with you on the discussion draft, and we appreciate the time to talk to you this afternoon.

[The prepared statement of Mr. Shea follows:]

Prepared Statement of Gerald M. Shea,
Special Assistant to the President, AFL–CIO

The AFL–CIO represents 11 million members, including 2.5 million members in Working America, our community affiliate, and 56 national and international unions that have bargained for health benefits for more than 50 years. Together, unions negotiate benefits for some 50 million people in America.

Our members have a significant stake in health care reform because unions represent the largest block of organized consumers in the Nation. In addition, unions also sponsor health plans through funds that are jointly-trusteed with management. Many union members work in health care, as well, so they have a dual interest in health reform.

Even as unions continue to negotiate benefits for our members, American labor has long advocated for health care for everyone, not just those in unions or with stable jobs. For over 100 years, America's unions have called for universal coverage

built on a social insurance model, an approach that has proven effective and efficient across the globe and one we have employed successfully for decades to provide income and health security for the elderly.

The AFL–CIO led the lobbying effort to enact Medicare in 1965, and we have backed many legislative efforts since then to expand coverage. We continue to believe that a social insurance model is the simplest and most cost effective way to provide benefits for all.

However, the condition of health care in America is too dire for those of us lucky enough to have good coverage to debate endlessly over what the best approach would be. It is time—indeed, it is past time—to enact comprehensive health care reform. Today our members are ready to stand with President Obama and Congress and help pass the President's plan for comprehensive health care reform.

AFL–CIO'S VIEWS ON COMPREHENSIVE HEALTH CARE REFORM

Today I would like to explain the AFL–CIO's views on what comprehensive health care reform should look like, and specifically our views on the historic tri-committee discussion draft unveiled in the House of Representatives last week.

We start from the premise that we can fix our broken health care system by building on what works. For most Americans, that means employer-sponsored health insurance (ESI), which is the backbone of heath care financing and coverage in America.

The AFL–CIO has advocated a three-point program to guarantee quality affordable health care for all—a program that consists of: (1) lowering costs; (2) improving quality; and (3) covering everyone by ensuring full participation of all public and private sector employers and making affordable health coverage available to everyone. All three of these objectives must be achieved together; none can be achieved in isolation. And we believe the tri-committee discussion draft will in fact help achieve all three of these objectives simultaneously.

We caution, however, that one financing option under consideration in the Senate Finance Committee—the taxation of employer-sponsored health benefits—would go in the exact opposite direction by destabilizing the employer-based health insurance system.

OUR PRESENT COURSE IS UNSUSTAINABLE

Whatever one may think about the way health care should be reformed, we can all agree that our present course is not sustainable—for workers, for businesses, for the Federal budget, or for the economy as a whole. If we continue down the current path, health care costs will crush families, business and government at all levels.

Our members are among the most fortunate workers. Thanks to collective bargaining, they generally have good benefits provided by their employers. Yet even well-insured workers are struggling with health care cost increases that are outpacing wage increases. And far too many working families find themselves joining the ranks of the uninsured or underinsured as businesses shut down or lay off employees.

In April and May 2009, the AFL–CIO conducted our 2009 Health Care for America Survey, which showed that people need urgent relief from the pressure of rising health care costs that are bankrupting families and endangering their health.

More than half of respondents said they cannot get the care they need at a price they can afford. Three-quarters were dissatisfied with their household's health care costs.

Ann from Georgia (self-employed with two children) wrote: "We have that HSA plan with supposedly low premiums. However, those 'low' premiums only start low. Every year they get higher and higher. One year they increased 129 percent in just 1 year. Our health care costs have exceeded 35 percent of our income for 2 years. We are on the verge of canceling health care insurance. We would have already done this if we didn't have two children."

A third of those with insurance—and three-quarters of those without—reported that they forgo basic medical care because of high costs.

Karen from Florida wrote: "My insurance deductible equals 4 to 5 months of take home pay each year. My insurance bill is split with my employer but equals 2 days of pay each month. How am I supposed to go to a doctor?"

Iris from Florida writes: "I am unemployed because I had to quit my job to care for my elderly mother. My children decided to pay [for medical insurance] for me. So what is the problem? The deductibles are so high that I cannot go to the doctor. And we keep paying $300 monthly just in case I have to go to the hospital. In the meantime, I cannot afford to go to the doctor."

As economic conditions have gotten worse, workers who lose their jobs have been losing their health care. Nearly a quarter of respondents said someone in their household lost coverage in the past year due to losing or changing jobs.

Renee from Ohio wrote: "It is pretty scary that millions of hard-working retirees as well as those working may lose their insurance, and yes I am talking about the auto industry. My husband could lose his benefits, which he thinks he will. I don't know how my kids will be able to get their annual checkups. How can anyone get ahead in this country? I don't understand how it came to this. I just don't want to think about the future anymore."

Once workers lose their health care coverage, it is hard for them to get it back. One-quarter of those without health insurance said they were denied coverage in the past year due to "preexisting conditions."

Kerry from New Mexico wrote: "I am desperate for our country to finally do something for my family so a health crisis does not kill one of us or leave us completely financially devastated."

The data bear out the stories these workers are telling us. Between 1999 and 2008, premiums for family coverage increased 119 percent, 3½ times faster than cumulative wage increases over the same time period.[1]

Workers' out-of-pocket costs are going up as well, leading to more underinsured workers who can no longer count on their health benefits to keep health care affordable or protect them from financial ruin. Between 2003 and 2007, the number of non-elderly adults who were underinsured jumped from 15.6 million to 25.2 million.[2]

Skyrocketing costs are pushing more workers out of insurance altogether. The current number of uninsured almost certainly exceeds 50 million. The Council of Economic Advisers estimates that number will rise to 72 million by 2040 in the absence of reform.[3]

Health costs are burdening American businesses, as well as workers. U.S. firms that provide adequate health benefits are put at a significant disadvantage when they compete in the global marketplace with foreign firms that do not carry health care costs on their balance sheets. The same is true for U.S. businesses in domestic competition against employers that provide little or no coverage.

The present course is unsustainable for the economy as a whole, as well. Health care expenditures currently amount to about 18 percent of our GDP. The Council of Economic Advisers estimates that this percentage will rise to 34 percent by 2040 in the absence of reform.[4] The Congressional Budget Office (CBO) projects that health care expenditures will rise to 49 percent of GDP by 2082.

The present course is likewise unsustainable for the Federal budget. If we fail to "bend the cost curve," health care spending will balloon our Federal budget deficit and squeeze out funding for essential non-health care priorities. Almost half of current health care spending is covered by Federal, State, and local governments. If health care costs continue to grow at historical rates, the Council of Economic Advisers estimates that Medicare and Medicaid spending will rise to nearly 15 percent of GDP by 2040.[5] As then CBO Director and now OMB Director Peter Orszag has noted, health care cost trends are the "single most important factor determining the Nation's long term fiscal condition."

To fix our long-term structural budget deficits, we have to fix Medicare and Medicaid, and to fix Medicare and Medicaid, we have to control health care costs in the private sector. There is no practical way to control public health care costs without addressing private health care costs as well. Private and public health care are delivered largely by the same providers, using the same drugs, the same treatments, and the same procedures.

In short, the health of our family budgets, our Federal budget, and our economy depends on the success of health care reform this year.

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[1] Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000–2008. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2000–2008; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2000–2008 (April to April). Accessed: http://ehbs.kff.org/images/abstract/EHBS_08_Release_Adds.pdf.

[2] 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, w298–w309. June 10, 2008.

[3] Council of Economic Advisors. "The Economic Case for Health Care Reform." June 2009. Accessed: http://www.whitehouse.gov/assets/documents/CEA_Health_Care_Report.pdf.

[4] Council of Economic Advisors. "The Economic Case for Health Care Reform." June 2009. Accessed: http://www.whitehouse.gov/assets/documents/CEA_Health_Care_Report.pdf.

[5] Ibid.

BUILDING ON WHAT WORKS

The AFL–CIO believes comprehensive reform can build on what works in our current health care system while creating new options for obtaining coverage and lowering costs for families, business, and government at all levels.

For the majority of Americans, what works in our current health care system is employer-based coverage—the backbone of health care coverage and financing in America. Over 160 million people under age 65 have health benefits tied to the workplace.

Employer-sponsored coverage has proven remarkably stable in the face of exorbitant health care cost inflation. Its survival is testimony to the strong interest workers have in keeping coverage tied to the workplace—even at the expense of wage gains for the past 30 years—and the interest of employers to recruit and retain talented workers through job-based benefits.

In fact, it is hard to imagine successful health reform that does not include a substantial role for employer-based coverage. Building on the core foundation of employer-provided health coverage will allow working families to keep what they now have . . . or choose from a new set of options to maintain coverage. We think building on this foundation will also help minimize the disruption that results from the difficult changes that are a necessary part of any reform, and thereby maximize public support for reform.

In order to build on this foundation, we must stabilize the employment-based system, which risks being destabilized by unsustainable cost inflation. We must reverse the steady erosion of employer-provided coverage in recent years. The percentage of 18 to 64-year-olds with ESI dropped 5 percentage points from 2000–2007, and without prompt dramatic action the rate of decline is expected to increase sharply.[6]

We believe the tri-committee discussion draft will stabilize the employer-based health care system through the following specific policy proposals: (1) a requirement that employers assume responsibility for contributing to the cost of health care for their employees through a "pay or play" system; (2) special assistance for firms that maintain coverage for pre-Medicare retirees, which will prevent further deterioration of the employer-based system; (3) a public health insurance option, which will inject competition into the health care system and lower costs throughout the system for employers and workers alike; (4) health care delivery reforms to get better value from our health care system and contain long-term costs; and (5) insurance market reforms, individual subsidies, Medicaid expansion, and improvements to Medicare, which will help make affordable coverage available to everyone.

PAY OR PLAY

A key reform needed to stabilize the employer-based coverage system is the requirement that public sector and private sector employers assume responsibility for contributing toward the cost of health care for their employees. Employers should be required either to offer health benefits to their workers directly, or to pay into a public fund to finance coverage for uninsured workers—a proposal known as "pay or play."

The tri-committee discussion draft outlines a reasonable and effective employer responsibility requirement that we believe would help shore up employer-based coverage. The proposal would ensure that workers could get affordable coverage either through their employer-sponsored plan or through a national exchange with a contribution from their employer. And it would extend, on a pro-rated basis, an employer's responsibility for part-time workers, to eliminate any incentives for employers to move workers to part-time status to avoid the new requirement.

We believe such a "pay or play" system has many virtues. It would bring in needed revenue from firms that opt to "pay," which would hold down Federal costs associated with providing subsidized coverage for low-income workers in those firms.

"Pay or play" would likewise hold down Federal costs by keeping employers from dumping their low-wage employees into new subsidized plans. In the absence of an employer responsibility requirement, publicly subsidized coverage for low-wage workers would prompt many employers of low-wage workers to discontinue current coverage to take advantage of available subsidies. The resulting increase in Federal costs could well doom health care reform.

"Pay or play" would help stabilize the employer-based health care system in several ways. It would level the playing field so that free rider businesses could no longer shift their costs to businesses offering good benefits. A recent study found more than $1,000 of every family plan premium goes to cover the cost of care for

[6] Elise Gould. "The Erosion of Employer-Sponsored Health Insurance." Economic Policy Institute. October 2008. Accessed: http://epi.3cdn.net/d1b4356d96c21c91d1__ilm6b5dua.pdf.

the uninsured, most of whom are employed.[7] "Pay or play" would encourage employers to offer their own coverage and penalize employers that do not. And it would minimize disruption for workers who already have health care coverage and wish to keep it.

"Pay or play" would thus go a long way toward extending coverage to the uninsured, since most of the uninsured have at least one full-time worker in their family. And it would be critical in making coverage affordable for workers who do not qualify for income-based credits or subsidies, especially if health care reform includes a new requirement that all individuals obtain coverage.

Arguments Against Pay or Play

Opponents of an employer responsibility requirement raise the objection that "pay or play" would increase payroll costs for businesses. We believe this objection is misplaced.

First of all, it should be emphasized that the overwhelming majority of businesses already provide health benefits that would likely meet the new requirements, so they would not see any new costs. In fact, they would see their costs **go down** as health care coverage is expanded—thanks to the elimination of cost shifting—and as other health care reforms take hold that drive down costs throughout the health care system.

The only firms that might see an increase in costs are firms that do not currently offer health care benefits, or firms that offer benefits that are inadequate to meet a reasonable standard. The vast majority of firms that currently do not offer health care benefits are small firms, and they are mostly low-wage employers. Comprehensive health care reform generally would give small firms more affordable options for providing health benefits for their workers, probably in combination with additional subsidies for employers of low-wage employees.

Opponents of an employer responsibility requirement warn that employers that have to pay more for health insurance would be less likely to raise wages in the short term. The widely endorsed economic view, however, is that such employers would still raise wages over the long term.

Opponents of "pay or play" next argue that employers required to pay more for health insurance might eliminate jobs or hire more slowly as a result. But the same dire predictions have been made routinely about proposals to increase the minimum wage, with comparable increases in employer costs, and those predictions have not been borne out. Recent studies of minimum wage increases have found no measurable impact on employment.[8] Economists have observed that employers faced with higher payroll costs from a minimum wage increase can offset some of those costs through savings associated with higher productivity, decreased turnover and absenteeism, and improved worker morale.[9]

The same would be true of an employer responsibility requirement. Any increase in employer costs would be offset by productivity gains and by a healthier workforce. The Council of Economic Advisers notes that the economy as a whole would benefit from more rational job mobility and a better match of workers' skills to jobs when health benefits are no longer influencing employment decisions.[10] Finally, it should be noted that the majority of firms that currently do not offer health benefits compete in markets where their rivals likewise do not provide benefits, so they would not be put at a competitive disadvantage.

Pay or Play and Firm Size

Health care reform must make coverage affordable for small businesses that have difficulty obtaining coverage in the current market. However, the AFL–CIO believes the "pay or play" requirement should apply to firms regardless of their size.

Smaller businesses will be allowed to meet the "play" requirement by buying coverage that meets fair rating rules through the new exchange, which would include the option of a public health insurance plan that makes coverage more affordable. We do support the inclusion of a small business tax credit, targeted at the smallest

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[7] Families USA. "Hidden Health Tax: Americans Pay a Premium." May 2009. Accessed: http://www.familiesusa.org/assets/pdfs/hidden-health-tax.pdf.

[8] A. Dube, T.W. Lester, M. Reich, "Minimum Wage Effects Across State Border: Estimates Using Contiguous Counties," Institute for Research on Labor and Employment Working Paper Series No. iiwps–157–07, August 1, 2007.

[9] J. Bernstein, J. Schmitt, "Making Work Pay: The Impact of the 1996–1997 Minimum Wage Increase," Economic Policy Institute (1998); D. Card, A. Krueger, "Myth and Measurement: The New Economics of the Minimum Wage," Princeton University Press, 1995.

[10] Council of Economic Advisors. "The Economic Case for Health Care Reform." June 2009. Accessed: http://www.whitehouse.gov/assets/documents/CEA__Health__Care__Report.pdf.

firms with low-wage workers, precisely because we believe an employer requirement should not exempt businesses based solely on size.

If small businesses are exempted from "pay or play," the number of employees is a particularly poor measure for the exemption because it is a poor predictor of a firm's ability to pay. A doctor's office or small law firm may have more capacity to pay than a larger restaurant or store. A carve-out for small firms with fewer than a specified number of employees also creates a potentially costly hurdle for firms nearing the threshold to hire additional employees. A better approach would be to apply the requirement based on payroll or gross receipts. Finally, we believe special treatment for such businesses should be phased out over time to eliminate disparities based on firm size.

Also, any "pay or play" requirement should take into account how workers in certain segments of our economy, such as airlines and railroads, schedule their hours and the classification of workers as full-time or part-time should ensure that these workers are not inadvertently excluded from coverage.

Special Assistance for Companies That Maintain Benefits for Pre-Medicare Retirees

We look forward to working with the committees to develop greater specificity on the proposal for a federally-funded catastrophic reinsurance program for employers that provide health benefits to retirees age 55 to 64. Such a reinsurance program would help prevent further deterioration of the employer-provided health care system, and is an essential component of any health care reform legislation.

A reinsurance program is critically necessary to help offset costs for employers that contribute to health benefits for pre-Medicare retirees. The pre-Medicare population generally has higher health care costs, and employers offering them coverage incur enormous expense. But without that coverage, individuals in this age bracket have tremendous difficulty purchasing health insurance in the individual market, or they are able to do so only at a very high cost.

We believe such a reinsurance program must have dedicated funding. In addition, in the longer term, we believe firms should be able to purchase coverage for their retirees through the exchange. This would help make coverage more affordable for firms that provide retiree health benefits.

PUBLIC HEALTH INSURANCE PLAN OPTION

The AFL–CIO supports the creation of a strong public health insurance option to compete with private health insurance plans. The tri-committee discussion draft includes a strong public plan that would compete on a level playing field with reformed private health plan options in a new national exchange.

We believe a public health insurance plan is the key to making health care coverage more affordable for working families, businesses, and governments, all of which are increasingly burdened by escalating health care costs. A public plan would have lower administrative costs than private plans and would not have to earn a profit. These features, combined with its ability to establish payment rates, would result in lower premiums for the public plan.

A public health insurance plan would also promote competition and keep private plans honest. Consolidation in the private insurance industry has narrowed price and quality competition. In fact, in 2005, private insurance markets in 96 percent of metropolitan areas were considered highly concentrated and anti-competitive, which left consumers with little choice.[11] A public health insurance option, coupled with a more regulated private insurance market, would break the stranglehold that a handful of companies have on the insurance market and would give consumers enough choices to vote with their feet and change plans.

We also believe a public health insurance plan would be critical for driving quality improvements and more rational provider payments throughout the health care system. A public health insurance plan can introduce quality advancements and innovation that private insurance companies or private purchasers have proven themselves unable to implement. For example, until Medicare took the lead in reforms linking payment to performance on standardized quality measures, private insurers and payers were not making appreciable headway toward a value-based health system. Just as Medicare is driving quality improvements that private plans are now adopting, a public health insurance plan could lead the way in developing innovative quality improvement methodologies, stronger value-based payment mechanisms, more substantial quality incentives, and more widespread evidence-based protocols.

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[11] American Medical Association. "Competition in Health Insurance: A Comprehensive Study of U.S. Markets." 2007. http://www.ama-assn.org/ama1/pub/upload/mm/368/compstudy__52006.pdf.

Because increased competition and quality reforms would help contain costs throughout the health care system, employers that continue to provide benefits directly would benefit from these savings, as would employers that purchase coverage for their workers through the exchange. And because premiums would be lower, spending on Federal subsidies for individuals who qualify for subsidies would also be lower.

A public health insurance plan would also guarantee that there will be a stable and high quality source of continuous coverage available to everyone throughout the country. By contrast, private insurance plans can change their benefits, alter cost-sharing, contract with different providers, move in and out of markets, and change benefit or provider networks. A public health insurance plan would be a reliable and necessary backstop to a changing private insurance market, and a safe harbor for working families that lose their workplace coverage.

A public health insurance plan available to everyone would also provide rural areas with the security of health benefits that are there when rural residents need them, just as Medicare has been a constant source of coverage as private Medicare Advantage and Part D plans churn in and out of rural areas every year.

Clearly, the public supports a public health insurance plan option. A recent New York Times poll shows that the public health insurance plan is supported by 72 percent of voters.[12]

DELIVERY SYSTEM REFORM

Variation in Medicare spending across States suggests that up to 30 percent of health care costs could be saved without compromising health care outcomes. Differences in health care expenditures across countries suggest that health care expenditures could be lowered by 5 percent of GDP without compromising outcomes by reducing inefficiencies in the current system.

Experts estimate we waste one-third of our health care spending, or $800 billion, every year on health care that is no real value to patients. According to the Council of Economic Advisers, the sources of inefficiency in the U.S. health care system include payment systems that reward medical inputs rather than outcomes, high administrative costs, and inadequate focus on disease prevention.[13]

We must restructure our health care system to achieve better quality and better value, and we must transform our delivery system into one that rewards better care, not just more care. We can start by doing the following:

- Measure and report on the quality of care, the comparative effectiveness of drugs and procedures, and what medical science shows to be best practices and use that information to create quality improvement tools that allow doctors to individualize high-quality care for each of their patients;
- Put technology in place to automate health care data; and
- Reform the way we pay for care so doctors have the financial incentives to continuously improve care for their patients.

The February 2009 economic recovery package, with its substantial investment in health information technology (HIT) and research on the comparative effectiveness of drugs and medical devices, marks a historic first step in the right direction.

The tri-committee discussion draft builds on the investments of the economic recovery package by encouraging greater emphasis on primary care and prevention, and greater emphasis on innovative delivery and payment models, such as accountable care organizations and bundled payments for acute and post-acute care. The draft also makes needed investments in our health care workforce—with emphasis on primary care—to ensure access to needed care and better reward primary care providers.

The tri-committee discussion draft emphasizes and invests in quality measurement and improvement methodologies. But we believe more can be done to foster innovation in health care delivery by building on the significant quality measurement and improvement underway within health care in recent years. The AFL–CIO has invested considerable resources and time working on system reform, as part of the broad collaboration of consumers, purchasers, physician organizations, hospitals, and government agencies at both the State and Federal levels.

This strong collaboration between payers and providers has created breakthrough improvements in health care delivery. The process improvement techniques pio-

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[12] New York Times/CBS News Poll on Health. Telephone Interviews conducted June 12–16, 2009. Accessed: http://graphics8.nytimes.com/packages/images/nytint/docs/latest-new-york-times-cbs-news-poll-on-health/original.pdf.

[13] Council of Economic Advisors. "The Economic Case for Health Care Reform." June 2009. Accessed: http://www.whitehouse.gov/assets/documents/CEA__Health__Care__Report.pdf.

neered in other U.S. industries—for example, six sigma quality standards and rapid-cycle problem analysis, solution development and testing, and widespread diffusion in a short time period—have been shown to work and hold enormous promise, but Federal leadership in delivery system reform is indispensable.

We must also put into place a system of broad consultation with consumers, purchasers, physicians, insurers and health care organizations in setting national priorities for health care quality improvement and in implementing standardized measures of quality throughout health care. With quality measurement as a foundation, reform can empower those who deliver care, pay for care, and oversee care to work with those who receive care to innovate and modernize health service delivery.

AFFORDABLE COVERAGE FOR EVERYONE

Today we have a fragmented health care system characterized by cost-shifting and price distortions because as many as 50 million people have no coverage.

According to Families USA, the uninsured received $116 billion worth of care from hospitals, doctors, and other providers in 2008, about $42.7 billion of which was uncompensated care.[14] The costs for uncompensated care are shifted to insurers and then passed on to families and businesses in the form of higher premiums. For family health coverage, the additional annual premium due to uncompensated care was $1,017 in 2008.

While our members generally have employer-based health coverage, stabilizing the employer-based health system will require covering the uninsured to make health care more efficient and prevent cost-shifting. We cannot cover everyone without bringing down costs overall, and we cannot control costs without getting everyone in the system.

The good news is that, according to the Council of Economic Advisers, expanding health insurance coverage to the uninsured will increase net U.S. economic well-being by roughly $100 billion per year, which is substantially more than the cost of insuring the uninsured.[15]

The most important policy proposal for extending health care coverage to the uninsured is "pay or play," which I discussed earlier in my testimony. But the tri-committee discussion draft includes several other proposals that would also expand health care coverage, including insurance market reforms, the establishment of an insurance market exchange, individual subsidies, the expansion of Medicaid, and improvements to Medicare.

Insurance Market Reforms

Ensuring access to health care coverage will require significant changes to the current private insurance market, in which people are now denied coverage or charged more because of their health status. Market reforms for everyone who buys coverage in the individual and group market will make coverage more fair, transparent, affordable, and secure.

The AFL–CIO fully supports the prohibition on rating based on health status, gender, and class of business; the prohibition on the imposition of preexisting condition exclusions; guaranteed issue and renewal; and greater transparency and limits on plans' non-claims costs. While we would prefer a flat prohibition on rating based on age, we believe the proposal to limit age rating to 2 to 1 is a strong alternative. Any variation allowed above that limit threatens to make coverage unaffordable for older individuals.

Insurance Market Exchange

The AFL–CIO also strongly supports the proposal to create a national health insurance exchange to provide individuals and businesses with a place to enroll in plans that meet certain criteria on benefits, affordability, quality, and transparency. We believe this will be a mechanism for simplifying enrollment and applying uniform standards.

The tri-committee discussion draft establishes a mechanism that offers consumers a way to compare plans based on quality and cost. While the exchange will initially be open to individuals and small employers, we believe there should be a commitment to allowing public and private sector employers beyond the small group definition to purchase coverage through the exchange after the first 2 years that the exchange is operational.

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[14] Families USA. "Hidden Health Tax: Americans Pay a Premium." May 2009. Accessed: http://www.familiesusa.org/assets/pdfs/hidden-health-tax.pdf.

[15] Council of Economic Advisors. "The Economic Case for Health Care Reform." June 2009. Accessed: http://www.whitehouse.gov/assets/documents/CEA__Health__Care__Report.pdf.

Subsidies for Low- and Moderate-Income Workers

Subsidies will be essential for making coverage affordable for low- and moderate-income individuals and families. We support the proposal to make subsidies relative to income, with more substantial subsidies applied to more comprehensive coverage for the lowest income enrollees. We also support ensuring that coverage is affordable by applying the subsidies to premiums as well as out-of-pocket costs.

Medicaid Expansion

We strongly support extension of Medicaid coverage to all under 133 percent of poverty, with sufficient resources to States to offset the new costs.

Medicare Improvements

In addition to eliminating subsidies that give private Medicare Advantage plans a competitive advantage over traditional Medicare and deplete the Trust Fund, the tri-committee discussion draft makes needed improvements in benefits for Medicare beneficiaries. The draft closes the gap in prescription drug coverage over time, eliminates cost sharing for preventive services, and improves the low-income subsidy program.

FINANCING HEALTH CARE REFORM

There are at least three key elements of health care reform that will also affect savings and revenues available for reform: A public health insurance option, delivery system reform, and an employer responsibility requirement. Though these policy proposals are absolutely necessary to improve the value we get for our health care spending, in the short run they will not be sufficient to fund reform.

The Senate Finance Committee has said that all savings and revenue for health reform must come from within the health care budget. However, because health care reform is an urgent national priority that will produce benefits across our economy and improve our national budget outlook, we agree with the President that we should look beyond health care spending to obtain additional revenues. We support the major elements of the President's budget proposal for the Health Reform Reserve Fund, including savings in Medicare and Medicaid, limiting the itemized deductions for households in the top two tax brackets, and other modifications to reduce the tax gap, as well as making the tax system fairer and more progressive.

One financing option under consideration in the Senate Finance Committee is a cap on the current tax exclusion for employer-provided health care benefits so that some portion of current health care benefits would be subject to taxes. We believe this is an extraordinarily bad idea.

Taxing Benefits Would Disrupt the Employer-Based System

Capping the tax exclusion would undermine efforts to stabilize the employer-provided health care system. Employers would likely respond by increasing employee cost-sharing to a level at which benefits would become unaffordable for low-wage workers, or by eliminating benefits altogether. Capping the exclusion would also encourage workers to seek coverage outside their ESI group when this is economically advantageous, thereby complicating the role of employers enormously and giving them another incentive to discontinue coverage.

Congress and the President have assured Americans that they will be able to keep the health care coverage they have if they like it. This approach makes enormous sense and generates broad public support. A cap on the tax exclusion would violate this basic understanding and threaten to disrupt the primary source of health care coverage and financing for most Americans.

Until health care reform has been proven successful in lowering costs and making coverage available to uninsured workers through new private and public plan options, we should not make any changes that threaten the source of health care coverage for 160 million Americans.

Taxing Benefits Would Be Unfair to High Cost Workers

The Senate Finance Committee is considering capping the tax exclusion for relatively high cost plans. This would be an unfair tax on workers whose benefits cost more for reasons beyond their control.

The exact same plan could cost well under $15,000 in one company and more than $20,000 in another depending on factors that have nothing to do with the generosity of coverage. According to one study, premiums for the same health benefits can more than double when an individual crosses State lines.[16]

[16] Stan Dorn, "Capping the Tax Exclusion of Employer-Sponsored Health Insurance: Is Equity Feasible," Urban Institute. June 2009. Accessed: http://www.urban.org/UploadedPDF/411894__cappingthetaxexclusion.pdf.

The cost of coverage can be the reflection of many factors: The size of the firm; the demographics of the workforce; the health status of the covered workers and families; 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.

Studies show that placing a cap on tax-free benefits would have the greatest impact on workers in small firms; firms with older workers and retirees, and workers with family plans that cover children. This is because insurance companies regularly charge higher rates for coverage for these workers.

Under one proposal, over 41 percent of workers at a firm with older workers would be taxed on their health care benefits, but only 16 percent of workers at a firm with younger workers would be taxed. Almost 30 percent of workers at a smaller firm would be taxed, but only 17 percent of workers at a larger firm. Over 41 percent of workers with family coverage would be taxed, but less than 20 percent of workers with individual coverage.[17]

If workers have to pay more taxes because some of their co-workers have costly medical conditions, health coverage would be transformed from a workplace benefit that everyone supports to one that splits workforces between the healthy and the sick.

Some argue that the existing tax exclusion is regressive, because higher income workers get a bigger tax advantage. But this is only one part of the story.

A recent report points out that while households in higher tax brackets get a greater benefit from the tax exclusion in absolute dollar amounts, low- and moderate-income workers would be impacted more from capping the exclusion because their taxes would increase by a larger share than those of higher-income workers. The report found that workers with employer-provided health benefits who make between $40,000 and $50,000 would see their tax liability increase on average 28 percent, while those who make between $50,000 and $75,000 would see their tax liability increase on average 20 percent. By contrast, workers who make more than $200,000 would see an average increase in their tax liability of only one-tenth of 1 percent. In short, capping the tax exclusion would not make it more progressive.[18]

Taxing health care benefits would not bring down health care costs, either. It would just shift more of those costs onto workers. Economists say the tax exclusion leads workers to get too much coverage, but capping the tax exclusion would not do anything to address a key cost driver: The fact that 20 percent of the population consumes 80 percent of our health care spending. Taxing health benefits would not change that fact.

CONCLUSION

The AFL–CIO applauds the work of the committees in outlining a strong, effective, comprehensive plan for guaranteeing quality affordable health care for all. We believe the tri-committee discussion draft would stabilize the employer-based health insurance system by simultaneously achieving the goals of lowering costs, covering everyone, and improving quality. We stand ready to work with all three committees to enact reform that achieves these goals. America's working families can wait no longer.

Mr. STARK. Ms. Hansen, the President of the AARP, would you like to talk to us about AARP's positions?

STATEMENT OF JENNIE CHIN HANSEN, PRESIDENT, AARP

Ms. HANSEN. Well, thank you, Congressman Stark, for this wonderful opportunity to represent AARP. I thank Chairman Rangel and Ranking Member Camp, as well as the rest of the Com-

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[17] Elise Gould. "How Capping the Tax Exclusion May Disproportionately Burden Children & Families." Economic Policy Institute and First Focus. May 2009. Accessed: http://www.firstfocus.net/Download/GOULD.pdf.

[18] Commonwealth Fund. "Progressive or Regressive: A Second Look at the Tax Exemption for Employer-Sponsored Health Insurance Premiums." May 2009. Accessed: http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2009/May/Progressive%20or%20Regressive%20A%20Second%20Look%20at%20the%20Tax%20Exemption/PDF__1269__Schoen__progressive__or__regressive__ESI.pdf.

mittee, for the opportunity to address this really vital and critical topic at this time.

Enacting legislation to give all Americans quality, affordable health coverage options is actually AARP's top priority this year. The draft tri-committee legislation marks substantial progress toward this goal.

Today, I am really proud to represent nearly 40 million members of AARP, half who are over the age of 65 and therefore in Medicare and half under 65. Both age groups face serious problems in today's health care system and AARP really appreciates the tri-committee for including critical reforms in its draft that will help AARP members of all ages.

For our younger members, the draft would get us closer to abolishing discriminatory insurance market practices that use a person's age to block access to health coverage or to keep prices too high to make a difference. To make insurance affordable for Americans age 50 to 64, AARP believes these individuals should be charged no more than twice what somebody under 50 is required to pay for quality health care. Why is this? Because older may mean wiser but it does not always mean richer. In fact, the income of uninsured adults, aged 18 to 24, is a little over $28,000 for the household and for the 50 to 64, it is $30,000 for the household.

But if insurance companies are allowed to charge people aged 50 to 64 more because of their age, and especially if it is more than twice what those under 50 pay, those who need it should be eligible for a subsidy in order to afford this coverage. There should also be strict limits placed on what these individuals are required to pay out of their own pockets.

AARP is also concerned with the so-called "hardship exemption." While this exemption would save those who cannot afford to pay for the required insurance policy, it would still leave them without affordable quality insurance. So the net result is they still are uncovered.

The tri-committee draft requires everyone, individuals and employers alike, to participate in health care reform and AARP applauds the tri-committee for recognizing the importance of shared responsibility. One of the greatest difficulties faced by our older members is the extraordinary out-of-pocket costs for health care. In fact, Medicare beneficiaries right now spend about 30 percent of their income on health care costs and they face costs that are six times the costs faced by those of us who do have employer-sponsored coverage. This is a particularly stark reality for the nearly half of Medicare beneficiaries who have incomes of less than $22,000 per year.

Prescription drugs are of course a big piece of Medicare beneficiaries' out-of-pocket expenses, which is why AARP has made closing the "donut hole" and improving the low-income assistance program's top priorities in health care reform. The tri-committee has led the way on both of these vital issues, including the closure of the "donut hole," as well as the important improvements to Medicare low-income supports in its draft legislation.

The draft also fixes Medicare's broken system for paying doctors. I think we have heard a lot about that, and we know that this is a whole system that has to be addressed. It also puts Medicare on

a path to fiscal stability by revising payment systems that Peter Lee has mentioned, as well as Mr. Shea, to reward quality rather than quantity of care. It includes incentives to reduce costly and preventable re-hospitalizations, which will help eliminate some of the waste in Medicare that is driving up the cost of health care and threatening Medicare's financial future.

It strengthens our workforce, and we have just addressed that. And we know that it is already quite fragile and its ability to meet current needs is quite challenged now, let alone what will happen in the future.

And it takes important steps to address racial and ethnic disparities in care that have been documented in research. Many challenges remain on the road to comprehensive health care reform but AARP and many of us who have been here to express those opinions, recognize that the differences that we happen to have cannot stop us from finding common ground and enacting comprehensive reform this year. We all know and have said that the status quo is unsustainable, and we cannot then afford to fail.

So thank you all for your leadership, and AARP looks to continue to work with you all. Thank you.

[The prepared statement of Ms. Hansen follows:]

STATEMENT FOR THE RECORD

SUBMITTED TO THE

Committee on Ways & Means

on

Proposals to Reform the Health System

June 24, 2009

AARP
601 E Street, N.W.
WASHINGTON, D. C. 20049

WITNESS: JENNIE CHIN HANSEN
AARP BOARD DIRECTOR

For further information, contact:
Nora Super or Ahaviah Glaser
(202) 434-3770
Government Relations & Advocacy

Chairman Rangel, Ranking Member Camp, and other distinguished members of the Committee, I am Jennie Chin Hansen, President of AARP. I want to thank you for your leadership on comprehensive health reform to ensure that all Americans have quality, affordable coverage options. This is AARP's top priority this year. Today, I am proud to represent nearly 40 million members of AARP – half of whom are over age 65 and therefore participate in the Medicare program, and half who are under age 65. Both age groups face serious problems in today's health care system, especially the 7 million of all persons age 50-64 who are uninsured today. Thank you for inviting me to here today to discuss your draft legislation.

AARP Health Reform Priorities

AARP has identified six priorities for our members that we believe must be included in comprehensive reform legislation.

1) Guaranteeing access to affordable coverage for Americans age 50 to 64: To make coverage affordable for people in this age group, health reform must bar insurers from denying coverage and charging unaffordable rates based on age or health status and provide sliding-scale subsidies for those who need help to make coverage affordable.

2) Closing the Medicare Part D Coverage Gap or "Doughnut Hole": The Medicare Part D "doughnut hole" is a major reason why nearly 20% of people who get drug coverage through Medicare delayed or did not fill a prescription because of cost – higher than any other insured group. Under current law, the hole keeps getting larger each year and will double by 2016. AARP is calling on Congress to close the doughnut hole so people are not forced to pay premiums while at the same time paying full cost for their drugs.

3) Lowering Drug Costs through Generic Biologics: Biologic drugs treat serious conditions like cancer and multiple sclerosis but can cost several thousands of dollars per month. Currently, there is no FDA process to approve less expensive generic versions of these drugs. AARP is calling on Congress to include the "Promoting Innovation and Access to Life-Saving Medicine Act" (H.R. 1427) in health reform to make these life-saving generic biologic drugs much more available and affordable.

4) Reducing Costly Hospital Re-Admissions through a Medicare Transitional Care Benefit: Health reform should include a Medicare transitional care benefit that would help people safely transition to home or another setting after a hospital stay and prevent costly, unnecessary hospital readmissions. AARP strongly supports the "Medicare Transitional Care Act" (H.R. 2773/S. 1295), as it should improve care and save money by providing for appropriate follow-up care to prevent avoidable re-hospitalizations.

5) Long-Term Care (LTC): Health reform should support people with chronic conditions who need long-term care. This will save money, improve quality of life, and help people live at home. AARP supports the "Empowered at Home Act" (H.R. 2688/S.434) to expand eligibility and give states incentives to help people receive care at home, and the "Retooling the Health Care Workforce for an Aging America Act" (H.R. 468/S. 245) to provide training and support for family caregivers and an improved workforce to care for older adults.

6) Helping Low-Income Americans in Medicare: Health reform should include the "Medicare Savings Program Improvement Act" (H.R. 716) and the "Prescription Coverage Now Act (H.R. 1536)" to improve access to Medicare programs that help those with limited incomes pay premiums and out-of-pocket costs. These bills increase asset limits so people who did the right thing and saved a small nest egg can still get help, and raise income eligibility standards so more people qualify.

Making Affordable Coverage Available to All

There are few issues of greater concern to AARP's membership than improving health insurance markets across the United States to ensure that all Americans have access to affordable, high quality coverage choices. Many older Americans, especially those aged 50-64 who are not yet eligible for Medicare and those with pre-existing chronic conditions, often cannot secure health coverage, at any price. Industry data show that insurers reject between 17% and 28% of applicants aged 50-64.[1] Those who can find individual coverage tend to receive less generous benefits than those with employer coverage, yet on average pay three times more in premiums and over twice the out-of-pocket costs of those with employer coverage.[2] The AARP Public Policy Institute estimates that 13% (or 7.1 million) adults aged 50-64 were uninsured in 2007 – 36% higher (or 1.9 million more) than in 2000 – and this figure is growing rapidly in our current difficult economy.

AARP believes the best way to make coverage affordable for everyone is by:

- Guaranteeing that all individuals and groups wishing to purchase or renew coverage can do so regardless of age or pre-existing conditions;
- Prohibiting higher premiums based on age, health status, or claims experience;
- Providing a choice of qualified plans through an Exchange or "Gateway" with adequate subsidies based on income and the actual premiums each individual faces in the market so coverage is affordable for everyone;
- Addressing costs system-wide through prevention and wellness, better care coordination, fighting fraud, waste, and abuse, and rewarding quality rather than quantity of care; and
- Ensuring that any cost-sharing obligations do not create barriers to needed care

We are pleased that many of these issues have been addressed in the Tri-Committee's health care reform discussion draft (Draft) released last week.

Exchange: The intent of the Exchange is to facilitate the purchase of coverage and products at an affordable price by qualified individuals and employer groups. AARP embraces the establishment of an Exchange, including the option for states to create their own or regional Exchanges. As described, the Exchange construct would provide balance and flexibility – clear federal guidelines and standards to assure affordable coverage while maintaining the traditional state role in the oversight of insurance.

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[1] AHIP, "Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits," December 2007.

[2] AARP Public Policy Institute, Health Care Reform: What's at Stake for 50- to 64-Year-Olds? March 2009.

Policymakers have learned much by observing and studying the laboratory of Massachusetts and its successful health coverage experiment. The Federal Employees Health Benefit Program has also been successful in providing meaningful choices to consumers, and we support both as a model for the structure outlined in the House health reform draft legislation.

We are also pleased that the Draft increases the Medicaid funding cap for Puerto Rico, the U.S. Virgin Islands, and the other territories. AARP believes that quality, affordable health coverage should be available to all Americans wherever they reside.

Underwriting and Age Rating: AARP believes no one should be denied coverage based on health status or charged higher rates based on age or health status. We strongly commend the Chairmen for including a ban on denying people coverage and on varying rates by health status, and for strictly limiting age rating in the Draft. AARP believes that if age rating is not seriously constrained with national health reform, insurers will likely charge higher rates to older people to substitute for rating based on health.

If any age differential is allowed, AARP believes it should be narrow – no greater than 2-to-1, as in the Tri-Committee's Draft. In addition, Individuals living in states where no or narrow age rating is allowed today should not be disadvantaged as a result of national health reform. We strongly commend the Committee's leadership in striving to limit age rating bands to a ratio of 2 to 1. Without such limits, those older Americans who find it most difficult or impossible to obtain coverage today may still be priced out of the market after health reform.

We have serious concerns about the adverse impact on AARP members of alternative proposals to allow insurers to charge older Americans up to five times more than younger people. We question why age rating, especially as high as 5 to 1, is necessary when virtually all health reform proposals under consideration include risk adjustment to compensate for higher costs of enrollees who are sicker or older. Independent actuaries confirm that appropriate risk adjustment should mitigate the need for age rating. We would encourage broadening the risk pooling to minimize adverse selection beyond Exchange plans.

Experience in Massachusetts indicates that without strict age rating limits and adequate subsidies, coverage would still be unaffordable for millions of older Americans. Although Massachusetts capped rate variation for age at 2-to-1, affordability remains a significant issue for some AARP members. Even at a 2-to-1 age rating, the lowest priced "bronze" benefit package costs 60-year-olds between $420 and $575 per month; allowing even higher age-related rates would be an insurmountable barrier to coverage for the uninsured in this age bracket, whose median annual income is just $30,000. Age is a poor proxy for income; older uninsured Americans do not have substantially higher incomes than younger uninsured individuals, whose median income is $28,461.[3] Continuing to allow health care coverage to remain unaffordable to those who need it most is a serious societal problem.

[3] Ibid.

Uninsured adults in their late fifties and early sixties experience worse health outcomes and use more services when they enter the Medicare program, and in the years before Medicare their uncompensated health care costs will continue to be shifted to those who have insurance.

Hardship exemptions for those who cannot afford coverage are cold comfort for those in an age bracket where quality coverage is essential for maintaining health and avoiding preventable conditions that will only increase spending once these individuals become eligible for Medicare. Hardship exemptions mean people are still without coverage, and health reform must provide affordable coverage to those who have the most difficulty obtaining it in today's market-and that includes older adults.

Subsidies: Shared responsibility is an important attribute of the proposed legislation. As the Draft proposes an individual requirement for obtaining health insurance and an employer requirement for providing health insurance, assuring affordability of plan premiums *is essential* if AARP is to support this legislation. Adequate subsidies for low- and moderate income individuals must be guaranteed. Subsidies must be adequate, available, secure and administratively feasible, and take into account any higher cost related to any level of age rating that is allowed.

For those who have the lowest incomes, we agree with the Tri-Committee approach that expansion of Medicaid eligibility is an efficient and effective way to assure quality coverage and access to care. AARP also applauds the Committees for establishing ways to give Medicaid beneficiaries the ability to receive coverage through private plans participating in the Exchange without losing the important beneficiary protections they receive under Medicaid. We believe it is essential that states should be required, as in the Draft, to provide wrap-around coverage in the Exchange. We also believe Medicaid should be the default option for Medicaid-eligible individuals who because of literacy, cognitive, or other issues do not make timely choices on their own.

Subsidies should be set on a sliding scale so individuals and families pay no more than a certain percentage of income on premiums as well as other out-of-pocket health care costs. Thus, subsidy calculations should include both family income and actual premium costs that may vary by region or age. In our view, no one should spend more than 10% of their income for health care, including premiums and all other out-of-pocket costs. Those with more limited incomes should pay even less, with exemptions from cost sharing for the poorest for whom any cost sharing can create insurmountable barriers to care. In addition, in order for subsidies to remain affordable and sustainable over time, we must also enact measures to manage skyrocketing costs.

Premium credits and subsidies should be generous enough to effectively help those with modest incomes meet the responsibility to have qualifying coverage. They should be provided on a sliding scale reaching high enough that vulnerable families and older adults can afford both premiums and cost sharing. Otherwise, Americans will continue to face the prospect of being uninsured or underinsured and will be forced to seek a hardship exemption. Further clarification is needed on how the subsidy would work.

Benefit Packages: We strongly support requiring insurers to cover a broad range of essential benefits, as suggested in the Draft. AARP strongly agrees with the Tri-Committee that preventive services – including services necessary to manage chronic conditions that otherwise result in serious, expensive complications – should be provided with no or minimal cost sharing. We urge the Committee to also include care coordination, disease management and other approaches to improve quality of care in the list of minimum services to be covered in order to help reduce spending for avoidable and costly institutional admissions, preventable complications, and errors – strategies that are particularly beneficial for people with multiple chronic conditions.

Individual and Employer Responsibility: The Tri-Committee Draft would require individuals to have health coverage that meets minimum standards and to report such coverage annually. Employers who do not provide qualifying coverage will be required to contribute to the cost of their coverage for their employees, including those who access forms of public coverage. Combining an individual mandate with an employer mandate takes advantage of risk pooling and reduces the overall cost of coverage.

Also, requiring everyone to participate greatly reduces insurers' interest in underwriting based on age or health status and ensures that healthier individuals are included in the risk pool. As with other elements of health care reform, however, AARP can support these requirements only with the assurance of adequate subsides. We cannot support mandated coverage that people or businesses cannot afford – subsidies must be adequate, available, secure and administratively feasible.

Public Health Insurance Option: AARP has repeatedly stated its commitment to finding quality, affordable health care options for our members. At its most recent meeting, the AARP Board of Directors approved principles to help determine whether or not a public plan option can help meet that commitment.

Based on the Draft, the Tri-Committee's public health insurance option appears to satisfy the following principles of bringing down health care costs and improving value of U.S. health care spending by:

- Providing access to quality care for all;
- Contributing to lowering all costs;
- Preserving choices of providers with adequate network to support access to care;
- Ensuring accountability and transparency in its operations; and
- Operating through a public-private partnership.

We understand the Tri-Committee's desire to encourage providers to participate in the Exchange by temporarily paying them rates based on but higher than current Medicare rates. However, we support the temporary nature of this requirement. AARP believes it is critically important that the public health insurance option should in no way negatively affect Medicare beneficiaries' access to providers.

We also agree with the Draft that the public option should play by the same rules as private insurers, and that the entity running the Health Insurance Exchange should not operate the public option.

Strengthening and Improving Medicare

Approximately twenty million AARP members rely on Medicare for their health coverage.[4] They spend on average about 30% of their out-of-pocket spending on health care – six times more than people with job-based coverage,[5] and those who cannot afford supplemental coverage face bankruptcy from high medical bills because Medicare has no upper limit on cost sharing. More than half of all Medicare beneficiaries have annual incomes below $20,000,[6] and the economic security of older Americans has only worsened in the economic downturn.

Medicare is a vital program that health reform must strengthen and make more affordable, both to ensure that current beneficiaries can get the high quality care they need and to sustain the program for future generations. AARP commends the Tri-Committee's recognition that strengthening and improving Medicare is essential to effective health care reform, and is pleased that many of AARP's key Medicare goals for health care reform are included in the Draft.

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 following are important Medicare changes that AARP believes should be included in comprehensive health care reform:

Lowering Rx Costs: AARP applauds the Tri-Committee's leadership for recognizing the importance of closing the Medicare doughnut hole. Medicare beneficiaries face disproportionately high out-of-pocket costs and closing the doughnut hole will go a long way to remedying this problem. The Draft proposes to reduce and, over time, actually eliminate the doughnut hole in Part D. This will be an important change for beneficiaries as it will save them thousands of dollars in drug costs and keep them healthier by ensuring they can afford their medications.

Of course other steps are also necessary to lower drugs costs, and each of these steps will make closing the doughnut hole easier and improve access to pharmaceuticals generally. These include:

- Expanding access to generics, including creation of a pathway for generic biologics;
- Requiring drug companies to provide Medicaid rebates for dual eligibles in Part D;
- Secretarial Negotiation of Drug Prices;
- Discounting the cost of brand name drugs for beneficiaries in the doughnut hole as announced by the White House along with Senators Baucus and Dodd; and
- Safe Importation of Drugs.

Making Medicare More Affordable: In addition to lowering the out-of-pocket costs for all beneficiaries, it is essential to use health care reform to improve the patchwork of

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[4] This number represents nearly half of the program's total beneficiaries.

[5] Health Affairs, Setting a Standard of Affordability for Health Insurance Coverage, June 4, 2007

[6] U.S. Census Bureau 2008 Current Population Survey, Annual Social and Economic Supplement, Table PINC-01.

programs that help low-income Medicare beneficiaries pay for prescriptions, premiums, deductibles, and other health costs.

The Draft proposes to do this in a number of key ways:

- First, it raises the income threshold for assistance to 150% of poverty, helpfully making the standard the same across programs.
- Second, it eliminates 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, it makes sure beneficiaries know that these low-income assistance programs exist and simplifies the application process to ensure that our most vulnerable beneficiaries get the help they need.

Keeping Medicare Sustainable: Skyrocketing health care costs, not the aging population, are the main driver of Medicare spending increases.[7] These spiraling costs must be reined in soon in order for the program to serve future generations. Without reform, Part B premiums – which have more than doubled since 2000 – will continue to absorb a growing share of the incomes of beneficiaries. Also, the current economic crisis is deteriorating Part A Trust Fund solvency even further.

Medicare Advantage was created to provide more choices, greater care management and savings for Medicare beneficiaries. There is much about Medicare Advantage that is commendable and should be preserved, but the program has become too costly, even wasteful, at a time when the Medicare program cannot afford any waste. AARP applauds the Tri-Committee's proposal to end the overpayments to Medicare Advantage plans. We also want to commend the Tri-Committee for recognizing that these overpayments must be eliminated with minimal disturbance to beneficiaries.

Fortunately, there are many proposals to improve the quality of the care in Medicare and also save money for both beneficiaries and taxpayers. With this in mind, Congress must pursue these solutions now, as an integral part of health care reform. AARP commends the Tri-Committee for including so many of these solutions in the Draft:

- Revising the way Medicare pays doctors and hospitals to reward high quality care rather than how much care is provided, including through a "medical home" pilot and an "accountable care organization" pilot as well as bonus payments for quality, quality reporting requirements and higher payments for efficient geographic areas;
- Working to reduce unnecessary re-hospitalizations through payment changes;
- Improving care coordination for dual eligibles;
- Reducing waste, fraud and abuse and creating effective systems for doing so into the future; and
- Reforming physician payment rates by permanently addressing the SGR.

Strengthening the primary care workforce is an essential part of ensuring the provision of quality affordable health care for all. The Draft recognizes this by increasing rates for

[7] Congressional Budget Office, *The Long-Term Outlook for Health Care Spending*, November 2007.

certain primary care services and creating initiatives that will shape the health care workforce for years to come. Going forward, effective practice models in Medicare 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 also should be encouraged, as they can provide quality care for individuals and recognize the valuable role and contributions of a variety of care providers.

We applaud the Tri-Committee's recognition of the importance of strengthening the nursing workforce and are pleased that the Draft provides up to $220 million a year within the Public Health Investment Fund for this goal. We also urge Congress to modernize Medicare's support for nursing education to produce more highly skilled advance practice nurses, including those who deliver primary care, preventive and care coordination services to address the needs of an aging and diverse population.

Reducing Costly Hospital Re-Admissions through a Medicare Transitional Care Benefit: More than 20% of older Americans suffer from five or more chronic conditions that account for 75% of total Medicare spending, mainly due to high rates of hospital admission and readmission. One-fifth of Medicare beneficiaries were re-hospitalized within 30 days of discharge; one-third were readmitted within 90 days, according to a recent *New England Journal of Medicine* study (April 2009). Half of those re-hospitalized within 30 days had not seen a doctor since discharge. The study estimated that Medicare spent $17.4 billion on largely preventable re-hospitalizations in 2004.

Transitions, such as those from hospital to home, are risky. Patients discharged without transitional or follow-up services frequently report difficulty remembering clinical instructions, confusion over correct use of medications, and uncertainty over their prognosis. Without assistance, most family caregivers lack the knowledge, skills and resources to effectively address the complex needs of older adults coping with multiple coexisting conditions. Preventable hospital admissions often result from poor communication among older adults, family caregivers and health care providers. Patients often report getting conflicting instructions from different providers.

The Draft contains a medical home pilot that will help enhance continuity of care and also uses payment policy changes to help put systems in place to address unnecessary hospital readmissions. Ultimately, AARP believes that a more comprehensive approach to resolving transitional care issues would ensure that the highest-risk Medicare beneficiaries receive transitional care services they need to help keep them out of the hospital and improve their quality of care. We therefore urge that the AARP-endorsed Medicare Transitional Care Act (H.R. 2773) be included in the final Tri-Committee health reform bill. H.R. 2773 specifically targets beneficiaries at highest risk for hospital readmissions or poor transitions, such as individuals with multiple chronic conditions, cognitive impairment, depression, or a history of multiple re-hospitalizations. The Medicare Transitional Care Act would fit well with re-admissions policies proposed by the Tri-Committee. AARP believes that, together, these initiatives will save—not cost—federal health care dollars, and we look forward to working with the Tri-Committee to achieve these savings.

Multiple, rigorous trials show transitional care services for older adults with chronic conditions can significantly improve outcomes, prevent hospital readmissions, reduce costs and increase patient satisfaction. For example, a randomized controlled clinical trial of the "Transitional Care Model" demonstrated significantly lower re-hospitalization rates from all causes sustained through 12 months and a 39% reduction in total health care costs for net savings of $4,845 per patient after one year. Patients age 65+ with heart failure received transitional care services (e.g., face-to-face visits and telephone follow-up) coordinated and delivered by an Advanced Practice Nurse (APN) for 60 days following initial hospitalization.[8]

Under the Medicare Transitional Care Act, a nurse or other health professional would lead an interdisciplinary care team in:

- assessing the needs of the high-risk individual and their primary caregiver and developing a comprehensive care plan,
- providing home visits and coordinating care with providers across settings,
- teaching self-management skills and assisting with medication management,
- arranging and coordinating community resources and support services, and
- accompanying the individual to follow-up physician visits as needed.

These services would be available to high-risk individuals during their hospital stay and up to 90 days after discharge. Performance measures would be established with public reporting and payment established based on these measures.

Reducing Racial and Ethnic Disparities: Reducing racial and ethnic disparities is essential to ensuring that all Americans receive the high quality care they deserve. The Draft takes important steps to address disparities, including issuing requirements for the collection of racial and ethnic data and providing temporary grants for reimbursement of translation services in Medicare. Ultimately, the capacity of the Office of Civil Rights must be strengthened in order to enforce both new and existing federal language access requirements. It is also essential to increase cultural diversity and competencies in our nation's health workforce.

Long-Term Care

Strengthening long-term care (LTC) or long-term services and supports (LTSS) also must be part of health reform. AARP believes all Americans should have the choice to get needed care and services at home because 89% of Americans age 50+ want to live at home as long as possible. This is also critical for cost containment as, on average, Medicaid can support nearly three older people and adults with physical disabilities in home and community-based services (HCBS) for the cost of one person in a nursing home. In addition, states that invest in HCBS can, over time, slow their rate of Medicaid LTC spending. Incentives to encourage states to invest in HCBS and balance their LTC

[8] Mary Naylor, et al. "Transitional Care of Older Adults Hospitalized with Heart Failure: A Randomized Controlled Trial." *Journal of American Geriatrics Society*, May 2004; 52:675-684.

systems, such as an enhanced Medicaid matching rate, are important, as are financial incentives to strengthen state infrastructure and service systems.

Support for family caregivers is critical, as they help individuals live at home and delay or prevent stays in generally more costly institutional settings. At any given point, about 34 million family caregivers provide and coordinate care to loved ones at home – unpaid assistance with an estimated economic value of about $375 billion in 2007, which reduces spending on inpatient, home health and skilled nursing facility care.

AARP is pleased to see many provisions to improve nursing home quality and accountability, such as:

- improved information on ownership, inspections, and payroll-based staffing data;
- additional information on Nursing Home Compare;
- a standardized complaint form and improved complaint resolution;
- stronger penalties;
- improved notification of facility closure; and
- improved staff training.

We look forward to working with the Committees to further improve these provisions.

HCBS services are cost-effective, what people want, and provide consumers with greater choice and control to help them live independently in their homes and communities. We strongly urge that provisions to expand HCBS and support family caregivers are included in comprehensive health reform. Specifically, provisions such as the following from the Empowered at Home Act (H.R. 2688/S. 434) and the Retooling the Health Care Workforce for an Aging America Act (H.R. 468/S. 245) should be included in health care reform.

It is also vital that the Committee consider other changes that will be made to Medicaid and their impact on optional services, such as HCBS. We caution against changes in Medicaid that could cause states to reduce HCBS, as they are "optional" services that states are not required to cover, but they are critical to older adults and people with disabilities. We also encourage the Committee to consider policy options that give people more choices to help them pay for the services they need to live independently.

Conclusion

The Tri-committee Draft marks substantial progress toward our shared goal of enacting comprehensive health reform legislation. While many challenges remain, we and other stakeholders share a broad and growing consensus that any differences should not stop us from finding common ground and enacting comprehensive reform this year. The status quo is unsustainable and we cannot afford to fail. We again thank you for your leadership and look forward to working with this Subcommittee and all of Congress to enact comprehensive health reform legislation this year.

Chairman RANGEL [Presiding]. Let me thank you for your leadership in helping us to get to at least where we are today.

And I call on Mr. Johnson, who is the Senior Vice President of Labor, Immigration and Employee Benefits for the Chamber of Commerce. We need you.

STATEMENT OF RANDEL K. JOHNSON, SENIOR VICE PRESIDENT, LABOR, IMMIGRATION AND EMPLOYEE BENEFITS, U.S. CHAMBER OF COMMERCE

Mr. RANDEL JOHNSON. Thank you, Mr. Rangel and Ranking Member Camp and Members of the Committee. I appreciate this opportunity to testify. The Chamber is the world's largest business federation, representing more than 3 million businesses of every size and sector across the economy. I think more importantly I want to note that half of Americans do receive their health insurance voluntarily provided by their employers. And the Chamber is committed to improving the health care system by lowering cost, improving quality and expanding coverage.

There are a couple of issues that I want to bring up in my oral statement. I also have a written statement which is a little longer. But I want to address process, the employer mandate, and the so-called "public option," which has already been much debated here.

As far as process goes, we understand a need for urgency but lets put it on the table. Only a few days ago, this bill was released. It is 850 pages long. We all enjoyed our weekends trying to get through it, but there are many parts that we still do not understand.

It is clear that the bill is going to be rushed to the floor. Markups currently have already been scheduled for next week and the week after, and there will not be adequate time for consideration or certainly deliberation by the Chamber's Employee Benefits Committee or my many members.

I did work on the House Labor Committee 10 years ago when Mrs. Clinton submitted her bill for consideration to the Congress. She was much criticized for that process because it came up here almost as a fait accompli, but it was the subject of many hearings in many, many committees, including this one. And looking back on that, I would say it was a bit of a model of transparency as compared to the process we are faced with today.

So we do hope that the process will be slowed down a bit. We know what the White House is saying and the schedule that the President has set for the Congress, but we do believe we need more time to consider a bill of this length.

There are many good ideas. We would like to be able to support a bill as it goes to the floor, but it is going to take some work.

With regard to the employer mandate, certainly that is our number one issue, along with the so-called "public option." We oppose the pay or play mandate that is in this bill. I was astounded, frankly, when I read this weekend that it imposes an 8 percent penalty on employers, let's call it what it is, it is a penalty or tax, if they don't participate in the so-called "play" part of the mandate. What is 8 percent? Well, that is a lot of money. Quick back of the envelope, 8 percent on someone making $40,000 a year is $3,200. If you have 20 employees, that is $60,000. That is a lot of money for a

small business to pay in addition of course to the FICA taxes they are already paying.

We realize that is based on the Massachusetts model, which has, by the way, been roundly criticized by both the left and the right. In the Massachusetts model, however, the penalty was about $300 per employee, not certainly 8 percent of payroll.

We think that this sort of imposition on businesses for those who cannot afford it, and not all businesses can afford health care or pay this kind of penalty, is going to be one more incentive frankly, and I will say it, for businesses to move overseas.

One of the worst aspects of this proposal is a very peculiar provision, which allows employees who are part of the employer plan to actually cash out and move to the so-called public option. And apparently, as we read the bill, this provision would say that the employer must in fact pay for that cash out. Obviously, an employer cannot plan on that basis, where employees move in and out.

We are always concerned of course about the minimum coverage provisions defined in this bill, which is set by this ubiquitous board of all-consuming powers, which many others have talked about.

The public option, much discussed in the first panel, I will not belabor it, I will just say it is called a "public option" for a reason. It is because one way or the other, it is going to have government support. Let's face it, if this plan goes bankrupt or does not have enough premiums coming in, the government is not going to let it go by the wayside and die. The government will step in and save it. It is not going to be taxed like private sector insurance companies are. It is a public plan, it is a government-supported plan, and that is why we call it a "public option."

Many supporters believe that a public plan is necessary. I think our position is let's walk before we run. Let's see how the insurance market reforms work, combined with the gateway, et cetera, and other kinds of reforms in this bill and let's see how they work before we move to this so-called new sort of Medicare-like option applicable to the entire public.

With regard to paying for reform, I know there are a lot of taxes on the table. It is no surprise that the Chamber is not too sympathetic to new taxes on our members. We have gone through a list of those in the written statement, and I will not go through those in my oral but each one of course is new money from the bottom line that employers like to use for hiring new workers, expanding, providing benefits voluntarily, which they already do, and creating work for American workers.

Now, that does not mean the Chamber is opposed to health care reform. Our members are paying the money for increasing health care costs. We want to continue to do that. We want to continue to cover our workers, so we support reform. But the public plan, the employer mandate, is something we cannot support. Peter mentioned many improvements in the system that we can go along with that are in this bill. Other provisions, such as medical liability reform, we would like the Committee to look at. We are ready to work with this Committee and the other three in the Congress, the jurisdiction of the other two, but we would ask the process be delayed a bit. Let's take our time to get this 850-page bill right. And

let's not do any harm before we move on and pass this legislation on to the President.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Randel Johnson follows:]

Statement of the U.S. Chamber of Commerce

ON: **Health Reform in the 21st Century: Proposals to Reform the Health System**

TO: **The House Committee on Ways and Means**

BY: **Randel K. Johnson**
Senior Vice President, Labor, Immigration, & Employee Benefits
U.S. Chamber of Commerce

DATE: **June 24, 2009**

The Chamber's mission is to advance human progress through an economic, political and social system based on individual freedom, incentive, initiative, opportunity and responsibility.

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.

More than 96 percent of the Chamber's members are small businesses with 100 or fewer employees, 71 percent of which have 10 or fewer employees. Yet, virtually all of the nation's largest companies are also active members. We are particularly cognizant of the problems of smaller businesses, as well as issues facing the business community at large.

Besides representing a cross-section of the American business community in terms of number of employees, the Chamber represents a wide management spectrum by type of business and location. Each major classification of American business – manufacturing, retailing, services, construction, wholesaling, and finance – numbers more than 10,000 members. Also, the Chamber has substantial membership in all 50 states.

The Chamber's international reach is substantial as well. We believe that global interdependence provides an opportunity, not a threat. In addition to the U.S. Chamber of Commerce's 101 American Chambers of Commerce abroad, an increasing number of members are engaged in the export and import of both goods and services and have ongoing investment activities. The Chamber favors strengthened international competitiveness and opposes artificial U.S. and foreign barriers to international business.

Positions on national issues are developed by a cross-section of Chamber members serving on committees, subcommittees, and task forces. Currently, some 1,800 business people participate in this process.

Statement on
Health Care Reform Legislation
THE HOUSE COMMITTEE ON WAYS AND MEANS
on behalf of the
U.S. CHAMBER OF COMMERCE (the "Chamber")
by
Randel K. Johnson
Senior Vice President, Labor, Immigration & Employee Benefits
U.S. Chamber of Commerce
June 24, 2009

Chairman Rangel, Ranking Member Camp, members of the Ways and Means Committee, thank you for the invitation to testify at this hearing. I am Randel K. Johnson, Senior Vice President of Labor, Immigration and Employee Benefits at the U.S. Chamber of Commerce. The U.S. Chamber of Commerce is the world's largest business federation, representing more than three million businesses of every size, sector and region. More than half of all Americans receive health insurance benefits voluntarily provided by their employers, and the Chamber is committed to reforming the health system to lower costs, improve quality, and expand coverage.[1]

Process

The Chamber applauds Congress for making health reform a priority. However, we have grave concerns about the process being used to advance this legislation. This Committee, in cooperation with the two other committees of primary jurisdiction, crafted the legislation before us today behind closed doors. On Friday June 19th, only a few days ago, you released a more than 850-page bill, and although it still contains significant gaps (including missing cost estimates and expected offsets), already we are engaged in hearings, with markups no doubt quickly following, and the bill will be rushed to the floor without proper time for consideration and revision.

As you rush to pass the most sweeping changes ever to the health sector, which encompasses more than 16 percent of the U.S. economy, consider that in comparison Congress spent almost a decade devising and refining the Family and Medical Leave Act, which provides 12 weeks of unpaid leave, a much more straightforward, and less controversial concept. Now, Congress seeks to impose massive and incredibly complex new health care mandates and restructuring apparently in less than four months. In this regard, I have to note that I was working for a committee on the Hill when Mrs. Clinton's plan was being considered 15 years ago, and she came under much criticism for drafting the plan behind closed doors. However, that bill was allowed serious and full scrutiny by both Congress and the public with many hearings, and I would argue that it was a model of transparency and a full deliberative process compared to the absurdly accelerated process Congress is undertaking now.

[1] See U.S. Census Bureau, Income, Poverty and Health Insurance Coverage in the United States 2007, p. 20, http://www.census.gov/prod/2008pubs/p60-235.pdf

As I was reviewing the legislation this weekend, I found myself almost wistfully recalling the days when I was on the Hill, when legislation was actually introduced as bills and time was allowed for review and analysis before hearings and markups were called. The idea, not novel at the time, was that those affected by these initiatives would actually have time to provide well-developed and meaningful feedback to policymakers. Unfortunately, Congress now appears to be in a time when the more complex a piece of legislation is, the less time that is given for its analysis.

While this paradox is sometimes justified as needed to pass legislation before its "opponents" can rally in opposition, it is actually a process which undermines democratic and open debate, a process which values "hiding the peanut" under the shell rather than revealing what lies beneath the shell. Finally, while many do describe our current situation with regard to health care as a "crisis," this is surely not the type of crisis which demands that Congress proceed on the schedule which the White House appears to be demanding. The tragedy of September 11th, 2001 was a crisis which demanded swift action; problems with the health care system do not rise to this level, and the stakes are too high to rush to judgment under the cover of overwrought claims of saving the economy.

The Chamber hopes that the sponsors of this legislation will conduct a process that truly engages stakeholders and discards this rush to legislate, and that they build legislation that solves the problems we face without creating massive new problems. Congress continuing on its current course is a recipe for failure, problems, partisan politics, and a continuation of the unsustainable, unacceptable status quo.

The business community has been supportive of reform for some time now, as health care costs have continued to rise much faster than the rate of inflation. Even as health insurance premium costs have more than doubled in the past decades, employers continue to pay $500 billion a year into the system voluntarily to cover employees.[2] It should be easy to draft a bill that employers can support – we are desperate in the face of these unsustainable cost increases. Unfortunately, rather than focusing on common sense, pragmatic reforms that both sides of the aisle could support, this legislation embodies a range of bad ideas that threaten to bring down many good initiatives which we do support.

Employer Mandate ("Pay-or-Play")

First and foremost, the Chamber adamantly opposes the "pay-or-play" proposal that holds a Sword of Damocles over the heads of America's job creators, requiring them either to provide some level of health insurance benefits (to be later defined by a government board) or surrender a huge eight percent of payroll to the government.[3] This proposal will

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[2] Employee Benefit Research Institute: "*EBRI Databook on Employee Benefits, Chapter 2: Finances of the Employee Benefit System.*" Updated September 2008.
http://www.ebri.org/pdf/publications/books/databook/DB.Chapter%2002.pdf

[3] To put that amount in perspective, this new tax would be more than the FICA contribution tax of 7.65%, already being paid by an employer. Further, for example, an 8% payroll tax on a worker's salary that is

hit hardest those businesses that can least afford to take another hit, especially from the government, and especially while we are trying to recover from one of the worst economic downturns in the nation's history. Talk of "shared responsibility" requirements is disingenuous – employers spent $1,454.9 billion on employee benefits in 2007, or 18.6% of total compensation. Employers spent $532.1 billion for group health insurance, and $199.9 billion on retirement income benefits in 2007.[4] Employers are already doing their share and more.

Such a broad new mandate will not increase coverage – rather it will lead to out-sourcing, off-shoring, hiring of independent contractors, spinning-off small new companies, reducing workforces, and reducing wages. While we struggle to create jobs and stem the tide of layoffs, this bill represents a stimulus plan for India, Brazil, China, and other countries where workers will be available for more competitive rates.[5]

Congress is divorced from reality on this issue – while such provisions make for good soundbites about taking from the greedy and giving to the needy, it is actually the poorest, and the lowest wage workers, who will feel the brunt of this new mandate. In the simplest terminology, the pay-or-play requirement greatly increases the costs (and thus lowers the value) of low-wage workers.[6] In order to keep their total compensation aligned with their economic value, the workers will have their wages reduced to account for the increased benefits costs of hiring them – and in the many cases where this is impracticable due to other laws and circumstances, these workers will be laid off, or never hired in the first place.[7] The RAND Corporation has estimated that depending on

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earning $40,000 is $3,200. If the employer employed 20 additional workers at the same rate, the employer's total contribution in taxes would be $64,000. In addition to the FICA tax paid by the employer, this is assuredly not an amount that can be absorbed as petty cash.

[4] Employee Benefit Research Institute: "*EBRI Databook on Employee Benefits, Chapter 2: Finances of the Employee Benefit System*." Updated September 2008. http://www.ebri.org/pdf/publications/books/databook/DB.Chapter%2002.pdf

[5] Further, of course, this new mandate is only one of many new obligations that Congress is considering imposing on employers, with others ranging from paid family leave to expansion of civil rights laws to include unlimited punitive and compensatory damages, radical expansion of OSHA criminal and civil penalties, and facilitating union organizing.

[6] See Katherine Baicker and Helen Levy, "*Employer Health Insurance Mandates and the Risk of Unemployment*," Working Paper No. 12528 (Cambridge, Mass.: National Bureau of Economic Research, October 2007), which concluded that an employer mandate for health insurance would be passed on to workers in the form of lower wages, and reduced job opportunities. The study estimated that 224,000 workers could become unemployed if firms were required to provide health insurance costing $2 per hour worked, on average. Also see Richard Burkhauser and Kosali Simon, "*Healthcare Reform: The Economics of 'Play or Pay' Employer Mandates.*" Employment Policies Institute, September 14, 2007. Their study, which examined the effects of a combined increase in the federal minimum wage to $7.25 and a $3.00 per hour pay or play mandate (in 2005 dollars) for both part-time and full-time workers, ages 17-64, estimated that 750,178 workers could lose their jobs. Also see Ellen Meara, Meredith Rosenthal, and Anna Sinaiko. "*Comparing the Effects of Health Insurance Reform Proposals: Employer Mandates, Medicaid Expansions and Tax Credits.*" Employment Policies Institute. February 2007, which calculated that an individual mandate requirement coupled with the effects of an employer mandate for firms with at least 25 employees could potentially reduce employment by 1.7 million jobs and that under this same scenario, 2.8 million workers could be shifted from full-time to part-time status.

[7] See Congressional Budget Office: "Key Issues in Analyzing Major Health Insurance Proposals-December 2008". Available at: http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf.

firm size and the level of penalty, new mandated coverage will cost $9.12 to $17.89 billion in premium contributions by employers, and penalty payments will be $4.23 to $12.48 billion.[8]

This is because businesses that can afford to offer benefits, do so. Certainly, many may be driven primarily by a paternalistic desire to take care of employees, but the vast majority of employers provide benefits because it is necessary to do so in order to be competitive. Benefit offerings attract and retain the best employees, improve productivity, reduce the use of sick days, and ensure that employees are doing quality work.

The businesses who do not offer benefits are primarily very small, very new, or operating on very slim profit margins. If Congress exempts these businesses then the mandate will be ineffective at advancing your goals, yet if you do not, these businesses will have to lower their head counts or close their doors. This begs the question of why Congress insists on these provisions. Regardless, the Chamber (which is comprised of 96 percent small businesses) will oppose a mandate no matter who is carved out – we are all too familiar with how these carve-outs work; they initially help to divide and conquer a constituency, then they shrink and shrivel.

One of the worst aspects of this proposal is that it includes a *de facto* "cash-out" for employees who opt out of employer coverage, and obtain coverage through the exchange. This creates a situation in which employees can be driven to the exchange with government subsidies, which will be especially valuable for the youngest, healthiest workers. Employers will then have to contribute what they otherwise would have spent on their benefits to the exchange. This is a recipe for adverse risk, inability to plan, employer plan death spirals, and the end of any notion of "keeping the plans you have."

Despite speculation on this issue by the Congressional Budget Office, virtually the only actual implementation of such a mandate thus far in the U.S. has been in the state of Massachusetts, where the pay-or-play program failed to generate significant revenue. Under that mandate, assessments on employers were expected to bring in $45 million in its first year and $36 million in 2008.[9] It failed to bring in any revenue in 2007 and just $7 million in 2008.[10]

In fact, an analysis done for the Office of Health Policy in the Department of Health and Human Services found that a payroll tax of 8% would cause more than 37 million people to be shifted into government-run or administered plans, as employers would pay rather than play.[11] This would constitute a massive disruption in health insurance.

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[8] RAND COMPARE: "*Effects of Employer Mandated Policy Options- December 30, 2008*." Available at: http://www.randcompare.org/analysis/mechanism/employer_mandate.

[9] John Hurst, "Small Businesses Pay for Plan's Shortcomings," *Boston Globe*, August 18, 2008.

[10] Id.

[11] Cost and Coverage: The Impact of implementing Various State Health Care Reform Proposals Nationally. Office of Health Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Summer 2008. http://aspe.hhs.gov/health/reports/08/reform/report.pdf

A better, smarter approach would be to focus on bringing down the costs of health insurance, and encouraging individuals to obtain coverage. This would bring market forces to bear on employers, as their employees would ask anew for benefits that satisfied their individual requirements, without hurting the economy – while also helping more people to obtain insurance and making health care more affordable for all.

Minimum Coverage ("Essential Benefits")

Even businesses that already offer generous benefits are determined not to be burdened by government-mandated levels of benefits and prescriptive instructions on how benefits must be designed. Because most government employees enjoy the extremely expansive FEHBP (Federal Employees Health Benefit Plan), there is an apparent belief by some in Congress that it makes sense to force all businesses offering benefits to approach the offerings of FEHBP. However, this would be completely unaffordable and impractical. The design of benefits is a decision that needs to be left between employers and employees. Government-dictated one-size-fits-all plan designs will be disastrous for business – to suppose that a computer programming company and a coal-mining company require or can afford the same kinds and levels of benefits reveals a lack of understanding of the realities faced by businesses and working Americans.

We are especially concerned about proposals to anoint a new committee of unelected bureaucrats, the majority of whom will have had no experience in designing benefits plans, who will basically make laws regarding required levels of benefits. Although Congress may feel an urge to punt this controversial issue to an outside "public-private" group, it is too important, and too critical for understanding the true potential impact of legislation to be simply handed off.

As we again look to Massachusetts, we see many problems which indicate that this model is hardly one to follow. Costs have primarily risen for individuals, as under the mandatory insurance scheme, the government must define what constitutes an acceptable insurance policy.[12] As special interests have lobbied for inclusion in the "minimum benefits" package, mandated benefits have raised the costs of health insurance by 23 to 56 percent.[13] The Massachusetts Division of Health Care Finance and Policy released a study that showed that mandated health insurance benefits cost insurance purchasers about $1.3 billion or 12 percent of their premiums each year.[14]

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[12] Paul Hsieh. "Mandatory Health Insurance: Wrong for Massachusetts, Wrong for America." *The Objective Standard*. Fall 2008 Vol.3 No.3. http://www.theobjectivestandard.com/issues/2008-fall/mandatory-health-insurance.asp

[13] Victoria Bunce and J.P. Wieske, "Health Insurance Mandates in the States 2009." Council for Affordable Health Insurance, p. 4-7.

[14] Massachussetts Division of Health Care Finance and Policy. "Comprehensive Review of Mandated Benefits in Massachussetts: Report to the Legislature." July 7, 2008. http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/mandates/comp_rev_mand_benefits.pdf

Government-Run Insurance Plan ("Public Option")

This legislation contains an especially troubling incarnation of a proposal to create a new government-run health insurance plan to "compete" with the private sector. This flies in the face of common sense.

Recent studies continue to find that government cannot and would not compete on a level playing field with private competitors in the insurance market. Government programs tend to hide administrative costs by outsourcing to various other departments and agencies, forcing individuals, enrollees, and participating businesses to pick up the slack. Government costs are artificially low due to cost-shifting to private payers – the consulting firm Milliman recently found that private insurance costs 20-30 percent more because of underpayment by government payers.[15] Proponents of government plans usually cite MedPAC reports that say government plans pay fairly and private plans overpay – however, numerous providers, hospitals and businesses have reported to the Chamber that private payers tend to support public plan enrollees, and reductions in payment from private plans (or increased enrollment in public plans) would be likely to put many out of business, or at least to severely curtail access to care. The fact that this proposal would directly use Medicare rates is extremely dangerous.

This would be compounded by the problem of a massive shift from the private sector to the public sector. The Lewin Group actuarial firm recently found that tens of millions would be drawn to a public plan by artificially low premiums – a situation that would only worsen the already debilitating cost-shift private payers experience.[16] A loss of 119 million Americans from the private sector to the public sector, together with the cost-shifting that will occur, would devastate the remaining private sector, and likely could lead to the inevitable government-run insurance "option" as the only option available.

A recent report by the Pacific Research Institute indicated that Medicare's costs have risen one-third more, per patient, than the total of all health care costs in America apart from Medicare and Medicaid.[17] This further research suggests that a government-run public plan option would not curtail costs for private health insurance, and could indeed lead to further cost-shifting.

The business community joins most Americans in opposing a "public option" that would likely be an unfair competitor or lead us toward government-run health care for all. A

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[15] Hospital & Physician Cost Shift, Payment Level Comparison of Medicare, Medicaid, and Commercial Payers. Milliman, December 2008. http://www.ahip.org/content/default.aspx?docid=25216

[16] The Cost and Coverage Impacts of a Public Plan: Alternative Design Options. Lewin Group staff working paper #4, April 2009. http://www.lewin.com/content/publications/LewinCostandCoverageImpactsofPubliePlan-Alternative%20DesignOptions.pdf

[17] Jeffrey Anderson. Medicare Costs Have Risen Far More Than the Costs of Private Health Care. The Pacific Research Institute, Health Policy Prescriptions. Vol 7. No.06, June 2009. http://liberty.pacificresearch.org/publications/medicare-costs-have-risen-far-more-than-the-costs-of-private-health-care

recent poll by the Kaiser Family Foundation found that while Americans are initially open to a "public option," when they learn that it might have an unfair advantage over the private sector or that it might lead to single-payer, they strongly opposed it.[18] Worse, this bill would create a government-run insurance plan that talks, walks, and pays like Medicare – despite the fact that proposals to enact Medicare-for-all have failed repeatedly, nearly every Congress for as long as most of us can remember.

Public plan proponents have continually changed their justification for the need for such a plan. First they said it was necessary to give new options to people who currently lack options in the insurance market – but the creation of a connector or exchange would solve this problem. Next they said it was necessary to "keep the private plans honest" – but private plans are going to be aggressively regulated (no more preexisting conditions, guaranteed issue and renewal, community rating), so this became another moot point. Next they said a public option was the only way to control costs and implement delivery system reforms, but it is apparent that public plans "control costs" by driving down reimbursement to providers, and this simply results in increased costs to the private sector. We can find no meaningful justification for creation of a new government-run insurance plan other than to gut the private market and bring a large portion of America into government-run health care. Whether or not this proposal is a Trojan horse for single-payer health care, it is apparent that its cause is ideological, not pragmatic or driven by a desire for market competition or good health policy.

ERISA Changes

The reason so many employers are able to offer quality, affordable health insurance to their tens of millions of employees is that the Employee Retirement Income Security Act of 1974 (ERISA) allows them to administer uniform benefits across state lines, with maximum flexibility to allow employers to design plans that meet their employees' needs.[19] This proposal would threaten the success of ERISA plans by apparently allowing a new host of lawsuits under state law, revisiting many issues raised by the Patients' Bill of Rights of past Congresses. Obviously, if this is true, we would be very troubled by these provisions.

Congress should be focused on lowering the costs of health care and expanding access to those currently without coverage. Why is there an effort to interfere with the parts of the system that are working well? The Chamber views such initiatives as counterproductive at best, and at worst, efforts to force more Americans out of private, voluntary employer-provided coverage, and into a government-run exchange that will inevitably drive individuals into a government-run insurance plan. These solutions in search of a problem will cause unnecessary disruption in current plan offerings – contrasting with the claims

[18] Kaiser Family Foundation Health Tracking Poll, April 2009. http://www.kff.org/kaiserpolls/upload/7891.pdf.

[19] Over a hundred million Americans have health, retirement and other valuable benefits voluntarily provided by their employer under a nationally uniform framework established by the Employee Retirement Income Security Act. See National Coalition on Benefits: About the Coalition. Available at: http://www.coalitiononbenefits.org/About/

of the President and many leaders in Congress that "if you like the plan you have, you can keep it."

Offsets and Pay-Fors, Fiscal Responsibility

Under the leadership of Speaker Pelosi, Congress made the bold and fiscally responsible decision to offset new spending and operate under a pay-as-you-go structure to avoid increasing the deficit. However, this and other pending legislation show that Congress did not get the right message – the right recipe for a good economy is not to tax and spend our way through the roof. Rather, we should spend smarter, write more targeted legislation, realign current funds already in the system, and reduce the deficit through restraint and responsibility.

This proposal may end up appearing deficit neutral on its face, but only because there are numerous proposals to pair it with massive new taxes. These taxes would be devastating to the economy, to businesses, and to the workers they employ. Among these wrong-headed proposals is a movement to create a European-style Value-Added Tax (VAT). A VAT would have negative implications throughout the economy, particularly hurting those with the lowest incomes, who would see the same increases in the costs of affected goods that those with higher incomes would see. This would hurt the already lowered consumption levels we are currently experiencing, lengthening the economic downturn.

Proposals to tax sugary drinks and alcohol would be similarly regressive. The revenues gained under such a proposal would come directly from those with the lowest incomes who have the fewest options to purchase and the least time and ability to change their dietary habits. These would also be the people most likely to further forego needed care if health expenditures through tax-free vehicles like Flexible Spending Arrangements and Health Savings Accounts were threatened.

Proposals to tax employee health benefits would also have extremely negative reverberations in the economy. These taxes would fall directly on workers, who would see their taxable income increased – although employers would also see FICA and payroll taxes increase, and would have to pass some or all of those costs on to the workers.

To alleviate this pressure some in Congress are proposing that only certain individuals have their benefits taxed – an administrative nightmare for employers and a recipe for bad health policy. Worst of all, some are proposing to give union workers a pass, thus directly taxing every non-union American worker to subsidize generous union benefits. Over the past several months of investigation, it has become increasingly apparent that there is no simple, fair, or good way to tax employee benefits without causing disruption in health insurance.

Congress' profligate spending has placed a serious strain on the good name of U.S. dollars and has made us a laughingstock to our creditors – just the other day, when Treasury Secretary Tim Geithner promised a Chinese audience that investments in the

United States were safe and smart assets, they laughed at him. Perhaps they have realized that despite the already tens of trillions of dollars in unfunded liabilities in our health programs, many in Congress are insistent on spending another trillion dollars or two on health care, which is sure to balloon out of control, as most of our government's health care spending has done.

The root problem here is not that Congress is having trouble finding palatable ways to raise taxes by more than a trillion dollars – it is that Congress is trying to spend more than a trillion dollars. Tax credits to families of four making more than $88,000 a year, expansion of Medicaid, a plethora of new boards, panels, committees, and irresponsible and unaccountable new multi-billion dollar funds… this litany constitutes a massive overreach. Finding insurance for the uninsured would cost a small fraction of this number, and implementing the necessary insurance market and delivery reforms to improve the system would also constitute a much smaller spend.[20] All of this leads to a conclusion that Congress should take this legislation back to the drawing board.

Reform We Can All Believe In

There is no reason for Congress and stakeholders to get stuck in this ideological morass; if we let go of the massive spending overreach, the partisan politics embodied in creating a government-run insurance plan and forcing employers to provide health insurance, and the government-knows-best attitude that leads to urges to pierce ERISA and create new committees with massive powers, there is still room and time to pass meaningful reform that all stakeholders can and should support.

Congress has rightly recognized that now is the time to reform the insurance markets. This will necessitate some hard decisions about how to enact and enforce guaranteed issue of insurance to all comers, guaranteed renewals, rate control, increased access to competing options, and more. And Congress has rightly recognized that these reforms will not be feasible unless everyone is in the system and has skin in the game – no gaming the system and waiting to buy insurance until you are sick.

If we can build connectors that work, and reform the insurance market, much of the work is done. We need to focus on reducing costs and making coverage affordable, and the initial task will be complete. This will be extremely challenging, necessitating a variety of delivery system reforms, payment and reimbursement reform, implementation of comprehensive strategies to boost health information technology, wellness, prevention, disease management, coordination of care, initiatives to support primary care and much more. This will require sacrifice on the part of many groups – insurers, hospitals, pharmaceutical companies, providers, workers, and yes, employers.

Somehow this mammoth bill has left out many of the key solutions we believe could lower health care costs and improve quality. Medical liability reform was not explored,

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[20] See Henry Aaron. "Covering the Uninsured: Cheap at Twice the Price," *Health Affairs*. August 25, 2008. http://www.brookings.edu/opinions/2008/0825_uninsured_aaron.aspx (Estimates that the uninsured could be covered for around $120 billion)

not even test projects through creation of specialized health courts. The massive Medicare claims database, which could be used to jump start quality and transparency efforts, is left to corrode. Employers are not given any safe harbors or encouragement to create wellness programs for employees. Enrollees in public programs are not given the option to instead take their government premiums and enroll in competing private options. And individuals and the self-employed are not given options to use pre-tax dollars to purchase health insurance, and thus still will not have tax parity.

The business community stands ready to work with Congress to pass such reforms. The Chamber will be on the front line fighting for the success of legislation that truly addresses these problems and proposes these solutions. But the Tri-Committee bill is a far cry from such a targeted piece of legislation – it appears to be broken beyond repair.

Mr. STARK. I just might comment, Mr. Johnson, the timeline when you were here and we did MMA, if you'll recall, this Committee has had six hearings and several bipartisan meetings, and the legislative proposal was released June 19th when we did MMA we got the draft on June 13th, that was pulled back, and on June 16th, we got the draft for a markup on June 17th. We have over a month prior to any proposed markup been having, and I say this because the Minority staff, unlike in 2003, the Minority staff has received information as the Majority staff has.

So I only say as procedure, we have attempted to bring this out weeks and months ahead of markup consideration, and the staffs on both sides of the aisle I think have had—everybody's Father's Day was spoiled reading this thing. So I would just like to suggest in consideration for both the Minority and Majority staff who have spent untold hours, that the information has been out there a long time, and we hope that will help us come up with a better product. Without—however you feel about the product, I think the procedures, we've tried to be very transparent and get the information out as early as we can.

Mr. RANDEL JOHNSON. Just a quick comment, Mr. Chairman. We do have a policy process at the Chamber, the Employee Benefits Committee, and we have a broad membership. It does take us a little bit of time to get a bill of this enormity out to our members and try and get feedback so we can figure out that we're in fact reflecting our membership's views.

Mr. STARK. Thanks. Thanks for your consideration.

Chairman RANGEL. Let me follow up on that. Not only have we had the hearings, but I wish before I get a chance to talk with you, we need the Chamber. It's important to the country, it's important to the Chamber, it's important to our economy, and I personally think it's important for competition to have a healthy workforce. Do you agree with all of that? Do you know the prices are soaring for employers as well as for individual employees? Some of the things that were laid out there, I would like to clear up.

What I would want you to do as I go to Mr. Higgins and the Republicans is to make bullets of the things that you've said, the mandatory, the inability for small businesses and those things, because we're too close on this thing for you not to be able to get to your membership and to recognize that maybe there's some fine-tuning to be done. That's why this is a draft bill. But we have to be joined at the hip on this, and I am convinced in talking with the Chamber people and businesspeople that we can come together. So just bullet these things and we'll get back to you. What we can't cover today, we'll cover this afternoon, fair enough?

Mr. RANDEL JOHNSON. Yes, Mr. Rangel. We have a conference call to the Chambers on Thursday, we'll be running through the provisions of the bill, a broad nationwide conference call, and we will certainly be——

Chairman RANGEL. Terrific. Now, Mr. Higgins through no fault of his own did not get a chance to question the last panel. And so you may proceed.

Mr. HIGGINS. Thank you, Mr. Chairman. A lot of the debate is centered around the so-called public plan or not-for-profit plan. The proponents of the not-for-profit say that it is advanced to drive

competition, to improve quality, to contain and lower costs. The opponents of change, the defenders of the status quo, say that a not-for-profit will put private plans at a competitive disadvantage. It will lead to a single payer system. It will be like Canada. It will be a European style. It will be a massive Federal Government takeover of health care. These are scare tactics that are designed to confuse people to a point where they say, well, the system may not be perfect now, but we can't risk changing things.

What I want to talk about is America. In America today, there are 298 million people. One hundred fifty-three million have employer-sponsored coverage. Fifteen million people have individual coverage. Eighty-one million in Medicare and Medicaid, and 46.7 million don't have insurance. Nine million of them are kids. In America, we pay 2.5 trillion dollars a year for health care, 20 percent of the American economy. These costs are expected to grow by 6.7 percent annually or up to 8 percent. We have a potential liability of another trillion dollars to try to cover those without insurance.

So as we focus on this public and private plan, if you look at all the studies that have been done, the Dartmouth study, contemporary and historical studies in the problems of the health care system in America, the Atul Gawande study in the New Yorker. It always cites the places that do it well. They cite specifically the Cleveland Clinic. They cite the Mayo Clinic. And guess what? Those places are delivering highest quality, low-cost care, and they just happen to be not-for-profit. The doctors aren't tenured. They're salaried. They have 1-year contracts. There is peer review. Doctors are doing what doctors are supposed to do and not dealing with insurance companies. You know, cardiologists, the national average salary for a cardiologist is $370,000 a year. At the Cleveland Clinic, the average is $336,000 a year. An oncologist, national average is $270,000 a year. At the Cleveland Clinic, it's $254,000 a year. There's a more generous compensation package for those at the Cleveland Clinic, including covering their malpractice insurance premiums.

The point here is, if we're going to do a not-for-profit plan it should be designed to do one thing. It should be a countervailing force for a system that everybody agrees is unaffordable, unsustainable and unacceptable. Let's look at what works. Now I know from information I got this morning that the President and CEO of the Cleveland Clinic is here in Washington. The problem is, he's not here before this panel, and that's who we should be looking to for information about how to structure the fundamental piece of health care reform, and that's a not-for-profit, not for unfair competition, but for fair competition, an American system where we pay more per capita than anybody else in the world. And our outcomes, our health care outcomes, are unacceptable and getting worse.

That's all I have, Mr. Chairman. Thank you.

Chairman RANGEL. Thank you. The Chair recognizes Mr. Camp.

Mr. CAMP. Thank you, Mr. Chairman. It was clear in talking to the last panel that many of them had not had time to read the bill. I presume that's the same with this panel. I don't know if any of

you spent the weekend. It was just released Friday night. Have any of you had a chance to read the whole bill in its entirety? Well, good for you. Two of you have. Skimmed? All right. Well, I do think what we're trying to get at today is actually how the provisions in the bill will affect health care as we know it.

And one of the things that the draft bill would require is that employers offer to pay for health insurance for full-time employees and their dependents, and if they don't do that, there's an 8 percent payroll tax. And I would say to Mr. Johnson, what impact will that have on the 14 million Americans currently unemployed? What will the potential of that payroll tax on health care do for the unemployed? And also for the prospects of economic recovery in general?

Mr. RANDEL JOHNSON. Well, for better or for worse, there has been a lot of studies done on the so-called pay-or-play mandate. Now these studies, because they're not exactly on the legislation before us because the studies were done before the legislation was introduced on Friday. But invariably——

Mr. CAMP. Can you speak into the mic a little bit more?

Mr. RANDEL JOHNSON. Yes sir.

Mr. CAMP. Thank you.

Mr. RANDEL JOHNSON. There's been many studies done, Congressman, on the impact of the pay-or-play mandate on lower-wage workers. Principally the pay part, a civil penalty, has an adverse impact on job growth and in fact will result in job losses and lower wages. Why is that? Because there's only so much money that employers have for the bottom line, and when they have to pay a substantial civil penalty, that payment is going to come from somewhere, and that's going to come from their operating budget, which is often taken out in terms of less job growth and adverse impact on workers in terms of their wages.

Now this isn't the Chamber talking. It's a variety of studies that I have cited in my testimony. What exactly will be the 8 percent, the impact of what is in this bill? Well, I think it would be some interesting modeling, but it's certainly not going to be helpful to many workers who are going to lose their jobs because of that mandate. Will it result in some additional coverage? Hard to say. I mean, these are the—this is the tension that the Committee is dealing with, I understand. But they've got to look—I ask that the Committee look at the true impact of an 8 percent penalty on employers and the fact that this is real money.

Mr. CAMP. There's also a new tax on employers in Section 411 of the bill, who promise to write health insurance that meets certain government-approved levels of benefits. And if employers make an unintentional mistake that really doesn't bring them up to the level of coverage required by the government, they're subject to penalties as high as $500,000, even if those mistakes are unintentional. Does that seem like a punitive penalty on small business?

Mr. RANDEL JOHNSON. Thank you, Mr. Camp, because I was not aware of that part of the bill, and I'll certainly bring it to the attention of our Chambers tomorrow. It seems like an awfully high penalty for an unintentional violation obviously. It's certainly in

the aspects of employment benefits or on labor law generally, it's far in excess of anything we see in other employment laws.

Mr. CAMP. Clearly there will be costs associated with this pay-or-play mandate, and I would ask you, Ms. Hansen, do you feel that this cost might cause employers to offset the costs by dropping retiree health coverage? Do you see that as a concern?

Ms. HANSEN. Of course, our concern is continuity of coverage for individuals. So I think it depends on how the program eventually is structured as well as our ability to make sure that there's an affordability factor, again, whether it's the consideration for the employer, or then if it gets passed on to the employee, that there is some way that that person can still participate in coverage. So, the difference will be subsidy. And ultimately it's coverage that we're still looking for.

Mr. CAMP. So the possibility of losing retiree coverage is something that would concern you a great deal because it would mean that continuity would be broken?

Ms. HANSEN. Well, we've been watching how companies have chosen to go this route, so I don't think it's just this particular effort. It seems to have been a trend going regardless of this movement.

Mr. CAMP. Certainly its health care costs have increased, and so you—certainly it would follow that if employer costs are increased even more that you might even see that problem exacerbated?

Ms. HANSEN. Well, I do agree that it's really about how much cost is, whether it's borne by one party or the other, it's having it affordable.

Mr. CAMP. All right. Thank you, Mr. Chairman.

Chairman RANGEL. Okay. I want to get back to the business of the Chamber. It was so good seeing you at the White House as stakeholders and agreeing that the system is broken, that employers are doing more than their fair share, that the prices are soaring, that most industrialized nations are competitive. General Motors once said they pay more for health care than they do for steel. Employees can't afford to leave or lose their job for fear of losing their health insurance. It's a better, healthier competitive America when they're educated and when they have health care.

Hey, this is Chamber type of talk. This is America type of talk. Half of your statement was knocking what we've done. I want you to help us to improve what we have done, because you can't challenge that we have mutual goals. You can challenge the process, but this is draft, D–R–A–F–T, proposal. And to be able to persuade you as the small businesspeople are persuaded, because quite frankly, from a political point of view, that's where I get my jobs, from the small businesses, they need this. They want to be able to afford to do this.

When we had businesses here at one of our half-dozen hearings, they said you do what you want. We're going to take care of our employees. And the employees said that, hey, we got our policy. We enjoy it. Just stop the premiums. The whole idea that unions have to negotiate instead of for wages, most of those things are going for health care. So when we say 8 percent, that was less than what they already pay. And I don't think you challenged the fact that

having a competitor when you're throwing these hundreds of billions of dollars out there with people who could never afford health care, heck, your corporations are paying for the health care of the uninsured in higher premiums. And now for us to bring those people to the marketplace with the security that they can get insured, you know that has to bring down the premiums for your members, and for the small businesspeople who hope to be your members one day.

So what it is that we've said that you now have bulleted that we can talk about but you can think there's a better way to do it? If you don't like the mandate, that means we've got to lead the whole for people to—that don't have the same consents for reform as you and I do to get a free ride? No. Everyone, the young and the ambitious and those that hope that they never get sick, has to be there in order to broaden the pool and reduce the premiums. So I'm disregarding your negative rhetoric because I have worked so hard with the Chamber to recognize that you need an educated workforce. It's not a local issue. And you've worked with me and others. You need a healthy workforce and not spend so much time in terms of providing paying for health care and spend more time with wages and being competitive with the foreigners. So just tick off those things, if done differently, you can say that's what I was talking about. Slow down the train and let's get on board.

Mr. RANDEL JOHNSON. Mr. Chairman, first, I can assure you that we don't, as short as the time we had to review the bill, we don't come up here without gauging where our membership is before we testify. The reality of it is, the employer community spends $500 billion on health care now voluntarily. I suppose—could they be required to spend more? Well, the Congress could make us spend more I suppose. We are already doing our fair share.

Many of our members and the bigger companies——

Chairman RANGEL. That goes unchallenged, so we strike that off. We want to make certain that you not get increased premiums for doing more than your fair share, because you're paying for people who don't have health insurance. You know it, I know it.

Mr. RANDEL JOHNSON. I understand. And we also have many members who simply cannot afford to provide health insurance or pay an 8 percent penalty because they cannot.

Chairman RANGEL. They can't afford to provide health insurance or pay the penalty, we're there to help them. It's in the bill. We'll go through that. We're just saying if you agree not to participate, you've got to pay something so that we can help your employees get insurance which 99 percent of large employers will maintain and want to do. I'm spending more time with the small businesspeople who need more help. There's no conflict with the CEOs in doing this. They're going to keep their plan. I want to reduce their premium.

So mandate—we'll talk about that. But anybody would tell you, you've got to get everyone in the pool if you're going to bring equity to everyone else. And I really think the major players are going to be helped by doing this, and they don't have to be told what to do. We just want to make certain that no one gets a free ride.

What were the other things that disturbed you about our behind the closet job that we've done?

Mr. RANDEL JOHNSON. Well, the public plan option, which was much discussed at the first panel, is troubling to us, because in various reasons that were laid out. One is it does rely on Medicare reimbursement rates, which results in a cost shifting——

Chairman RANGEL. What does it do?

Mr. RANDEL JOHNSON. Relies on Medicare reimbursement rates. I believe that's right.

Chairman RANGEL. Well, it bumps up the Medicare rates, but this is what the doctors are relying on. If they don't want to participate, they don't have to participate.

Mr. RANDEL JOHNSON. I think many doctors feel they have to participate in Medicare because that's where the money is and that's where the patients go.

Chairman RANGEL. If that's where the money is, that's what they're looking for, what do you want us to do, deny them the money? Where are they going to get the money if we don't assist 50 million people to go out there and to compete?

Mr. RANDEL JOHNSON. Well, Mr. Chairman——

Chairman RANGEL. And not only that, we are including a whole lot of physicians, primary care physicians, to come in to help the country to provide basic health care. You support that. You have to. I'm submitting that we are going to agree to more. It may be the process, and you're entitled not to like it. We can make up for it. But I just want you to take off some of the things that happen in the dark of nightness that you say that I can't get on board here, because we've got to work it out.

Okay. We'll pass on and we'll—you say you're having a conference call?

Mr. RANDEL JOHNSON. We do one Thursday, and I guarantee there will be a lot of Chambers because a lot of people are starting to pay attention.

Chairman RANGEL. Well, try to get it in an orderly way where you can get your questions, your objections so that at least we can tell you where we stand. But we're not going to leave this train without you. Okay. Who's supposed to be recognized? Mr. Herger is recognized for 5 minutes.

Mr. HERGER. Thank you, Mr. Chairman. And I'd just like to point out, now we've been talking about this for a while now. This is the first hearing we've had actually since we've had a bill that's been presented. That bill was just presented on Friday, 850 pages worth. Of our six panelists here, only two have mentioned they had an opportunity to read it. So, Mr. Chairman, we do have some concern. We have some major concerns. And I don't think these concerns should be overlooked or made light of. These are major concerns that it isn't just the Chamber of Commerce that has concerns, small businesspeople and citizens all over this Nation have concerns of how we're going to pay for it and how we're going to do it. And bringing this up on a Friday right before a weekend, Father's Day weekend, and then just coming up the next week of panelists who were chosen before, again, I don't think we should be making light of this.

I also have in front of me, it's not just the Chamber of Commerce. NFIB, National Federation of Independent Business, came out, a quote from them. They say NFIB opposes employer man-

dates that threaten the viability of our Nation's job creators, and an 8 percent pay-or-play mandate will inevitably harm job creation. Research shows an employer mandate could cost 1.6 million jobs, hardly what this country needs in these challenging economic times.

Now, Mr. Johnson, in addition to requiring employers to offer and largely pay for health insurance, this draft Democrat bill would allow non-elected officials to mandate a minimum benefit package. And just as Mr. Draper, a small businessman, mentioned in his testimony, or alluded to, is it possible that this minimum benefit package would be so expensive that the 8 percent payroll tax could be a cheaper and more predictable option for employers? And if so, what impact would this have on employer-sponsored health insurance that the majority of Americans are accustomed to and who currently like?

Mr. RANDEL JOHNSON. Yes, Congressman. And if you look at the bill, and that was one of the areas I did get through, would it be cheaper? Unlikely the way they've spelled it out, which is this board apparently with the minimum benefits package would at least have to include hospitalization, outpatient hospital, professional services, prescription drugs, rehabilitation, mental health and substance abuse disorders, preventive services, maternity benefits, baby and child care.

So—and then it says the board can add on to that. We don't know what the board is really going to do, and this is important, because it controls both what would be the adequate package for the purposes of playing instead of paying, and also who would benefit—what kind of companies could benefit to participate in the gateway. The bottom line could very well be that some companies will say, I'm not going to bother to figure this out. It's complicated. Or, Congressman, that my type of plan doesn't fit. I have a generous plan, but it doesn't fit the definition of this board, and so I'm going to walk away from this, and I'll just do the minimum. I'll do the minimum benefits package, or perhaps I'll pay the fine, and to heck with it, you know, I've had it. I've tried to do the best I can. The government thinks it's doing its best. It knows best. So, fine. I'll just do the minimum package and skip the hassle. And that will result in less coverage overall for some number of Americans. How many? It's hard to say, but that's one of these uncertainties we don't know because we haven't had adequate time to sort of vet the bill with our membership.

Mr. HERGER. And of course the big thing we've been hearing from the President, we've heard from a number of my friends in the Democratic party have indicated that if you like what you have, you can keep it. But the bottom line is, even if Mr. Draper's employees like what they had——

Mr. DRAPER. They don't.

Mr. HERGER. And we see these rates—and they don't—if they see these rates, let's say they did.

Mr. DRAPER. Okay.

Mr. HERGER. Because most Americans like what they have. So you have some who don't. But let's say most of the Americans who work for small business who like what they have, Mr. Draper could very well be forced into taking this 8 percent because that's cheap-

er than perhaps the 10 or 11 percent or whatever it might be that you could be paying now.

So, therefore, we would not be able to keep what we like. We'd be forced into a potentially Canadian-U.K. type system where we're rationalized. Do you see that as a concern?

Mr. RANDEL JOHNSON. I think it's the very uncertainty of this sort of question that is beginning to alarm the American public which accounts for the recent poll in the Washington Post where it says most respondents are very concerned that the health care reform would lead to higher costs, lower quality, fewer choices, a bigger deficit, diminished insurance coverage and more government bureaucracy.

It's these kinds of uncertainties about the bill and the impact of these kind of provisions I think are getting out and are troubling people, and that could be the result, Congressman, who knows. But it's an awfully big question to go forward without answering.

Mr. DRAPER. In Des Moines we only have two choices, so it's hard to get fewer than that. I guess you could. You could get one.

Mr. HERGER. Thank you, Mr. Chairman.

Chairman RANGEL. The situation is, we have about seven votes on the floor. And so we have to, and we apologize for it, recess until 3:00 p.m. And for Members, that is 3:00 p.m., or if there happens to be another vote after that. So, Mr. Levin, if you would want to stay. So we hope all of you can stay with us until three and have lunch. We certainly will understand if your schedules cannot permit it, and the Committee stands in recess.

[Recess.]

Chairman RANGEL. We can't apologize enough to our dedicated panel for staying here while we probably did less productive work than you did during this break, but we certainly want to thank you for your dedication helping us out, and we'll start off, or continue rather, with Sandy Levin of Michigan.

Mr. LEVIN. Thank you. Sir, let me, as we reconvene, try to follow up on what you and Mr. Chairman have raised and to talk at least for a minute or two with you, Mr. Johnson. In recent hours, much punctuated, we moved from the public plan as the focus to a discussion of the employer mandate, and I think in a sense that was a useful transition, so we talk about a number of these provisions.

And in your testimony on page 4, you say that you adamantly oppose the pay-or-play proposal. And you call it a sword of Damocles. And then after you say employers are already doing their share and more, you say that those who can't—who don't cover, don't, because businesses that can afford to offer benefits already. And then you say further on, a smarter approach would be to focus on bringing down the costs of health insurance.

Picking up the theme that our Chairman has put forth, I would like to encourage the Chamber to participate actively in the discussion, including the issue of an employer mandate. Because I think the reality is that there's going to have to be some requirement of coverage with perhaps some exceptions, and we left that open in the bill as to what if any exceptions would be made and what kind of credits would be given to employers, depending perhaps on size. So this is an issue that needs to be addressed. I think there will

be a requirement in order to bring more people within insurance, but its exact shape remains to be determined. And so when you say here that, on page 4, that you adamantly oppose a proposal and it doesn't matter what's in it, you essentially withdraw your organization from a discussion of what the plan might look like. And I think what Mr. Rangel has said to you and others of us believe, that it would be better if we could have broader participation. So I don't know if you want to comment on that, but the issue of employer participation, look, we're talking about an employer-based insurance system being maintained, and if that's true, I think almost certainly that will mean that more employers need to cover their employees.

So I would hope that you might in future presentations not talk about a sword of Damocles and it doesn't matter how it's shaped, you oppose it, to saying that you have whatever you want to say. Does that make any sense to you?

Mr. RANDEL JOHNSON. Yeah, it does, Congressman, and I will—obviously, I'm going to go back to my policy committee and we'll see where we go.

Mr. LEVIN. Good. Mr. Shea, do you want to talk quickly about the issue of taxation of benefits, of health benefits?

Mr. SHEA. Thank you, Congressman. I said we think this is a very bad policy because not only is it asking people to pay when they're already paying a lot of money, pay more, when they're already paying a lot of money, it is also inequitable because small firms, any size groups with large numbers of older workers, really retirees, high-risk industries, there are a lot of factors, or just health status, there are a lot of factors. And we've looked at plans side-by-side. So I got an example from one of the construction trades of two Western State plans, same trade, same age, and roughly the same demographics otherwise. The difference in cost in the two plans for similar benefits was one was 10 thousand and something, one was 16 thousand and something. And actually the one at 16 thousand had higher copays and deductibles. The difference was claims experience. And what that means, as you know, is health status. Well, I don't see how the Congress is going to be able to go to their constituents and say we're going to do this, and, you know, some people are going to get hit—smaller firms are going to get hit harder. So that's a huge issue.

The other thing is, I just—I started my comments by saying I don't think you can do this without going outside the health care system in the short term. In the long term, if we can capture some good percentage of that 30 percent of the annual expenditure that we waste, according to the Institute of Medicine, then we'll have a lot of money to fund reform. But that's going to take a few years.

Mr. LEVIN. My time is up. It gives me 30 seconds, 15 seconds, Mr. Johnson. Regarding bringing down cost of health care, and it's on page 7, when you get on that telephone call, talk more, if you would, with those on it specifically about what kinds of plans might bring down the cost of health care. Because Jerry, Mr. Shea, I hope it's not only a longer term. A number of us think we have to find some additional measures to straighten out, for example, physician reimbursement in the shorter term, and not only the longer term. And we would like your assistance on that, too.

Mr. RANDEL JOHNSON. Well, and we're totally committed to doing this right away as soon as possible. I'm just talking about the effect. And by the way, while I'm on the subject, Congressman, thank you for your legislation on quality and delivery system reform. It's the kind of proposal which really is moving this whole discussion along, so I just wanted to thank you.

Mr. LEVIN. Thank you, Mr. Chairman.

Chairman RANGEL. Thank you. Mr. Sam Johnson of Texas.

Mr. JOHNSON. Thank you, Mr. Chairman. You know, Mr. Johnson, during the first panel, we talked about what would happen if the health care choices commissioner loaded up the essential benefits package with a lot of mandates on coverage, my understanding of this bill is that the commissioner will have the ability to regulate both government-run and employer-sponsored health insurance plans. One thing that's yet to come in the hearing is whether or not this health care choices czar could unilaterally decide to cover abortion services in this newly formed government-run plan. And I think the President said that's something he wanted to do.

If that's the case, that would be an historic reversal of public policy, and if this government-run plan could be designed to cover abortion on demand and taxpayer funds are used, I think that the cost of health care in this country, if one bureaucrat in Washington had the power to decide what kind of health—type of health benefits your companies had to provide to its employees, if, for instance, they decided not only abortion but acupuncture and hair transplants and whatever, would employers decide to get out of the health care system?

Mr. RANDEL JOHNSON. Well, without taking a position specifically on—I think you pointed to the broad authority this board has to add a long litany of required procedures or treatments, depending on who has the most—who has the ear of which politician on Capitol Hill and the board. So, it's opening a door to an analyst's list. And I think, Mr. Johnson, you agree, we've never seen a government program be reduced. It's always gotten expanded. And so at some point, an employer would say I'll just pay the fine and get out of this business instead of trying to figure out how to squeeze my plan, which is a very generous plan, into the square peg of this new mandated government board, you know, required health care benefits package.

So it's a real, you know, unknown peg in a hole that we're concerned about, given how wide open this bill has left it to this mandated program.

Mr. JOHNSON. No, I agree with you. I think they would get out. Mr. Kirsch, you cite the New York Times article as evidence that Americans are completely sold on a government-run health care plan. However, that same New York Times poll also found 63 percent are concerned their own health care would get worse under a government-run system. Sixty-eight percent believe a government-run system would limit their access to treatment and quality care, and 53 percent are concerned they would have to give up their own doctor under a government-run system. Sometimes with polls you got to get past the first question to find a real answer, and I wonder if you would comment on that.

Mr. KIRSCH. I would love to. In fact, the whole thing about a poll is if you'd ask it as a negative question, you'll get that answer. So we actually did a poll back in January to find out what would happen in a real debate, and I think you'll see from the questions we asked, we didn't pull our punches. So let me give you some examples of the questions we asked. The first one was, "a public health insurance plan will force people into lower quality care, including long waiting times and rationing of care," which is the argument that we hear oftentimes from folks on your side of the aisle, versus "a public health insurance plan that would provide people the choice of an affordable plan that includes at least the same benefits as Members of Congress get, including a wide choice of doctors." That argument wins by 38 points.

Let me go on. We hear this cost shifting argument: "Like Medicare and Medicaid, the new public health insurance plan will reimburse doctors and hospitals at much lower rates, causing many doctors and hospitals to shift costs to people who buy private insurance." The other argument was: "A public health insurance plan will be able to control overall health care costs for everyone by using its purchasing power, like the Veterans Administration does now, to drive competition and lower the prices paid for health care service and prescription drugs." People favor that argument by 45 points.

Let me do one more that we also hear from people who oppose the plan make. "Establishing a government health insurance plan will mean that millions of people will lose their private health insurance coverage because employers will drop their private insurance and dump people on the public plan," an argument that Members on your side of the aisle have made oftentimes today, versus the argument "under the current system, millions of people are already losing their health coverage every year, having a choice of public or private health insurance plans will make sure that Americans always have an option for quality, affordable health care." Americans side with that argument by 47 points.

So we did this poll to find out in a real debate in which Americans hear both sides of the arguments, where will people come down. We thought we might win these by a little, may lose some of them. We won every one of them, mostly 30 to 40, almost 50 points. And so the first question is what Americans want choice isn't complicated. People like a choice of a public or private health insurance option, and the choice should not be a Member of Congress' choice. It should be a choice that each person makes.

Mr. JOHNSON. Well, I think you got the Member of Congress thing backward. We don't get free health care by any stretch of the imagination.

Mr. KIRSCH. This isn't free. People have to pay based on what they can afford.

Mr. JOHNSON. Thank you, Mr. Chairman. We're out of time. I yield back.

Mr. MCDERMOTT. Thank you, Mr. Chairman. Thank you all for waiting, because we need to hear from you, the things you've got to tell us. But particularly Mr. Draper. These other folks are here representing organizations and they're paid for sitting here and so forth, but yours doesn't look like quite that circumstance, and——

Mr. DRAPER. Our lobbying budget is very small.

Mr. MCDERMOTT. And before I came back to Washington this last week, I stopped and talked to two people I know in Seattle who run small businesses. One is "Cupcake Royale," a woman named Jody Hall, who was down at the White House testifying on behalf of small business, and the other one was Molly Moon, who runs an ice cream store. And they have employees about like you, 10, 12, 14 people.

And what I'm interested in hearing from you is what is a small business? How should we do that? Should it be by volume of people that they employ, or should it be on the basis of their income, or what would you use? And then second, I see in your testimony you say the most basic coverage makes up 8 percent of our gross payroll. So is that too much to ask of a small business? Now I know you don't represent the thousands and thousands of small businesses, but I'd like to hear how you decided that you could spend up to 8 percent of your payroll on health care.

Mr. DRAPER. I mean, we didn't have much of a choice on spending up to 8 percent of our payroll on health care, because that's the cheapest plans we can get. I think one thing is that somebody who's in their twenties kind of looks at employer-sponsored health care as kind of old fashioned and that you're tied to this company for life. You need to stay with them. If you leave, you have to try to get COBRA. Once you leave, you have to try to get another company to pick up your health care.

So it makes it kind of inefficient if you want to move around and kind of do your own thing. And so the employees at SMASH didn't want us to even shop for a health care plan through the company. Everybody wanted individual plans that then the company subsidizes. So everyone is in their twenties, single, and their individual plan is about $200 a month, which comes out to about 8 percent of payroll.

Mr. MCDERMOTT. What does that cover? Could you give me——

Mr. DRAPER. An individual plan through Wellmark under Blue Cross and Blue Shield is just really rudimentary. It's just basic. It's not dental, it's not vision. It's pretty high deductible. I think they say you get one free doctor's visit, but it costs $10. And the copays kind of depend on what you get done. So, if I go in for sinus surgery which was $12,000, you end up paying about $1,500 of that surgery, which is only 10 percent, but when the national savings rate is below zero, I don't think the average person has $1,500 laying around. As a small businessperson, I have just money coming out my ears, so it's not a problem for me.

One of the things that I look at is the difficult thing and why I say it fluctuates between 8 percent and 24 percent is that there are the hidden costs, and if you actually use care, you have to pay for it. And so even if you're paying $200 a month, if you have several problems that year, you may pay even more in actual hospital bills than you do in premiums. And so our company has agreed to pay those bills for our employees. Just because I know that somebody has to pay them. And if one of the employees is in financial trouble because of bills, that puts the whole company in trouble. I

mean, they're not easily replaceable, so if one person goes bankrupt we can just get rid of them and bring in somebody else.

I don't have a problem with the 8 percent if I knew that then they could go—if I paid 8 percent, I'd be fine with it if I knew that they could get full coverage at an affordable price through the exchange.

Mr. MCDERMOTT. So you're saying that if they—since you're a small business and you I think you say you have 12 people——

Mr. DRAPER. Yeah.

Mr. MCDERMOTT. So if we set the limit at 20 and said anybody under 20 is a small business, that those people could go into the exchange and get their insurance and the subsidies that might go with that, and you would pay 8 percent, seems like a reasonable deal to you?

Mr. DRAPER. Yeah. I mean, that would be fine with me just because our costs are set. I wouldn't be fine with it if, you know, it's about $600 for an individual—for a family policy through the individual market. So if I was paying 8 percent and then they went onto the exchange to get a family policy and it was the same price as it is now, that would irritate me. So it's a little tough to see exactly—it's hard to compare in a hypothetical situation. But if paying 8 percent did lead to a drop in health care prices, I would support that. And I don't think 8 percent is necessarily too much to ask, and I don't think it's too much of a responsibility for small business just for the fact that I already pay for my employees' withholding tax and unemployment tax. If you guys came in the shop, I would pay the sales tax you owed. These are just some of the responsibilities you have to deal with when being in a small business and being at the top of the ladder. And I don't mind paying taxes if they're going to something efficient, I know they have a purpose. It's only the taxes that are unnecessary, like what I pay now, which is for private health care, but I'm also paying taxes subsidizing people without health care to go to the ER.

Mr. MCDERMOTT. Could I stop you? I see my time is almost up. I want to ask one question. Some people are saying that we should not make a small business five people if the five people have incomes of $100,000, a small lobbying firm here in D.C., they shouldn't be eligible for the small business thing, how much do you pay—what's your average salary in your business?

Mr. DRAPER. It probably comes out to $45,000 a year. It's a base of $38,000 plus bonus, so that's kind of what it averages out to. But then there's lower paid employees that are just hourly. If they're one of our employees, they would essentially be in the mix. So I think you're pretty much going to have to do something that's a mix of number of employees versus payroll. You don't want people just starting sham fake businesses so they can get out of getting health care and just pay an 8 percent fee. But I think if you do a mix of employees and payroll, it should be pretty simple.

Mr. MCDERMOTT. Thank you very much.

Chairman RANGEL. Mr. Ryan.

Mr. RYAN. Thank you, Mr. Chairman. Ms. Hansen, let me ask you—you took Bob Novelli's job or Bill Novelli's job, or?

Ms. HANSEN. No. Actually, I'm a volunteer. The President's role in the organization——

Mr. RYAN. Gotcha. Gotcha. Okay. I was just trying to remember. Bill retired, did he not?

Ms. HANSEN. He went to Georgetown.

Mr. RYAN. Yeah. Right. Great. He's a good guy. I want to ask you about AARP, your position on these issues, and just sort of your sense of the future. I've been very impressed with the—I think you called it your Divided We Fail campaign with the elephant and the donkey.

As you know, the current unfunded liability for Medicare is $38 trillion. Medicaid, which does affect the over 65 population, it's a tougher number to crunch because of the State involvement and Federal—some estimates come in at about $20 trillion of unfunded liability. Are you concerned that we're creating a new entitlement here that will rack up a similar unfunded liability?

Ms. HANSEN. Well, I think framing it as a new entitlement as compared to looking at the basis of coverage——

Mr. RYAN. You don't see this as a new entitlement?

Ms. HANSEN. I think it's a choice of a health care program that would cover people. So I personally, from my role, am not calling it an entitlement. I wouldn't call it that personally.

Mr. RYAN. Just to say, if you qualify for it and you get it, that's an entitlement. Such as if you're under 400 percent of poverty, you go in the exchange, you get the subsidy. Therefore it is by definition an entitlement. Just for the record.

Ms. HANSEN. Well, I think there's—my understanding, and I may be wrong, but I think that people are actually going to pay for that as well, so it's not just a free—it's only if you——

Mr. RYAN. Well, people on Medicare pay part of their premiums as well, so—and there's copays in Medicaid. So, yeah, we're not saying it's 100 percent, but it's subsidized. So the point I'm trying to ask is, is AARP concerned because they had this great impressive campaign that we have pending insolvency of Medicare and Social Security, are they not concerned that we're adding to the list of new programs and liabilities?

Ms. HANSEN. I think AARP is concerned about solvency and economic stability for the future, yes, we are concerned about that, because besides the fact that our members are 50 and above, our members are parents and grandparents and great grandparents. So we are very much concerned about economic security for the future of this country.

Mr. RYAN. So every year we delay fixing just Medicare and Social Security, we go about 4 trillion, 3 to 4 trillion in debt to those programs, the sooner we act, the more likely we can prevent those in and near retirement from having effects to their benefits. Most of the plans that some of us on this side of the aisle have put out plans to make those programs solvent. They don't affect people over the age of 55. The more delay that occurs, the less likely changes will not affect people over the age of 55. So my—let me ask it this way. If it is clear that this new benefit creates a new unfunded liability for the Federal Government on top of the already existing ones which AARP has put an impressive campaign out there to fix, will AARP come out against this and have a problem with this?

Ms. HANSEN. No. We're on record for wanting some real change in the existing program itself.

Mr. RYAN. Are you on record for the public plan?

Ms. HANSEN. We—the board of directors actually met within the past 2 weeks before any document was seen. We came up with five core principles, and the principles, I'll read them——

Mr. RYAN. Don't go through all of them, no offense, because I've got a 5 minute thing. Does this bill satisfy all of your five principles?

Ms. HANSEN. As it's come out right now, the plan that the——

Mr. RYAN. The Tri-Comm plan.

Ms. HANSEN. The Tri-Comm does seem to house the core principles.

Mr. RYAN. So as far as you know, AARP, this bill satisfies your principles?

Ms. HANSEN. We're just saying—we're saying elements of the bill certainly are supportive of the issues we care about.

Mr. RYAN. Mr. Johnson, real quick. If the actuaries are right, and when I say the actuaries, Lewin, CBO, HSI, all of them from varying degrees show us slippage, meaning private sector dumps some people on the public plan, 8 percent payroll tax. That means a payroll tax eventually goes to 23 percent, at least for those firms that make this decision, as Mr. Draper mentioned he would make. What do you think the effects of a 23 percent payroll tax on labor in America are going to be to our economy?

Mr. RANDEL JOHNSON. Well, it's—it would be devastating. We're already paying of course the tax and we have this 8 percent proposal, and 23 percent, I mean, that's a 23 percent jump on wages that you have to pay with no attendant increase in productivity. So that will result in lower job growth or elimination of jobs because you've got to make up for that loss at the bottom line somehow otherwise. I mean, it's pretty elementary economics I think, Congressman.

Mr. RYAN. Thank you. My time has expired.

Chairman RANGEL. Mr. Becerra of California.

Mr. BECERRA. Thank you, Mr. Chairman, and to all the panelists, thank you for your great patience and all of your very important testimony. I'd like to begin by asking a little bit about this whole notion about what will happen if we have this new marketplace for options.

Mr. Draper, you're a businessman. You have folks who work for you. You mentioned how you thought you could live with a plan that worked to reduce costs so that you could then as an employer feel comfortable making some contributions. Let me ask a question. Would it be your intention to dump your employees into any particular plan?

Mr. DRAPER. What do you mean, like steer them toward one particular plan?

Mr. BECERRA. People continue to use this word "dump" as if we're going to take a flock of American consumers and just drop them onto a particular plan in a marketplace where, my understanding is, the choice will be the consumer's, not the employer's, not the health insurance company's choice, not even a public insurance plan's choice, but who it will serve. The choice will be that of the consumer, your employee. So let's say you decide you no longer want to offer health insurance, first I would ask if—because it

sounded to me like you would be willing to provide some contribution, but if you decided not to, do you think you would want to then dump your employees onto any particular plan?

Mr. DRAPER. I mean, not really. We already have the cheapest plan we can get, so I'm not sure what other plan we would dump them onto.

Mr. BECERRA. And the point here is that, one, you're willing to make a contribution, so you're willing to try to help them get a plan. But the way this new program would work is that your contribution would make it possible for your employees then, if you were to not offer a plan directly, to take your contribution, use it to then be able to go into that marketplace and shop for any number of plans that would be out there, a competitive menu of plans that would be provided by private insurers and a public insurance option that would be out there. And whether somebody would attempt to dump employees into this new marketplace, ultimately the choice wouldn't be the employer's about where they would end up.

Mr. DRAPER. Yeah, that's true.

Mr. BECERRA. The choice would be the employee's or the consumer's about which plan they would select.

Mr. DRAPER. Yeah. And, I mean, I think it doesn't—it wouldn't have as much of an impact on us, because we already buy individual policies for the plans. And so we already do what the exchange is doing, and that they get to pick out whatever individual plan that they want. I think one of the biggest problems you have now is that it's kind of like when I watch old people at Walgreen's trying to enlarge their own photos, in that it seems easier because, well, you have control over it, but they don't know how to operate the machines. It saves Walgreen's some money because they don't have to do it anymore. But it takes them longer and gets them a worse product if they do it themselves.

I don't read plans professionally. I mean, it's not what I sit around doing. Most of my time is spent thinking how can I generate more money to send in taxes to the Federal Government. And I think that's probably what you guys want me to be doing rather than spending time sifting through plans.

The problem we have now is that they're written so complicated that it's hard to understand exactly what your deductibles are. So I wouldn't want, you know, just my employees to be shopping through the complicated plans we have now in the same way I wouldn't want the employees investing my money for me. It's just—I don't have faith that they'll be able to do it. My dad is an insurance attorney, so he actually reads through our plans for us, but not having that kind of crutch makes it really hard. So I think on the one hand you need the exchange to really simplify, like people were saying earlier, have a standard for how to compare plans one to the other, which we don't have now.

Mr. BECERRA. Well, the good thing is, it sounds like what you do is you give your employees a choice of what plan they want to take.

Mr. DRAPER. Yeah. They can get any plan they want, and we just, through my dad's recommendations, we'll recommend to them this one is a good plan.

Mr. BECERRA. And you have goals this health care reform proposal would in essence build on that model that you described——

Mr. DRAPER. Yeah. I think it matches up with what I said earlier. Most young people want to be able to buy a plan that's not tied to a company. They want to just buy a plan that they can take with them for life. And so it appeals to us more less than if we had a huge company plan. It would be more of a shift, but right now it's not that big of a deal for us.

Mr. BECERRA. Thank you. Mr. Shea, I was wondering if you could comment on the last series of comment and answer that was given about a job loss that might occur if we were to move toward a more cost-effective form of health care.

Mr. SHEA. Well, the ball game here is cost. And if we don't figure out a way, with all due respect, if you don't figure out a way with our health control costs, we can't do any of this stuff. That's really what we've got to focus on. But in terms of sort of what people could afford, you know, we have probably 5, 6, 7 million people who are in multi-employer plans. These are people who work in the culinary area and transportation and janitorial and building and all kinds of trades. You know, in the building trades, I looked at this. The vast majority of those employers who pay into these funds and provide good benefits have under 10 employees.

Now the problem for those employers is they're providing good wages and good benefits, and they have to compete against people who don't provide benefits. And that's the economic distortion that having everybody pay into would play. But then the other thing is, just in terms of I just think you need to simplify this, at least for my mind. Most employers now provide coverage. They want—all employers want to, I think, most do. Those who don't are either in the lobbying firm that doesn't want to pay even though they make a lot of money, and those people ought to pay.

And then there's the people who are probably small, but certainly low wage. And in your plan, as I read it, you're going to provide substantial subsidies, tax system subsidies, for those people. So it seems like you've asked them to do something but you've given them support in being able to do it. And you eliminate this economic distortion.

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

Chairman RANGEL. Mr. Nunes for 5 minutes.

Mr. NUNES. Thank you, Mr. Chairman. I have just a quick question by show of hands. Of the six of you that are up there at the dais now, how many of you have health care coverage, health insurance? You all—all six of you have health insurance. How many of you would like to trade your insurance in for Medicaid? Anyone?

Mr. DRAPER. I don't know the details on Medicaid. So it's just hard for me to say that I would trade for Medicaid, because I don't know how it works.

Mr. NUNES. I'm pretty sure that you probably wouldn't have a lot of constituents that are on Medicaid.

Mr. KIRSCH. Actually, in New York, Medicaid coverage is better than private coverage.

Mr. NUNES. In California it's not. But for the record, none of you——

Mr. KIRSCH. But it is in New York.

Mr. NUNES. For the record, none of you wanted to trade in your own health insurance for Medicaid.

Mr. KIRSCH. I would actually have no problems. Given New York, given the excellent benefits and coverage in New York in Medicaid would be better, and I actually get coverage now through a State employee plan that my wife's part of.

Mr. NUNES. So one of you would like to trade in your health insurance for Medicaid. Five of you would not. What was that, Mr. Draper?

Mr. DRAPER. I'd be willing to try.

Mr. NUNES. You'd be willing to try? You probably wouldn't have to try for very long.

Mr. DRAPER. Put me down on the record as a maybe.

Mr. NUNES. Okay.

[Laughter.]

Mr. NUNES. We'll have you down as a maybe. So that leaves four of you who don't want to, of which I think three of the four are supporting the plan, which, you know, basically what we're going to do with this plan is we're going to put more Americans onto Medicaid. And as you may or may not know, Medicaid in California is completely imploding, and there are specialists who will not see Medicaid patients, and I haven't found a constituent yet in my district that likes being on Medicaid.

And so I can't for the life of me figure out why if we're doing so-called comprehensive reform on health care that we are leaving, not only leaving Medicaid alone, which is a $20 trillion unfunded mandate, but why we would be expanding Medicaid to put more and more Americans onto Medicaid.

Mr. Draper, you said that you had—your business last year was a million dollar business.

Mr. DRAPER. Yeah. This year it will be a million dollars. Last year it was probably $820,000.

Mr. NUNES. And you had—you said you had 43 employees today?

Mr. DRAPER. No, we have 12.

Mr. NUNES. Oh, you have 12 employees? Okay. I misunderstood you. Okay. So of the 12 employees, how many—do you offer health care coverage to all 12?

Mr. DRAPER. Yes, we do now.

Mr. NUNES. And of those—and, what, just a private plan?

Mr. DRAPER. Yeah. They each get an individual plan that they can purchase and then the company pays them back for it, and we also pay for any bills beyond their insurance.

Mr. NUNES. So 100 percent, there's no—they don't pay anything on their own? You pay 100 percent of the health care coverage?

Mr. DRAPER. Yes.

Mr. NUNES. Okay. So of that, you know, one of the plans that myself and Mr. Ryan have talked about is actually giving refundable upfront tax credit for your employees to have so that they'd be able to go out and purchase health care on their own and get to the question that you asked about or the comment, you talked

about portability. You would like to have portability coverage for your employees so that if they left your work, they'd be able to go somewhere else.

Mr. DRAPER. Yeah.

Mr. NUNES. So, I mean, do you see a problem with the plan that some of the Republicans have of giving basically a refundable up-front tax credit to your employees to go out and choose their own health care plan?

Mr. DRAPER. Yeah, I mean, I've said before that I don't see a problem with regulation, but I just don't think that only regulation is going to help us. When I talked to Grassley yesterday, and they said, what we really want to do is just regulate. A headline in my mind said, from the people who brought you bank regulation comes health care regulation. And I worry that if it's only regulation that you'll have the people from the insurance companies regulating themselves and things won't actually get that much better. And it's tricky for me to see how just regulation is going to make rates go down.

Mr. NUNES. But we're—well, our plan calls for——

Mr. DRAPER. I would support a tax break, but I don't understand if that's actually going to get them any better health care.

Mr. NUNES. Well, for a family of four, for example, under our plan, we'd have—they'd get $5,700. And if they were making—I don't know what your employees' average wage is, but let's say that you had an employee that was making less than $20,000 a year. They'd get $11,000 a year to go out and pick their own health plan, any health plan they want. And I would imagine that $11,000, is that more than the plan that you offer today?

Mr. DRAPER. Per employee? Just a second. Let me think.

Mr. NUNES. It probably is.

Mr. DRAPER. Yeah, it would be more than the average.

Mr. NUNES. So one of the things that I'd like——

Mr. DRAPER. If you were going to get a family plan, though, it would be about $700 a month.

Mr. NUNES. So—yeah. So less—yeah. Under our plan, we would give the person in your company that's making less than $20,000 a year, $11,000 to go get their own health plan, which would be better than the health plan that you offer. And I appreciate—I mean, I think it's good that you came here to testify, and I appreciate your openness and honesty. But the one thing that we want to make sure we do and try to get across to the American people is that pushing more people to government-run health care is not necessary. We can have universal coverage for all Americans if we're willing just to take time and to come up I think with better legislation, Mr. Chairman, than the current legislation that we have now. But I thank you for having the hearing.

Chairman RANGEL. The Chair recognizes Mr. Doggett. And before any of you get in trouble, don't apply for Medicaid, because it's for the poor. And I'd like to assume that you've beaten that barrier, so Medicaid won't be available for any of you, I hope. Let me call Mr. Doggett and thank him in advance for the great contributions he's made to the Committee on health care.

Mr. DOGGETT. Thank you, Mr. Chairman, and thanks to each of our witnesses for the insights you've offered. Mr. Draper, I had

a small businessperson from Austin, Texas contact me and say the bureaucracy of the health insurance companies makes the government look efficient. As a small businessman, I want to make it clear that I totally disagree with the United States Chamber of Commerce. Something has to be done. Health insurance is the biggest expense I have next to payroll. I've not been able to give raises for several years because the money budgeted for raises was used up on higher health insurance premiums.

I tried to let my staff know that the $200 a month raise that they would get was taken by Blue Cross. Is that similar to the experience that you hear about? That was from Mark Siefken in Austin, did you hear that from some of the folks in your area?

Mr. DRAPER. Yeah. For us it comes out to about a 1 percent raise for everybody every year that goes to health insurance. So, it's kind of a good news/bad news situation. The good news, you got a raise. The bad news, it goes to Wellmark. And for us, though, the only tough spot that we're in is that everybody we employ is under the age of 27 and single. And so right now, even an inefficient system is still pretty affordable for us, because we don't have much demand.

But within the next 6 years as, you know, everyone starts a family, then our rates will go up from about 8 percent to 26 percent if we are shopping in the same market that we're in, and we'll have to totally redo again to figure out, well, we can't stay in the individual market. We have to go through somebody else, and you spend time looking for that. And so that's kind of the tough spot that we're in. And companies that do employ people who are older with families are the ones that have it a lot worse than we do.

Mr. DOGGETT. And rather than rely on some State regulatory agency that may well be owned by the regulated, you believe in the competitive system and that one type of competition that should be there is the option for your employees to look at a public plan?

Mr. DRAPER. Yeah. And, I mean, I look at things a little differently coming from Iowa in that almost everybody in Iowa goes to public schools like I did, you know, government runs efficiently. When Cedar Rapids flooded, everything's been more or less cleaned up and gotten back to normal. So there isn't the serious antipathy to a government-run plan as there may be on the east coast. And so for me, I can't imagine how would you get a company—anything that runs as inefficiently as the health care company, even the government.

Mr. DOGGETT. It sounds like my constituent in Austin. And it is amazing that some of the people that are always up here criticizing how inefficient government is are so fearful of an efficient plan of the type we've had with Medicare that has inspired confidence with millions of people across this country.

Ms. Hansen, I know you're very familiar with, and I appreciate the support AARP has offered. You mention it in your testimony, for legislation that I have advanced last Congress and again this Congress to try to help the poorest of our seniors with their prescription drug bills. Isn't it correct that we still have several million seniors who are not able to get the full access to prescription drugs they need under the Extra Help program?

Ms. HANSEN. There are many people, millions of people who haven't taken advantage of it. So it's an opportunity for us to continue to make sure that people enter the program they are qualified for.

Mr. DOGGETT. And to the extent we work from the bottom up, from helping those most in need with extra help, we actually can take steps to close the donut hole in coverage there, because the more people we cover through Extra Help, the less they're exposed to that donut hole.

Ms. HANSEN. Without a doubt. I think it's a real opportunity to help that fragile group. But at the same time, as I mentioned earlier, since our membership is everyone, the middle-income population is hurting quite a bit, given the fact that Medicare beneficiaries right now, as you know, pay 30 percent of their revenues, and that's high.

Mr. DOGGETT. Let me just ask Mr. Shea one question here as my time expires. The notion that we ought to tax employer-provided health insurance to pay for the serious shortcomings in our system seems to me to be a tax on the type of insurance coverage that every American would want. That the policies that would be taxed are those that might provide dental coverage or have lower copays, that type of thing. Is that the case, that these policies that some over in the Senate propose to levy a tax on, are good policies that most Americans would want?

Mr. SHEA. They certainly are. And as I said before, the price of those policies varies by the health condition of the group or the age of the group or where the group is. And so it's—how you apply a tax across that is unfathomable to me.

But the other point I would make here is, you know, if you want to throw a hand grenade into the discussion in the American public about health reform, you know, the figures from some of the Washington Post stuff this morning, you go out and advertise that what you're going to do to solve this problem, this problem is high health costs. That's how people define the health care problem around the country. They can't afford it even if they have insurance. If you go out and tell them our solution to the high health cost problem is we're going to tax your benefits, they—I don't know what they're going to do in the voting booth, but they certainly would look at you like you've got to be crazy.

Mr. DOGGETT. I couldn't agree with you more. Thank you. Thank you, Mr. Chairman.

Chairman RANGEL. The Chair would like to recognize Ms. Brown-Waite.

Ms. BROWN-WAITE. Thank you, Mr. Chair. I would like to address Ms. Hansen for a moment. First of all, my name is Ginny Brown-Waite. I often get called Jennie. So when I saw your name, I thought now this is a woman I can relate to.

I just have a couple of questions. I'm concerned that AARP may not be doing its homework, and let me tell you why. As you know, as you may know, I have the highest number of people on Medicare of any Member of Congress. During the stimulus bill, we realized that the money that was going for health IT in hospitals was actually coming from the Medicare trust fund Part A. Are you aware of that?

Ms. HANSEN. No, not directly as to where it's coming from. I thought the stimulus was an add-on.

Ms. BROWN-WAITE. No. The money for the health—for the health IT for hospitals came from the hospital trust fund. I contacted AARP and alerted them to this, and first they denied it. And then they called back and acknowledged it. But they said we're still supporting the bill.

I think that Americans are beginning to wonder about AARP when they would support things that obviously raid a trust fund, namely Part A, for the hospitals. That is I believe scheduled to be paying out more than it takes in before the raid, it was scheduled for 2017. When I talk to AARP folks at home, they were appalled at this.

So I have to ask the question, and bear in mind, not only do I have those who are 65 on Medicare, but I also have a lot of people who are 55 to 64 who fall in that difficult-to-get insurance gap. I could understand AARP supporting a bill that helped them that didn't bankrupt the country.

But I have to ask, why would AARP be interested in making sure that, for example, those under 25 are covered and those who may be illegal aliens, I just have—I think that the American public is starting to question AARP and where they're going. So I really would like to hear from you on that, and then I'd also like to ask you about Medicare Advantage.

Ms. HANSEN. Yes. If I could answer the first question. I think we have been on record as supporting health information technology, and then we have actually had the support of all of our colleagues under the Divided We Fail banner. And I think—I'm a nurse by background, and so I also have run a program that has used IT on behalf of our elders. And one of the things that researchers show that Medicare beneficiaries, about one in five in a given year will likely go to a hospital, to your point that hospital care is critical. But oftentimes it's because medications are not well used or they come back from a hospital within 30 days. A lot of it is about information that was not appropriately recorded or transferred correctly. And so what has been shown, for example, in the Veterans Hospital, using IT, that their medication error rate is only 1 percent.

Ms. BROWN-WAITE. Correct. I don't think we disagree about the use of IT. I think we disagree about should AARP have supported something that will cause the trust fund Part A to become insolvent even sooner.

Ms. HANSEN. Right.

Ms. BROWN-WAITE. I mean, I don't think anybody questions health care IT.

Ms. HANSEN. Right. But I think my followup point is, when you minimize mistakes through IT, they don't have to go to the hospital, and therefore you save money actually on Part A just because the mitigation of unnecessary hospitalization saves money in the trust fund.

Ms. BROWN-WAITE. It may very well, but initially, the cost, the total $16 billion, came out of the trust fund. So when I tell seniors this at home, they are appalled that AARP would support something such as this. This is a very comprehensive bill, and I think

that AARP needs to be very, very cautious what they are supporting. There are many good parts to the proposal, the 800-some page proposal. There are some good parts to it, and I think we need to work together in a bipartisan manner to make sure that, you know, what eventually we will all be voting on is something that is going to benefit the uninsured.

I have a question, a quick question, though, about the Medicare Advantage plan. According to CBO proposals, the proposal to cut Medicare Advantage payments by $160 billion, as this bill would do, would result in about 3 million seniors being forced out of Medicare Advantage plans. I know that AARP even has a Medicare Advantage plan, and there's a very high satisfaction level. Do you have any concerns about how AARP members in various Medicare Advantage plans will be affected by this bill, including those who may be in your program?

Chairman RANGEL. Response in mail.

Ms. HANSEN. I will do that. Thank you.

Chairman RANGEL. The Chair recognizes Mr. Blumenauer.

Mr. BLUMENAUER. Thank you, Mr. Chairman. I'm sorry Mr. Nunes is not here. I'm mystified by his line of inquiry to people asking people with insurance whether they would like to sign up for a program designed for poor people without insurance. Now, admittedly, there are some States that—New York—that have a fairly generous program. But it seems to me to be sort of a disingenuous question. Would you like to have the insurance program that we have for the poorest people in America, people who couldn't afford private insurance, people who would have difficulty even in the subsidized form that we're talking about here, and the Republicans offering a tax credit that would not help them at all? It's bizarre. So it seems to me that we ought to—I'd love to have a further discussion of this Committee about the merits of Medicaid for poor people and compare how they would be treated under our program where it would be expanded so they wouldn't be left out, and over time if they were able, they could transition into the exchange. But it is a false choice to somehow ask you with private insurance if you want to have insurance that was designed for the poorest people in the United States who have no other access. But he's not here, so I——

Mr. NUNES. Actually, I am here, if you'd like to——

Mr. BLUMENAUER. Good. Then I look forward at some point——

Mr. NUNES. If you'd like to yield.

Mr. BLUMENAUER [continuing]. Having this debate when you have time to yield to me. I wanted to just sort of put that as part of the record.

Mr. NUNES. So you don't want to yield to me to answer your question?

Mr. BLUMENAUER. I don't have time now. I didn't see you here, and I didn't want to interrupt you while you were questioning. I'd like to finish my line of inquiry. But I'll come back and we can debate this.

Chairman RANGEL. Well, I will give you time to explain why you asked them whether or not——

Mr. BLUMENAUER. Okay. Thank you. Then I will yield.

Chairman RANGEL [continuing]. Program for the poor.

Mr. BLUMENAUER. Okay. I will yield. Mr. Nunes, do you want to ask me a question?

Chairman RANGEL. Why did you ask them whether or not they would want to join a poverty program?

Mr. NUNES. Because the bill that you guys have introduced, Mr. Chairman, expands Medicaid. And in my opinion——

Chairman RANGEL. I'm asking, why would you ask these people who are not poor?

Mr. NUNES. Because they are here supporting the underlying bill, and they are supporting putting more people to Medicaid.

Chairman RANGEL. They are. Poor folks.

Mr. NUNES. And it is my goal in this country, I don't believe that poor folks in this country need to have Medicaid.

Chairman RANGEL. That's good. Okay.

Mr. NUNES. I think that poor people in this country should have universal access to coverage. And we have a plan that we'd love to share with you that would give them access to that.

Chairman RANGEL. I understand. And I want you to understand his question was that he does not believe that poor people should be entitled to Medicaid. What that has to do with you who are not poor, I don't know, but I hope you got an answer, and this answer will not be taken out of your time. You may proceed.

Mr. BLUMENAUER. Thank you, Mr. Chairman. And I do look forward to a spirited debate about how poor people are going to be helped with a tax credit, how poor people are going to be helped to jump into the private market. In times past, the reason we've had Medicaid is because the private market couldn't deal with them. It's not going to be any cheaper. In fact, one of the reasons that we restricted a little bit under this plan is that it will be a little less expensive over time. But I welcome that debate with my Republican friends about their vision of taking away Medicaid and giving a tax credit or forcing them into a private market that they can't afford now. I welcome it.

I do have one question for Ms. Hansen. You didn't get to it in your testimony. We both are very interested in getting more efficiency out of the Medicare system now, and in your testimony you talk about a transitional benefit and what that could do. Would you care to make a comment about the transitional benefit that you didn't have time to refer to in your testimony?

Ms. HANSEN. Thank you, Congressman Blumenauer. We thank you as well as Congressman Boustany for jointly supporting this, the Medicare transition benefit, and that is it actually relates to the Congresswoman's question about hospital care. And so I'd like to tie that back together, that the efficiencies of doing things right and correctly the first time with giving some support to people upon leaving with evidence, there is researched information published in journals showing that there are cost savings to be able to be incurred in which case the patient, the elder would not have an error happen after a hospitalization because somebody would be there.

Generally we're speaking about a nurse in this research, that the cost savings to help people take their medications safely and know what to do, allows them to then perhaps not become a statistic,

which is shown in Medicare data that within 30 days one out of five people goes back into the hospital. This particular piece of legislation would help address that, and I also would then come back to say that this makes such a big difference on both Part A, Part B and Part D. Savings would be incurred.

Mr. BLUMENAUER. Thank you. Mr. Chairman, I appreciate your courtesy. I would hope that we would be able to look, one of the areas that I hope we can strengthen in our draft is the transitional benefit. We have some legislation that we've introduced that I personally think we should look at, because we may be able to strengthen transitional benefit in the draft. I think it would save more money over time and help people that we want to help. Thank you. And I yield back.

Chairman RANGEL. Mr. Thompson.

Mr. THOMPSON. Thank you, Mr. Chairman. I appreciate the opportunity to question the witnesses. I'd like to talk a minute about, or ask you some questions about the idea of preventive health care. I'm one who believes that this is very, very important and that it will go a long way in accomplishing what many refer to as bending the cost curve of health care.

And so, to that end, I'd like to know if you think it's important that we have a minimum benefit standard in order to achieve good coverage and should preventive health care be part of any minimum coverage we insist that these plans offer.

Mr. KIRSCH. Well, certainly, yes. And one of the really good things about the benefit package you've done, is you have prevention with no out-of-pocket costs. One of the encouraging things, actually, that many large businesses have done, is move to that. Understanding that financial barriers to prevention actually raises costs and you want to get folks in the system.

The other thing that's really good about the legislation is it includes major investments in developing more primary care practitioners, because we need the folks actually able to deliver that preventive care so——

Mr. THOMPSON. As far as it impacts health outcomes, is this something that we can expect to see better outcomes and better prices?

Mr. KIRSCH. Absolutely. And, you know, the old adage, an ounce of prevention is worth a pound of cure. It's not just true for each person, it's true for the health care system as a whole.

Mr. THOMPSON. Anybody disagree?

Mr. RANDEL JOHNSON. If you are going to mandate a package, I certainly think that wellness programs, preventiveness, ought to have first dollar coverage and be part of that. At the Chamber we're very much, our members are very aggressively pursuing wellness programs, Safeway is a very, Steve Burd, the CEO of Safeway has a very strong program in that area. Great payoffs, it just takes a while to get the payoff until the program runs its course. But, sure, I think——

Mr. THOMPSON. Through the long-term impacts, but there are certainly short-term impacts, cost savings as well, if you catch your problem, especially for a child, it's a lot cheaper to treat that, than to treat a child in a hospital. Kids' hospital costs are more expensive, etc.

Mr. RANDEL JOHNSON. And we have a conference coming——

Mr. THOMPSON. Even the Chamber agrees. On a roll here. I'd like to ask the AARP witness, why is it that AARP believes that we should eliminate the cost sharing for preventive care? Why do you all think that's important?

Ms. HANSEN. Well, there's evidence in research right now that the barrier of that first payment oftentimes precludes people from having prevention. And so the ability to minimize this, and that they've even shown this with certain medications. There are some programs that have decided to design their insurance so that they will even cover some chronic disease medications. So, it's a different way to think of prevention. It's not just, say, the well check-ups, or the mammography, but it also is about some areas of first dollars that make a difference for people to get over that threshold, to use a service and then you do save money on the back end.

Mr. THOMPSON. So, the more folks you get in on that front end, the more you save, the more expensive and this is even for older folks, not just youngsters in the front end of the service.

Ms. HANSEN. That's true for, yes, for different ages.

Mr. THOMPSON. And the AARP has been very supportive of remote patient monitoring and telehealth as a means by which to, on the threshold on remote monitoring to stay out of hospitals and save moneys. Can you elaborate on that a little bit?

Ms. HANSEN. Certainly. I think oftentimes it's the rural areas, like Davis, that have really shown the effectiveness that this, the ability sometimes to deal with even part of the workforce shortage right now, the ability to have a large center like UC–Davis, have all the specialists there and have a smaller clinic that's further away to be able to use this for both diagnosis and consultation. That's for the providers. But for patients to have their blood pressure numbers checked through the phone system and so that your doctor's office has this information, these are areas that are, that we think are up and coming.

Mr. THOMPSON. Thank you. Mr. Chairman, I asked questions of the last panel about the telehealth, as well, and everybody seems to be in agreement that it not only helps people, but it saves money. And I have a letter here from a coalition of folks that, Health IT Now, who are in strong support of the health IT that we've worked so much on and also on the expansion of telemedicine.

And they point out that the estimated cost savings to Medicare from widespread adoption of telehealth services range between $2 and $4 billion. And I'd like to submit this for the record and I'd even be willing to use these savings to fund some of the telehealth ideas that I've been pushing to the Committee.

Chairman RANGEL. Without objection. Mr. Johnson, you should feel, for any time you hear these things that people like to just wave you in and say, count you in. Let's see, Mr. Roskam, Illinois.

Mr. ROSKAM. Thank you, Mr. Chairman. I'd like to yield 1 minute to Mr. Nunes.

Mr. NUNES. Thank you, Mr. Roskam. I want to make sure, Mr. Chairman, that I reiterate my point that it's not necessary in this country to have people on Medicaid. It's not necessary. And I thought it was rather ironic that the folks that have health care

that are testifying today, in fact, all but one, didn't want to be on Medicaid. And you point out that, you know, you'd be poor, you'd have to be on Medicaid.

The point that I'm making and I want to make it perfectly clear to this Committee, is that we don't have to have Medicaid in this country. We are spending enough money now to where we could give, on the plan that we have, up to $11,000 for that individual that's now on Medicaid, to go choose their own health plan on an exchange or wherever it may be. That's the money we're spending today. We don't have to add any money to the budget, and I want to make sure that I clarified this point because, you know, I think that it's an important point for Republicans to say that we believe we have a better plan. We believe that people don't have to be on Medicaid. We think there's a better option and a better way. And I thank Mr. Roskam for yielding his time.

Chairman RANGEL. Well, he can keep his minute because I don't think that you made your point. You're on the Federal plan, I'm on the Federal plan. Would you want to turn in your Federal plan for Medicaid? That's a stupid question for me to ask you. And I just thought your point is well taken, we should eliminate Medicaid, we should follow the Republican guidelines. I just thought your question, the way you were trying to make your point was not relevant, but you want another minute, I'll give you another minute.

Mr. NUNES. Well, I thank the gentleman for allowing me to continue to explain this. What the plan that we have, that we put out there——

Chairman RANGEL. Talk about Medicaid, mister. For the minute, talk about why you don't want Medicaid and how relevant it is for them to be against having Medicaid.

Mr. NUNES. Because I believe that Medicaid is poor quality health coverage. And we have to improve it. The doctors in my district do not want to see Medicaid patients. Under the plan that we've put out, we give $11,000 for anyone that's on Medicaid, to allow them to go pick a plan just like you and I have. That would be a minimum plan to what you and I have. I think that we should give the plan, similar to what we have, to even people that are on Medicaid. And I believe we have the money to do that.

Chairman RANGEL. Your point's well taken and the time that we've taken away from you will be duly restored.

Mr. ROSKAM. Thank you, Mr. Chairman, for your courtesy.

Ms. SCHWARTZ. Excuse me, Mr. Chairman, before we move on, could I just make a point of, maybe, information? Maybe Mr. Nunes didn't get through all of the 800 pages. Because, in fact, this bill says, after 5 years, anyone on Medicaid, which is the program you object to, will be able to go into the exchange and choose any private or public option. So, in fact, it does address your interest and you may want to take a look at those particular provisions because it does, in fact, allow individuals to go into the exchange.

Mr. NUNES. If the gentlelady——

Ms. SCHWARTZ. Just pointing out information, and I yield back.

Chairman RANGEL. Please. Please.

Mr. ROSKAM. Thank you. Thanks, Mr. Chairman. Mr. Shea, question for you. On page 2 of your testimony, and you've made it

very clear during your answers, I just want to read a sentence, "... we caution, however, that one financing option under consideration in the Senate Finance Committee, the taxation of employer-sponsored health benefits, would go in the exact opposite direction by destabilizing the employer-based health insurance system." I agree with you and I accept that premise.

It seems like Mr. Johnson is also making that argument in a different context, but it's the same argument. And what he's saying is, look, if you put this tax burden, or if you put this liability, or this mandate on business, there's going to be a consequence to it. You're arguing, and I'm paraphrasing, if you tax this employer-based system, you're going to have less of it, let's not do that, let's build on it.

Mr. Johnson is saying, if you put this mandate on small business, or big business, or whoever it happens to be, you're going to get less of it. Why can you make the argument and why is he denied the argument?

Mr. SHEA. Thank you, Congressman. I really think there are two different things and I will explain by saying, it's destabilizing because this is an important structural element of how we now put together employment-based coverage.

Mr. ROSKAM. Agreed.

Mr. SHEA. So, if you take out part of that structure, and you can listen to me, but you can listen to lots of employers. I sat at this table a month or so.

Mr. ROSKAM. Agreed.

Mr. SHEA. Lots of employers would say that. Employees, some people, young people might want to go out and get their own thing. That's very different from saying that all employers should pay financially to cover people with health care.

Mr. ROSKAM. Okay. Then, let me make his argument maybe a little bit better than he made it. We're competing all over the world right now. We've got worldwide American companies that are competing with nations and so forth. Why are we putting this disproportionate burden, in this sense, on American companies? I think that, I'm kind of calling you out. I think you're arguing in the alternative and——

Mr. SHEA. Well, I, you know, if somebody wanted to put it on the table, the social insurance system, which spreads the risk all over the population, gives you much lower costs, as all of our industrialized competition has, we'd be for that. We've been for that for 100 years. We're saying that what we have here is employment-based coverage. It does load costs onto the payroll, which puts American companies at a disadvantage, but what alternative would you offer?

Mr. ROSKAM. Well, I think there's a whole host of alternatives and in 30 or 40 or 50 more seconds, I'm not going to get through them. Let me make one other point, though. And I'm happy to, I'm not trying to be clever, but there's, I represent the western and northwestern suburbs of Chicago. A lot of building trades. I am hearing from building trades' members who are very, very concerned about what they're hearing from this plan. Their attitude is, look, got a good plan here, we got a good thing going and we've successfully negotiated what some people would characterize as Cad-

illac plans. The rank and file building trades members that I'm hearing from are communicating to me, as their Congressman, be very careful that that isn't in jeopardy. The yellow is on, my time is up, and I yield back.

Mr. SHEA. I'd like to continue the conversation.

Mr. POMEROY. Thank you, Mr. Chairman. Excellent panel. Mr. Draper, I, in particular, want to commend you. Your testimony was excellent. You have a silk screen business?

Mr. DRAPER. Thanks. And, yes.

Mr. POMEROY. I feel enormous pressure to enact health reform in light of knowing that. Are you going to go pick one of these? I spent all day in the Ways and Means Committee, and all I got was this lousy shirt. We've got to give you——

Mr. DRAPER. We do have a shirt, though, that says, American, Only the Insured Survive.

Mr. POMEROY. Very good, very good.

Mr. DRAPER. I did that when I was uninsured.

Mr. POMEROY. Let me ask you about, we have only 5 minutes, so we have to kick this one around pretty quickly. How's the status quo working out for you?

Mr. DRAPER. I explained it a little earlier, but I think it's, for us right now, it's okay, because everybody who works in the company is single and below the age of 26. The problem that we get into, that a lot of other businesses are in now, is that, as people age and we have to try to get family policies, then we either have to, if we stay in the same market that we're in now, it'll go from about $200 a month to about $700, $800 a month, which would mean we'd have to try to take time and renegotiate to figure out how to do it to get into a plan with somebody else.

And so, my biggest concern is, for right now, I think what we have is inefficient, but it's not as crushingly inefficient as it will be for us in about 6 years.

Mr. POMEROY. Even with coverage in place, and because of the young, single status of your workforce, affordable coverage, coverage you've been able to manage in your cost structure, the uncertainty, in fact, well, I said uncertainty, I meant actually, certainty, of rapidly rising health care costs, meaning rapidly rising health insurance premiums is a great concern to you.

Mr. DRAPER. Yes. I mean, they go up each year. The bigger concern is, though, that you can't adequately budget how much it's going to be every year because your cost goes up if people get sick, which I've always found ironic, that you buy insurance but you still pay for health care. And so, that's the biggest problem.

And we've agreed to pay our employees' bills, not because I'm the nicest guy in the world, but just because I know that somebody is going to have to pay them. And it's easier for the company to pay the bills and take the hit than to rely on the individual. Because if one of the individual employees has to start paying their own medical bills, if they go into personal bankruptcy, then the whole company is in trouble. And so, we kind of have to take that burden upon ourselves.

And the tricky thing about that is, you can't budget for it. I've never met a business that went out of business because they didn't realize they had to pay income tax. And they said, well, duh, things

just went really bad, there's this thing called income tax, and it just hit us like a freight train. But people do go out of business because of insurance. Because insurance costs are unpredictable. And anything that's 6 to 24 percent of your payroll, you do not want to be tied to that as an unpredictable indicator.

Mr. POMEROY. Point very well made. Let's see if we can find some agreement across the spectrum ends of this panel. I'd like Mr. Kirsch and Mr. Johnson to give their thoughts on the role cost containment needs to play in this reform bill. The, basically, we spend a lot of time talking about the insurance layer, but what about underlying costs drivers and what must this bill do to address some of those? Mr. Kirsch, first, and then Mr. Johnson.

Mr. KIRSCH. Absolutely. As we say, if we're going to fix the economy, we have to fix health care. Which means we have to have a system which is retooled to deliver better quality at lower costs. And we can do that. As we've seen and as Mr. Higgins was talking about before, there are so many examples where paying for things that work, finding the right kind of incentives for providers, having good information out there, can create a health care system that provides better value. And one of the reasons we think we need structural changes to do this, and the kind of structural changes that you've put in multiple ways through the legislation is to drive a delivery system that focuses on value as opposed to just paying for services, oftentimes, that aren't what we need to pay for.

Mr. POMEROY. Thank you. I see my yellow light is now on. Mr. Johnson, quick response on the same question.

Mr. RANDEL JOHNSON. Yes, I don't disagree with any of that. I agree with it.

Mr. POMEROY. I thought I could get you guys to agree.

Mr. RANDEL JOHNSON. I think the gateway idea, the exchange idea, is, it opens up a kind of a website for people to shop around for the best plan possible, is, depending how it's structured, is acceptable to the Chamber and something we'll want to work closely with the Committee on. I think, obviously, comparative effectiveness, quality initiatives, so there's the cost control, it's obviously the most difficult part of this entire debate.

Mr. POMEROY. But it would be irresponsible to put $100 billion into the status quo without trying to do something that structurally is addressing these cost drivers. Would that be a fair statement?

Mr. RANDEL JOHNSON. Yes.

Mr. POMEROY. Thank you, Mr. Chairman.

Chairman RANGEL. Mr. Johnson, you keep agreeing. When you put in your objections, you make certain right next to it, you put in what you support, right?

Mr. RANDEL JOHNSON. I always do.

Chairman RANGEL. Okay. That would be great.

Mr. RANDEL JOHNSON. Thank you.

Chairman RANGEL. Mr. Pascrell left and he will be returning, so it's my pleasure to ask Ms. Berkley of Nevada to inquire.

Ms. BERKLEY. Thank you. Thank you, Mr. Chairman. And thank you all for staying and helping to educate us on an issue that's obviously very important to all of us and to millions and millions of Americans. It's been very interesting sitting here. My expe-

rience with Medicaid in the State is completely different from my colleagues. People are most anxious to sign up, but we don't have enough money for it and the reason the doctors aren't that crazy about taking Medicaid patients is because they don't get reimbursed. And doctors, like anyone else, want to get paid for their services.

So, it's not a matter of people not wanting to be on Medicaid, so many people want to be on Medicaid that it's constantly a challenge. I know there may be some patients that don't like Medicaid, but most of my Medicaid patients don't like dying without any health care, so I just have a different point of view.

I've learned also, and this came as a big surprise, that our public plan is going to be taking care of hair transplants and abortions and cosmetic surgeries. I'm sure that's going to be a boon to the plastic surgeons in Las Vegas and they can fully embrace this.

And as far as AARP is concerned, there have been a number of instances where I disagreed with the official position of AARP, but your job, as you know, is not to please Members of Congress, but your membership, and I think AARP does an outstanding job with that.

Let me ask you a couple of questions. Right now, Las Vegas is really suffering. We are having an economic meltdown of monumental proportions. I'm having major layoffs in my major business, which is the gaming industry. I've got mega-gaming corporations that are laying off people by the thousands. They are losing their health insurance and they can't afford COBRA. I also have a large number, half of the people that were employed in Las Vegas, before this economic meltdown, were employed by small business and the number one problem that they had is providing health care for their employees.

I see the public option as a way of helping all of these people and I'm just wondering if you have any alternatives to that that you'd like to share with me but when it comes to a crisis situation, I've got it, and I've got to provide health care. Right now a third of the people I represent have no health care insurance. That's crisis proportions, as far as I'm concerned and I'll stop so you can speak and if anybody, Mr. Kirsch, would you like to start?

Mr. KIRSCH. Well, yeah, she reinforces exactly what you've said and it is a crisis in people's lives, it's a crisis in a deeply personal way that one health care problem can lead to not only personal suffering for them or a family member, but financial bankruptcy. And to have a system like you all have proposed, which makes health care affordable, has good benefits and meets people's needs, doesn't have the false calculation that if we don't cover something it saves money, it just shifts the cost onto the worker, forcing people like Mike, who are responsible to pick it up. We need to have health care that's affordable based on incomes and be sure that it does that so that you can really afford it, based on your income. And to have a new entry in the system called a health insurance option that will drive down costs and care about the public's health first, as opposed to a corporate bottom line, is exactly the kind of reforms that we think make great sense and are so much welcome here.

Ms. BERKLEY. Mr. Shea.

Mr. SHEA. Thank you, Congresswoman. We still talk about 47 million uninsured. There's no question that we're over 50 million as a result of the economic situation. And a lot of the people who lost coverage are people who had, with their job, good coverage. And so, the pain is just enormous.

And so, the public plan is just a sensible approach. It gives us, while I have the microphone, I'll mention I was never asked whether I opposed Medicaid. I was asked whether or not I wanted to switch to Medicaid. I have no reason to switch to anything, the plan that I have. But Medicaid obviously plays a very important role for very low income people.

And this bill would, Medicaid, people with children who are very poor have Medicaid. People who are very poor who don't have children, don't have Medicaid because they don't categorically, this bill would change that and that's an important addition in terms of the coverage for very poor people.

Ms. BERKLEY. I appreciate the distinction because I think the lumping in, the Medicaid thing, kind of shocked me when that came up. I didn't know how it was fitting in.

Mr. SHEA. But let me make one other point, which is, I made it before, but it's really the concern that's my daily experience. And that is, to try to get some competition into the insurance market. We don't have any competition in the insurance market based on our experience for negotiating benefits every year for 50 million Americans.

There is no competition and when you look at the numbers in terms of the monopoly situation, we don't have organizations that are representing people and aggressively fighting for them with providers and saying how can we reduce these costs. We have people who make cozy deals with providers in the private, that's what we have. That's what the private insurance industry does. Everybody makes a lot of money, everybody's fat and happy. Except the people who are paying the bills. That's the problem we have to solve.

Chairman RANGEL. With health insurance going into the, having the public health option competing with the private sector, lowering the price of the premiums for employers that have been doing the right thing all along, hey, that's a great selling point. We'll have our conference call. You're going to leave here on this bill, I'm telling you.

Mr. RANDEL JOHNSON. Well, we can take out a few things and then start from there.

Chairman RANGEL. We got to do it. Mr. Tiberi.

Mr. TIBERI. Thank you, Mr. Chairman. Mr. Shea and Ms. Hansen, I kind of want to direct my questioning toward you. In my district, Ms. Hansen first, a third of the seniors have Medicare Advantage and like it. Obviously, you're an organization that represents seniors. My mom, who's, my mom and dad are on Medicare. My mom has had an issue over the last several years where she's had doctors literally, her doctors, stop covering Medicare patients. Literally. Including her. Where she's had to go get a new doctor. We've read about, even in the New York Times, the distinguished gentleman's hometown newspaper, where Medicare, many doctors have declined new Medicare patients.

And so, what many of us on this side of the aisle are concerned about, and I know from a central Ohio perspective, we have doctors and hospitals complaining every single day about health care, about insurance companies. But even more so, about Medicare fee-for-service and more so about Medicaid. And I think that's where some of the concern on this side of the aisle has been, is that, in fact, I had a family in my office the other day from Columbus, Ohio, complaining about, in Children's Hospital, the wait to see pediatric specialists is months. Because of the lack of doctors going into pediatric specialties.

And this bill specifically doesn't deal with pediatric specialties. We deal with primary care, but we don't deal with specialties. And the assumption is, all these specialists make a lot of money. Well, in Children's Hospital in Columbus, and in Cleveland and in Cincinnati, they can't get enough specialists.

But my point to you, ma'am, Ms. Hansen, and then I'll have a question for you, Mr. Shea. A real life example. But Ms. Hansen, as an organization that represents people who are 50 years old and older, what do I tell my, the 30 percent of seniors who like what they have, and believe under the President's proposal they'll be able to keep what they have when in actuality, they may not?

Ms. HANSEN. Right. Well, we too are concerned about this transition that would potentially occur. But I think what we do support is that there should be value and quality for what you do get, relative to the Medicare Advantage program. So, I think the fact that——

Mr. TIBERI. But if the patient's happy with it, isn't that a good barometer?

Ms. HANSEN. Well, if they're happy with it, is one thing that is certainly a barometer. But another barometer is the level of quality that actually gets delivered. So, we support people getting plans, hospitals, providers, getting paid more for a level of high quality.

Mr. TIBERI. Would you be opposed to the Majority's plan if it reimbursed at today's Medicare rates?

Ms. HANSEN. I'm sorry. I couldn't hear.

Mr. TIBERI. Would you be opposed to the Majority's plan if the public plan reimbursed doctors and hospitals at Medicare rates.

Ms. HANSEN. I think that my understanding is that that is part of the potential proposal.

Mr. TIBERI. Would you be opposed to that if it reimbursed at today's Medicare rates?

Chairman RANGEL. I would be.

Mr. TIBERI. Okay.

Chairman RANGEL. Because they can plan increases, Medicare rates.

Ms. HANSEN. Well, I think the other point that you also bring up about having physicians being paid appropriately, that's something that I said in my oral opening statement that there needs to be a re-anchoring so that the sustained growth rate issue that causes specialists in general doesn't cover your pediatric specialists because it's not Medicare. But the ability to cover that is important.

Mr. TIBERI. Thank you. Mr. Shea, you represent, obviously, a perspective. My dad's a retired union official. I have family members who are steelworker retirees, AFL–CIO, UAW, teachers. I have my best friend who is a teacher, a union employee. I have heard from them the concern with respect to the public plan that ultimately, and my question to you is this. Ultimately, if the public plan ends up allowing employers, either through a collective bargaining negotiation or on their own to ultimately change a current benefit, meaning, if an employer decides, you know what, I'd rather pay this 8 percent penalty and allow my employees to go into a public option, or the other view that the lack of competition will ultimately force private health care to disappear and all that will be left is a public option.

As somebody who represents union members throughout America, many of whom collectively bargained for their health care benefit, is that something that if that happens, you all would be concerned about?

Mr. SHEA. Well, we'd be concerned about any major disruption in the market, but job number one, as I've said repeatedly, is controlling costs. And we see the function of a public plan as being controlling costs. Our experience in sponsoring health funds, which we do, and our experience in dealing with employers is, we see no sentiment for wanting to dump or put people into a public plan.

It probably would be advantageous for some people, but all the employers, there's a very strong connection, be it a good idea or a bad policy, there's a very strong connection between people who work, and getting health care at work, it is local, it's there for them. They have a problem, they have a human resources group to go to, or a union business agent to go to, to say, can you help me out with this kind of problem. They like that local connection. So, there is really a strong, even if there were a cheaper plan, there's a strong reason why people would want to maintain——

Mr. TIBERI. And most of your members enjoy their plan?

Mr. SHEA. Yes. And most of the people who are on the plans would tell you, you know, we're going out of business as a result of the cost. That's the problem.

Chairman RANGEL. Mr. Pascrell, welcome back.

Mr. PASCRELL. Mr. Johnson, thank you for your good faith testimony today. Some things I do agree with you. And some things I have questions about, so. You said that businesses are already doing their fair share and more. I would not disagree with that. This package that's in front of us, which is, maybe it'll be different in a week from now. Who knows? But this package takes steps to make it more affordable for businesses to continue doing their fair share. And you know quite well that in the last 8 years, insurance costs for small firms has increased 130 percent. In just 8 years.

We achieved the affordability in the package that's before us right now by providing businesses with more choice through a public insurance option and by eliminating the cost shifting associated with the uninsured by insuring universal coverage through shared responsibility. And that's what many of the questions have been focused on, first panel, second panel. That's what we're looking for.

The second point is that you stated that the Massachusetts pay-or-play requirement failed to produce revenue. I believe that's what

you said. Did you say that? In your written statement, yes, I'm sorry. Put on your mic, please.

Mr. RANDEL JOHNSON. Much less than expected.

Mr. PASCRELL. Yeah. And I would agree with that, by the way. But that was not the goal of the Massachusetts plan. The goal of the Massachusetts plan was to shore up employer provided insurance in Massachusetts. That's what the legislation said. And in that respect, it's been an overwhelming success, wouldn't you say? In that respect.

Mr. RANDEL JOHNSON. Perhaps in that, you know, the Massachusetts plan has come under so much attack from both the left and the right, perhaps in that individual area, I can't disagree with you because I can't really respond to it.

Mr. PASCRELL. Okay. Third, you commented on one-size-fits-all. One-size-fits-all plan designed, if it was designed that way, implying that employers currently have the ability to work with their employees and their insurance companies to choose among endless insurance options. I would encourage you to ask Mr. Draper or any small employer in this country, several of them were here today but did not testify, and they will tell you that the only choice they have is between the cheapest plan offered to them, you mentioned it, Mr. Draper, that usually fails to fit their specific needs, or laying off valued employees, or cutting their salaries, whatever a boss usually does.

Now, I'm going to give you a chance to respond. You claim that the business community joins most Americans in opposing a public plan. That's what you said. But as you've heard from many panelists, that doesn't mean that they're right, but many of them believe that they've already spoken, that the public is not on your side on this issue. They overwhelmingly support having that choice.

Now, what are your thoughts about the three things I've just stated?

Mr. RANDEL JOHNSON. Well, to get the last first, but I think those polls will show, for example, the Kaiser poll asked that question but then, and I think The Washington Post polled it too, but once they go on and there's a qualification or clarification saying, however, that public plan option may have the result of driving private sector plans out of the market and therefore leave that public option as the last one standing, then the support falls away, markedly. That's the Kaiser poll.

Mr. PASCRELL. But how come the response is never, look at the savings we're going to have in the delivery system, we're going to be more efficient, we're going to attempt to end recidivism, we're going to attempt to look at the procedural process, but you don't disagree with that, do you?

Mr. RANDEL JOHNSON. Well, I do.

Mr. PASCRELL. Oh, you do disagree with that?

Mr. RANDEL JOHNSON. Well, no. If you're talking about the public plan, what follows——

Mr. PASCRELL. Well, let's now forget about the public plan. Let's look at the whole possibility of reducing costs through different practices than you've been involved in. I mean, we have anecdotal evidence, people go to the hospital, they're there 15 to 17 hours, and their bill is $26,000. They go through the procedures

and nothing is wrong with them, that's legion. In normal hospitals across the United States of America, and they never see what their bill is. They never get a bill.

Mr. RANDEL JOHNSON. Right. And then they go back a second time and they——

Mr. PASCRELL. Yeah.

Mr. RANDEL JOHNSON. Right, no, I agree, that's——

Mr. PASCRELL. What would just the process of giving everybody a bill to see what it cost them in the hospital take?

Mr. RANDEL JOHNSON. A greater transparency is something we certainly would support.

Mr. PASCRELL. That would bring religion to the whole process wouldn't it? Thank you, Mr. Johnson.

Chairman RANGEL. Ms. Schwartz, I wanted to take this opportunity to thank you for the great opportunity that you made toward this bill. Okay, well, we have to get them on the list. Would you yield to Mr. Boustany? Well, we'll have Mr. Davis here. When I passed over him, he was not here. We adjust this to Mr. Davis and then we'll go right back to Ms. Schwartz, okay? Mr. Davis, you're recognized for 5 minutes.

Mr. DAVIS. Thank you, Mr. Chairman. I'm the picture of flexibility and when I have the opportunity to speak, I appreciate the opportunity. I just have been a small businessowner, myself. I would comment that small businessowners aren't forced only into the cheapest choice. I ran a company for 12 years and we carried a Cadillac plan. It was when the public approach, or semi-public approach came to Kentucky, that we had to search for options because costs went through the roof and there was no competition.

And contrary to the statements, there's no way to reduce costs and delivery systems without reengineering the overall center for Medicare services processed to move into insurance reform and deal with liability. And I can just say that from a business finance consultant going through processes, having seen that.

But the one thing I'd say, though, is the small business issue, I think, is at the crux. I apologize, Mr. Draper, because we have some obstacles in the form of human beings between the two of us. Like the name of your company. When I was in the Army, there was an operation named SMASH that had a probably different product than what you're selling there. I'm sure you're quite innovative in the technology approach. But I can relate to your situation, very much, dealing with health issues. I learned a lot about the mandates, how each new one complicated my processes and increased my costs.

And frankly, the ability and the flexibility we had in provision of care. You said you have 12 employees now? And the way I read the tri-committee bill, in subtitle (B) Credit for Small Business Employee Health Coverage Expenses, pages 153 to 155, you and your business would not qualify for the small business tax credit. You say your average employee's salary is $45,000. The ceiling in this bill is $20,000. And it's for fewer than 10 employees.

And did you know these factors would disqualify you for the tax credit?

Mr. DRAPER. Are you saying for the tax credit of $11,000 that Nunes was talking about?

Mr. DAVIS. The small business tax credit that's referred to in subtitle (B).

Mr. DRAPER. A tax credit only for people making under $20,000.

Mr. DAVIS. Right. You would not qualify for the full tax credit.

Mr. DRAPER. Yeah, I knew that.

Mr. DAVIS. And yet, you'd still have to comply with either providing qualifying coverage or, the question is, how do you feel about that discrepancy, or that inequity, considering you've got two more employees and your multiplier impact in the community in terms of creating further taxpayers by the churn of the income is going to be vastly greater than a company with $20,000 average income?

Mr. DRAPER. Yeah, I mean, from a personal standpoint, I don't think we should give money away, you know, to anybody. So, I think it should be everybody for themselves. From a business standpoint, I know that the only way our business will succeed is if we're competing in a steady market. You don't want a lot of ups and downs. And that's why I support the public plan because I think it would at least stabilize it. So, you don't have somebody who loses coverage who has to go off of coverage, who goes through financial crisis. I think that's what's dangerous for the economy. I support being required to have health insurance, in the same way that in Iowa I'm required to have car insurance. The car insurance requirement is easier to get past because it's a one to one collision. And that, when somebody hits you and they don't have car insurance, you have to pay for it. And you see that directly.

What people don't see with health care is that when somebody goes to the hospital ER, I still have to pay for it through my tax revenue. So, while I don't like to be required arbitrarily to have health insurance, if everyone is required to have health insurance, I can get behind that. Because then I'm not paying out of one side for the private and out of the other side for the public. And so when people talk about numbers and statistics, I'd like to see how much government money, even in Iowa or nationally, goes in to medicine for people who go into ERs. What percentage of income is that? And therefore, what percentage of my taxes are going to the ERs? And I think that's kind of the unknown cost of what we have now.

Mr. DAVIS. Well, do your employees like the coverage that you're able to give them right now?

Mr. DRAPER. I mean, the coverage that we have to give is fine. I didn't say that we had to get the cheapest option, I just said, we have the cheapest option.

Mr. DAVIS. If they had to take less coverage for you to participate in support of this public plan, would you be willing to do that?

Mr. DRAPER. If they had to take less coverage?

Mr. DAVIS. Yeah, to reduce, to basically reduce access to benefits. To be able to comply?

Mr. DRAPER. I mean, the way that I read it, you don't have to.

Mr. DAVIS. How about waiting periods for services they can get on 24 to 48 hour notices? Would they support a 6 to 8 week waiting period for that equity?

Mr. DRAPER. I mean, it depends on what the service is for. But why do you need the waiting periods?

Mr. DAVIS. Well, that's a good question. But this is the inevitable outcome of the system that we're talking about.

Mr. DRAPER. But I don't think it's inevitable. I mean, I think it's inevitable if you have a single payer option in a country like Canada. But if you are able to blend public and private in the United States and come up with your own unique option, you can come up with something that's better than what they have in other countries. I mean, we shouldn't set the bar for ourselves so low.

Mr. DAVIS. I don't think we're setting it low. Actually the question I'm coming back to, we're both businessmen here. And I appreciate your coming in. But, if the bill were enacted, the reason I was asking about how you would choose simply this, is that you deal with a capacity issue in your business. If you had limited revenue or your revenue was suddenly reduced by 20 percent, there is only things that you could do with that in terms of capacity to serve your customers. The inventory you could carry and needless to say, if you have limits on cash or waiting time, goes out to get product to customer or you're not potentially able to serve them, and that, without dealing with these capacity issues, that ultimately is what's in this.

Mr. DRAPER. Yeah, I mean, I think there's a lot of unknowns, but it's hard to say that revenue is going to go down by 20 percent just arbitrarily because the theory is that everybody has to get health insurance.

Mr. DAVIS. No, no, no. I'm speaking in your business itself.

Chairman RANGEL. Ms. Schwartz.

Ms. SCHWARTZ. Thank you, Mr. Chairman. That was sort of a spirited discussion. So, I was actually sort of enjoying it. But thank you for the opportunity to follow up. I think the, following up on the previous questions, I think the real question I have for you, and I'll ask particularly Mr. Kirsch and Mr. Draper, too, to speak to this is, would we be better off if we actually make some of the changes, the changes that are in this legislation? I think, but the particular interests I think that many of us have is that we recognize and it's been said by a number of the panelists, that we have to contain costs.

That particularly, for something for government, and our ability to sustain and our commitment under Medicare, and we plan to, and our economic competitiveness for both large and small businesses, we need to both contain costs and improve quality and get better outcomes on health care. And that we have to help all Americans get affordable, meaningful coverage. We think that's a goal we can meet, as Americans, and that we should. And I appreciate all of you agreeing with that goal.

Now, there are obviously some disagreements as to exactly how we get there, but I think recognizing the reality, I think one of the reasons we've spent so much time on small businesses, is that, and Mr. Draper's situation in particular, is that the group that has the greatest difficulty right now in obtaining coverage are people who, as individuals and as small business. Because they don't have the ability large companies have to negotiate rates with insurance companies. Or to maybe do some of the innovative wellness and prevention programs, you can spend extra dollars on that. You may even have more dollars to spend on health care coverage and get-

ting really good plans and the union shop, they might actually have negotiated some very good benefits.

But the fact is, right now, it is very hard without some of the protections and opportunities that are going to be provided in this bill to be able to get affordable, meaningful coverage. So, I wanted to ask both Mr. Kirsch and Mr. Draper about some of the market reforms and protections, making sure that when you buy insurance you don't have to be 27 and healthy to be able to buy an affordable policy. That if you have preexisting conditions, if you're older, if you're a woman, if you're in a business that actually has some high risks, that you will be able to buy affordable coverage.

The legislation that we're talking about today does that. It actually says to the insurance industry, large or small employers, in the exchange, we're going to actually comply with these changes. We're going to set new rules. And make it more affordable. We're not pushing anyone into a public option. So, my question for you is, would it be helpful to, do you think, to business and to individual Americans to be able to buy affordable insurance that's meaningful? And it is going to take a few dollars to get this up and running, but in the long run, I think we can do some of the quality changes that we want to talk about with the next panel, that we actually will improve quality and reduce costs for all of us. So, that's kind of the bottom line. But Mr. Kirsch, would you just briefly speak to that?

I feel like we've gotten away from that as we talk about possibilities that no one really thinks is going to happen.

Mr. KIRSCH. Right. And you're absolutely right. There will be, as I said in my testimony, one question that individuals and employers and basically every American is going to ask, will at the end of the day, will I have a guarantee of good, affordable coverage?

And your legislation does that. It says, you're not going to have to worry about denying preexisting conditions, charging more because you've had a health history. We think one thing you could do better is you're still allowing people to be charged more because they're older. There's no reason to do that because you're making affordability based on income, which is the right way to do it.

But let's get everybody in a system, and for small businesses, the legislation is incredibly important. Because what you've done, you're putting small businesses, which are now subject to incredible vagaries of the market. One employee gets sick, rates go through the roof. In an exchange, costs are predictable with benefits for individuals and small businesses.

Ms. SCHWARTZ. I've heard from small businesses in this matter, just to answer your comment, who have seen rates go up 40 percent from one year to the next. Someone's gotten sick and they're in a small policy. Talk about unpredictability for small businesses. You have 10 employees or, and suddenly you see increased costs, not just of 10 percent but of 40 percent, that's pretty unsustainable and maybe unsustainable from one year to the next, let alone over a long term.

So, as you move forward and you may keep some of your employees for more than just a few years and they may actually get older, and even if they're younger, they may actually, someone finds

themselves quite sick, having, understanding that they're going to have a commitment for ongoing care. I think that's really important. They won't lose coverage, they won't be charged more for their health status. I assume that would help you be able to grow the number of jobs in your business and grow your company.

Mr. DRAPER. Yeah, I mean, I support the plan, not because I work for a group that hired me to support the plan. I support it just because I read through it and think that it makes sense. And that one thing the exchange does is, the oddest thing about our free market insurance is that it's not a market. You can't compare prices between doctors, between surgeries. You have eliminated the only thing that makes a free market, which is price comparison. And so, the system we have now is just so backward and inefficient, that I think you need to reform part of the exchange but a public option is also necessary because in a place like Iowa, everything is controlled by two companies. There's no actual competition.

Ms. SCHWARTZ. There's no real competition.

Mr. DRAPER. So, I think everything working together with regulation and competition, it would come out better in the end.

Ms. SCHWARTZ. And maybe some transparencies, you can actually compare apples to apples in an exchange, for example.

Mr. DRAPER. Yeah.

Ms. SCHWARTZ. All right. Well, thank you very much and thank you all for your testimonies.

Chairman RANGEL. Mr. Boustany.

Mr. BOUSTANY. Thank you, Mr. Chairman. I have a question for Mr. Shea and Ms. Hansen, in particular. You know, we're talking about a government option. But there are a lot of details that will go into a government option that have not been fleshed out and I have a lot of concerns about. Now we're going to put the Secretary in charge of creating an insurance product. The Secretary is going to have to provide for reserves, which will be taxpayer money to back up that insurance product. Of course, it will collect premiums and do all these other things.

So, you're basically building an insurance company from scratch. You're going to have to either contract out with insurance expertise or build it in-house, a very expensive proposition. You also have to build out a provider network. And the question I have for the two of you is, what happens if physicians, by and large, choose not to participate in the government option?

I mean, currently, a lot of physicians are backing out of Medicare and Medicaid because of low reimbursement. And all the bills being proposed, including this one that we're talking about today, are going to utilize Medicare reimbursement or near Medicare reimbursement. So, what if physicians choose not to participate and you have no provider network?

Mr. SHEA. I really think that's an important issue. Because one of my fears is, if we wind up with a public insurance plan that is very weak, physicians are simply going to say, I'm not interested. There's no compunction on me, I don't have to, it's not like Medicare, I'm not going to tie this to Medicare. We've got to have some rules that require, I think, require providers to participate in this.

Mr. BOUSTANY. So, you would have the Secretary require all physicians?

Mr. SHEA. I'm not saying how it would be done, or all physicians, but you have to have some sort of a structure so that if a public plan is going to be at all meaningful, they have to have a supply of providers. Of course, they have to pay fewer rates for that. And this whole issue of rates which we've been discussing is really, really important. And we've lumped together in a way that I don't think is useful.

Medicaid rates are largely too low. In Massachusetts, when they passed the plan, part of the deal was, to get the physicians on board, was to raise the Medicare rates. That improved everything for everybody. Medicare is a situation where they do their rates based on cost.

Mr. BOUSTANY. Actually, they're not really based on cost.

Mr. SHEA. Well, let me get, it's their calculation of cost. What has happened is that we've build such an expensive health care system——

Mr. BOUSTANY. When you say, you talking about CMS' calculation?

Mr. SHEA. Yes.

Mr. BOUSTANY. Yes. Okay.

Mr. SHEA. We've built such an expensive system, that a calculation of minimum costs doesn't cover actual experienced costs. So, I think you could justify the Medicare rates. I think it would be wrong to go Medicare rates because it would be too big a shock to the system.

Mr. BOUSTANY. It would be a problem. I've had 20 years clinical experience as a physician and also sat on the board of a community hospital and saw the intense financial pressures because of reimbursement rates not covering costs. It's a serious problem. And I would submit that it is a serious problem about physician participation, based on my knowledge of physician behavior.

And so, for Ms. Hansen, I would say, I know my colleague, Mr. Ryan, talked about Medicare. I'm hearing from a lot of my Medicare constituents who are very concerned about the ongoing debate and whether this will accelerate the insolvency of the Medicare trust fund because it's going to put more pressure on the government in terms of fiscal outlay to create this government option.

So, you have to have concerns as a leader at AARP in this, also knowing that physicians, many of them across the country, and in specialties and in primary care, are backing out of covering Medicare patients. So, we have a stressed Medicare system and we're now talking about creating a new government program, call it an entitlement because it's going to be an open-ended requirement for funding at the end of the day. So, I'd like to hear your comments on this.

Ms. HANSEN. Well, I think the ability to make sure that there is a good provider network, you're absolutely right. I think right now there are concerns, Medicare or not. I think that even the commercial market is finding some challenges there. So, I think that one of the areas that AARP is supportive of is making sure that physicians are going to be paid appropriately and we have supported having legislation to fix the SGR.

Mr. BOUSTANY. Do you support coercive measures by the Secretary of Health and Human Services to push physicians into providing care for a government program?

Ms. HANSEN. We have not discussed that. Our principle is making sure that providers are rewarded for quality as well as appropriate reimbursement.

Mr. BOUSTANY. Thank you. I yield back.

Chairman THOMPSON. Thank you. Mr. Etheridge.

Mr. ETHERIDGE. Thank you, Mr. Chairman. And I'll, I want to thank each of you, you've been very good for sticking around for a long time with the schedule we have today. Let me ask Mr. Draper just one quick question of you. I ask it from having been in business for 19 years and had responsibility for helping with human resources and a host of other areas in providing, and at one point, responsible for health care so I know the challenges you face, number one, in paying for it and, number two, in making sure you have it for your employees as different plans change from year to year and costs go up.

But you mentioned in your testimony that the most basic insurance coverage offered to you is catastrophic coverage. And of course, I think that's one of the issues that most people fear in this country is that whatever their plan is, they'll have a catastrophic issue and history has proven that by and large that's what throws people in bankruptcy. They run into a huge medical cost and then they tend to lose what they have. So, my question is, is catastrophic coverage enough for you to feel that you and your family would be protected from bankruptcy due to the medical costs and to feel confident that you would have access to routine medical care if you needed it within the plans that you now have?

Mr. DRAPER. Now, personally, I have a family plan through my wife, and so the catastrophic coverage from the employees, I think, I mean, it covers catastrophic coverage, you want catastrophic coverage just so you don't develop a brain tumor when you're uninsured, then you'll never get insured. So, you have to have some basic insurance. I think the reason why people go into bankruptcy is because even if they have the catastrophic coverage, the deductibles each year are so high, and the savings rate for people is so low that $10,000 is enough to send somebody into bankruptcy. A $10,000 bill in a year. It may not make sense for anybody who has saved money or has money but for the people right on the edge, that's the problem. So, I don't think that catastrophic coverage will prevent people from going into bankruptcy.

Mr. ETHERIDGE. Thank you. I'll get that on the record. Mr. Johnson, let me ask you one question because in looking at the testimony that you put in, you indicated support for exchange and inclusion of both nongroup and small group markets, which would cover small businesses and others. And in that, I think you said you indicated that the Chamber of Commerce supports the concept of an exchange as advanced by the President and of course, I think you have indicated here that, and many of those views are components of a reform legislation, and now you've long advocated that position of pooling.

So my question is, do you support the concept of an exchange to allow for pooling? And would you, and who should be allowed to go into that exchange?

Mr. RANDEL JOHNSON. Well, we do support the concept of an exchange. Exactly how it's constructed and should be, I'm not quite sure. We are concerned, this goes to your question, Congressman, we are concerned about the Board apparently having a gateway power to define who goes into the exchange and who doesn't and we aren't certain what that level would be.

It would appear to be that the government would be empowered to have, to define, who meets that favored criteria. Since we don't know what that criteria is, that's an issue to us. But I think that's something we could work on.

Mr. ETHERIDGE. But your point is that concept makes sense.

Mr. RANDEL JOHNSON. Yes, it does. And the Senate Health Committee, we said the same thing in the Senate Health Committee testimony and I think that's a key part of all these bills, that we can work on together.

Mr. ETHERIDGE. Okay, thank you. And I yield back, Mr. Chairman.

Chairman THOMPSON. Thank you. Mr. Davis.

Mr. DAVIS. Thank you, Mr. Chairman. Let me, if I can, and I'll direct this question, I guess, to Mr. Kirsch, Mr. Shea, or Ms. Hansen. One of the things we're wrestling with, and I recognize that this is a little bit beyond the scope of the hearing, but one of the things we're wrestling with is obviously how we pay for all of this. And just to take advantage of your expertise while we're here, I want to spend a minute or so asking you about one option that's the subject of debate. And that's the plausibility of taxing for some individuals, the value of the benefits provided by their employers.

Does anyone on the panel favor taxation? I suppose, frankly, no one's advocating a full scale taxation, but taxation beyond a certain level. Who on the panel favors a partial taxation of employee benefits? Just by a show of hands, so I can see that. Does anyone on the panel favor a partial taxation of benefits provided by employers?

Mr. Kirsch, you're nodding your head no. And just tell me for the record why you don't favor such an option.

Mr. KIRSCH. Well, first of all, we don't think it makes sense to have health care be more expensive for people when the big problem is how much health care already costs. So, we don't think it makes sense to tax people who are fortunate to have good benefits, which basically means they have things like maybe dental care or vision care or a larger network or lower out-of-pocket costs. We want everyone to have that. We don't want to make it more expensive. And then, in addition, if you look at what actually happens, when you try to set a value, if you even buy that premise, there are huge geographic variations, there are variations based on business size, on age and health status of workforce, so it's wrong in the first place and there's no way to arrive at a number that's equitable.

Mr. DAVIS. So, again, just to make sure I fully understand this, some people have argued that well, if you set, say, a reasonably high cap. Let's say you set $16,000 a year and only tax benefits

above that. Some have argued that that would have the effect of only taxing people with so-called Cadillac plans. You disagree with that.

Mr. KIRSCH. Let me actually put on another hat. That until this job, I was a small businessowner. It was a nonprofit small business, but we had employees in several offices in New York and because costs in New York City are so much higher than in Rochester, we are paying, I think $18,000, $19,000 for a family policy in New York City that had lower benefits than the same policy in Rochester that was like, $12,000.

If you live in New York City, which has high health care costs, it has nothing to do with the benefit level, just happens to be an expensive place to live. Why would we tax those people?

Mr. DAVIS. So, in other words, someone making, someone who has a $16,000 benefit, the face and profile of that person might not be a CEO but it could be someone who's making $70,000 or $80,000 a year, correct?

Mr. KIRSCH. Well, in New York City, you know, we paid higher salaries than upstate but maybe we paid someone $60,000 for what we paid $45,000 in Rochester. At $60,000 a year you're not going to be able to afford $18,000 a year, or have to pay taxes on it, it's crazy.

Mr. DAVIS. And I'm assuming that some people have higher value plans because their health situation leads to obtain higher value plans. Is that a fair assumption?

Mr. KIRSCH. Yes. I mean, basically if they've been sick or are older, their plan is going to cost them more. Not because it's worth more in terms of the benefits, just, it's going to cost more.

Mr. DAVIS. Mr. Shea.

Mr. SHEA. We agree with everything that Richard said and I have spoken on this before, but let me add one other thing which is that if you look at the companies that have a lot of early retiree costs, pre-Medicare retirees, and they are continuing to provide them benefits because the industry is changed, they've bought the people out, they didn't want to just dump them off because, you know, it's hard to get insurance. Everybody knows that 55 and up. The costs, I've looked at some of the numbers in the union plans, the costs increase because of that retiree, can be enormous. So, $20,000 a year? Not because of Cadillac benefits, I mean, they're good benefits, but because there are a lot of retirees in the plan.

Mr. DAVIS. Let me slip in a question, my final 30 seconds. I thought, I didn't agree with where Mr. Boustany was going but I think his question is an appropriate one. What is beyond the extra 5 percent, beyond Medicare, that goes to doctors participating in the public option, or accepting people who are participating in the public option? What's an appropriate incentive for the government to offer doctors? Are there some ideas you can throw out? Because I think that the concern's a valid one, that just as some doctors are not accepting Medicare and Medicaid, they won't accept public option patients beyond the extra 5 percent the Medicare recipients get, or the doctors covering Medicare recipients get, what are some appropriate inducements to offer doctors so they will accept in the public option? Ms. Hansen.

Ms. HANSEN. You know, when I said the word, quality was there, and I think looking at the performance of producing good outcomes on behalf of their patients, practicing with the areas that show some evidence that this is what should occur, so there should be bonuses, perhaps, as one way to reward the effective practice of care for people.

Mr. KIRSCH. And that's a great answer. One of the things we think is very important that the public option can do, is be able to do that kind of innovation and payment systems and so our policy is that should not be tied to Medicare. Starting with Medicare is ok as a basis, as a way to help you get started. We want, though, the public option to do the kind of innovative reimbursement systems, the right incentives, that Jenny's talking about so that we actually can improve care and control costs. And so that doctors want to be in a system that provides the right kind of incentives for them doing good care.

Mr. DAVIS. Thank you, Mr. Chairman.

Chairman RANGEL. The Chair recognizes Mr. Ron Kind.

Mr. KIND. Thank you, Mr. Chairman. I'm going to be brief. The panelists have been above and beyond the call of duty, shall we say, with your patience, your testimony today. One of my main focuses with health care reform is trying to address the needs of small business and family farmers. Mr. Draper, I'm looking at you right now. And in the past, I've introduced bipartisan legislation. I think very good and reasonable bipartisan legislation, both the House and the Senate called the Shop Act, which very simply would establish a national exchange or national purchasing pool for small businesses to be able to join along with tax credits and incentives to make it more affordable.

Because a small group market clearly failed. Too many small businesses and family farmers, if you're talking about the 47 million uninsured, most of them are working Americans, either in small businesses or on farms that can't afford coverage because of the lack of a good small group market. A lot of that Shop Act proposal, the principles are contained in this draft discussion right now.

The tough decision we have to make is where do we draw the line as far as exempting small businesses and family farms from the mandate of providing coverage for their employees. What's the reasonable line that can be drawn? What factors should be considered? Mr. Draper, I want to get your thoughts on this. One, there are a variety of options we can look at. One is based on gross sales, or gross revenue for that business or farm. Another is based on the size of the payroll for that small business. The other is based on an adjusted gross income, where you back out all the input costs and you're left with basically net profit at the end of the year.

Mr. Draper, I'd be interested to get your thoughts on where we should exempt, what level should we exempt small businesses from having to provide health care coverage for their workers?

Mr. DRAPER. Yeah, I mean, that's one of the many things that makes me glad I don't have to write this bill. It's tricky because you could set it at a certain amount, say, income that they'd be exempt. And so, for 4 years they'd be paying 8 percent, but then say you have a recession like this year. Company's income goes down,

suddenly, 30 percent of the companies that were paying in now aren't paying in, there's a budget shortfall, so it's tricky to draw the line. I mean, I would, I'm more for requiring everybody to have health insurance, no matter how we do it. Just for the reason that if you require everybody, the theory is the rates will go down.

If you require everybody to have health insurance and the rates go up, obviously that will be frustrating, but this is one of the things that in order to move forward into the future, you've got to kind of do something and just because you don't know exactly what's going to happen doesn't mean you should stop trying to do anything. So, I don't know where it would be to draw the line. You may just want to require health care for everybody and not try to worry about, you know.

Mr. KIND. I appreciate that response. But just to be clear, there will be shared responsibility, so if the business isn't required to provide coverage, the individual will still be required to obtain health coverage and that is how we're going to try to work with them to make it affordable for low-, middle-income families so they can go into the market and purchase health care on their own.

But my question, and Mr. Shea, maybe you want to jump in here, is if we are going to exempt small businesses, many of whom are really operating on a tight margin and having the requirement of providing coverage themselves could put them over the end and they wouldn't be able to stay in business, what should be the calculation that we use? Mr. Shea. Do you have?

Mr. SHEA. I'm not going to be very helpful to you, Congressman. I think, like Mr. Draper, the best approach is to put everybody in and then subsidize those people who really are at the low end who warrant it. But once you start keeping some people out, you're going to get distortions. You're going to get gaming. So, I think you put everybody in. And the other reason I say that is just something that hasn't been mentioned here.

Most of the people who don't provide coverage, who are low margin, small employers, are competing against other low margin, small employers. So, if you put all of those people in, it's not like you're going to give some people a disadvantage, you know, everybody is going to be in the same situation. And if you have enough subsidy so that we don't lose wholesale jobs, and I think that's just something you've got to design in, I think it'll work.

Mr. KIND. Mr. Kirsch.

Mr. KIRSCH. Yes. I agree. I think shared responsibility means we make it affordable for all small employers and they pay in a reasonable way. And I think the analogy here is the minimum wage. I mean, we don't say to some small businesses, you don't have to pay a minimum wage. We say, a basic requirement of being in business is to contribute to long-term retirement through Social Security, and to pay at least a minimum wage. And so, let's now do the same for health care, but let's make it affordable.

The problem right now is, as you know, health care is not affordable to too many small employers. There are a lot of things you've done in this legislation, numerous things to make it affordable and then every employer can pay because you've made it affordable, even the smallest low-wage employer because you've made an affordable option in this legislation.

Mr. DRAPER. Yeah, I think you pretty much want to have to try to include every business just because trying to exempt some, I mean, it's difficult just because the other side will say, oh, but what about the small business? But, looking at the big picture, if you guys wanted to help small business, just eliminate income tax for small businesspeople and raise capital gains tax.

But so, it's hard to argue for it. I think it may be tough for some people, but I think people in small business are used to getting it, and it's kind of the only way to do it is to require everybody to have it.

Mr. KIND. Thank you. Thank you, Mr. Chairman.

Chairman RANGEL. You have been one outstanding panel. And one patient panel, I might add. And I only can offer to you, remember this day as you kicked off an historic piece of legislation that is long overdue in our great Nation and that you have been a part of it.

In the early 1960s, I walked with Dr. Martin Luther King for 54 miles. I had no idea what I was doing. But I don't tell that to my grandkids today. I told them I was a part of that great civil rights movement. And I want you to really and truly believe that your testimony is going to help get this thing started. We're going to have the outstanding businesspeople of our community understanding that their concern with our country, the employees, competition, education, health care, and all of you are going to be very proud of the contribution.

We are collectively thankful and I know that Mr. Camp joins with me that we're going to get this thing done. Thank you so very, very much. I yield to Mr. Camp.

Mr. CAMP. Well, no, I just want to echo. Thank you all for taking the time. It's been a long day waiting and then a long time at the witness table and I certainly appreciate all of your effort today to help eliminate what we're looking at which is a health care proposal that is a significant one. And I just want to thank you for your testimony.

Chairman RANGEL. Thank you. Now, we will call the next panel. Dr. Baxter. He's from my hometown and if we could package, where's Dr. Baxter? If we could package the enthusiasm that the doctors and staff have at William F. Ryan Health Center, it would be good for the country. You do a great job and our community appreciates it.

The American Academy of Family Physicians, the President of that group, Dr. Ted Epperly. We hope that you feel very proud of this package because we've invested a lot of money in expanding the number of physicians, especially primary care and we're going to make certain that we give the opportunity to do what doctors were trained to do and that is to take care of patients and provide health care.

And our nurses. The Rhode Island State Nurses Association on behalf of the American Nurses Association in Silver Spring, Donna Policastro. Some believe that the nurses are really the backbone of the hospitals and we want to appreciate, not only what you've done, but to appreciate and encourage and provide incentives in terms of pay for the professional work our nurses do.

Chip Kahn. Chip. Well, it's good to have you with us. I remember the meetings that we had and I told the hospitals that we're going to pass you by, but what an opportunity to participate, to help us, to give us direction and we couldn't have done it without the professionals. We tried to do the right thing as legislators, but we can't do it without the people on the ground that deal with these problems every day helping us so that we can avoid making big mistakes.

And Richard Warner, a doctor from the Kansas Medical Society House of Delegates, the AMA Alternate Delegate and past President of the Kansas Medical Society, we welcome you here and I'm going to call upon Mr. Larson, John Larson to share with us his support for Ronald Williams, who's the Chairman and CEO of Aetna Insurance Company, from Connecticut who, unfortunately is with the President, as he has joined with us in sharing his expertise in this field. The Chair would like to yield to the Chairman of our Caucus, John Larson.

Mr. LARSON. I thank the distinguished Chairman and I make apologies on behalf of Mr. Williams who was, along with our other panelists, waiting patiently to bring testimony but he has, as the Chairman has indicated, been called to the White House, where he is at a health care event and focusing on prevention.

I just want to echo what the Chairman has said about Mr. Williams. The Aetna is an outstanding company in the State of Connecticut. And Mr. Williams has been an exemplary Chief Executive. He has toured the State with Senator Dodd conducting forums on health care. Aetna, as you might suspect, leads the Nation, in fact, was the first national insurer to offer consumer directed health care plans. It was the Aetna that through information technology in bringing new levels of transparency to the health care system, has paved the way for innovation and driving them, what the President continues to emphasize, is at the heart of bringing reform to this system. And that's the cost. With health care approaching 20 percent of our GDP, it's important that we focus on this. But also add that with respect to a public plan, Chairman Williams has been asked whether he could compete with a public plan or not, and he said, all things being equal, yes. And I think that's what these hearings are about to make sure we hear how we can make all things equal and move forward on behalf of the American people. Again, I want to thank the Chairman and on behalf of Ron Williams from the Aetna indicate the gratitude to be here, but as the Chairman understands, he was called away to a meeting to a higher authority at the White House. Thank you, Mr. Chairman.

[The prepared statement of Mr. Williams follows:]

Prepared Statement of Ronald A. Williams,
Chairman and CEO, Aetna, Inc., Hartford, Connecticut

Chairman Rangel, Ranking Member Camp and Members of the Committee, I am Ronald A. Williams, Chairman and CEO of Aetna. Thank you for the opportunity to speak here today as we approach a critical juncture in the national health care reform discussion. Let me start by emphasizing that we share a common goal. We want to get everyone covered with adequate health insurance, improve the quality of health outcomes, and get better value for each dollar spent on care—with the goal of reducing cost and improving affordability for the American people.

Your effort moves us closer to those goals, and I applaud the Committee for trying to offer solutions that address the issues of cost, quality and access. Your plan would maintain the overall strength of the employer-based system, allow people to keep what they have, and provide solutions to improve the individual and small group market. While we may not agree on all the specific details of your overall plan, our intent is the same.

For example, I called for reforms that would guarantee that health insurance companies have to issue health insurance regardless of health status and limit medical underwriting. We can make these reforms if we also have in place an individual coverage requirement, just like Massachusetts, so that insurance is not just about getting it when you are on the way to the hospital.

Facts About the Health Insurance Industry

To fully appreciate that we have common interests, it is important to understand the goals and values of insurers today. Unfortunately, many people have made assumptions about our sector that may have been true 20 years ago but are not based in marketplace realities today.

We are not, in fact, one of the key drivers of health care costs. U.S. health care spending topped $2.4 trillion in 2007, while the combined profits of the top 10 health insurers were approximately $8.3 billion. It is important to understand that insurance premiums are directly tied to the cost of underlying services in health care, including doctor, hospital and other provider costs. In 2007, the cost of health care services grew at an annual rate of 6.4%, resulting in overall premium increases, on average, of 6.1%.

Aetna today processes 206,000 calls a day and well over 50 million a year—over 45.5 million calls were answered in an average of 19.3 seconds and 94 percent were resolved the first time; we processed 407 million medical, dental and pharmacy claims in 2008. Of these, only 0.3%, or 1.2 million, were not processed correctly. Getting all this right takes long-term investment, staying current and complying with the changing regulations from more than 50 jurisdictions and a commitment to constant improvement that can be implemented carefully.

But it would be a mistake to see our business model as a simple claims-paying operation. In fact, the competitive nature of our business requires us to generate strong value on behalf of the members that we cover. We have become leading innovators in chronic disease management, wellness and prevention, performance-driven payment models, quality management, and end-of-life care.

We also have been leading the health information technology (HIT) movement to give consumers and their doctors tools that empower them to make better decisions about their care pathway—using their personal health information in real time. Since 2005, we've invested more than $1.8 billion in HIT, and we're seeing real value for that investment.

Notably, our unique clinical-decision support technology, CareEngine®, provided through ActiveHealth Management, has been used to analyze more than 18 million complete patient records against current standards of care to identify gaps in care and to alert physicians with "care considerations" that they can act on. These clinical alerts have been reviewed by specialists at Harvard, and as a result we are able to say that Harvard approves of the language and how these clinical tools have been built. We have also submitted many of these measures that are used to support the clinicians to the National Quality Forum, and 33 are being reviewed for endorsement. We feel that we are raising the bar in the measurement of quality by our ability to collect diverse data and integrate it into useful decision support for clinicians.

CareEngine was tested in a randomized clinical trial, with the results published in 2005 and again in 2008. The use of the technology and the subsequent physician actions prompted by these care alerts produced a reduction in patient hospitalizations of 8% and a savings in charges of more than $8 per member, per month (PMPM). In a 2008 followup study,[1] the tool's impact was further validated by findings that showed the use of advanced clinical-decision support with care alerts reduced overall charges by 6%, with charge savings in excess of $21 PMPM.

We are an essential element of health care today, helping employers and consumers get better care. Much of the innovation in our health care system is fueled by private insurers working alongside employers to ensure the health and well-being of employees. In fact, many of the payment and quality reforms currently proposed for the Medicare program were actually created, tested and proven by employers and insurers working hand in hand in the private sector.

[1] The Journal of Health Economics, "Information Technology and Medical Missteps: Evidence From a Randomized Trial," 2008; 585–60.

Our ability, however, to innovate and deliver diverse product offerings across the country is very much affected by our complex regulatory environment. We are one of the most heavily regulated industries in the Nation. We are regulated uniquely by 50 States and by multiple jurisdictions within each State; we are regulated by cities, in some cases, and several Federal agencies. Each regulatory body takes a different approach to how it handles regulation of the health insurance market and enforcement of the rules. These regulations today could fill a small town library.

The unintended consequences of these regulations are that each has a different effect on cost to the consumer and our ability to provide innovative product offerings. It is one of the reasons we see individual health insurance in New Jersey that is about 300% more expensive than similar plans offered in neighboring Pennsylvania. Bringing a more common approach to regulating the market—if it is with an eye on simplification—could make the market more responsive and increase consumer access to more cost-effective products. If we are going to set national rules, they need to preempt other statutes that try to accomplish similar outcomes.

We are also committed to continually reducing the administrative costs, and have made a pledge to the President to simplify our interactions with doctors, hospitals and other providers to produce savings and, more importantly, to streamline our system so that uniformity throughout reduces costs, improves interaction times, and addresses the key "friction points" that the medical community has asked us to address. The industry has committed to the following administrative simplification reforms:

- Automate and standardize the electronic processes used by health plans to do business with providers including: claims submissions, eligibility verification, claims status, payment and remittance.
- Eliminate the variation in how our industry implements administrative standards through the designation of an organization to develop uniform rules that would be incorporated in future versions of IT standards enabling providers to access consistent insurance information.
- Implement uniform standards for health plans' personal health records (PHRs) to ensure that patients and their providers have accurate, real-time information available 24 hours a day regardless of location. PHRs will help reduce duplicate tests, ensure up-to-date medication history, and facilitate better quality care by physicians.
- Adopt uniform quality performance measures that are actionable for physicians, hospitals, and other clinicians and issue consumer-friendly reports that assist patients in making more informed decisions.
- Propose that an independent third-party entity is created to: coordinate the collection of information on provider licensure, board certification, and adverse actions; and facilitate credentialing by hospitals and health plans across all private plans and public programs.
- Propose that a multi-stakeholder national task force is created to develop a process similar to the National Correct Coding Initiative (NCCI) to address correct coding for all populations and health care services covered by public programs and private insurers.

The differences between Medicare and private plan administrative costs are often referenced, despite the significant differences in the target populations and services provided. Even so, when compared on a per-member, per-month basis, administrative costs are nearly the same for Medicare and private plans.

Cost and Quality

Underlying medical trend is rising about 12–15% per year due to the cost and utilization of medical services. Recently, *The New Yorker* magazine, in a story by Atul Gawande, highlighted a worrisome problem in this country that some are now calling the "McAllen, Texas Problem." McAllen has one of the highest Medicare expenditures per capita in the country, yet its population is no sicker than most other places. But because it has high provider capacity, this capacity drives up volume and cost. A lesson for our country—we need to align incentives with quality outcomes, not volume.

The problems we face in health care can be solved. In fact, the industry came close in the 1990s, when the medical cost trend dipped from 8.1% in 1992 to (−1.1%) in 1995. Back then, you had a medical home called a primary care physician whom you needed to consult before you could see a specialist; you had limited choice of doctors and hospitals from a closed network, a network that agreed to tighter payment rates for services; and payments to providers were bundled for highly intensive procedures and allowed providers to keep some of the savings. Ultimately, that model did not work as consumers wanted more choice and more control

over their options, and providers wanted more control over the options they could offer. We don't advocate it now. We may have achieved many of the right results but in the wrong way.

Consumers' expectations remain essentially the same today as they were in the '90s. Today most experts agree that 30% of health care is unnecessary, and yet the majority of Americans believe they don't get the tests and treatment they need. Fifty-five percent of Americans say insurers should pay for what a doctor recommends, even if a treatment has not been proven more effective than a cheaper one. If our collective goal is to achieve affordable coverage for all Americans, it is essential that we address these issues and make delivery system reform happen.

A lot of exceptional work is being done to examine the issue of paying for quality vs. volume. In cooperation with providers and employers across the country, we continue to experiment with aligning quality incentives and payments to providers when they follow the medically recommended care pathways, as determined by the various medical professions. As a result, we have seen improving averages in breast cancer and colorectal screening, improving back surgery outcomes while reducing the use of imaging, improved use of antibiotic management leading to fewer readmissions (in one network alone readmissions went down 19% over a 60-day period), and we have seen similar results in diabetes management, oncology and cardiac care. When we focus on the patient in a holistic manner, we get better quality outcomes for patients and overall reduced costs. These are programs that have been done in cooperation with groups such as the Leapfrog Group and our own Bridges to Excellence program. These programs have reduced cost while improving quality. When people get the right care at the right time, the whole health system benefits, and we achieve value-based health care for all.

Making insurance affordable will require us to bend the health care cost curve; all of us have a role in this effort. But we must start with a major reform of the payment system, as this is the underlying cause of the over expenditure we live with today.

Prevention and Wellness

Health care reform needs to include strong prevention and wellness initiatives; it is the most important investment we can make in our future. Today, our health care delivery system is largely oriented toward the treatment of disease, rather than focusing on preventable health conditions. Refocusing our system to prevent disease and promote wellness can lead to better health for all Americans and positively impact costs systemwide.

More than half of Americans are living with at least one chronic disease. Nearly one in five 4-year-olds is obese, with significant disparities in prevalence among different racial and ethnic groups. The United States spent $217.6 billion on direct costs in treating non-institutionalized Americans for chronic disease in 2003, while experiencing an added $905 billion in losses associated with indirect costs.

We must refocus the health care 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:

- Using consumer engagement and targeted incentives to encourage sustained healthy behavior and change unhealthy behaviors;
- Developing an integrated, holistic approach to care management to allow for early intervention and education; and
- Promoting coverage policies and initiatives that encourage the use of high-value health care and address the needs of specific population segments.

Our own experience, as both an employer and as a leading national health insurer, tells us how effective this approach can be. Our *Wellness Works* employee programs are engaging employees, helping them get healthier and contributing to lower medical costs. The *Get Active Aetna* program, for example, is a 16-week fitness action campaign through which 55 percent of employees logged 970,000 exercise hours in 2008—walking a total of 3,397,524 miles, the equivalent of walking 136 times around the Earth.

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. 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 reduc-

tion in inpatient admissions for coronary artery disease and an 18 percent reduction in inpatient admissions for strokes.

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 specific 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 activities. Grants for community-based wellness and fitness programs should also be considered, and wellness and prevention initiatives should be implemented in public programs.

Insurance Markets

Keeping what you have: We need to make the health insurance market work for everyone, and I believe we can. But as the President has stated: "If you like what you have you should be able to keep it." Choice is always at the center of what Americans want to maintain. Whatever we do, we need to ensure we do not implement reforms that adversely affect the ability of the insurance market to offer choice. In a *New York Times* poll reported in Sunday's newspaper, 77% of Americans, an overwhelming majority, said they are happy with the coverage they have. Your bill recognizes that people want the ability to keep what they have, but if the rules are too sweeping or strict and the regulatory structure too complex and constraining, you will limit choice and destabilize existing markets. If strict rules tilt the playing field too much in favor of exchanges, consumers will slide out of their plans into these exchanges and face higher premiums that they will not find acceptable. Tax credits and/or subsidies should be offered inside and outside the proposed exchanges. If we fail to do this, it will destabilize risk pools causing an additional rise in premiums.

Large Employers (50+)

Today, more than 177 million Americans get their insurance through the employer-based system, and the large majority of the 50+ market is self-insured. Employers expect great value for their spend in health care; they want wellness and prevention for their employees, chronic disease management, quality outcomes, and they want measurable results for each of these areas. This is not a system that should be changed, and by an overwhelming majority most employers don't want to see this market touched by reform.

- More than 95% of employers polled in a recent survey overwhelmingly want to continue to provide their employees this type of coverage.
- It is the employers' long-term commitment to their employees' health that has driven much of the innovation we have today in terms of services that help improve and sustain employee health.

But, outside this market, insurance does not work well for everyone, and we need to reform these markets if we are gong to achieve full access for all. We do need specific reforms for the individual market and those parts of the small group market that are not working. We also need to remember that 18 million people are insured in the individual market, 30 million in the 2–9 market, and about 38 million in the 10–50 small group market. We should not expose these policyholders to disruptions that include higher rates. Where the market is not adequate we recommend the following:

Specific Solutions for the Individual and Under-10 Small Group Markets

The Committee's reforms would make important progress in addressing the lack of coverage in this market. Only about 35% of the people in this market have access to insurance because of affordability concerns or preexisting conditions. By reforming the individual market, which should also include small businesses with fewer than 10 employees, we can tailor insurance market solutions to effectively address the needs of the uninsured without disrupting or even unraveling the entire insurance market.

We can cover the uninsured if we:

- Guarantee issue of insurance and align it with a strong individual coverage requirement.
- Subsidize those that truly need help and possibly those at high risk.
- Provide affordable coverage options, which improve choice and reduce complexity.
- Provide modified community rating for age, geographic location and family size, but toss out health status and gender.

- Design benefit options that meet specific needs of consumers. Most consumers, when using their own money, pick a benefit design that is similar to the Massachusetts Bronze plan. The premium for this plan is about 55% lower than the premium for FEHBP's Blue Cross Blue Shield standard plan.

We think it makes sense for these plans to be offered via an exchange and believe it should be national or Statewide, run by the State Insurance Commissioner. If the Federal Government decides to set the rules for the exchange, they should preempt State rules. Exchanges should be operated under a consistent set of Federal rules.

Setting rating bands is all about which part of our population subsidizes which other part. In making policy decisions, we need to be mindful of how reforms may impact different segments of the population. While the very purpose of an insurance pool is to spread risk, how much should a 23-year-old with a lower than average income pay to lower the rate for a 60-year-old with a higher than average income? It's only when we truly reduce the cost of health care that we will be able to provide affordable coverage. The National Association of Insurance Commissioners should be asked to provide recommendations on rate bands; once set, they should be reviewed periodically to ensure rate bands are not unfairly and adversely affecting different segments of the population. These bands should offer a cap but should not be so tight as to make insurance unaffordable for too many Americans.

Small Group 10 to 50

For small businesses with between 10 and 50 employees, 85% of whom offer their employees (about 38 million people) health insurance, we need a package of solutions that makes the current market work better. I believe the intent of the Small Business Health Options Program (SHOP) Act is the right approach, as it provides a package of solutions intended to address the major issues for these small businesses—rate volatility and affordability of coverage. We support:

- Allowing groups to keep what they have.
- Individuals entering the exchange if their employer doesn't offer coverage.
- Rating rules that are consistent nationally (and consistent in and outside the exchange)—rating rules should not be set in statute.
- Overall age band of 5 : 1.
- Subsidies for the costs of high-risk individuals.

I would call on the Committee to leave some details to regulation, understanding that making our new model work will require time and experience. This would allow greater flexibility in meeting different consumer needs and expectations. Examples on this point include benefit package design, where we need not legislate in a "one-size-fits-all" manner. Rate banding is another example; while moving to a national standard is advisable, we need to allow for flexibility in designing rate bands that are based on actuarial modeling and reflect our collective intent to expand access and increase affordability. This may take some experience with a new system to get right.

The Public Plan

I've been asked whether we could compete with a public plan. All things being equal, I would say, yes, we can provide better value, quicker innovation and do a better job in areas such as wellness, prevention, and chronic disease management.

However, everything I have read so far says that a public plan would pay providers Medicare rates or something close to them and would control the delivery of care itself. The government would be, in other words, setting prices for services and paying below what providers consider to be market rates. There is no competition in this scenario. And, the government is missing the point—it is not how much we pay that is the problem, it is what we pay for that caused high-volume consumption of health care services. If everyone is paid at the same rate, how does that spur competition?

It would be extremely difficult for the government to be both a player and a referee. I cannot support this kind of public plan and see it as a danger to the stability of community and rural hospitals and to health care overall. It would lead to continuing to reward episodic care, as opposed to care management. It will be costly to implement, taking dollars away from an already burdened health care system. And, it could be a plan of last resort, creating a new problem for us to manage.

Conclusion

In closing, I want to be clear that we seem to have many more areas of agreement than we do areas in dispute. By making insurance coverage a matter of personal responsibility, you are laying the groundwork needed to help resolve the problem of access for so many of the Nation's uninsured. And, this requirement would serve

as a key building block for other important reforms, such as guaranteed issue regardless of the consumer's health status and preexisting conditions.

I also hope you will take away from this discussion how vital the private sector is to innovation. Whether we're talking about health care product designs, quality measures or payment system reforms, the private sector has worked with employers and consumers to find new ways of delivering innovation and value to an ever-changing marketplace. With changes in the regulatory system, that value can be compounded many times over. We are an integral part of the health care system that will continue to deliver real value and new ideas if allowed to participate on a level playing field.

That is why a public plan option makes such little sense for health care consumers going forward. If we get everyone in the system and implement needed reforms across the individual and small group markets, it serves little purpose to weaken the ability of private insurance to deliver the level of service and value that so many Americans are happy with today.

Thank you for the chance to offer our perspectives and recommendations. We look forward to working with you to pass meaningful reform that addresses affordability, access and quality. I'm confident that, together, we can arrive at a solution that America can afford, and we can get it done this year.

Chairman RANGEL. I'm going to call on the Chairman of the Subcommittee, Mr. Stark, to welcome you, but again, you're an outstanding panel. I've been talking, Mr. Stark would miss the camp and we haven't, and we have thought that in order to get the maximum of the benefit that we know another cluster of votes are going to take place on the floor. So, if we ask our witnesses to restrict their comments to 3 minutes and our Members that are here to 3 minutes, we might avoid the collision with the people on the floor and get the benefit of all of your questions in. So, Mr. Stark, would you welcome Dan Baxter. And I've already introduced them all.

Mr. STARK. Dr. Baxter, would you like to inform us, in any way that you're comfortable?

STATEMENT OF DANIEL BAXTER, M.D., MEDICAL DIRECTOR, WILLIAM F. RYAN COMMUNITY HEALTH NETWORK

Dr. BAXTER. Thank you, Chairman Rangel, Ranking Member Camp, and distinguished Members of the Committee.

I am the Chief Medical Officer of the William F. Ryan Community Health Center in New York City, which is named after a beloved, former colleague of yours. The vast majority of Ryan's 40,000 patients represent those groups most often left behind in our health care system, including the poor, working poor, racial or ethnic minorities, those publicly and privately insured, and those that have no insurance at all.

In fact, in the last year the percentage of patients at the Ryan Center with no health insurance rose from 20 percent to 25 percent. In our waiting rooms and in the faces of our patients we are privileged to serve, we witness the urgent need for fundamental health care reform. From the perspective of the Nation's health centers, current public programs are uniquely qualified to meet the needs of our most vulnerable communities.

Patients can access not just primary care, but the full spectrum of services tailored to meet their individual and family needs. Despite chronic funding shortfalls and patients with multiple medical conditions, community health centers have demonstrated a record

of quality care and cost control unmatched in the health care system. For all of these reasons we applaud the Committee's inclusion of a public plan option as part of health reform. Not only are current public programs the only insurers that cover our low-income and medically underserved patients, they are also the only payers that recognize the unique role of safety net providers such as community health centers, and also public hospital systems such as New York City's Health And Hospitals Corporation.

The public programs are the only insurers that pay us adequately. By contrast, private insurers pay health centers less than 50 cents on the dollar for the care that the health centers provide; and, in fact, at the Ryan Center we have been forced to drop certain private insurance plans due to the unsustainable revenue losses from treating patients covered by these plans. It is our hope that as more and more patients gain coverage, a new public plan will follow the example set by current public payers by reimbursing health centers and other safety net providers appropriately and predictably for the care they provide.

At the Ryan Center every day we see new patients who present with long-term, serious complications of treatable diseases, such as high blood pressure and diabetes, because of prior lack of access to primary and preventive care. Also, it's very common for us to see uninsured patients who cannot afford medically necessary but very costly outpatient investigation such as MRIs or cardiac stress tests. A properly regulated and monitored public health care plan will devote precious resources to ensure efficient and cost-effective care for such patients without being preoccupied with the need to balance medical care against profits.

For more than four decades, long before the term became fashionable, community health centers have routinely practiced the model of care that has provided a genuine "medical home" for their patients. Even though many patients have complex problems, including daunting psychosocial issues, community health centers have met the challenges, preserving both cost effectiveness and quality of care.

I want to applaud the house proposal for recognizing the need to preserve and expand this system of care by increasing funding for the new public health investment fund and for the "medical home" demonstration bill. In conclusion, Mr. Chairman and honorable Members of the Committee, community health centers across America are proven, established, cost-effective models that can bring their considerable experience and expertise to solving many of the challenges facing our system today. America's community health centers stand ready to provide you support and guidance as you negotiate final proposals in the coming weeks and months.

Thank you for your time and attention.

[The prepared statement of Dr. Baxter follows:]

Testimony of Daniel Baxter, MD
Chief Medical Officer, William F. Ryan Community Health Network
House Committee on Ways and Means
Hearing on "Health Reform in the 21st Century: Proposals to Reform the Health System"
Wednesday, June 24th, 2009

Chairman Rangel, Ranking Member Camp, Distinguished Members of the Committee:

Thank you for the opportunity to testify before the Committee today, and thank you for all of the hard work that each of you has put into the crucial task of reforming the nation's health care system. My name is Daniel Baxter, and I am a board-certified internist and the Chief Medical Officer of the William F. Ryan Community Health Network, one of the oldest health center organizations in the country, and one of the largest in New York. As with many of the 18 million patients served by nearly 1,200 health centers across the country—including the districts of most members of this Committee--the vast majority of Ryan's patients represent those groups most often left behind in our health care system, including the poor and working poor (80%), racial or ethnic minorities (75%), those publicly insured, and—perhaps the most rapidly growing segment of patients—those who have no insurance at all. In fact, in the last year alone, the percentage of patients at the Ryan Center with no health insurance rose from 20% to 35%, and 24% of Ryan Network patients were at 151 percent of the Federal Poverty Level or above, an historic high. At our Center, in our waiting rooms and exam rooms, and in the faces of our patients we are privileged to serve, we witness the urgent need for fundamental health care reform every day.

"Safety Net" Providers and the Role of a Public Plan

From the perspective of the nation's health centers, our current public programs 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 specialty care, case management, and transportation and language assistance, as well as dental care, mental health services, and prescription assistance programs.

For all of these reasons, **we strongly support the inclusion of a public plan option as part of any health care reform proposal this Committee recommends**. Not only are current public programs the only insurers that cover our low-income and medically underserved citizens, they are also the only payers that recognize the unique role of "safety net" providers such as community health centers, and are the only insurers that pay us adequately. By contrast, nationwide, the private insurance market pays health centers less than 50 cents on the dollar for the comprehensive primary care they deliver to the 3 million privately-insured patients they serve. For example, at the Ryan Center, we have been forced to drop certain private insurance plans, due to unsustainable revenue losses from treating patients covered by these plans. Moreover, these plans are often high-deductible, limited-benefit plans made available to the low-income workers we see at our center. It is our strong hope that as more and more patients gain coverage, a new public plan will follow the example set by *current* public payers, by reimbursing health centers and other safety net providers **appropriately** and **predictably** for the care they provide. Finally, as already provided in the Committee's proposal, it is critical that insurers enrolling people in underserved communities be required to include in their networks health care providers located in those communities.

Apart from the very real and serious challenges America's community health centers face in the current health care environment, there is an over-arching, urgent need for comprehensive health care reform, which can wait no longer. As the Committee well knows, the current system is unsustainable, irrational, and obscenely wasteful, and any failure to change it portends a bleak future where *real* rationing of care will become the rule. At the Ryan Center, it is a common daily occurrence to see new patients who, because of prior lack of access to basic primary health care, including preventive care, present with serious long-term complications of treatable diseases such as high blood pressure and diabetes. Moreover, it is also a very common daily occurrence to care for uninsured patients who cannot afford medically necessary,

but costly, out-patient hospital investigations such as MRIs or cardiac stress tests. With transparency, accountability, proper regulation and regular monitoring, a public health care plan will devote precious resources to ensure efficient and cost-effective care for such patients, without being preoccupied with the need to balance appropriate medical care against profits.

The Clinician's View of Health Reform

As a clinician for almost 35 years, I am especially intent on America having health care reform which is both efficient and cost-effective. I can attest to the adage that the most expensive piece of medical equipment is a pen in the hand of a doctor. I strongly support any plan to establish panels of recognized clinical experts to clarify for front-line practitioners important evidence-based "best clinical practices," as a reference point which will help restore rationality, integrity, and common sense to medical care. However, such clinical guidance alone is not sufficient to diffuse the fearsome costs of modern medical practice: the knowledge of "best clinical practices" must be accompanied by a system that recognizes doctors who in good faith follow these practices and improve quality of care, as well as by credible reimbursement for primary and preventive care. This three-pronged approach—guidance for "best clinical practices," integration and recognition of those who strive to improve quality, and fair reimbursement for primary and preventive care--will save untold billions of dollars in wasteful, unnecessary, and often dangerous medical care.

Health Centers as "Medical Homes"

In discussions about reforming the health care system, the imperative across all platforms and all proposals must be a serious and credible investment in **accessible, affordable, high-quality primary care for all,** as a down payment on a more effective *and* efficient health care system. I say "investment," because we know that comprehensive primary and preventive care saves untold billions of dollars on down the line, and that, paradoxically, with medical care, "less can often be more"—that is, thoughtful care supported by evidence-based, best medical practices,

as above, ensures both good health *and* significant cost savings. Currently, 60 million people in America—the "medically disenfranchised"--lack consistent access to primary care. They and millions of others who confront additional barriers to care require a source of regular, primary and preventive care, a "medical home," to maximize the value of our investments in health reform.

For more than four decades—long before the term became fashionable--community health centers have routinely practiced a model of care that has provided a genuine "medical home" for their patients. Even though many patients have complex health problems, including daunting psychosocial issues, community health centers have demonstrated a record of quality care and cost control unmatched in the health care system. **I want to applaud the House proposal for recognizing the need not only to preserve this system of care, but to expand the "medical home" model to communities nationwide, through increased funding for the Health Centers Program as part of the new Public Health Investment Fund, and through the "medical home" demonstrations in the bill.**

Strengthening the Primary Care Workforce

As coverage expands, we must also ensure that patients have access to doctors and other health professionals. The National Health Service Corps is a vital tool for recruiting new clinicians, and Committee's proposal would effect an historic investment to the NHSC, and thereby encourage thousands more practitioners to practice in medically underserved areas.

The Ryan Center is an active participant in several different primary care residency training programs, as well as a training site for City University of New York's Sophie Davis School of Biomedical Education. We recognize the importance of doctors-in-training gaining experience in community-based settings with underserved patients. However, to achieve this goal, health centers across the country must have financial support for such training, since the direct and indirect costs of such training are often prohibitive. The Committee's proposal invests

significantly in primary care workforce training, particularly the National Health Scholars Program and graduate medical education in primary care, and recognizes that community health centers must play an important role in primary care training.

Conclusion

Mr. Chairman, and Honorable Members of the Committee, daily I see patients who personify the importance of what this Committee is trying to do, and who remind me of the urgency of bringing fundamental reform to our health care system. Community health centers across America are proven, established, cost-effective models that can bring their considerable experience and expertise to solving many of the challenges facing our current system.

Every congressional session is *a priori* historic, but I am certain that we all can agree that, with regard to the magnitude of the problems we face with our current health care system, this session will be truly historic. Thank you, Chairman Rangel and other members of the Committee, for your willingness to undertake such an enormous and challenging task. America's community health centers stand ready to provide you support and guidance, as you negotiate final proposals in the coming weeks and months. Thank you for your time and attention, and I'd be happy to answer any questions you may have.

Mr. STARK. Thank you for your patience and your contribution. Dr. Epperly.

STATEMENT OF TED EPPERLY, M.D., PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS

Dr. EPPERLY. Chairman Rangel, Mr. Stark, Ranking Member Camp and Members of the Ways and Means Committee, I am Dr. Ted Epperly, President of the American Academy of Family Physicians, which represents 94,600 across the United States.

On behalf of the academy I am pleased to testify today on your discussion on draft legislation to reform health care in this country. Your draft bill goes a long way toward providing quality, affordable health care coverage for everyone in the United States; a change AAFP has supported for two decades. We commend your leadership and we profoundly appreciate the inclusion of efforts throughout the draft to improve primary care.

Achieving quality, affordable health care coverage for all will require a significant investment in the health care system; however, simply paying for more of the same fragmented, uncoordinated procedure-based health care will not make us healthier and we will not begin to control health care costs. Because of the cost-effectiveness of primary care services, one of the keys to reforming the health care system is to reemphasize the centrality of primary care and do so by supporting primary care including the patient-centered medical home, where every patient has a personal physician responsible for their care, emphasizing cognitive clinical decisionmaking, rather than procedures, aligning incentives to embrace value over volume and ensuring the adequacy of the primary care workforce.

We appreciate your work with SGR. Medicare is a critical component of the U.S. health system and must be stable and predictable for patients and providers. Eliminating the past "scoring debt" accumulated by this arcane, inexact, and clinically irrelevant SGR formula is critical to restoring stability and predictability. We applaud this and concur with the establishment of separate expenditure targets that place a greater emphasis on the cognitive clinical decisionmaking that is a hallmark of primary care.

We also applaud the Committee for including a medical home pilot program in Medicare. The use of the PCMH by Medicare and other insurers can achieve savings while simultaneously improving quality. We further applaud the inclusion of 5 percent bonus for primary care services, and up to 10 percent for those services provided in the health professionals' shortage area. And, Congress should make the primary care bonus permanent.

The AAFP supports a health insurance exchange, a market where Americans can one-stop shop for a health care plan, private or public; compare benefits and prices, and choose the option that best meets their needs, much like Members of Congress and their families do. Patients should have a choice of health plans and a public plan should be among them. But the public plan should not be Medicare. While for transition purposes, there may be some similarities to the program, we urge Congress to de-link the public plan for Medicare by a date certain.

Successful and sustainable health reform will require an adequate primary care physician workforce, equivalent to approximately 45 percent of the physician workforce. It also means not allowing unbridled growth of subspecialty training which fosters costly, fragmented care. The training of U.S. physicians is currently borne by Medicare to ensure an adequate primary care workforce for all Americans. GME funding should be derived from all payers.

In conclusion the problems associated with primary care medicine are multifaceted and thus require multifaceted solutions. Payment, student scholarships, loan forgiveness and tax policy are all parts of the solution. Reforming the health care system is a complex endeavor. The status quo is not working. We urge Congress to invest in the health care system we want; not the one we have. Thank you very much.

[The prepared statement of Dr. Epperly follows:]

Statement of the American Academy of Family Physicians

Before the Ways and Means Committee
U.S. House of Representatives

Regarding
Health Reform Legislation

Presented By
Ted Epperly, MD, FAAFP
President
American Academy of Family Physicians

June 24, 2009

AAFP Headquarters
11400 Tomahawk Creek Pkwy.
Leawood, Kansas 66211-2680
800.274.2237
913.906.6000
fp@aafp.org

AAFP Washington Office
2021 Massachusetts Avenue, NW
Washington, DC 20036-1011
202.232.9033
Fax: 202.232.9044
capitol@aafp.org

Chairman Rangel, Ranking Member Camp and members of the Ways and Means committee. I am Ted Epperly, MD, President of the American Academy of Family Physicians, which represents 94,600 members across the United States.

On behalf of the Academy of Family Physicians, I am pleased to comment on your discussion draft legislation to reform health care in this country. Your preliminary bill goes a long way toward providing quality, affordable health care coverage for everyone in the US. The AAFP has called for fundamental reform of the US health care system for two decades. We commend the Ways and Means, Energy and Commerce and the Education and Labor Committees for their leadership and commitment to find solutions to this complex national priority. Finally, we appreciate including efforts to improve primary care throughout the draft bill.

In addition, we call your attention to a joint letter you have received from the American Academy of Family Physician, American College of Physicians and American Osteopathic Association. Together, these three organizations represent over 300,000 physicians and who want Congress, the Administration, and the American people to know that the nation's primary care physicians are in strong support of health care reform. Continuation of the current physician training system and flawed physician payment system is a steep pathway to decreased access to and growing cost of health care for all Americans. We must take advantage of this historic opportunity for change and enact meaningful, sustainable, comprehensive health care reform.

The AAFP by virtue of established policy s highly supportive of many sections of this draft legislation. As such, my comments today will be germane to those sections not only consistent with our policy but also of most interest to family physicians.

FOCUS ON PRIMARY CARE: KEY TO REFORM

As the nation has learned through the years, simply paying for more of the same fragmented, uncoordinated, procedure-based health care will not make us healthier and certainly will not contain the accelerating costs of health care. Thus, we believe that making primary care the foundation of health care in this country is critical.

Primary care is the only form of health delivery charged with the long term care of the whole person. The primary care relationship, with its comprehensive nature, has the most effect on health care outcomes. More specifically, AAFP defines primary care as care provided by physicians trained for and skilled in comprehensive first contact and continuing care for people with any undiagnosed sign, symptom, or health concern not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis.

Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, hospital, critical care, long-term care, home care and day care). Primary care is performed and managed by a personal physician leading a team of, and collaborating with other health professionals, and using consultation or referral, as appropriate. Primary care emphasizes a team approach, which may include nurse practitioners and physician assistants.

An abundance of studies demonstrate that Primary care is cost-effective because it includes coordination of health care services. It also promotes active communication [joint decision-making] between patients and the health care team and makes the patient a partner in his or her health. This is termed "patient self management support," which emphasizes the partnership aspect of this mode of care.

Thus, it is the Academy's view that a reformed system should provide health coverage for all, promote primary care, support coordination and reduce fragmentation of care, minimize administrative complexity, prohibit denial of insurance on the basis of a preexisting condition, require an affordable basic benefit package that includes prevention and wellness and protect against catastrophic costs.

The Academy believes the key to designing a new health care system is to reemphasize the centrality of primary care by:

- Redesigning the manner of primary care delivery modeled on a "patient-centered medical home," i.e., every patient having a personal physician in charge of their care;
- Aligning financial incentives to support this system, and,
- Taking steps to ensure the adequacy of our primary care workforce.

Many of these key provisions are contained in your draft legislation.

AFFORDABLE HEALTH CARE CHOICES

This section allows individuals to keep their current insurance if desired; makes numerous changes to the insurance industry; establishes a public plan option and requires individuals to purchase health insurance. The AAFP, with some caveats, supports these provisions as an important foundation to cover all individuals.

Insurance Market Reforms

Specifically, we support the health insurance exchange contained within the bill, i.e., a market where Americans can one-stop shop for a health care plan -- private or public -- compare benefits and prices, choose the option that is best meets their own needs. In addition, the AAFP [although with no policy on a specific amount] supports the sliding scale subsidy amounts so that individuals can purchase meaningful coverage. We also advocate for guaranteed availability and renewability of coverage and the prohibition of preexisting condition exclusions and denials.

Benefits

Regarding the benefit provisions, the AAFP has long-supported tiering benefits so that basic benefits, such as primary care provided by or through the medical home; prenatal care; well-child care; immunizations; basic mental health care, evidence-based preventive services; chronic care management; and hospice care, will have no financial barriers, thus, no co-payments. We believe it is important to incentivized that which we know is important and effective.

As a result, we support the bill's provisions that make available four different tiers of benefits packages and allow consumers to select the one that best meets their needs, as well as the requirement for a core set of benefits for essential health services. We believe that insurance without adequate benefits is meaningless.

We also believe that an independent advisory committee, chaired by the Surgeon General, to "recommend and update the core package of benefits," ideally would be less prone to political concerns and ensure equality among benefit plan offerings.

Academy policy also states that "health care will be a shared responsibility of individuals, employers, government, and the private and public sectors". Thus, we applaud the section of the bill that requires all individuals have coverage and allows individuals to maintain their current coverage, if desired.

Public Plan
The AAFP supports a public plan option that is consistent with the following principles:

- Recognizes the value of, and promotes primary care, including through adoption of the Patient-Centered Medical Home (PCMH).
- The administrators of the public plan must be accountable to an entity other than the one identified to govern the marketplace.
- The public plan cannot be Medicare.
- The new public plan must be actuarially sound.
- The public plan cannot leverage Medicare (or any other public program) to force providers to participate.
- The public plan should not be required to use Medicare-like payment methods permanently.
- The insurance market rules and regulations governing the public plan must be the same as those governing private plans.
- The public plan cannot be granted an unfair advantage in enrolling the uninsured or low-income individuals who will presumably be eligible for subsidies in the new marketplace.
- Public and private insurers should be required to adhere to the same rules regarding reserve funds.
- The public plan would also need to contribute to value-based initiatives that benefit all payers.

We also support the variety of payment mechanisms that can be employed by the public plan, in particular, the PCMH and care management. In addition, we applaud the emphasis on care that improves health outcomes; decreases health disparities; addresses geographic variations; prevents or manages chronic illness and supports care that is integrated, patient-centered and of high quality and efficient. These goals all are entirely consistent with AAFP policy.

Administrative Complexity
We appreciate any efforts to reduce the burdensome nature of the current insurance system and thus are supportive of the provisions included in the bill that will reduce administrative complexity, e.g., standardized claims forms.

MEDICARE AND MEDICAID IMPROVEMENTS
Medicare is a critical component of the U.S health system and must be preserved and protected. Efforts to remedy the Medicare physician payment system are needed and the House discussion draft of health reform legislation begins to take bold, appropriate steps to do so.

Sustainable Growth Rate
The AAFP acknowledges the committee's recognition of the longstanding problems associated with the outdated, dysfunctional formula known as the Sustainable Growth Rate (SGR) and we applaud members for proposing its rebasing. This is an important, necessary and welcomed step. Eliminating the past scoring debt accumulated by this arcane, inexact and clinically irrevelant method is imperative to restoring stability and predictability to this insurance program for our nation's seniors.

PCMH Pilot Program
We also wish to applaud the committee for including a "medical home pilot program" in Medicare. We appreciate the inclusion of urban, rural and underserved areas, as well as a number of models, such as the Independent Patient-Centered Medical Home and Community-Based Medical Home Model. Your definition of the Patient-Centered Medical Home is entirely consistent with the one established by the AAFP and other primary care organizations. We also support the PCMH demonstration project in Medicaid.

The section also requires the Secretary to establish standards for and review of these models, as well as a payment methodology. At the conclusion of the pilot, the Secretary will perform an analysis of the various projects and we are confident that family physicians will be shown to have provided high quality care at a lower cost to the federal government. We appreciate the fact that these additional payments will have no impact whatsoever on payment for other evaluation and management codes.

Bonus for Primary Care Services
We also applaud the inclusion of a bonus of 5 percent for primary care services and up to 10 percent for those services provided in a health professions shortage area. These payments would be provided for evaluation and management services, as well as other physician services deemed as "ensuring accessible, continuous, coordinated and comprehensive care." We support the inclusion of the specific designation of family physician (along with general internists, general pediatrics and geriatrics) and the threshold for the bonus being 50 percent, which according to our analysis would mean that 68 percent of family physicians would qualify.

To ensure that the primary care bonus is targeted to and received by those physicians who ensure accessible, continuous, coordinated and comprehensive care, Congress should consider granting 'deemed status' to certain specialties such as family medicine that are, by definition, primary care and make this bonus permanent. In addition, we would encourage Congress to explore the calculation of this bonus by both identified codes and specialty designation. If structuring in this way results in a lower score, it might provide the opportunity to increase the bonus to the 10-percent level in all areas.

PQRI
The provisions intended to streamline the Physician Reporting Quality Initiative (PQRI) are necessary and welcomed. The discussion draft calls for expedited feedback to providers, providing them with a more efficient appeals process. As this program matures, we would request your consideration of additional incentives for physicians that are both clinically and economically meaningful. Consistent with this would be support of maintenance of certification (MOC) as automatically qualifying for the PQRI bonus.

Patients with Limited English Proficiency
We appreciate the bill's requirement to perform a study, and then demonstration project, on how Medicare providers can be reimbursed for providing translation and other services to beneficiaries with limited English proficiency. Communication is the foundation of effective medical care and family physicians want to bridge this language gap with our patients but also realize that it costs money to provide translation or other services.

Comparative Effectiveness Research
The AAFP also strongly supports the inclusion of comparative effectiveness research in the draft bill. Specifically, we support the establishment of a Center for Comparative Effectiveness Research (CER) within the Agency for Healthcare Research and Quality.

If we wish to improve patient care and control costs in this country, this type of research is crucial. It is only with CER that we can provide evidence-based information to patients and physicians for use in making health care decisions. As Alexander and Stafford said in the June 17th issue of JAMA: "Without attention to timeliness, transforming evidence into practice, inclusion of strategies beyond drugs and devices, minimizing regulatory mixed messages, and the comparative costs of therapies, current investments in comparative effectiveness will fall far short of their ultimate potential for improving the health and health care of all. The primary problem is not the absence of knowledge regarding comparative effectiveness, but the absence of the necessary mechanisms to put this knowledge to work." A sizable portion of this research agenda, then, should focus on how this research reaches front-line practices and whether the bench research holds up under real-world situations and in the majority of patients. For this reason AHRQ should be the largest focus of the CER agenda.

Our policy on this issue is guided by the following principles:

- Comparative effectiveness research is critically important to our members – family physicians see patients with common problems every day for which there is no solid clinical evidence.

- As CER develops, some therapies will be proven to work better than others and the deliverers of those therapies will challenge the results. Nevertheless, the health of the public should trump individual business concerns.

- We are pleased that the National Institutes of Health (NIH), like the Agency for Healthcare Quality and Research (AHRQ), will be receiving funding to perform CER. We believe a core values of CER include consideration of different patient populations, comorbidities, cultural differences and values, which will be challenging but important.

In addition we believe CER should use a broad range of methodologies, including randomized controlled clinical trials, observational studies and other approaches, including "practice-based network research (PBNR)," which, when used in tandem with controlled clinical trials produces the real-world information useful to physicians in their practices. Likewise, the composition of the Advisory Council should include clinical researchers who conduct practice-based network research.

Graduate Medical Education

It is clear from numerous government and private studies that more Americans depend on family physicians than on any other medical specialty and that family physicians are the main source of primary health care for the Medicare population. Sixty percent of people aged 65 and older identify a family doctor as their usual source of health care. Rural and Hispanic seniors also are more likely to identify a family physician as their source of health care. In addition, nearly one-half of the physicians who staff the nation's Community Health Centers are family physicians. And, since 1971, the National Health Service Corps has placed more than 18,000 health care providers in underserved areas – and almost half of the doctors were family physicians.

The majority of health care is provided in physicians' offices now and will be in the future. We believe that primary care physicians should comprise about 45 percent of the physician workforce. The training of these primary care physicians should be modernized to promote the methods of health care delivery in the 21st century. A sufficient and appropriately trained primary care workforce is essential for a healthier population in the US. This includes expansion of primary care training positions and reversing the loss of training capacity over the last decade. It also means not allowing more growth of subspecialty training since this allows more potential primary care physicians to choose subspecialization. The growth of subspecialty positions over the last decade cut the number of internal medicine graduates choosing primary care careers in half. Finally, the modernization requires more training to occur outside of hospitals—a model based what was presumed best in 1965 and not where most people get care now. The Patient Centered Medical Home will not be in a hospital for most people—so training should not be either.

Thus, we encourage Congress to include provisions necessary to achieve the desired goals which include adequate numbers of primary care physicians to meet the health care needs of all, If health care reform and coverage for all is to be successful, there must be a sufficient number of primary care physicians to care for the population. The Academy wants to help Congress guarantee coverage by ensuring adequate access to care.

In order to ensure an adequate primary care physician workforce, Congress should provide the necessary emphasis on primary care training which would include carving out and dedicating a funding stream that provides incentives to grow the numbers of practicing primary care physicians. The best way to do this is to modernize primary care graduate medical education by increasing accountability and responsiveness for same through the primary care residency programs. Funding for physician training, especially primary care, should be derived from all payers, not Medicare and Medicaid alone. A modest contribution by private insurers of approximately $20 per insured per year would be sufficient to modernize and fund primary care GME. By directly funding primary care residency programs and holding them accountable for producing a workforce consistent with the population needs and other goals associated with health care reform, Congress will have taken responsible steps to ensure both care AND coverage.

The Academy supports the demonstration project that would allow Direct GME funding to be directed to a federally qualified health center (FQHC) and would encourage the expansion of this demonstration to include residency programs and other nonhospital settings that develop and operate a primary care training program.

We also support:

- redistribution of unused residency slots to primary care and encourage accountability provisions to ensure that these slots do indeed create primary care physicians.
- Language intended to permanently resolve the volunteer preceptor issue and the didactic training issue.
- preservation of residency slots from closed hospitals

The Academy also supports provisions that are directed toward increasing accountability of GME training programs as recommended by the Medicare Payment Advisory Commission. The study to be conducted by the Government Accountability Office on the evaluation of training programs, including whether programs have the appropriate faculty expertise to teach the topics required to achieve such goals is consistent with the goal of increased accountability and we hope will provide an assessment of the degree to which GME dollars are directed to and used by programs that are responsive to community need, especially in terms of meeting the primary care needs of current and future populations

PUBLIC HEALTH AND WORKFORCE DEVELOPMENT

The AAFP strongly supports a cohesive, comprehensive strategy to align the US health care workforce with a reformed health care system. We are concerned about the decline in the number of medical students pursuing a career in primary care, at a time when the demand for primary care services will only be increasing. The National Health Care Workforce Commission proposed in the discussion draft is needed to recommend the appropriate numbers and distribution of physicians, including primary care physicians, general surgeons, and other specialties facing critical shortages, policies to achieve such workforce goals, and benchmarks to evaluate the impact of such policies.

Primary Care Student Loan Funds

The AAFP has long supported loan repayment and scholarship programs and is grateful that the discussion draft includes the Primary Care Student Loan program. Along with the other primary care organizations, we support establishing a loan repayment program, not to exceed $35,000 per year, for individuals agreeing to serve as physicians in general internal medicine, general pediatrics and family medicine in areas that are not Health Professional Shortage Areas, but that have a critical shortage of primary care physicians in such fields and excluding these repayments from an individual's gross income. We support National Health Service Corps which also plays a vital role.

We suggest that the government study the impact of student debt on choice of specialty, minority representation in training and practice in primary care specialties, including recommendations for achieving a primary care workforce that is more representative of the US population.

Revitalizing Training in Primary Care

The AAFP has long called for the revitalization of Title VII Training in Primary Care Medicine. We believe that successful health system reform will require a larger primary care workforce. Title VII Training in Primary Care Medicine programs provide support vital to family medicine education and training. We must increase this investment in effective programs that encourage medical students to enter primary care specialties.

The AAFP has requested $215 million, which was recommended by the HRSA Advisory Committee for Training in Primary Care Medicine and Dentistry, for the programs within Title VII Section 747 for fiscal year 2010. However, we note that the discussion draft limits the authorization for Sections 723, 747 and 748 to $200 million. It is not clear from the draft how the authorized funding would be distributed among those sections, but we are concerned that this authorized level will not be adequate.

The problems associated with primary care medicine are multifaceted and thus require multifaceted solutions. Increasing the value and prestige and importance of the primary care specialty is critical to luring the best and the brightest into this specialty. Reimbursement, student scholarships, loan forgiveness and tax credits are all parts of the solution.

CONCLUSION

Thank you for the opportunity to provide our thoughts on your draft bill. Due to its length, we continue to analyze its provisions, specifically, the sections on quality, fraud and abuse and the lengthy Medicaid section.

We acknowledge that reforming the health care system is a complex endeavor. But, without meaningful reform, one fifth of our economy is projected to be health care costs within only 10 years. Currently, 47 million Americans are uninsured and scores more underinsured. Half of all bankruptcies in this country are caused by health care related debt and many of those who declare bankruptcy *do* have health insurance. Now is time to reform the system. We urge Congress to invest in the health care system we want, not the one we have.

Mr. STARK. Thank you.
Ms. Policastro. Did I pronounce that correctly?
Ms. POLICASTRO. You did a very good job. Thank you.
Mr. STARK. All right. Would you like to proceed?
Ms. POLICASTRO. Yes.

STATEMENT OF DONNA POLICASTRO, EXECUTIVE DIRECTOR, RHODE ISLAND STATE NURSES ASSOCIATION, ON BEHALF OF THE AMERICAN NURSES ASSOCIATION

Ms. POLICASTRO. Good evening, Chairman Rangel, Ranking Member Camp, distinguished Committee Members and congressional staff. Thank you for inviting the American Nurses Association to this timely discussion on health care reform. I am Donna Policastro, a certified nurse practitioner for 33 years, and an Executive Director of the Rhode Island State Nurses Association, speaking today on behalf of the American Nurses Association.

The ANA is the only full service national association representing the interests of the Nation's 2.9 million registered nurses in all education and practice settings, and advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, and sharing a constructive and realistic view of nursing's contribution to the health of our Nation. The ANA commends the work of the House Ways and Means, Energy and Commerce, and Education and Labor Committees.

The tri-committee draft legislation clearly represents a movement toward much needed, comprehensive and meaningful reform for our Nation's health care system. ANA appreciates the Committees' recognition that in order to meet our Nation's health care needs we must have an integrated and well resourced national health care workforce policy that fully recognizes the vital role of nurses and health care providers and allows them to practice to the fullest extent of their scope.

ANA remains committed to the principle that health care is a basic human right and all persons are entitled to ready access to affordable quality health care services. ANA also believes that a health care system that is patient centered, comprehensive, accessible and delivers quality care for all is something that should not be partisan or a political issue. ANA supports a restructured health care system that ensures universal access to its standard package of essential health care services for all individuals and families. That is why ANA strongly supports the inclusion of a public health insurance plan option as an essential part of comprehensive health care reform.

We believe that inclusion of this public plan option would assure that patient choice is a reality and not an empty promise and that a high-quality public plan option will above all provide the piece of mind that is missing from our current health care environment. It will help make health care more affordable for patients, generate needed competition in the insurance market and guarantee the availability of quality, affordable coverage for individuals and families, no matter what happens.

There are a wide variety of ideas currently circulating about health care reform, but all include discussion of prevention and

screening, health education, chronic disease management, coordination of care and provision of community-based primary care. As the Committee has clearly recognized in its draft, these are precisely the professional services and skills that registered nurses bring to patient care.

As the largest single group of clinical health care professionals within the health care system, licensed registered nurses are educated in practice within an holistic framework that views the individual family community as an interconnected system that keep us well and help us heal. Registered nurses are fundamental to the critical shift needed in health services delivery with the goal of transferring the current sick care system into a true health care system.

Our ends are backbones of the health care delivery system. Advanced practice registered nurses, in particular nurse practitioners and nurse midwives, are proven providers of high-quality, cost-effective primary care. ANA nurses are strong supporters of community and home-based models of care. We believe that the foundation of a well-based health care system is built in these settings, reducing the amount of both money and human suffering that accompany acute care episodes.

ANA supports the renewed focus on new and existing community-based programs, such as community health centers, nurse home visitation programs and school-based clinics. ANA supports the use of community-based, multi-disciplinary teams to support primary care through the medical home model. This model demonstrates the commitment to quality, coordinated care by all health providers, and represents a focus; not just on treating illness, but on emphasizing wellness and prevention. ANA is especially pleased that under this proposal nurse practitioners have been recognized as primary care providers and we'd be authorized to lead medical homes.

In conclusion, I'd like, once again, the American Nurses Association thanks you for the opportunity to testify before this Committee. We appreciate your clear commitment to nursing and your understanding of the important role nurses play in the lives of patients and the system at large. Nurses are eager and willing to work with you to support and enact meaningful health care reform today.

Thank you very much.

[The prepared statement of Ms. Policastro follows:]

Committee on Ways and Means
United States House of Representatives
Hearing on Health Reform in the 21st Century:
Proposals to Reform the Health System

Testimony Provided by
Donna Policastro, RNP
Executive Director, Rhode Island Nurses Association

On Behalf of the American Nurses Association
8515 Georgia Avenue
Suite 400
Silver Spring, MD 20910
http://www.nursingworld.org

June 24, 2009

The American Nurses Association (ANA) appreciates this opportunity to testify regarding the Tri-Committee Health Care Reform Discussion Draft. Founded in 1896, ANA is the only full-service national association representing the interests of the nation's 2.9 million registered nurses (RNs), and advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace and sharing a constructive and realistic view of nursing's contribution to the health of our nation. Through our 51 constituent member associations, ANA represents RNs across the nation in all practice settings.

ANA commends the work of the House Ways and Means, Energy and Commerce, and Education and Labor Committees for their work in crafting the *TriCommittee Health Care Reform Discussion Draft.* This legislation clearly represents a movement toward much-needed, comprehensive and meaningful reform for our nation's healthcare system.

We particularly want to express our appreciation for the committees' recognition that, in order to meet our nation's health care needs we must have an integrated and well resourced national healthcare workforce policy, a system that focuses on wellness and prevention, and a high-quality public health insurance option that complements and competes fairly with options offered by private insurers.

The U.S. health care system remains in a state of crisis. Despite incremental efforts at reform, the number of uninsured continues to grow, the cost of care continues to rise,

and the safety and quality of care are questioned. Harvard researchers have found that 62% of all personal bankruptcies in the U.S. in 2007 were primarily caused by health problems—and 78% of those filers had insurance. The overwhelming problems of the health care system require significant attention on the part of health professionals, policy-makers, and the public.

ANA remains committed to the principle that health care is a basic human right and all persons are entitled to ready access to affordable, quality health care services. ANA supports a restructured health care system that ensures universal access to a standard package of essential health care services for all individuals and families.

Public Plan

That is why ANA strongly supports the inclusion of a public health insurance plan option as an essential part of comprehensive health care reform. And we are not alone. According to a New York Times/CBS News poll conducted just this month, Americans overwhelmingly support substantial changes to the health care system and are strongly behind the public health insurance plan option.

Under the comprehensive plan put forward by the three House committees, people would have the freedom to keep their current plan, choose another private plan, or choose a high-quality, affordable public health insurance plan.

We believe that inclusion of this public health insurance plan option would assure that patient choice is a reality and not an empty promise, and that a high-quality public health insurance plan option will, above all, provide the peace of mind that is missing from our current health care environment. It will help make health care more affordable for patients, generate needed competition in the insurance market, and guarantee the availability of quality, affordable coverage for individuals and families no matter what happens.

According to the Kaiser Family Foundation and the Health Research and Educational Trust, premiums for employer-sponsored health insurance in the United States have been rising four times faster on average than workers' earnings since 1999. Overall, insurance premiums have increased more than 87 percent on average, over the past six years, while wages have increased approximately 20 percent (KFF Employer Health Benefits 2008 Annual Survey).

The public health insurance plan option could bring positive competition to bear on the private insurance market, encouraging patient-centered, value-driven health care delivery. Rather than an impetus for "crowd out," as critics suggest, such fair and transparent competition would create a win-win for those whom the healthcare system is supposed to serve, the people of the United States.

ANA does not believe that regional health cooperatives or state-level public plans, both of which have been proposed as alternatives, are appropriate options for the scope of

change required. Their record suggests that they would have neither the financial stability nor the bargaining leverage needed to shrink health care costs in the long term. They are non-starters if the Congress is interested in true comprehensive reform of the system. ANA agrees with Karen Davis, president of the Commonwealth Fund, that "a national organization with authority to purchase health care at reasonable rates is integral to success in controlling costs."

ANA deeply appreciates the commitment to a public health insurance plan in the bill, and we look forward to partnering with you to make this plan a reality.

The Role of Nurses

There are a wide variety of ideas currently circulating on health care reform, but all include discussion of prevention and screening, health education, chronic disease management, coordination of care, and the provision of community-based primary care. As the committee has clearly recognized in its draft, these are precisely the professional services and skills that registered nurses bring to patient care.

As the largest single group of clinical health care professionals within the health system, licensed registered nurses are educated and practice within a holistic framework that views the individual, family and community as an interconnected system that can keep us well and help us heal. Registered nurses are fundamental to the critical shift needed in health services delivery, with the goal of transforming the current "sick care" system into a *true* "health care" system.

RNs are the backbone of hospitals, community clinics, school health programs, home health and long-term care programs, and serve patients in many other roles and settings. Advanced Practice Nurses (APRNs), in particular Nurse Practitioners and Nurse Midwives are proven providers of high-quality, cost effective primary care.

As the Committee has clearly recognized, the support, development and deployment of this keystone profession, is essential for any quality health reform plan to succeed. ANA commends the committee for the many measures in the bill that would bolster the nursing profession – particularly the reauthorization of and investment in Title VIII Nursing Workforce Development Programs—and for its demonstrated commitment to fostering full integration, coordination, and collaboration at all levels among our nation's health care workforce.

Medical Home

In particular ANA applauds the use of "community-based multidisciplinary teams" to support primary care through the Medical Home Model. This model demonstrates a commitment to quality, coordinated care by all health providers, and represents a focus, not just on treating illness, but on emphasizing wellness and prevention. ANA is especially pleased that under this proposal, Nurse Practitioners have been recognized as primary care providers and would be authorized to lead Medical Homes. APRN's skill and education, which emphasizes patient and family-centered, whole-person care, makes them particularly well-suited providers to lead the Medical Home Model.

The ability of APRNs to provide high quality, cost-effective care has been widely recognized by patients and the health care community and is supported by significant research and critical analysis. According to the American Academy of Nurse Practitioners, there are over 125,000 Nurse Practitioners (NPs) practicing in the United States today. APRNs serve a critical role by filling gaps in primary care. At least 66 percent of NPs practice in primary care settings. Twenty percent practice in remote rural or frontier settings.[1] APRNs have also made a special contribution by increasing access to care for the poor and uninsured, as well as those in underserved urban and remote rural areas.

ANA deeply appreciates the committee's recognition that in order to successfully transform our nation's health care system, we must have a holistic workforce policy that fully recognizes the vital role of nurses and other providers, and we look forward to working with you to advance the Medical Home model outlined in the TriCommittee Draft.

Given the importance of APRN's to primary care, we encourage the Committee to consider an initiative that would cover the cost of Graduate Nursing Education through Medicare. This would enhance our nation's ability to prepare primary care providers by substantially boosting the number of highly-skilled APRNs available to care for individuals and families across the country.

Quality

ANA supports comparative effectiveness research not only for drugs and devices, but also for evaluating therapeutic approaches and delivery system models. As one aspect of that support, we recommend that the federal government gather evidence about which wellness and prevention programs have demonstrated effectiveness and provide incentives for their accelerated diffusion in the workplace, schools, and communities. Thus we support the creation of permanent Task Forces on Clinical Preventive Services and Community Preventive Services, respectively, such as described in Title III of the bill.

Many recent studies have demonstrated what most health care consumers already know: nursing care and quality patient care are inextricably linked, in all care settings but particularly in acute and long-term care. Because nursing care is fundamental to patient outcomes, we are pleased that the legislation places strong emphasis on reporting, both publicly and to the Secretary, of nurse staffing in long-term care settings. The availability of staffing information on Nursing Home Compare would be vital to helping consumers make informed decisions, and the full data provided to the Secretary will ensure staffing accountability and enhance resident safety.

ANA hopes that, in this same vein, the Committee will look toward incorporating public reporting of similar nurse staffing measures and nursing sensitive indicators in acute

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[1] American Academy of Nurse Practitioners, *Nurse Practitioner Facts*. AANP Web site: www.aanp.org/NR/rdonlyres/51C6BCOF-F1CO-4718-B42F-3DEDC6F5F635/O/AANPNPFacts.pdf.

care through the Hospital Compare Website, as recommended by the National Quality Forum (NQF) in its 2004 publication *National Voluntary Consensus Standards for Nursing-Sensitive Care: An Initial Performance Measure Set.*

To quote the NQF Report foreword-- "These consensus standards can be used by consumers to access the quality of nursing care in hospitals, and they can be used by providers to identify opportunities for improvement of critical outcomes and processes of care. Furthermore these standards can be used by purchasers to incentivize and reward hospitals for better performance."

ANA strongly supports the focus that the discussion draft places on collection of quality measures and the use of evidence-based best practices throughout the bill, and we look forward to partnering with you on advancing quality measures in health care reform.

Wellness and Prevention Programs

A reformed health care system must value primary care and prevention to achieve improved health status of individuals, families and the community. As the Committee recognizes, this means that money, resources and attention must be reallocated in the health system to highlight the importance of, and create incentives for, primary care and prevention.

Nurses are strong supporters of community and home-based models of care. We believe that the foundation for a wellness-based health care system is built in these settings, reducing the amount of both money and human suffering that accompany acute-care episodes. ANA supports the renewed focus on new and existing community-based programs such as Community Health Centers, Nurse Home Visitation programs, and School-Based Clinics, and we applaud the Committee's recognition throughout the bill of the vital importance of addressing health disparities.

It is essential to expand the research base on best practices in chronic disease prevention and early intervention. Therefore, we are gratified to note that grant money in the House bill could provide greater funding and support for research and innovation in the fight against the nation's most prevalent and costly chronic diseases.

ANA and other nursing organizations can be this Congress' trusted advisor, in collaboration with Community Health Centers and others, in exploring the real world significance of various care management provisions under consideration by this Committee to improve the health status of individuals, families, communities and our nation.

Closing

Once again The American Nurses Association thanks you for the opportunity to testify before this Committee. ANA appreciates your clear commitment to nursing and your understanding of the important role nurses play in the provision of essential health care

services to individuals and families across the country. The need for fundamental reform of the U.S. health care system is more necessary than ever. Bold action is called for to create a health care system that is responsive to the needs of consumers and provides equal access to safe, high-quality care for all in a cost-effective manner. ANA and nurses are ready to work with policy-makers, industry leaders, providers and consumers to support and advance meaningful health care reform today. Thank you.

Mr. STARK. Thank you.

And next we'll hear from Louise's husband, who is well-acquainted with this Committee; and, I'm happy to introduce Chip Kahn, the President of the Federation of American Hospitals.

Chip.

STATEMENT OF CHARLES N. KAHN III, PRESIDENT, FEDERATION OF AMERICAN HOSPITALS

Mr. KAHN. I hope Mr. Rangel, Mr. Stark, Mr. Camp, and others on the Committee will forgive me for my checkered past.

On behalf of the Federation of American Hospitals I appreciate the opportunity to offer our views on the House Tri-Committee Health Reform draft. FAH is the representative of over 1,000 investor-owned or managed community hospitals and health systems from across the country.

President Obama and the Congress are right to place health reform at the top of the domestic agenda. The House draft provides a good starting point for reform. The draft raises the right issues. It gives us a roadmap to coverage for all Americans. I would cover four or five points about the draft. We'd make other points in the written testimony that I'll commend to the Members and then be happy to discuss if you'd like.

First, after conversations with the Chairman, the members of FAH set the same goal as our highest priority—affordable coverage for all.

[Brief power outage.]

Mr. KAHN. And we demonstrated that through a proposal that we prepared, the health coverage passport, which shows that universal health coverage can be achieved by building on our current system. The House draft is consistent with the principles upon which we based our proposal. It subsidized those Americans who lack sufficient, disposable income, to afford coverage. It builds on the employer-based system. It includes insurance reform and it requires Americans to obtain coverage.

However, the draft wavers from our prescription an important aspect of its health insurance exchange. The draft includes a public option. We understand President Obama and many of you feel strongly that there should be an alternative to private insurance and HMOs. But, in our view, the public option is not necessary to achieve successful reform and will leave clinicians and providers alike with insufficient payment to serve our patients. So we respectfully request that you consider a nonprofit or co-op model, if you believe eligible consumers should have other choices.

Second, we understand that Congress is going to call upon hospitals to contribute to the funding of health coverage. We stand ready to participate if payment effects are fair; but, we feel strongly that fairness includes reimbursement reductions calibrated to take effect only with commensurate increases in coverage. Third, we deeply appreciate that the draft recognizes the multiple purposes of the safety net-oriented disproportionate share payment in Medicare and Medicaid and appreciate the thoughtful approach the Committee's taken toward that in the draft.

Fourth, we appreciate the Committee draft taking a position on prohibiting physician ownership and referral to hospitals. We think

you take a sensible approach on bundling. It needs research and it needs development. And, finally, we are very appreciative that on readmission policy you focus on those readmissions that are most vulnerable and ought to be assessed.

Finally, the draft recognizes the need to use care measures to enable clinicians and hospitals to improve services for those they serve, and to give consumers information that will enable citizens and Americans to choose the right caregivers. However, the draft falls short in supporting the processes needed to make this quality happen. The draft does not sufficiently embrace the initiative developed by Stand For Quality, an organization of 200-plus multistakeholders. It includes patients, consumers, labor, clinicians, hospitals, nurses, employers; everyone involved in the health care system in any way.

Stand For Quality has proposed new support for the National Quality Forum and the Agency for Healthcare Research and Quality, and recommended a closer, more formal communication and consultation between the government institutions that establish and oversee the Nation's quality agenda and the universe of groups outside government whose shared mission is to make quality happen. We hope you will review the recommendations of Stand For Quality and that they may be included in the mark that you will take up in the next few days.

Finally, we deeply appreciate the invitation today and look forward to working with the Committee as the draft develops toward enactment.

Thank you.

[The prepared statement of Mr. Kahn follows:]

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

TESTIMONY OF

THE FEDERATION OF AMERICAN HOSPITALS

JUNE 24, 2009

Presented by:

Charles N. Kahn III

President & Chief Executive Officer

Chairman Rangel, Ranking Member Camp, and other distinguished Members of the Committee, on behalf of the Federation of American Hospitals (FAH), I appreciate the opportunity to offer our views on the House of Representatives' Tri-Committee Health Reform discussion draft. The FAH is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include general community hospitals and teaching hospitals in urban and rural America as well as inpatient rehabilitation, long term acute care, psychiatric and cancer hospitals.

It is gratifying for me to come before the Committee today. President Obama, the Congress, and the members of this Committee are right to place health reform at the top of the domestic agenda. In my view, we are at one of those inflection points in history when health reform is not only possible but desperately needed because too many Americans lack access to affordable, quality health care. Beyond the tragedy of the almost 50 million uninsured Americans and despite the best efforts of so many, all of us experience a health care system that spends too much and is not as effective and efficient as it should be. The time for action has come, and the FAH looks forward to participating in the development of constructive change that will bring better, more affordable health care to all Americans.

For a task so momentous, it is appropriate that the Congress approach this priority with due care. The ambitious and comprehensive Tri-Committee Health Reform discussion draft presents a good starting point for health reform. The draft raises all the right issues. It gives us a roadmap to affordable, quality health care for all Americans. At the same time, we recognize that the Committee has offered the draft as a work in progress. It is meaningful to the FAH, and to all of us who care so deeply about health care in America, that we can today offer our observations and

recommendations. We look forward to working with the Committee and the rest of the Congress as the draft legislation evolves from its current form to enacted law.

COVERAGE

The FAH is particularly pleased that the primary goal of the Tri-Committee Health Reform discussion draft is to ensure that affordable health coverage is available for all Americans. More than two years ago, the members of the FAH set the same goal as our highest priority and released our own proposal, the "Health Coverage Passport" (HCP) to illustrate how universal health coverage could be obtained in the context of the American health care system.

The FAH based the HCP on four guiding principles to achieve universal coverage: (1) to assure low income coverage there must be sufficient subsidies; (2) to expand coverage based on the current avenues to coverage available for Americans; (3) to reform the insurance system where necessary; and, (4) to recognize a responsibility for all Americans to obtain coverage.

In general, the draft meets these principles. It provides the subsidies that Americans lacking sufficient disposable income will need to obtain coverage; it builds on the current employer-based system; it addresses the need for insurance reform; and it includes a requirement that will ensure that coverage is obtained by all Americans.

Americans have said repeatedly that they want to build on the current health care system. Clearly, the draft honors this principle. It aims to preserve what works in our current system, allowing Americans to keep the coverage they have, and provides the building blocks for the support others need to attain health coverage. These include sliding scale subsidies for purchasing health insurance, reforms to private insurance and efforts to limit cost growth.

The ingredients for coverage expansion are present in the draft. However, the draft wavers somewhat from our prescription for reform in its construct of insurance reform. We called for reforms that would assure ready access to private health insurance for Americans who are not eligible for employer-based coverage or the existing public programs. We also recognized that there might need to be structures at the state level where these Americans could purchase affordable coverage, similar to the health insurance exchanges in the draft. In our model, we assumed that a reformed private health insurance market with guarantee issue, guarantee renewability, modified community rating, and market protections would suffice. We did not envision a government-run public option as presented in the draft.

In our view, the public option is not necessary to achieve successful reform. We feel very strongly that a private market can best serve those eligible Americans without the need for government intervention. We further feel that the stability of the critically important employer-based health insurance market depends on a vibrant private health insurance industry.

We do understand, however, that President Obama and many of you feel strongly that there needs to be an alternative to the current private insurance carriers available in the health insurance exchanges proposed in this draft, where so many Americans will purchase their coverage. The FAH does not disagree that such an alternative could be beneficial. If the Committee agrees an alternative is a necessary feature of the exchanges, we ask the Committee

to consider a non-governmental, non-profit or co-op model that would offer eligible consumers another choice without forming a new government-run insurance plan.

The governmental construct, from the view of the FAH, is problematic for many reasons. We believe it will eventually result in government price setting for most, if not all, health care settings. We feel strongly that a mixed system of payment built on private negotiation will serve the consumer well and keep providers and clinicians viable and available to serve patients and their communities.

The FAH fears that the draft leans in a different direction and, instead, would create an insurance system dependent on Medicare payment in the near term and over time. For the first few years, the public plan option would require Medicare payment rates and over time would give the Secretary of HHS total administrative authority to set the rates that would be paid. This is unfortunate because, as critical as both the Medicare and Medicaid programs are to so many Americans, for providers and clinicians, these programs chronically underpay for services. To assume that either model would become predominate is to raise real concerns that insufficient resources will be available to provide the care Americans expect and deserve.

There has been a legitimate debate in recent months about the sufficiency of Medicare payments to hospitals. MedPAC has asserted that such payment is all that is necessary for the maintenance of an efficient hospital. The FAH does not agree with this analysis, but even accepting the merits of the Medicare argument, the draft expands Medicaid significantly so that hospitals would potentially be subject to a Medicare-Medicaid payment mix with an expansive public option that was not envisioned in the the MedPAC analysis. Additionally, the draft includes reductions in Medicare payment that may further exacerbate the vast expansion of the Medicare-Medicaid payment proportion of hospital payment.

While we welcome what would appear to be the draft's intent not to require hospitals to participate in the public option, hospitals are there to serve their communities and the option not to serve is, in fact, no option at all.

Further, we find that the draft assumes a level of authority over pricing and payment methodology that is even more extensive than the level under the current Medicare program. Section 223 of the draft clearly gives the Secretary of HHS authority to establish payment rates and Section 224 permits the Secretary to "modernize" payment. Under Section 224, the Secretary would have the authority, absent Congressionally-mandated and reviewed demonstrations or pilots, to develop payment policies to include value-based purchasing, accountable care organizations, bundled payments, and adjustment of payments to address geographic variation.

While we applaud and support some of these initiatives, we have concerns about others, and would be extremely apprehensive to have them applied by Secretarial authority without sufficient review. While Section 224 pertains only to the coverage offered under the public option, we are concerned that the exercise of reform through administrative action implied here would not allow for sufficient vetting of policy and clearly lacks any semblance of the negotiation and engagement that is so essential to the operation of a viable and competitive

health insurance market. We do not believe government has a monopoly on "good ideas" about cost containment and delivery reform and, considering past experience with Medicare, are concerned this approach will not result in the best outcome for patients or those who serve them.

The FAH feels strongly that the only way to avoid the issues related to the exercise of administrative authority through the public option is to remove it from governmental authority and stick to the draft's newly restructured and highly regulated private health insurance market.

Finally, despite the enforcement of the individual and employer mandates in the draft, hospitals will invariably be faced with uninsured patients who have avoided health insurance. The FAH urges the inclusion of a mechanism under which hospitals would be enabled to automatically enroll uninsured patients. Enrollment could take many forms - it might look like current presumptive enrollment in Medicaid, or use some type of default mechanism to coverage in the new health insurance exchange. Whatever the approach, it is essential that under full implementation of the envisioned coverage expansion that anyone who seeks care at a hospital and who does not have health coverage can be enrolled in coverage at the hospital.

We realize the Congress is going to call upon hospitals to contribute financially to health coverage expansion. A key tenet of the FAH "shared sacrifice" policy is that any reimbursement reductions should be calibrated to and triggered by associated increases in coverage. Hospitals are under significant financial pressure, and before essential resources are removed, it is critical to assess the actual coverage expansion. For example, if the Committee chooses to target a certain portion of the hospital market basket, the FAH believes that such reductions should only occur once the CMS Actuary determines that certain increased coverage goals have been attained. The FAH seeks to work with the Congress on ensuring this critically important and fundamentally fair policy is part of this health reform legislation.

In addition, the draft exercises appropriate restraint by calling for the Secretary to submit a report to Congress in 2016 with recommendations on what, if any, changes to DSH may be warranted going forward at that time. As you know, DSH payments are absolutely vital to maintaining the fragile health care safety net, especially considering well-documented Medicare and Medicaid payment shortfalls. This will remain so, for the foreseeable future, and likely under virtually any level of coverage expansion. The Committee demonstrates great wisdom in waiting until coverage expansions and broader health reforms take hold and can be fully evaluated before considering changes to the DSH program.

The FAH, however, does recommend one immediate change to DSH policy in the interim – equity for rural hospitals. For reasons that are unclear from a policy perspective, the statutory formula for determining DSH payments to hospitals provides lower payments to rural hospitals treating the same proportion of indigent patients than it does for larger urban hospitals. Rural hospitals anchor health care delivery in their communities, and a key goal of health reform must be to strengthen these institutions to enable them to continue to treat the growing number of indigent patients in rural areas. We urge the Committee to establish DSH payment equity for rural hospitals.

REFORMING DELIVERY & REDUCING COSTS

- **Self-Referral Ban to Physician-Owned Hospitals**

Rising costs remain the most menacing health care issue for most Americans. Reducing those costs and appropriately aligning incentives begins with inclusion of Section 1156, the self-referral ban to physician-owned hospitals. The FAH remains appreciative of this Committee's longstanding support for this policy. In the last two years, the House of Representatives has passed similar legislation three times, and the Senate has passed it once. The Obama Administration also included this policy in its FY10 Budget Proposal, recognizing it as an important policy objective which has the added benefit of being an offset to health reform. Additionally, the Congressional Budget Office (CBO) has concluded that self-referral to physician-owned hospitals raises health care costs by increasing utilization. Now is the time to pass this legislation once and for all.

Section 1125 is compromise legislation: it is prospective in application, protects current physician ownership arrangements, and allows existing facilities to grow if they meet certain requirements. This policy will benefit patients and communities, save taxpayer money, end a serious conflict of interest that can affect patient care, and allow full-service community hospitals to provide vital care for all those in need.

- **Readmissions**

The FAH supports the principle of decreasing potentially preventable hospital readmissions and appreciates the direction of several key elements of the draft's readmissions policy. However, we are concerned the key measure of performance – the "excess readmissions ratio" – creates the potential for large, counterproductive payment reductions. Large cuts through this policy would substantially undermine hospitals' ability to invest in and adopt systems changes that would minimize preventable readmissions.

While we are troubled with these potential payment reductions, we are pleased that the draft recognizes the need to adopt readmission performance measures that have been endorsed by a multi-stakeholder consensus group, such as the National Quality Forum. We also appreciate that the draft would exclude readmissions that are unrelated to the prior discharge. We would urge that any expansion of conditions be linked to the national priorities as defined in Section 1441. In addition, the Committee takes an important step forward by offering financial assistance to certain DSH hospitals to help with addressing patient noncompliance issues, a key factor in hospital readmissions. We strongly recommend, however, that, at a minimum, all DSH hospitals be eligible for this assistance, not just those with $10 million in DSH payments as transitional care and patient compliance are readmissions issues for all hospitals.

The FAH also commends the Committee for recognizing the central role of physicians and others throughout the continuum of care in admitting, discharging and providing continuing care for patients. For readmissions policy to achieve its goal, hospital and physician incentives must be aligned. The Committee is correct to pursue a readmissions policy that would align incentives for clinicians and hospitals.

Regarding post-acute care providers, however, the bill prematurely applies an arbitrary interim policy that reduces their payments when a patient is readmitted to a hospital within 30 days of discharge, even if the readmission was clinically necessary and unrelated to the care provided in the post-acute setting. It makes little sense, then, to subject post-acute providers to payment reductions based on such an arbitrary policy, especially since the draft correctly calls for the development of more carefully calibrated measures governing readmissions from post-acute providers.

- **Post-Acute Payment Reform**

The draft steers just the right course in directing the Secretary, in a reasonable time frame and with the input of stakeholders, to develop a detailed plan to reform post-acute payments, and then authorizing the Secretary to conduct demonstrations, including, as appropriate, a variety of bundling approaches, to test what works and what doesn't. Clearly, the Committee recognizes the enormous complexities of reforming these payments with minimal disruption to patients. The list of issues that the Secretary's detailed plan must consider is appropriately exhaustive, including whether payment for physician services should be included in the bundle. As a result, the bill adopts the patient and thoughtful approach that is necessary.

- **Accountable Care Organizations (ACO)**

The FAH supports initiatives that focus on new methods of furnishing quality medical care to patients through integration. Creating greater accountability in the delivery of care through payment incentive arrangements is a positive and important step toward this goal. Section 1301 seeks to reach this goal, but does so in a way that would limit access regarding who can submit proposals to participate as a pilot program. Physicians will be an important part of any successful ACO, but hospitals should be afforded the opportunity to take leadership roles in establishing a pilot ACO and guiding care integration with physicians, especially when the focus is on controlling both Medicare Part A and Part B costs.

- **No "Super-MedPAC"**

The FAH is appreciative that the draft proposal does not contain a policy under discussion by certain policymakers to change the mission of the Medicare Payment Advisory Commission (MedPAC) from a congressional advisory body to an Executive Branch decision-making entity. Since its inception in 1997, MedPAC has fulfilled a key function for helping guide Medicare policy for Congress. Health care policy naturally is complex and can impact constituencies in unintended or unexpected ways. MedPAC has functioned appropriately in advising Congress on policy options and recommendations, and this Committee, in particular, has taken its advice seriously but not without using its independent judgment as it seeks to clarify how its recommendation would impact real people. The FAH believes it is the purview of Congress to legislate on significant health care policy changes and believe the traditional role of MedPAC should be maintained.

IMPROVING QUALITY

- **Establishment of National Priorities and Performance Measures for Quality Improvement**

The FAH is pleased that the Committee recognizes the importance of national quality measurement in numerous sections of the legislation. The FAH is a member of "Stand For Quality," a nationwide 200 plus multi-stakeholder coalition representing patients, consumer advocates, labor, clinicians, hospitals, employers, purchasers, researchers, and more, who have all come together to improve health care quality and delivery.

Quality health care happens at the bedside, not in Baltimore at CMS. The quality of care delivered to patients improves fastest and most efficiently through a coordinated multi-stakeholder approach that is patient-centered.

We appreciate the Committee recognizing that performance measurement is a key building block to quality improvement and must be supported by a strong national infrastructure linked to a set of national priorities established by the Secretary. By building on the current public-private initiatives, we can create a sustainable infrastructure to support high quality, affordable health care for all.

To make this happen, the FAH and Stand for Quality recommends the draft legislation focus on six clearly established goals:

- Setting national priorities to guide reporting and improvement activities and assess progress.
- Endorsing and maintaining measures for national use through a multi-stakeholder consensus process.
- Developing measures to fill identified gaps in priority areas.
- Strengthening a public-private stakeholder consultation process.
- Providing a national strategy for the collection, aggregation and public reporting of quality measures
- Identifying, developing, testing and disseminating innovative methodologies for improvement in quality of health care.

Unfortunately, the Committee draft falls short of these goals. While the draft recognizes the importance of priority setting and development of new measures, Subtitle C does not clearly define how the national priorities are linked to identifying gaps in useable quality measures, the use of measures in a wide variety of public and private payment programs, the process for collecting, aggregating and publicly reporting on measures.

We believe that Subtitle C would be enhanced by adding several sections including a section that would link the definition of "multi-stakeholder" already in the legislation to the consultative process. The consultative process provides input to the Secretary of HHS and CMS on the establishment of priorities, the endorsement of quality measures, the use of quality measures, and identification of gaps in quality measurement, and the aggregation of quality data for public

reporting. The consultative process does not take authority or power away from the Secretary or CMS, it merely provides the Secretary with options informed by patients and those providing care to them.

Throughout the draft, there are distinct references to quality measurement in a variety of Subtitles and across health care sectors such as Medicare Advantage Plans, prevention and wellness. We believe that overall national quality would be greatly enhanced if the use of quality measures required for implementation and quality improvement in other sections of the bill would build on the national priorities established by the Secretary, by creating a specific legislative link to an enhanced Subtitle C. Such a linkage would harmonize the information provided to the public and facilitate a process that focuses every element of the health care system on the key factors that will improve patient care.

The FAH is pleased to see Sec. 2401, "Implementation of Best Practices in the Delivery of Health Care." Quality improvement must focus on research on the factors that facilitate the behavior change necessary to improve quality and foster an environment of continuous improvement.

The FAH believes that quality improvement happens most efficiently when reliable methodologies are developed to quickly disseminate information to clinicians, patients and providers. We believe the Agency for Healthcare Research and Quality (AHRQ) is the correct entity to carry out this task, and would urge the Committee to reassess the quality improvement language already in the draft to focus on the outcomes of the quality improvement process including the provision of technical assistance and learning aids for health care organizations to disseminate what's learned through QI efforts. We believe that good science and methodologies for improving patient care can be more effectively and efficiently distributed than under the current system.

Section 1709 establishes a new Assistant Secretary for Health Information responsible for ensuring the collection, collation, reporting and publishing of statistics on key health indicators which will include the development of standards for the collection of data on health and health care. The FAH believes strong consideration should be given to the role that increased use of electronic health records will play in the collection of health information in the future. While we support the requirement for the Assistant Secretary to coordinate with the Office of the National Coordinator for Health Information Technology (ONC) to carry out these duties, we are concerned about the potential overlap between the responsibilities of the Assistant Secretary and the responsibilities of the National Coordinator for Health IT as the collection of health information becomes increasingly automated.

While the draft calls for the Assistant Secretary to consult with offices and agencies within HHS and the heads of other appropriate federal departments, there is no requirement for the Assistant Secretary to undertake a multi-stakeholder consultation process. The FAH believes that consultation with both public and private stakeholders will ensure a more streamlined process for the collection of health information that takes into account the operational challenges faced by those health organizations, including hospitals, that generate these data.

We appreciate the draft bill designating Trust Fund dollars to support the establishment of national priorities that would be implemented across all programs. However, we believe that the national goal setting, measure use, measure endorsement and consultative processes would require more than the annual $7 million currently in the draft legislation. The FAH would suggest that to effectively accommodate the complexity of establishing a national infrastructure to measure and report quality across the health care spectrum that the Committee consider increasing the Trust Fund allocation.

The FAH is willing to work with the Committee on the development of language to support initiatives to define the consultative process, the use of quality measures and the identifications of gaps in the measurement development process.

OFFSETTING HEALTH REFORM

The FAH recognizes the importance of shared sacrifice, but we need to be very careful that health reform legislation does not arbitrarily reduce hospital revenue. Hospitals are facing serious financial burdens now and for the foreseeable future that place significant pressure on our ability to meet community health care needs. Thankfully, the Tri-Committee draft rejects many of the hospital reimbursement cuts proposed by the Administration. We are particularly pleased that this legislation does not impose cuts to Medicare and Medicaid Disproportionate Share (DSH) payments to hospitals.

There is no doubt that health coverage expansion done right could lead less uncompensated care to hospitals. However, it is next to impossible to predict the impact of reform and the potential utilization that would result from such dramatic changes in the marketplace, which are without precedent. It also is worth noting that a key source of revenue for hospitals is reimbursement from the individual health insurance market, which is often at beneficial rates for hospitals. The draft legislation targets this population for the health insurance exchange and (with or without the public option) would naturally result in reduced revenues to hospitals.

As Congress addresses hospital reimbursement, we also urge you to keep in mind that:

- Hospitals are estimated to have a -6.9% overall Medicare margin this year;
- The FY2010 proposed Medicare inpatient payment rule would cut hospital payments an estimated $41 billion over 10 years; and
- Medicare and Medicaid payment shortfalls to hospitals are chronic and well-documented.

- **Market Basket Updates**

The FAH opposes incorporating productivity adjustments as a permanent, arbitrary reduction to hospital market basket updates. Acute care hospital Medicare margins have been negative and falling for seven years, beginning in 2003. MedPAC projects that the overall Medicare hospital margin will reach negative 6.9 percent in 2009. This is an unsustainable path. Imposing additional, annual reductions, currently estimated at 1.3 percent, will exacerbate an already intolerable burden on hospitals struggling to meet the health care needs of seniors.

In addition, productivity adjustments as described in the bill are largely inapplicable to hospitals. The hospital market basket is structured specifically to capture the costs hospitals incur in providing a unit of inpatient care. Yet, the proposed productivity adjustment measures efficiency gains for the broader economy, virtually exclusive of hospitals, which remain extremely labor intensive among other differences. Indeed, the cuts that this adjustment would impose would make it that much more difficult for hospitals to make the investments necessary to achieve the very gains in efficiency that are cited as justification for this productivity adjustment.

Finally, it would be imprudent to adopt, permanently, the same productivity adjustment that MedPAC has, for the last three years, rejected when issuing its recommendations for a full hospital market basket update.

Apart from productivity adjustments, the FAH recommends that inpatient rehabilitation facilities (IRF) receive a payment update in 2010. IRF margins are deteriorating, volume is declining, patient acuity is increasing, and this hospital sector, like all hospital sectors, has suffered from the collapse of the general economy. In addition, IRFs have been subject to an update freeze that began during FY08 and continues through the remainder of FY09. It is unreasonable to deny these critical facilities an update for FY10 as well.

FRAUD AND ABUSE

The Tri-Committee's draft contains a number of proposals aimed at reducing fraud, abuse, and waste in government programs. Many of the proposals are sound and target areas of the health care continuum in which fraudulent activities have been rampant and require better detection and prosecution. Other proposals, however, may be subject to restrictive interpretation resulting in greater burden to health care providers than real benefit to the federal programs.

- For example, Section 1641 requires repayments of Medicare and Medicaid overpayments within sixty days of identification. A sixty-day time frame for repayment may often be insufficient to complete an internal review of a potential overpayment, verify whether an overpayment exists, and take required action to repay the monies with the required written explanation. We urge the Committees to consider requiring a 60-day timeframe that is triggered when an overpayment is identified and then verified by internal review.

The FAH believes the Committees should also consider adding exceptions to the self-referral statute and safe harbors for the anti-kickback statute to protect certain payment incentive and shared savings arrangements. The draft contains a number of other policies that focus on payment incentives as a way better to integrate care and control costs. Thus, these fraud and abuse statutes should not stand in the way as a barrier to implementing these types of policies through negotiated programs involving hospitals and physicians.

OTHER ISSUES

In closing, there are several other issues in the draft that are of significant importance to our member companies that we would like to briefly address.

- **Investor-Owned Hospitals Parity – Access to Grants to Improve Delivery and Outcomes**

FAH member hospitals, like all community hospitals, play a vital role in the communities we serve, and in some circumstances, investor-owned hospitals are the primary access point to essential health care services. While not necessarily within this Committee's jurisdiction, we are troubled that the grants throughout Title II aimed at improving the health care workforce and access to health care are limited to nonprofit hospitals. We urge the Congress to open up access to grants based on need, not on tax status.

- **Administrative Simplification**

The FAH strongly supports administrative simplification, but recommends that Sec. 501 of the draft legislation be amended to require the Secretary to seek guidance on administrative simplification standards from existing public and private standard setting entities and then develop regulations in consultation with professional organizations representing entities and constituencies referenced in SSA Section 1172(a) - HIPAA. We also recommend that all regulations be subject to Notice of Proposed Rulemaking.

- **Psychiatric Hospital Stays and Mental Health Parity**

The FAH supports the provision in the discussion draft eliminating the 190-day lifetime limit on psychiatric hospital stays. Furthermore, we appreciate that the draft extends the mental health parity requirement as an essential benefit.

* * * * * * * * * *

Thank you for the opportunity to testify before this esteemed Committee on this critically important piece of legislation. The FAH stands ready to assist Congress as it moves through its consideration of the many issues that are important to all Americans and the hospitals that serve them in their time of need.

Mr. STARK. Chip, thank you very much for your contribution.

Mr. Minnix, would you like to enlighten us, please?

STATEMENT OF WILLIAM L. MINNIX, JR., PRESIDENT AND CEO, AMERICAN ASSOCIATION OF HOMES AND SERVICES FOR THE AGING

Mr. MINNIX. Thank you, Mr. Chairman, and distinguished public servants.

I am Larry Minnix. I represent the American Association of Homes and Services for the Aging, 5,600 mission-driven organizations in everyone's community; everything from small, adult-based centers to very large and comprehensive retirement communities.

I represent the issue nobody wants to talk about in health care reform, but everybody will face sooner or later if we live long enough, so it's time to confront it. And we believe that long-term services and supports can be a contributor to health care reform, not a detraction from it and a burden that many feel we cannot bear. So I want to talk about how we can finance long-term care through a public option as we look to the future, and some things that need to be done to improve the Medicare program.

We certainly agree with the direction that you all are taking in health care reform and support the principles. From our standpoint, you are moving in the right direction as a matter of helping iron out the details. You may not realize it. While 40-something million Americans don't have health insurance, 250 million Americans are uninsured for long-term care. Ten million, 65 and older, on any given day are in need of long-term service and support, over 65. It's almost that many under 65, younger adults, with disabilities.

There are 44 million caregivers, and they spend an average of 35 hours a week doing that job. It costs employers $2,000 a year for lost time, work, and stress-related illnesses. They spent out-of-pocket caregiving, $5,531 a year; $9,000 a year if they are a long-distance caregiver. The single biggest payer source is certainly Medicaid, and we have overburdened the Medicaid system with long-term care costs at $100 billion this year and growing. But families spend two and a half times that out of their own pockets.

So we already have a huge problem. Now, what's the solution? We believe that the HELP Committee bill, the Class Act, if you will, that Congressman Pallone introduced to this body previously, and now is embodied in the HELP Committee bill, is a solution. We all, when we begin work, put into a national insurance pool; and any of us at any age get daily cash benefits to help the caregiving stay at home.

For younger, disabled populations, it may be the difference between being able to work and not being able to work. Had a plan like this been in place today when the Pepper Commission recommended some kind of insurance model a generation ago, Medicaid expenditures for long-term care would be 50 percent of what they are today. So, if you think of what you could do with $50 billion to help us address the rest of the health care system, we also have some recommendations around improvement of the current Medicare program.

You've heard some things about care management, transitions care, culture change in nursing homes. You look at some of the quality improvement things going on in nursing homes, especially around the advancing excellence campaign. Nursing home care can get better. We need to stabilize the financing, overhaul the public oversight to make it more modern and more accountable and transparent. All of those are fixable problems. None of it is going to work long-term though without a different approach to financing aging and disability-type services in what we believe is a public option.

Private, long-term care insurance cannot do it. It has its place but it cannot do it, and Medicaid is the fallback for everybody and you all know what government-imposed poverty and asset transfer does. So we believe there's a solution, and let's wrap it into health care reform.

[The prepared statement of Mr. Minnix follows:]

Testimony of
American Association of Homes & Services for the Aging
William L. Minnix, Jr.
President & CEO

Before the Ways and Means Committee
June 24, 2009

Introduction

On behalf of the 5600 mission-driven, not-for-profit members of the American Association of Homes & Services for the Aging (AAHSA), I want to thank the Committee for the opportunity to address the Tri-Committees draft legislation to provide affordable, quality health care for all Americans and reduce the growth in health care spending.

AAHSA members (www.aahsa.org) help millions of individuals and their families every day through mission-driven, not-for-profit organizations dedicated to providing the services that people need, when they need them, in the place they call home. Our member organizations, many of which have served their communities for generations, offer the continuum of aging services: adult day services, home health, community services, senior housing, assisted living residences, continuing care retirement communities and nursing homes. AAHSA's commitment is to create the future of aging services through quality people can trust.

We commend the three committees for their extraordinary collaboration on developing a comprehensive approach to ensuring that all Americans have access to affordable health care coverage. The task is daunting and the committees and their staff are to be commended for the volume of research, deliberation and drafting they have been able to accomplish in such a relatively brief period. The expansion of coverage, the improvements in the insurance marketplace, the proposed solutions to problems with coverage and access which we see in this draft legislation are all elements that must be resolved in any successful reform of our nation's health care system.

There are many provisions in this draft legislation that mirror AAHSA's public policy and that we have urged Congress to adopt for years. We are pleased the committees recognize the value and importance of improving the payment system for nursing homes and address critical workforce issues, access for beneficiaries, quality improvement and transparency. We also appreciate that this legislation is a draft, and will take this opportunity to indicate those areas where we have concerns and recommend alternatives. And of course, we are more than willing to work with the committees to address any recommendations we make.

Health Reform and Long Term Services and Supports

We applaud the committees for addressing very key issues confronting our health care system – issues that affect all of us. Assuring access to affordable and meaningful health insurance, acknowledging a shared responsibility as individuals, employers and government to ensure coverage of essential health benefits,

addressing cost, and investing in our health care workforce are fundamental. These elements affect our members and the people we serve as providers, as employers and as citizens.

While the health reform discussions have focused on the acute care system, we note that the principles that underlie this draft bill resonate in the long term services and supports field and mirror AAHSA's public policy and the policy adopted by well over 100 organizations representing aging services and other providers, consumer groups and persons with disabilities.

The care and services our members provide are an integral part of the health care system. According to a recent poll conducted by the Mellman Group, 85% of Americans believe that long-term services and supports should be included in national health reform and will be surprised if they are not. Instinctively, Americans recognize that there is a critical nexus between the services they need to maintain their health and the medical care itself.

An estimated 10 million Americans currently need long-term services – personal care, assistive technology and other supportive services, and this number will grow. However, we lack a coordinated, national public-private system for adequately, efficiently and humanely delivering high quality services. The elements for such a system mirror the elements in the committees draft legislation:

COVERAGE AND CHOICE: Only 6-7 million Americans have private health insurance coverage for long-term services and supports, and this coverage has been slow to grow for a number of reasons, including affordability, exclusion for health reasons, and the nature of the product. Medicare covers relatively little long-term services and supports. Medicaid has become the default public long-term services and supports program, despite longstanding efforts to restrict eligibility. While Medicaid coverage has broadened in recent years, it still gives beneficiaries few choices of services, providers or settings.

AFFORDABILITY: Nursing home care averages $70,000 per year and can run over $100,000 a year in some areas. Home care costs average $15-20 per hour. These costs are unaffordable for the majority of individuals and increasing reliance on Medicaid for coverage of long-term services and supports is unsustainable for federal and state governments.

SHARED RESPONSIBILITY: Low take-up rates for private long-term care insurance have resulted from underwriting practices that prevent up to 20% of applicants from qualifying for coverage and from the relatively high premiums charged for this coverage. Individuals who finance long-term services and supports on their own can quickly spend down a lifetime of savings. Americans need an accessible and affordable structure to responsibly plan for the cost of their own long-term services and supports.

PREVENTION AND WELLNESS: AAHSA strongly supports efforts to encourage healthier lifestyles to prevent diabetes, heart disease and other conditions that are expensive to treat. Research into more effective treatment and prevention of Alzheimer's disease and other forms of dementia could significantly reduce future spending on long-term services and supports. Nevertheless, the longevity trend which is giving us increasing numbers of centenarians means that more and more Americans will need long-term services and supports in the coming years.

Recommendation:

AAHSA urges the committees to include a national insurance program for long-term services and supports as part of the final health care reform legislation. Insurance is the correct approach, as the need for services is a risk and not a certainty. The inability of the private market to adequately

> serve this population, coupled with the increasingly unsustainable burden on Medicaid, points directly to the need for a national insurance program.
>
> The CLASS Act (H.R. 1721), introduced by Rep. Frank Pallone, represents a model that we urge the Committees to adopt in final legislation. It has been included in the health care reform legislation proposed by the Senate Health, Labor, Education and Pensions Committee as Title XXII. The CLASS Act creates a voluntary insurance program specifically for services not covered by traditional health insurance and will provide an affordable product that covers basic needs, provides choices, and helps prevent impoverishment. Including the CLASS Act in health care reform legislation complements and completes the work of the Committees to address the health care needs of all Americans.
>
> The CLASS Act parallels the recommendations AAHSA's own Financing Cabinet made for the reform of the long term services and supports financing system. The cabinet made its recommendations based on a two-year examination of all the issues involved in financing long-term services and supports. As with any form of insurance, the cabinet determined that the more universal the coverage, the more affordable it would be for all participants.
>
> Only a fundamental reform of the long-term services and supports system as proposed in the CLASS Act will achieve the Medicaid savings necessary to prevent Medicaid from imploding under the impending needs of the baby boom generation.

AAHSA will now address specific provisions in the committees draft legislation that affect aging services providers.

Skilled Nursing Facility Payment System (Sec. 1111, 1101)

We commend the committees for incorporating into this legislation the recommendations from the Medicare Payment Advisory Commission (MedPAC) to restructure the payment system for skilled nursing facilities. Restructuring the payment system is needed to more accurately account for caring for medically complex residents. Section 1111 implements a position that AAHSA, as well as MedPAC, has advocated for many years.

Indeed, two years ago AAHSA submitted testimony to the Ways & Means Health Subcommittee urging the committee to revisit this deeply flawed payment system. The current system, which the Tri-Committee draft legislation corrects, is based on Resource Utilization Groups (RUGs) that do not accurately determine acuity of need and do not responsibly calculate cost. This is particularly true for medically complex patients who generally require not only extensive nursing care but also significant amounts of medication, supplies, tests, respiratory care, and other so-called non-therapy ancillaries (NTA). Medicare reimburses skilled nursing facilities for many very expensive patients at considerably lower rates than Medicare pays for patients whose care costs much less. The Inspector General, MedPAC and the GAO have all reported on these inaccuracies.

In February 2009, MedPAC wrote to CMS urging that the system be revised, stating:

> The shortcomings of the current SNF PPS are extensive and create inequities for beneficiaries and providers. The PPS poorly targets payments for nontherapy ancillary services (NTA), such as intravenous medications and respiratory care, so that patients who require these services are harder to place than other patients and the SNFs that treat them are financially disadvantaged. The current design overpays for rehabilitation therapy services and relatively underpays for medically complex

care. In addition, the lack of proportionality between payments and costs for therapy services creates financial incentives to furnish care that may be of marginal benefit to the patient and results in facilities selecting certain patients over others. These design flaws are partly responsible for the widely varying financial performance between nonprofit and for-profit SNFs and between freestanding and hospital-based SNFs. The Commission believes these glaring problems create an urgent need for reform and warrant correction.

Section 1111 directs the Secretary to revise the prospective payment system (PPS) by adding a separate NTA component; replacing the therapy component with one that establishes payments based on predicted patient needs; and adopting an outlier policy. These requirements mirror the recommendations made by MedPAC.

Recommendation:

AAHSA strongly recommends that the final health care reform legislation contain Section 1111. Fixing the RUGS payment system corrects an imbalance that resulted in overpayments for therapy services and underpayments for NTA services. This imbalance had a significant negative impact on not-for-profit SNFs.

Skilled Nursing Facility Payment Update (Sec. 1101)

The Tri-Committee bill freezes skilled nursing facility payments for FY 2010 for a nine-month period effective January 1, 2010. AAHSA was disappointed to see this provision included in the legislation. CMS is already planning to reduce providers' payments by a net 1.2% through a regulatory change, and the failure to implement the update further reduces payments to providers by 3.3% or more.

We urge the Committee to reject this proposal, which would penalize the very health care providers who are making the greatest effort to ensure high quality care for frail older people.

Seventy-six percent of nursing home residents are paid for by Medicaid or Medicare. Very few residents currently have private insurance to cover the cost of their care. The heavy reliance on these two programs makes their payment policies even more critical to nursing facility operations than they are for health care providers that have more varied sources of payment.

The inequity of the current payment system, as described in the discussion of Section 1111, is particularly evident when determining whether the update is warranted. Not-for-profit SNFs have very low Medicare margins; for 2007, MedPAC found that although skilled nursing facilities as a whole achieved 14.5% margins, not-for-profit facilities had Medicare margins of 4.5%. The large margins used by MedPAC to justify eliminating the update are simply non-existent in the not-for-profit sector. The market basket update is essential to smoothing out this disparity and giving facilities caring for the most complex patients the necessary resources.

Adequate Medicare reimbursement makes a major difference to nursing homes' ability to recruit and retain staff, the single greatest determinant of the quality of care facilities are able to provide. Denial of a payment update to facilities that already are struggling to break even on the services they provide to Medicare beneficiaries would run directly counter to the many initiatives we are pursuing to raise nursing home quality.

Because payment policies are so critically tied to adequate staffing, we would add, on a positive note, that we are very supportive of Sec. 1414 (f) in the Tri-Committee bill, which mandates separate reporting of

nurse staffing on Medicare cost reports. This information will give Medicare, MedPAC, and Congress significant information on how Medicare dollars are spent.

Recommendations:

AAHSA urges the Committee not to eliminate the market basket update for FY 2010 as this unfairly penalizes those providers who care for the more medically complex and have higher staffing and therefore have very low margins.

AAHSA strongly supports Sec. 1414(f), cost reporting for nurse staffing, as a critical element for determining appropriate use of Medicare funds.

Post acute care services payment reform (Sec. 1151-1152)

AAHSA supports directing the Secretary to develop an appropriate post-acute care payment system and appreciates the thoughtfulness in approach taken by the Committees. In addition, we support directing the Secretary to develop quality measures to determine the appropriateness of readmissions. We would add that any policy should be coordinated with quality measures for hospitals.

Post-acute services must be better coordinated to prevent the rehospitalizations that are costly to the Medicare program and arduous for beneficiaries. Better transitions among different levels of services are one of AAHSA's big ideas for the future of aging services. The issues to be considered by the Secretary cover many of the concerns AAHSA has noted, including ensuring quality of care and beneficiary choice and addressing corporate and regulatory differences. We believe that in addition to traditional bundling, the Secretary should examine the appropriateness of alternatives such as care transition, medical homes, and house call initiatives.

AAHSA is concerned, however, with the interim policy adopted in Sec. 1151, which essentially creates a non-rebuttable presumption that all readmissions to hospitals within 30 days are the fault of the post-acute care provider. This policy would be much too broad; as an example, a patient who is admitted to a nursing home to recover from hip replacement would have to be rehospitalized if he suffered a heart attack ten days later. The incentive for post-acute providers would then become denying admittance to patients who risk being rehospitalized.

We are also concerned that this approach will exacerbate the problem with placing medically complex patients identified in MedPAC's March 2009 report (p. 167). This policy punishes high quality providers who take very ill patients equally or greater than poor quality providers who have no incentive to accept medically complex patients.

We strongly agree that reducing or eliminating avoidable re-hospitalization is an important goal not just financially but also as a consumer issue and a quality issue. We recognize that post-acute care providers have an equal responsibility with hospitals to prevent rehospitalizations whenever possible. However, we urge the Committees to eliminate this specific provision and instead make sure that the Secretary moves quickly to determine what is an "avoidable hospitalization" and appropriate incentives and penalties.

Recommendations:

AAHSA supports the provisions in Sec. 1152, but requests that the committees not adopt Sec. 1151. AAHSA would be happy to work with the committees as to develop alternative interim policies.

Reducing Health Disparities (Sections 1221-1224)

AAHSA supports the provisions in these Sections and is very pleased that the committees recognize the importance of addressing cultural competence generally and language specifically. We encourage including aging services providers in these studies; many of our members have multi-lingual campuses, and of course that includes residents from many backgrounds as well as staff. The Better Jobs Better Care research and demonstration program (www.bjbc.org), funded by the Robert Wood Johnson Foundation and Atlantic Philanthropies, and the AAHSA Commission on Ethics in Aging Services have produced tool-kits and other resources to assist providers develop and maintain workplaces that respect diversity of staff and residents.
http://www.aahsa.org/uploadedFiles/resources/Governance/Legal_and_Ethical_Policies/Ethics_Whitepaper_WEB.pdf

Recommendation:

AAHSA strongly supports these provisions and encourages inclusion of aging services providers in studies and demonstrations.

Extension of therapy caps exceptions process (Section 1231)

AAHSA has long advocated for a reasonable payment system for outpatient therapy services. We appreciate continuation of the exceptions process, but ultimately the question of how to pay for outpatient therapy needs to be addressed, either by repealing the arbitrary cap structure entirely or by developing another system for payment.

Medicare currently covers physical, occupational and speech therapy, but limits or "caps" the amount of therapy an individual can receive in a given year.

Therapy needs have increased as the population ages and people live longer. Limiting the therapy that one can receive in a particular year often hinders an individual's ability to regain physical strength and daily living skills that are required to live independently. In addition, an individual may exhaust his or her permitted therapy early in the year and have a new need for therapy later in the year as a result of a new medical setback (surgery, injury from a fall, heart attack, etc.)

Caps on therapy coverage first were imposed by the Balanced Budget Act of 1997, but soon afterward Congress imposed a series of moratoriums on the caps because of their potential impact on beneficiaries with serious injuries and health conditions.

The last moratorium expired at the end of 2005. Instead of renewing it, Congress created an exceptions process under the Deficit Reduction Act, which is continued each year.

Recommendations:

Optimally, Congress should simply repeal the caps. Although repeal scores as an increase in federal spending, the caps have been in full effect for only a few weeks in the last twelve years. They have not effectively reduced federal spending.

Alternatively, the provision in the Tri-Committee bill should be adopted. We suggest that the Secretary be directed to create a permanent process for determining appropriate payment for therapy treatment. The legislation should specifically direct the Secretary to design and implement

a new system that (among other things) includes an outlier process and conforms to the Data Quality Act. The Secretary should also be directed to convene a Technical Advisory group to assist in the design of this new system, which would include relevant consumer and provider groups and scientists.

Nursing Home Transparency (Title IV, Subtitle B)

AAHSA supports these provisions, with the exception of Section 1421, which we will address separately.

This bill will increase transparency and promote accountability by requiring all nursing homes to disclose their ownership. We share the Tri-Committees' view that the public must have complete information about the individuals and corporate entities who may effectively be held accountable for the quality of services provided in a nursing facility.

Recognizing that consumers need adequate and more easily accessible information, the bill also improves the information available to consumers on Nursing Home Compare, and directs that improvements be made to make the site more user-friendly for the public.

It is difficult for consumers to obtain adequate and useful information on nursing homes so that they can make an informed decision for themselves or a loved one. The information that is available is not written for the lay person and does not contain critical information to assess the quality of life and care provided by the home. This lack of good information is particularly disturbing because consumers seldom have the time or capacity to research homes.

Therefore, by default, the primary source of information for consumers is Nursing Home Compare, the website established and maintained by CMS. Nursing Home Compare contains the results of the latest surveys for each Medicare and Medicaid-certified nursing home, quality measures based on the information collected for the Minimum Data Set (MDS) Repository, and some general information regarding each nursing home. Although an effort has been made to explain each reported measure and deficiency citation, the site never actually explains the process and the meaning of the results, how surveys are conducted, what they mean and don't mean. How should the consumer assess the meaning of a deficiency that ranks as a "2" and affects a "few" residents? Consumers cannot even determine if cited deficiencies relate to many incidents or one incident. Nor is there any lay explanation of the facts underlying the deficiency so that a consumer can understand the meaning of the deficiency. What is the actual impact on "quality"? How should the consumer use this data? Other issues that have been raised about the information provided on Nursing Home Compare relate to the reliability of the data1, as well as understanding that compliance with regulations is not the same thing as quality. None of these questions is answered, even though understanding how to interpret survey data and integrate this data into one's analysis of any particular nursing home seems like fairly basic information.

Furthermore, Nursing Home Compare measures and reports only compliance with minimum standards of care. It does not identify nursing homes that consistently achieve outstanding quality of services, and unfortunately, there really is no other data source for identifying which nursing homes have high quality. As a result, everyone from CMS to consumer groups to nursing homes ourselves urge prospective residents or their decision makers to visit the nursing homes they are considering if at all possible. The time to visit prospective homes and the tools to analyze the information obtained from Nursing Home Compare and their visits are critical to the ability of consumers to make thoughtful and intelligent decisions.

Other important provisions included in this bill relate to workforce. As noted earlier in our testimony, the bill corrects a long-standing omission on Medicare cost reports by requiring information on dollars spent for nursing – nursing costs are a critical element in assessing quality. Breaking out these costs separately on Medicare cost reports will enable policymakers, regulatory agencies and consumers to easily determine which facilities are using the resources provided by Medicare to maximize their quality of care.

The bill also includes provisions adding dementia management and abuse prevention to direct care worker training programs. Finally, the bill addresses concerns about the scope and length of training for certified nursing assistants, and calls for a study on the content of training programs for staff and whether the minimum hours should be increased. We strongly support a study of these issues. One of the key findings from the Better Jobs Better Care research and demonstration program was that there simply does not exist a definition of core competencies for staff in long-term care settings. As a result, existing programs may not be sufficient and more importantly fail to provide optimal education, training and advancement. A study of education and training in this field is long overdue.

Finally, AAHSA urges the Tri-Committees to remove the provisions in Sec. 1421 that increase civil money penalties. AAHSA believes that the provisions increasing penalties for deficiencies are unnecessary and unduly punitive. Extensive remedies currently exist to address inadequate performance by nursing homes, through fines, denial of payment for new admissions, exclusion from Medicare, and imposition of temporary management (in addition to the national independent monitor program created in the bill). We believe based on our work on the Advancing Excellence Campaign with CMS, AARP and other consumer groups, and the other provider organizations that education, training, support and positive reinforcement of nursing homes that engage in continual quality improvement are the building blocks for improving quality in our nursing homes, protecting residents, and leading to the time when there will be only two types of nursing homes – the excellent and the non-existent.

Recommendations:

AAHSA supports the Nursing Home Transparency subtitle; it addresses critical areas that will strengthen transparency for consumers, improve quality, and improve the workforce. However, AAHSA urges the Tri-Committees to remove the provisions in Sec. 1421 increasing penalties, and, rather, encourage CMS to utilize fully the remedies that already exist to address quality concerns.

Conclusion

We appreciate the committees' efforts. Comprehensive health care reform is a truly monumental task. AAHSA is pleased to be a resource in this effort and we assure the committees that we are more than willing to be a resource on each of the recommendations we have made and on health reform generally.

Thank you.

Mr. STARK. Thank you. Thank you very much.

Dr. Warner will now click his heels three times and give us the Kansas solution to our problems.

Welcome to the Committee, doctor.

STATEMENT OF RICHARD B. WARNER, M.D., MEMBER, KANSAS MEDICAL SOCIETY HOUSE OF DELEGATES, AMA ALTERNATE DELEGATE, PAST PRESIDENT, KANSAS MEDICAL SOCIETY

Dr. WARNER. Thank you, Mr. Stark, and Chairman Rangel, Ranking Member Camp and Members of the Committee.

I am Richard B. Warner, M.D., from Overland Park, Kansas, and I appreciate the opportunity to talk with you about the reform of health insurance and its market. My perspective is that of a psychiatric physician in private practice. I am a recent past President of the Kansas Medical Society and a member of the Kansas delegation to the American Medical Association.

I also serve on the Board of Directors of the Kansas Health Insurance Association, which administers the high-risk pool for the State of Kansas. In 2004 the Kansas Medical Society adopted a set of principles of health care reform to guide its staff and leadership in responding to proposals for health care reform, and these were updated in 2008. They form the underpinning of my remarks.

The first point to understand about health insurance is that while it is a resource that helps people to be able to pay for medical care, it also aggravates the inflation of prices in the medical market. With third-party payers covering the largest part of medical expenses, people are insulated from the financial consequences of their health care purchasing decisions. The effect of that is profoundly inflationary, and we have a spiral in which a person needs health insurance to be able to afford care, but the insurance contributes to the higher and higher prices that we all see.

We then see a variety of measures put in place to attempt to restrain prices in spending.

The first KMS principle calls for a pluralistic, competitive delivery system, with choice of physician, facility and health plans; not only in private health plans, but to the extent practical, in publicly financed public health care programs as well. It suggests that the system should harness the power of choice, individual responsibility and market forces as a superior approach to a government-controlled system.

Applied to the idea of a public option health insurance plan, it would raise a caution because of the risk that a government-designed, marketed, and funded health plan would eventually undermine the markets both for health insurance and health services. The likely price controls of such a plan would eventually bring about a shortage of services, as is starting to be seen in Medicare. A likely cost shifting as is now seen with Medicare and Medicaid and SCHIP programs would distort pricing in the private market and result in the crowding out of private plans.

The second of the KMS principles calls for public policies which encourage the development of affordable, portable health insurance products, including those which emphasize greater consumer financial responsibility for their health care purchasing decisions, such as through the use of percentage-based co-insurance and health

savings accounts, combined with higher deductible insurance policies. These approaches would have patients participating in both the first and the last dollars of their transactions, which would offer a natural restraint to both utilization and price inflation.

While asserting that all Kansans should have health insurance, the KMS principles state that mandating universal coverage by law is neither desirable nor likely. That would apply to both individual and employer mandates. To Federally mandate that individuals purchase health insurance would likely make it easier for States or the Federal Government to also insist on various mandated benefits, which would drive up the price of the insurance. To mandate employer purchase would lock more people into plans with very small risk pools and it would defeat the goal of individually owned and portable insurance.

Finally, I would like to say a few words about the importance of the patient-physician relationship, which is based on the Hippocratic ideal of placing the patient's best interest ahead of one's own interest or that of any group. That relationship forms the moral bedrock upon which medical care rests; and, it is what allows patients to reveal whatever is necessary to properly diagnose and treat whatever may ail them.

Financial and clinical systems should have as their mission to support what the patient and the physician undertake. Competitive markets in which no insurance plan, private or governmental, develops monopsony-like control will provide the best support. Allowing patients and physicians to privately contract for care also is a step toward them being able to shape care decisions in the best interest of the patient.

Thank you for the opportunity and I look forward to discussing these ideas further.

[The prepared statement of Dr. Warner follows:]

Prepared Statement of Richard B. Warner, M.D.,
Member, Kansas Medical Society House of Delegates,
AMA Alternate Delegate, Past President, Kansas Medical Society

Chairman Rangel, Ranking Member Camp, and Members of the Committee, I am Richard B. Warner, M.D. from Overland Park, Kansas, and I appreciate the opportunity to talk with you about the reform of health insurance and its market. My perspective is that of a psychiatric physician in private practice. I am a recent past President of the Kansas Medical Society and a member of the Kansas delegation to the American Medical Association. I also serve on the Board of Directors of the Kansas Health Insurance Association, which administers the high-risk pool for the State of Kansas.

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The first of the KMS Principles calls for a pluralistic, competitive delivery system with choice of physician, facility, and health plans, not only in private health plans, but to the extent practical, in publicly financed health care programs as well. It sug-

gests that the system should harness the power of choice, individual responsibility, and market forces as a superior approach to a government-controlled system. Applied to the idea of a "public option" health insurance plan, it would raise a caution because of the risk that a government-designed, marketed, and funded health plan would eventually undermine the markets both for health insurance and health services. The likely price controls of such a plan would eventually bring about a shortage of services, as is starting to be seen in Medicare. The likely cost-shifting, as is now seen with Medicare, Medicaid, and SCHIP programs, would distort pricing in the private market and result in the crowding out of private plans.

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Finally, I would like to say a few words about the importance of the patient-physician relationship, which is based on the Hippocratic ideal of placing the patient's best interest ahead of one's own interest or that of any group. That relationship forms the moral bedrock upon which medical care rests, and it is what allows patients to reveal whatever is necessary to properly diagnose and treat whatever may ail them. Financial and clinical systems should have as their mission to support what the patient and the physician undertake. Competitive markets in which no insurance plan, private or governmental, develops monopsony-like control will provide the best support. Allowing patients and physicians to privately contract for care also is a step toward their being able to shape care decisions in the best interests of the patient.

Thank you for the opportunity of sharing these brief remarks. I look forward to discussing them further with you.

Sincerely,

Richard B. Warner, M.D.

Mr. STARK. Mr. Chairman.

Chairman RANGEL. I'll be brief. I just want to thank this panel. I want you to know the diversity of the interest in this subject matter and the fact that we are dealing with a discussion draft allows us to try to perfect some of the things we have. And as far as the Ryan Community Health Center and health centers around this country, whatever you do, I wish we could page it.

But, one of the things is that we recognize that doctors and nurses have to spend so much for their education and sometimes they can't do what their hearts and minds want done. They can't afford to practice the medicine; and so we are providing that in a larger group to let doctors do what doctors want to do. And, certainly we hope at the end of the day everybody can be on board.

Chip Kahn, you may remember when we met a couple of years ago, we knew it wasn't going to be easy. We knew it was going to be compromise and we still are working on that. And I heard your concerns about the public health options. This is what I don't understand. It appears to me that doctors have people coming in, dish

notwithstanding, that just can't afford the services that you provide.

It seems to me, even though it may be risky to say that if you can't get it, that's in that inveterate no-insurance, you've got to get some money; that some way or other somebody's got to pay for their care. It just doesn't go away. And so however it is, it would seem to me if I was running hospitals, I would say, is it true that the Congress is going to give insurance to 50 million people? Is it true that half of that number that under insurance will get decent policies?

Is it true that we can dedicate ourselves to health care and not check and see how much each and every patient has and how we have to spread this to people who are already paying high premiums? How does that opportunity to do what hospitals want to do without having been concerned with their budget? What has that got to do with the public health option people who would be uninsured that may end up in your hospital and they come in with an insurance policy in their hip pocket and say doctor, whatever you have to do we're prepared to pay?

Mr. KAHN. Let me say two things about that, Mr. Chairman.

On the one hand—and the bill does include insurance reform for the individual, individual market, and for those in some level of small group—you are going to create the health insurance exchanges. And you are going to call for in the health insurance exchanges a radical, which we support, change in the regulation of insurance. You are going to have guarantee issues. You are going to have guarantee renewability. You are going to have very limited preex. You are going to have whatever rate bands you have that are very narrow, and you are going to be watching those guys like a hawk. And it's going to change how insurance is offered to individuals, particularly. So we think that's a good thing.

Chairman RANGEL. Isn't that good? Isn't that terrific?

Mr. KAHN. We think it's a good thing, and what we want to do is see how that works. And from our standpoint, the public option we think on top of that would make it sort of too difficult. And let me make one other point which is we understand, and we can argue about what kind of crowd-out there's going to be. But at least in the individual market there are 15 million people that have coverage today that are individuals; and a lot of those people are going to come into the exchange, because they are going to be able to do it.

And, right now, they have coverage, probably have 2,500, 5,000 deductible; pay a lot for that. They're going to pay less in the exchange, but also, quite frankly the policies they have now pay hospitals a heck of a lot more than the private insurers are going to pay hospitals inside the exchange before you even add Medicare. And with all due respect, in the bill, all the public option would pay hospitals is Medicare. And, frankly, with the expansion of Medicaid, which we support but which would affect about 50 percent of the uninsured, you combine that with a public option that could be sizeable that adds more Medicare payment and does crowd-out some private business that we now get better payment for, it could cause us a problem.

So we would rather see the reforms take place in the insurance market; and, then, if it doesn't work, if you need to have this public option, you can always do it. Congress can always come in and do it in the future, but we think from the get-go it's something that ought to be avoided and that's why I took the position I did. But we want to be supportive and helpful of you as you develop the legislation and figure out a way to make it work.

Chairman RANGEL. Well, you came in on the ground floor. You gave your support and you gave your opposition; and that's what we're encouraging everyone to do. Give this historic opportunity a chance, and I just want to thank you, because you came in early on. You are pre-Obama.

Mr. KAHN. Thank you, Mr. Chairman.

Mr. CAMP. Well, thank you, Mr. Chairman.

Mr. Kahn, obviously, if hospitals get Medicare-rate payments that's going to be a problem. And the Lewin Group estimates that would be a $36 billion cut to hospitals. Is that in line with what you estimate?

Mr. KAHN. I've seen the Lewin numbers and I know there's a debate as to whether those, and I haven't seen the CBO numbers.

Mr. CAMP. Look. Look, let's not talk about numbers. Do you think your member hospitals could continue to provide the best quality care to their patients if they got paid Medicare rates?

Mr. KAHN. I believe that if we got paid Medicare rates only that would be a big problem for hospitals. I know we can get into a debate about MedPACs.

Mr. CAMP. But they couldn't provide the quality of care they are providing now. Is that your answer?

Mr. KAHN. I think if it was only a Medicare payment, but the problem is in the model in the bill, there's a big expansion of Medicaid, which is useful for the indigents who'll be covered, particularly the individual adults. But when they come to the hospital, we are going to get Medicaid rates. So we're not even talking about necessarily the Medicare side. We are expanding the Medicaid load.

Mr. CAMP. But both of them cause a problem in the ability to provide quality care. Let's talk about care instead of numbers.

Mr. KAHN. Yes, sir. And that's why I said we prefer to have a system in which at least from the get-go there's private insurance offered through the exchanges. That's our preference.

Mr. CAMP. And I thought I heard from your testimony that you feel the bill as drafted would undermine employer-provided insurance, because you mentioned about people moving into the public plan and the pressures that would put on providers.

Mr. KAHN. Now, what I said in my testimony regarding employers is.

Mr. CAMP. It was in answer to a question. It wasn't in your written testimony.

Mr. KAHN. Yes, at the end, I guess 4 or 5 years from now when all the employers could potentially become eligible for the exchange, we are concerned that the public option could grow. Obviously, that would be up to the individuals that were sent into the exchange by the employers, but we are concerned about that. Yes, I think there could be on the price.

Mr. CAMP. Okay. Thank you.

Dr. Warner, look. Medicare pays physicians less than commercial rates; Medicaid even less than that. You know, a government-run plan paying Medicare rates would draw people from a private plan into the government plan. And what impact would that have on doctors? We've heard about the impact on hospitals, but what would that do on physicians and their ability to practice and give patients access?

Dr. WARNER. I think it would have a deleterious effect, quite frankly. We know with Medicare today 97 percent of doctors "participate with Medicare," but what that really means is that 97 percent of doctors have signed an agreement of participation. It doesn't really tell you how many doctors are welcoming patients into their offices. And, I know, certainly anecdotally, I am hearing from patients the difficulty they are having getting appointments with doctors. Particularly if they haven't been established with a doctor, to be a brand new patient, is getting harder and harder.

If you spread that over a larger portion of the population, I don't even think it's a matter of whether you pay Medicare or Medicare plus 5 percent. The fact of the matter is you have a price-controlled arrangement, and price controls always, ultimately, lead to shortages. It has taken a long time to come to that with Medicare, but it has finally arrived, and it would arrive I believe with another similarly constructed program. That's why I suggest at the end of my comments the idea of allowing private contracting, which would allow a patient to use whatever benefit is available from the insurance. But also, contract with the physician for maybe nothing above that or something above it that is worked out by the patient and the physician and allows everybody much more freedom, and will probably result in many more doctors participating.

Mr. CAMP. All right. Thank you.

Mr. STARK. Thank you.

Dr. Warner, as I read your testimony I would be better off, if I had a high deductible plan or a health savings account, I would perhaps be more careful how I spent my medical care dollars if I did that. Is that your position?

Dr. WARNER. Yes, and I think you can generalize that from across the country.

Mr. STARK. Let me ask you this, then. In the Overland Park area, what does an echocardiogram cost?

Dr. WARNER. I couldn't tell you. I'm a psychiatrist.

Mr. STARK. All right. How about knee surgery? What's the average cost?

Dr. WARNER. It's expensive.

Mr. STARK. You don't know. Okay. How about just an E&M, 15-minute visit? Do you know what that costs in the Overland Park area?

Dr. WARNER. I couldn't tell you Congressman. I know my own fees.

Mr. STARK. Doctor, you just made the case. You are the expert and you don't know what this stuff costs. How in the hell would I know what it costs as a pedestrian if a physician practicing in the community has no concept of what these things cost? How do you expect the poor patient to be able to negotiate this without knowing the cost? It's just ridiculous.

It's a wonderful thing to suggest that I should be able to keep track of my own costs, but if a doctor doesn't know, how do you expect a patient who can't spell most of these things to know? It just doesn't make any sense. What you want to do is just kick these guys out and not let them get the services they need. I think that is just the most ridiculous thing. The health savings accounts and the rest of these things are tax avoidance schemes that do nothing to deliver medical care.

Chip.

Dr. WARNER. Do I get to answer that, Mr. Stark?

Mr. STARK. Well, you did answer it. You don't know what these things cost. How do you expect me to know?

Dr. WARNER. I did not get a chance to answer your comment.

Mr. STARK. Go ahead. How do you expect me to know if you don't know?

Dr. WARNER. You will know, if you live in a world in which patients actually are paying the price of medical.

Mr. STARK. Yeah, if they could get the price. But when the doctor doesn't know the price, how am I supposed to find it out, on the Internet?

Dr. WARNER. Well, we have certain antitrust rules that prevent knowing other doctors' charges for things. So, if I know it, I know it anecdotally.

Mr. STARK. You made your own case. You don't know the price of medical care and you expect your patients to know it.

Dr. WARNER. I expect under a condition in which patients are actually participating in the price, they would know it.

Mr. STARK. You don't actively participate in what you charge your patients? Come on!

Dr. WARNER. When patients call me, I tell them right up front. Do you want to know what you're getting into? I tell them my fee and I tell them the arrangements.

Mr. STARK. Doctor, you made your own case.

Chip, just one issue. On the historical perspective, people have been suggesting that we have a BRAC-type Medicare Payment Advisory Commission that would basically set prices; and, we would just have to react yes or no, which would leave us pretty much out of the loop in establishing these things. Do you have a concern about that?

Mr. KAHN. Well, I actually was working here on the staff when MedPAC was originally formed that's been discussed as the kind of entity that would have this kind of power. And I think MedPAC does great work in analysis in providing you advice and guidance, but I would be really reticent to sort of hand over to them something as important as setting payment rates. I'd say 60 or 70 percent of their ideas are great. But 30 or 40 percent of their ideas aren't. And they really need to be adjudicated both either in the Department through a Secretary going through the regulatory process or, I think, the Congress ought to be on top of this. And I think Congress has done a good job.

And, you know, I know a lot of people say well, gee, Congress can never act. But if you look over time, over the last 30 years of Medicare, whether it's DRGs, RBRVS, the Medicare Advantage program, there are plenty of times when Congress wanted to change

things that could come in and do it. So I feel that things ought to stick with the regular order in the old fashioned way, and you're obviously going to make a lot of changes in this bill. Obviously, there will be new secretarial powers through this bill, but I would be very reticent to hand off to some kind of health board or super MedPAC your responsibilities, frankly.

Mr. STARK. Thank you.

Sam, Mr. Johnson, would you like to inquire?

Mr. JOHNSON. Thank you, Mr. Stark.

I'd like to tell you that the specialists know what the costs of medicine are, and docs are quite private about their cost estimates. And they can tell you in a New York minute what the cost is, if you go to the right guy.

I think that was a bad line of questioning, frankly.

You know, it's unfortunate that the Democrat bill contains a provision which would gut doc-owned hospitals, and prevent these facilities from adding hospital beds or additional operating rooms, et cetera, and force hundreds of hospitals in this country that are currently under construction to close their doors.

Dr. Warner, as a physician, have you had any experience with physician-owned hospitals, and any thoughts about Federal regulation forcing them to shut their doors?

Dr. WARNER. Well, I think it's unfortunate if Federal regulation results in the shutting of the doors of such facilities. I think they've become an integral part of many communities.

Because of the investment of physicians in the facilities, you have extra care, I think, in the development of the standards and the programs of the hospitals. I can tell you that in the State of Kansas and in Wichita, the Sedgwick County, and Topeka, Shawnee County and the Metropolitan Kansas City area, of Wyandotte and Johnson Counties, we have programs in which specialists and facilities offer charitable care on referral from safety net clinics, and those facilities are operating fully in those programs, in some cases more than others, more than the community.

And so I think they're certainly shouldering their burden of charitable care as well as providing excellent care and competition.

Mr. JOHNSON. Thank you. They are in Dallas for sure.

You know, the White House has published a list of options that include more than $100 billion in cuts from hospitals, pushing physicians out of the program. I think the Chairman said that he anticipates $500 billion to come from providers.

So I'm guessing that the rest will come from new taxes of sorts. Soda maybe; cigarettes, you know, are taxed 61 cents to pay for children's health care.

And we need about 22 million new people to start smoking to pay for that expanded program. Makes me wonder how many Cokes Americans would have to start drinking to pay for trillions of dollars in health reform.

Dr. Warner, if Americans are drinking more soda and smoking more cigarettes, what's that going to do to the cost of health care in this country?

Dr. WARNER. Well, I mean, you're describing a spiral. But let me also say it's a reservation I've had. Whether we've talked about it in the State of Kansas or we talk about it at a Federal level of

using particularly cigarette taxes to support insurance payments, because we're looking to reduce the number of smoking at the same time that we're trying to draw revenue from that.

And what you do is you set up a situation in which you can't possibly raise the revenues that you intend to use to pay for your program; and therefore you have to start looking for other ways to raise that. And some of those, I think, will probably not be too pleasant.

Mr. JOHNSON. Thank you. Mr. Kahn, I think you would agree. I'm out of time, so I can't let you respond.

Thank you, Mr. Chairman.

Mr. STARK. Thank you.

I'm sorry, Mr. Levin, would you like to inquire?

Mr. LEVIN. Thank you.

I was going to ask Dr. Warner a question. So let me start with you, Chip, welcome. It's nice to see you again.

So you basically represent hospitals, right?

Mr. KAHN. Yes, sir.

Mr. LEVIN. You know, and I think the spirit with which you come is important and is constructive. And I think our questions relate to how you implement that spirit.

And by the way, I'm sorry Dr. Warner had to leave.

I just want to say that, maybe for the record—I'm sorry he had to leave—with third parties covering the largest part of medical expenses, people are insulated from the financial consequences of their health care purchasing decisions. And then it goes on to say it's profoundly inflationary.

I just urge everybody to talk to a family that has had illness in the family, of any extensive nature, and ask them what it means to say that the prices paid should be a matter of discussion and bargaining between the patient and the provider.

I think for a rather minor procedure, maybe that works. But for a chronic illness—even I mean, say knee surgery, we're going to have patients negotiating with providers about the cost of the knee surgery? It's hard enough to explain to patients what knee surgery is all about.

And I've met a number of people who have had knee surgery and they have trouble explaining the wonders that the physician performed.

So I find that so unrealistic, and Mr. Stark tried to get at that, and I just think it's worth repeating.

All right. So you represent hospitals. And you say in terms of the public, in terms of an option, "it does not disagree that an alternative could be beneficial," but then you kind of shy away from a public option, and you want some kind of a co-op, which I don't think most of us quite understand.

And then you talk about the price setting. For the hospitals you represent, who sets the payment that's received?

Mr. KAHN. Well, in terms of Medicare, it's set by regulation. Medicaid is a State-by-State basis, but it's basically set——

Mr. LEVIN. So the government——

Mr. KAHN. And then the private sector payment is negotiated in almost all cases.

Mr. LEVIN. And so for Medicare and Medicaid, we know it's government.

Mr. KAHN. Mm-hmm.

Mr. LEVIN. And my time's up. Except to ask you, tell us some day when you come to our offices about the negotiations that go on between hospitals and insurance carriers and how much true collective bargaining there is between the hospital and the instructed carrier as to the fee you receive.

Mr. KAHN. I actually can say that, I mean, most of my companies probably have, you know, 1,300 or 1,500 contracts per hospital. And I can say that there's a lot of give and take between the Blue Cross plans, between the large carriers, and the PPOs and the hospitals. I think if——

Mr. LEVIN. That's——

Mr. KAHN. If Bev Wallace was here, who works for one of the companies, she could, you know, make your hair stand on end in terms of the contentiousness of those deliberations.

Mr. LEVIN. Okay. We'll talk about that soon, but my time is up.

Mr. KAHN. Okay.

Mr. STARK. Mr. McDermott, would you like to inquire?

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Dr. Epperly, welcome. University of Washington is well represented here today.

Dr. EPPERLY. Thank you.

Mr. MCDERMOTT. You are a perfect example for us to get a response to a question I've had. Washington, Alaska, Montana, Idaho, and Wyoming are all covered by the University of Washington Medical School. They put students all over 27 percent of the United States land mass.

Those young people go out there and are trained in rural areas; but at the end of their training, not very many of them go back out to those places in Idaho and Montana and Wyoming. And I think it's largely because of debt.

So I made a recommendation that we would have a tuition-free at State medical schools in exchange for 4 years of service in primary care.

Now you've also had to do with the Uniformed Services, so you know you go to medical school, you have a requirement when you come out. What percentage of the University of Washington students would sign up for that kind of a tuition-free education and guarantee that they would serve 4 years in a designated area where they were underserved?

Dr. EPPERLY. Excellent question, Mr. McDermott.

I would say to you that hard to know for sure, but more than are now. Maybe 20–25 percent. You're exactly right. I chose the United States Army to pay for my medical school. Once I got accepted to the University of Washington, I served for 4 years, then it became a 21-year career for me.

I would have happily served back in my home State of Idaho if that had been offered to me as a scholarship.

So I very much support your thought in terms of if we can look at scholarships or loan repayment to try to create a workforce of primary care physicians, I think there's a lot of merit in that, and I think you'd have a lot of takers in that.

A lot of these kids from those areas are looking for something to help them, so that they don't end up choosing a sub-specialty as a default to their financial loans.

Mr. MCDERMOTT. Let me give you another element to that. One of the programs we have is the Health Service Corps. People go through medical school, accumulate $200,000 worth of debt, and say "Oh, my God, what can I do about it?" And they jump into the Health Service Corps.

I contend that you would be better off to get them up front, agreeing that that's what they were going to do, so that they would train to be a general practitioner, or whatever you want to call it, primary care servicer, and that it would also change the teaching in the medical school.

Dr. EPPERLY. Mm-hmm.

Mr. MCDERMOTT. That it would be directed at making them prepare to go out.

You've been involved in training programs and everything else, and I went to medical school like you did, where you were trained by specialists, who trained you in their little area. And I never saw any of that stuff when I got out.

So I'm looking at the ability—of better to have them up front make the commitment than at the end, when they're suddenly facing a huge debt.

Dr. EPPERLY. Excellent question. Totally agree with you. Scholarships on the front end will align the workforce better than a loan repayment on the back end.

If you can have people desire primary care on the front end and make that decision, it will hold them in place to do that.

On the back end, with loan repayment, they can drift off into all sorts of areas. You may not capture the workforce you're trying to create.

Mr. MCDERMOTT. What number of people stay in primary care, once they're trained?

Dr. EPPERLY. Once they're trained, meaning after residency? Or after medical school?

Mr. MCDERMOTT. Yes. After their residency, they go out into primary care. How many of them stay?

Dr. EPPERLY. In Family Medicine, almost all of them, 98–99 percent. And in Internal Medicine, however, 98 percent will sub-specialize. And in Pediatrics, 85 percent will sub-specialize into sub-specialty areas.

That's why we're facing such a crisis with primary care. We're not getting them to stay in General Medicine or General Pediatrics. Family Medicine, family physicians are staying in that area.

Mr. MCDERMOTT. And if we did those same scholarships for nurses and PA's?

Dr. EPPERLY. I think it's a great idea.

Mr. MCDERMOTT. Thank you.

Mr. STARK. Thank you.

Mr. Thompson, would you like to inquire?

Mr. THOMPSON. Yes, I would. Thank you, Mr. Chairman.

I want to just follow up on what Dr. McDermott had to say. It's tough in rural areas to recruit and retain providers. And I rep-

resent one of those areas. And in addition to recruiting and retaining them, we have an aging problem.

So 48 percent of the docs in my district are over 50 years old, 30 percent are over 60 years old. So it's a problem that's not getting better. And we need to be able to figure out how to solve that, or all of our efforts on health care reform are going to be for nought.

Dr. Baxter, you're from New York, and I don't know if you were here earlier, but my questions to all the panels have dealt with it in part: Telehealth. And telemedicine is something that's generally talked about in regard to rural health care.

But there's a lot of underserved areas in urban parts of the country, as well. And in your area, in your home State, would an expansion of telemedicine be helpful and help provide better care and bring the cost down?

Dr. BAXTER. Absolutely, Congressman. And in fact, the Ryan Center has a form of telemedicine, in terms of having x-rays done onsite at Ryan, such as ultrasounds, chest x-rays being read immediately, with our referral hospital, St. Luke's Roosevelt Hospital.

And well, of course, as you know, New York's a big State, and there are medically underserved areas, not only within New York City itself, but elsewhere.

So I think that this is definitely an area that needs development, and as much as it's practical in a large urban setting, we're also trying to do that.

In fact, we also for emergency preparedness have a relationship with specialty hospitals, say involving burns, so that if there were, God forbid, a major accident——

Mr. THOMPSON. Excellent point. They use it in my area for treatment of prisoners too, so you don't have to spend a lot of money with guards bringing prisoners——

Dr. BAXTER. Exactly——

Mr. THOMPSON. So a lot of different applications——

Dr. BAXTER. So for all sorts of applications, yes.

Mr. THOMPSON. Thank you.

Dr. Epperly, you're from Idaho, and certainly a State that falls into the rural category; but a big percentage of your health care is performed in metropolitan areas, so, sir, you would agree is underserved?

Dr. EPPERLY. Yes.

Mr. THOMPSON. Thank you.

Dr. EPPERLY. And in fact we've used tele——

Mr. THOMPSON. Just a yes was good. I've got just a little bit of time.

Dr. EPPERLY. Yes.

Mr. THOMPSON. I apologize.

Ms. Policastro, I want you to mention, I want to hear from you on the idea of dealing with the scope of practice laws. Because I don't think we cracked this nut of fixing the primary care problems, unless we change how we deliver health care. And if we can't somehow figure out how to make sure advanced-degree nurses and physicians' assistants factor into this somehow—and you referenced it in your opening testimony—we're never going to get there.

And any comment that you have I would appreciate.

Ms. POLICASTRO. All right. I agree with you. You know, our scope of practice is defined within our own State's nurse practice act. So every State has a different nurse practice act, which is regulated by the board of nursing. For nurse midwives, many nurse midwives in some States fall under the board of medicine.

So there's inconsistencies within the definitions and regulations of scope and practice per State. So we really need to put all those scopes back into alignment.

Scope of practice generally means that I do not practice as a nurse practitioner beyond what I'm qualified to do. And that's when I would collaborate with other health care professionals to assist my patient in treating and assessing their problem.

Mr. THOMPSON. Thank you very much.

Thank you, Mr. Chairman, for your indulgence.

Mr. STARK. Mr. Pascrell, would you like to inquire?

Mr. PASCRELL. Thank you, Mr. Chairman.

It's been a long day, Mr. Chairman, for all of us, and you would think our health system was in good shape, listening to the opponents of a public health plan. But when you look through all the data and statistics, I'm sure most of our panelists are a great panel—the person read that famous New Yorker article, chapter and verse, specifically the system that costs more, that doesn't necessarily translate into better care.

We ought to take—that should be like 101. And that is what has led to the work at Mayo Clinic and Cleveland clinics and other places throughout the United States. Thinking outside of the box I think is very, very, very important.

I think the system is upside down. What's up should be down and what's down should be up. And what we want to do is raise quality and reduce cost.

Mr. Kahn, I think there's some merit in what you suggest, that perhaps we're moving too quickly in trying to do all of this together, rather than maybe concentrating on the savings, the changes in procedure that were recommending efficiency in the system of delivery; and then making judgments about what we need to pay for and how we're going to pay for it later on, with this experience.

And the draft—the legislation doesn't go into effect, as you know, until 2013.

So I might agree to some degree on those things; but I definitely disagree with you on some of the points. I just had a point and a question to ask you, if you will.

You say it is non-negotiable, as you know, that the effort must be fully paid for, whatever we do here. We made that commitment, the President's made that commitment. I would hope all of us would be on the same page about fully funding for what we do, unlike what happened for the last 8 years, when we paid for nothing. Really.

Mr. KAHN. Mm-hmm.

Mr. PASCRELL. So we cannot make claims of addressing the impact that health care has on our economy by passing legislation that is fiscally irresponsible. I think we are committed to that, all of us.

Some on the panels have pointed out that any pricetag should be considered in the context of the whole economy in overall health care spending, since they're so integrally connected. I think the President has done a fantastic job in relating the cost of health care to the overall economy. Pretty soon, one-fifth of every dollar will be health care.

I agree with that approach. But unfortunately that means that we have to make some very tough decisions to pay for this package, whatever it winds up to be. And some folks are going to feel some initial pain.

Several of the panel members have throughout the day understandably voiced concern about payment policies that affect their respective industry. And I can understand that. I can appreciate that.

But in the absence of the savings options that you have expressed some concern about—I'm almost finished with the question—I invite you to present to the Committee what specific alternative Medicare savings options that the CBO will score as savings. What are your alternatives to present to us that the CBO would score as a savings that we could put into that column?

Mr. Kahn.

Mr. KAHN. Let me say first that the hospital community—not just the ones I represent—understand that there has to be a great deal of delivery reform, and we're very supportive of that. The delivery reforms in the short run are not going to pay for this bill, and we understand the bill has to be paid for.

And we understand that the Medicare payment is one potential area for coming up with some funding for this bill, frankly. And with all due respect, I understand that, we're ready to work with the Committee, and obviously we need a fair situation.

But I'll just be blunt with you. I can't sit here and negotiate with myself. I think it's really up to the Committee, as you did in the draft, to offer some Medicare policy and then hopefully offer us an opportunity to work with you.

And what I said in my testimony was, what we asked for, one, is sort of fairness in terms of how these requests are made; and two, that you at least consider that if there are reductions made in payment, that those be calibrated over time with the increases in coverage, because hopefully as more and more Americans are covered, hopefully most of them won't go to the hospital, but some will, and we're ready to provide services for them. And that will increase revenues to hospitals.

Mr. PASCRELL. With all due respect——

Mr. KAHN. So I'm looking for a balancing in terms of that——

Mr. PASCRELL. I understand that. And what you say makes sense. But the Chairman has gone out of his way since we started this process many weeks ago to make sure nothing is off the table when we get to that part of the legislation. We are not—as far as I know, nothing's been taken off the table.

So I don't think we should exclude anything or be afraid to include anything at this particular time. And I think he's made it very, very clear. I support that situation, and it's not written in stone.

Mr. STARK. Thank you.

Mr. PASCRELL. Thank you, Mr. Chairman.

Mr. STARK. You bet.

Mr. Blumenauer, would you like to inquire?

Mr. BLUMENAUER. Thank you, Mr. Chairman.

Ms. Policastro, I appreciate your support and focus, your testimony and the need for a public option. But I wondered if you would be willing from the perspective of your experience or that of your organization, to elaborate on the potential problems of some of the compromises that are being floated about co-ops or public options that might be sort of a locally based public insurance plan, as opposed to a national uniform option, as envisioned in this legislation?

Ms. POLICASTRO. Yes. The American Nurses Association is not in favor of co-ops. We are in favor of—for a better phrase—pure public option to deliver health care.

We believe that co-ops equal volume versus quality. We have seen historically that some co-ops, because of the way they're governed, are governed by the community in which they serve and the patients which they serve, but there have been barriers in the governance issues between the physicians who deliver the services and the patients who are members of those co-ops.

So historically, I can tell you in Rhode Island, for example, many years ago, there was a group called the Rhode Island Health Association that is no longer in the State because it just didn't work.

And the American Nurses Association believes purely in the public option. We believe wholeheartedly, we believe that the public plan will bring needed competition to the market, and that comparative effective research helps doctors and nurses make decisions about treatment in medical homes who encourage primary care.

So we stand tall that we're against the co-op model.

Mr. BLUMENAUER. Thank you. I missed the exchange. I had a previous speaking engagement. But I would like to, Mr. Chairman, enter into the record an article about Oregon's experience with it's last physician-owned hospital calling 911 for assistance before it closed, if you wouldn't mind.

Mr. STARK. Without objection.

Mr. BLUMENAUER. Thank you.

I would conclude on one last point. One of the areas that we've been working on, that there is bipartisan support, deals with end-of-life treatment.

It's appalling that Medicare will pay for all sorts of procedures, test tubes, and needles; but we haven't figured out a way to reimburse a physician to sit down with a patient and the family at the most difficult time.

A physician, it could be a nurse practitioner. But somebody in the medical arena to help people understand their choices, what they're facing, give them a sense of working through what the path is. We've got language, and I appreciate the Chairman and the staff working with us to incorporate some of what we've got in legislation.

But I wondered if any of you have some thoughts about that advisability and the long-term consequences of meeting the needs of families in this condition?

Dr. EPPERLY. Yes, sir. I would speak to that.

It's such a valuable and important time in a person's life. As a family doctor, I deliver babies, I take care of people at the end of life. And both of those are incredibly important moments. And I would say to you the value of primary care in the patient-centered medical home is having that relationship with that individual and his or her family, so that you can make appropriate choices that meet the family's and the patient's need where they're at.

There can be a lot of dignity and quality in those moments. There can be a ton of costs savings in those moments. I think that's all about the relationship with the patient, through that patient-centered medical home, to make those kind of decisions. That's what a return to primary care can do to the health care system. That's why it's important and it's foundational.

Mr. BLUMENAUER. Thank you.

Mr. STARK. Thank you.

Mr. BLUMENAUER. I would just—may I ask one question that they submit later?

Mr. STARK. Sure.

Mr. BLUMENAUER. I won't ask for an answer, Mr. Chairman, now, but we have been working on legislation for a transitional benefit. There's a lot of talk about readmissions and there may be penalties here or something there.

We think one of the ways to do that would be to provide a transitional benefit to be able to work with the patient. We would ask you to look at—there's a little bit in the language of the bill I think that needs to be strengthened. And any of you that have some reflections on that would be deeply appreciated in the days ahead, so that we're doing the right thing there.

Thank you very much for your patience.

Mr. STARK. Mr. Meek, would you like to inquire?

Mr. MEEK. Yes, sir. Thank you, Mr. Chairman.

Mr. STARK. Thank you.

Mr. MEEK. I'd like to thank the panel for your testimony today. And you know, being from a State like Florida, we have just under 19 million people, some 4 million of those individuals are uninsured.

We also have a population, 18 percent of Medicare beneficiaries that are duly ineligible, that would usually be ineligible for Medicaid or Medicare.

And we know that there will be some folks falling through the cracks, even with the proposal that we have on the table now. I know that a lot of folks have been—and I've been listening to your testimony and also I've read some of your testimony—very concerned about what we're doing in light of reform.

In a State like Florida that—talking about the 4 million citizens that are uninsured, and that's 9 percent of the Nation's uninsured population—I want to try to address especially States like mine that have a number of undocumented individuals that are there, that are running up costs as relates to our emergency rooms and other critical care facilities, not only around in our State, but throughout the country. How do you think we can best address these issues of the uninsured and the ineligible? How do we bring them under this tent that we're trying to put them under?

Mr. KAHN. Mr. Meek, I'd like to say two things.

One, I think that the tri-committee draft does preserve the disproportionate share payments under Medicare and Medicaid with a study to see what the interaction will be between that and reform. And clearly the undocumented aliens are going to fall through the cracks here. I assume they're not going to be involved in whatever reform is done.

So that's particularly important for hospitals, because generally they end up at the hospital if they need health care, and most of that payment goes to hospitals. So that's critically important.

Second, I think matched with the individual responsibility mandate that you have in the bill, and the subsidies and the expansions in Medicaid, it is really critical for hospitals that there be automatic enrollment, that when someone comes into the emergency room or enters into the hospital, and in the new world, once the reform goes into effect, and is not covered, that we have the ability to very seamlessly sign them up and get them covered there, so that one, if they have to pay something, they may have to meet their responsibilities for the coverage; but at least then they've got the coverage and they can carry that coverage forward, and we can provide the services in a way that always goes better when people have coverage.

Mr. MEEK. Would it be fair to say even when you—and just real quickly to your question, and I appreciate it—would it be fair to say in some of these areas where we have the small and large counties, especially agricultural counties—in the State of Florida we have a tourism industry—we will have some individuals that will walk into the emergency room for care, that are going to be in the middle of—maybe be the wrench within the machinery——

Mr. KAHN. Right——

Mr. MEEK. To allow us to have this smooth transition that we would like to deal with. I didn't know if there were any add-ons or concerns. I know we want to study it. But I think there's a lot of documentation out there as it relates to that population, cost that hospitals cannot do anything there——

Mr. KAHN. I——

Mr. MEEK. Yes, sir——

Mr. KAHN. I think if you reduce the uncompensated care, which you will through all the new people that are covered——

Mr. MEEK. Mm-hmm——

Mr. KAHN. And you maintain the level of the disproportionate share payments, or maintain them at a high level, I think you'll solve that problem. I think then there will be a buffer for the hospitals, for these people that fall through the cracks, and at the same time, there will be many more people in the hospital now who are insured, either through Medicaid because of new eligibility rules, or hopefully most of them through coverage through the bill.

Mr. MEEK. I'm sorry, can Dr. Baxter, just very quickly, Mr. Chairman?

Mr. STARK. Go ahead.

Mr. MEEK. I'm sorry——

Mr. STARK. Dr. Baxter.

Dr. BAXTER. Yes. I think the goal, of course, is to keep undocumented immigrants from having to come to the hospital for very expensive care that could have been prevented if primary preven-

tive care had been provided. And that's one area where community health centers, I think excel.

We, of course, do not at the Ryan Center ask for any proof of citizenship. But it would be disingenuous of me to say that I really don't know whether or not we have undocumented immigrants.

And I think part of the goal is to have a friendly, welcoming, safe place that mothers can bring their children in for vaccinations, people can come in for treatment of their diabetes.

And so again, I think of course the role of my colleagues in the hospital system is important. But I'm sure that the Committee agrees that let's try to head them off at the pass, so to speak, before they really require hospital care.

Mr. MEEK. Okay. Thank you. I'm over my time. I'm sorry. Thank you, Mr. Chairman.

Mr. STARK. Thank you. And I would like to again thank the panel for their patience, their indulgence, and their guidance. We'll be talking to you, I'm sure, as we proceed the next week or two.

And the Committee is adjourned.

[Whereupon at 7:08 p.m. the hearing was adjourned.]

[Submissions for the Record follow:]

Statement of Nancy G. Brinker

Testimony Highlights

- The Susan G. Komen for the Cure Advocacy Alliance appreciates the Committee's focus on prevention, early detection and chronic disease management, as well as the goal of access to affordable, high-quality health coverage for all, including those with preexisting conditions.
- There are two key access issues we recommend adding to the draft legislation: extending access to **patient navigation** services to help guide patients through the complex health care system, and ensuring access to **clinical trials**.
- As the House of Representatives finalizes legislation to reform the Nation's health care system, Members are asked to consider the unique needs of persons who are fighting or who have faced a disease like cancer, because they encounter the most challenging obstacles in the current U.S. health care system.

Introduction

Mr. Chairman, Ranking Member and Members of the Committee, the Susan G. Komen for the Cure® Advocacy Alliance appreciates your attention to prevention, early detection and chronic disease management in the health care reform draft proposal released earlier this month. We support your goal of ensuring access to affordable, high-quality health care for all Americans, including people who are currently deemed uninsurable because they have a preexisting condition like cancer.

Komen Advocacy Alliance's Principles for Health Reform

The Komen Advocacy Alliance is the nonpartisan voice for more than 2.5 million breast cancer survivors and the people who love them. Our mission is to translate the Komen promise to end breast cancer forever into action at all levels of government to discover and deliver the cures. Cancer patients and survivors have some of the most challenging experiences with the health care system at a time in their lives when they are most vulnerable. Thus, the Susan G. Komen for the Cure® Advocacy Alliance believes that health reform must:

- Increase investment in Federal and State programs for underserved patients.
- Protect cancer patients from excessive out-of-pocket costs.
- Ensure access to affordable, high-quality insurance for all, including those with preexisting conditions.
- Enhance quality and value by focusing on prevention, wellness, and chronic disease management.
- Address the shortage of cancer care specialists.

Additional Issues to be Considered

The health care reform draft proposal addresses many of these priorities. However, there are two additional issues that should be included in the bill: Extending access to patient navigation services to help guide patients through the complex health care system, and ensuring access to clinical trials.

Patient Navigation Services: We recommend that the Committee reauthorize and fully fund the Patient Navigator Outreach and Chronic Disease Prevention Act of 2005 (P.L. 109–18) for 5 years, FY2011 through FY2015. Current authorization expires at the end of FY2010. Komen recommends enhancement of the original Act by adding minimum core proficiency standards for patient navigators.

- Navigating the complex health care system can be an insurmountable task for patients facing a complicated or chronic disease, especially if they are underserved, have a lower level of medical literacy, or do not speak or read English well. Patient navigators are trained to serve as personal guides and help people overcome obstacles to receiving timely cancer treatment and care. This includes obtaining financial resources, tracking appointments and coordinating transportation.
- Patient navigation is a proven concept that is cost-effective, promotes prevention, saves lives, and addresses health disparities.
- Minimum core proficiency standards are vital because effective patient navigators should be culturally competent, good communicators, compassionate, and experts at navigating the health care system.
- The program should be fully funded; between FY2006 and the current FY2009, the Patient Navigator Act received only about $2.4 million (in FY2008) of the $25 million that was originally authorized.
- There is significant support for the Patient Navigator program in the cancer community, and it is widely applicable to other chronic diseases.

Access to Clinical Trials: Part of ensuring access to cancer care includes access to clinical trials. Barriers to clinical trials must be removed for all patients—including cancer patients—without regard to the type of health insurance plan or health status. This can be accomplished by (1) a codification in law of Medicare's current reimbursement policy for routine expenses for patients in approved clinical trials, and (2) making needed changes to ERISA, the Public Health Service Act and the Internal Revenue Code to accomplish the same policy for private insurance plans.

- Each year, thousands of people gain access to the highest-quality cancer care and receive new treatments before they are widely available by participating in a clinical trial. Millions more benefit from the findings. Yet, while more than 1.4 million Americans are diagnosed with cancer each year, fewer than 5 percent will participate in an approved clinical trial.
- Some health insurance companies do not cover routine medical care expenses for patients enrolled in approved clinical trials, or refuse to cover complications that sometimes occur during the course of an approved clinical trial. Failure to cover these items may mean otherwise eligible people are turned away, or are exposed to high out-of-pocket costs when they encounter complications.
- These issues could be addressed by including language from the "Access to Cancer Clinical Trials Act" (S. 488) by Senator Sherrod Brown (D–OH).

Attached to this testimony are more detailed comments on the health reform draft proposal, including the importance of patient navigation and clinical trials, as well as the need for a continued focus on prevention, wellness, chronic disease management and access to care for underserved populations.

Susan G. Komen for the Cure Advocacy Alliance
Comments on the Health Reform Draft Proposal

Committee on Ways and Means, U.S. House of Representatives

As your Committee continues deliberations on reforms to the Nation's health care system, we urge you to consider the unique needs and challenges of people with preexisting conditions like cancer. Cancer patients and survivors have some of the most challenging experiences with the health care system at a time in their lives when they are most vulnerable. Thus, the Susan G. Komen for the Cure® Advocacy Alliance calls on your Committee to:

- Increase the investment in Federal and State programs that provide cancer screening, treatment and patient navigation services for underserved populations.
- Protect cancer patients who have health insurance from excessive out-of-pocket costs that may lead to severe financial hardship and even bankruptcy.

- Ensure access to affordable, high-quality health insurance for all, including people with "preexisting" conditions like cancer—so everyone can continue to have health insurance, even if they lose or change jobs.
- Enhance the quality and value of health care by focusing on prevention, wellness and chronic disease management.
- Address the chronic shortage of cancer care specialists, particularly in underserved areas.

1. Increase the investment in Federal and State programs that provide cancer screening, treatment and patient navigation services for underserved populations.

PROBLEM: Almost 46 million Americans lack health insurance.[1] Without reforms, the number is projected to climb another 7 million or more by 2010, due in part to rising health costs and high unemployment.[2] Lack of adequate health insurance has a decidedly negative effect on cancer screening rates, as well as the stage at diagnosis and a person's chances of survival:[3]

- Patients with private insurance are more likely to be diagnosed at earlier stages, and are more likely to survive at all stages of diagnosis than the uninsured.
- Cancer patients who are uninsured—and those who were Medicaid-insured at time of diagnosis—are 60 percent more likely to die in 5 years than those with private insurance.
- In addition, disparities in cancer incidence and mortality rates must be addressed. For example, those with lower socio-economic status and people in underserved areas are more likely to be diagnosed and are more likely to die from cancer.[4]

As the ranks of the uninsured swell, demand grows for public health programs, including programs that provide cancer screening and cancer care services. Unfortunately, Federal and State safety net programs are dramatically underfunded, leaving huge gaps for the neediest Americans. For example:

- The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) provides potentially life-saving cancer outreach, case management, and screening to low-income, uninsured and underinsured women. Yet, the program is so underfunded it is only able to reach less than one in five eligible women.[5] The program is increasingly forced to turn women away or establish waiting lists for these vital services.
- All States allow underserved women to access Medicaid for breast or cervical cancer treatment if they are uninsured, need treatment for breast and cervical cancer, and meet other eligibility criteria. However, 20 States only allow this access to Medicaid if the woman's screening is funded by the State or tribal screening program—a large concern given the dramatic underfunding of those programs.[6]
- Navigating the complex health care system can be an insurmountable task for many patients facing a complicated or chronic disease, especially when they are underserved, have a lower level of medical literacy, or do not speak or read English well. To address this, Congress passed the Patient Navigation Act, a pilot grant program to provide patient navigation services to those in need. Unfortunately, the Patient Navigation Act has received only a small portion of the $25 million that was originally authorized.

SOLUTIONS: As Congress overhauls the health care system, it must close the gaps plaguing Federal and State safety net programs that provide vital cancer screening, treatment and patient navigation services for our Nation's underserved populations.

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[1] U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2007," August 2008. Available online: http://www.census.gov/prod/2008pubs/p60-235.pdf.

[2] Todd Gilmer and Richard Kronick, "Hard Times And Health Insurance: How Many Americans Will Be Uninsured by 2010?," Health Affairs, Web Exclusive, w573–577, May 28, 2009.

[3] Elizabeth Ward, et al., "Association of Insurance with Cancer Care Utilization and Outcomes," CA: A Cancer Journal for Clinicians, Vol. 58, No. 1, January/February 2008, p. 9–31.

[4] American Cancer Society, "Cancer Facts & Figures 2009."

[5] See the Center for Disease Control's website for the National Breast and Cervical Cancer Early Detection Program. Available online at: http://www.cdc.gov/cancer/NBCCEDP/.

[6] Tally of States based on M&R Strategic Services, "Treatment Act Survey: Final Report," February 16, 2007, updated based on the experience of Susan G. Komen for the Cure Advocacy Alliance. The Treatment Act is the subject of a forthcoming report by the Government Accountability Office, which Komen helped initiate.

2. Protect cancer patients who have health insurance from excessive out-of-pocket costs that may lead to severe financial hardship and even bankruptcy.

PROBLEM: Having health insurance does not necessarily protect a person from financial harm in the event of a health event like a cancer diagnosis:

- A recent survey of employer-sponsored health insurance plans shows employees' out-of-pocket spending grew more than a third between 2004 and 2007, while wages remained stagnant.[7]
- The exposure to high costs can be disastrous. A recent study by Harvard University found that half of all bankruptcy filings were partly the result of medical expenses, and 68 percent of those who filed for bankruptcy had health insurance.[8]
- A national survey commissioned by the American Cancer Society Cancer Action Network shows one in five cancer patients has significantly or completely depleted their savings because of medical costs—one in seven has incurred thousands of dollars in medical debt.[9]

Many health insurance policies have annual and lifetime caps on benefits or other limitations and exclusions. Patients may be exposed to large out-of-pocket expenditures because cancer treatments can be very expensive—some therapies run hundreds of thousands of dollars a year and may require extensive and long-term monitoring and followup.

SOLUTIONS: Congress should protect patients from high out-of-pocket costs by reducing or eliminating annual or lifetime limits on the benefits, and possibly by establishing an annual maximum limit on out-of-pocket medical expenditures.

3. Ensure access to affordable, high-quality health insurance for all, including people with "preexisting" conditions like cancer—so everyone can continue to have health insurance, even if they lose or change jobs.

PROBLEMS: For the 161 million Americans with employer-provided health insurance, a change in employment also likely means a new health insurance company with different benefits and network providers. But persons with preexisting conditions like cancer may run into challenges:[10]

- Cancer patients and survivors with employer-provided health insurance may lose jobs, change jobs, or have to cut back hours or leave a job during treatment—and lose their group health insurance.
- As a result, cancer patients or survivors may experience "job lock," in which they cannot leave their current job for fear of losing their health insurance. This runs counter to the trend of today's mobile workforce, in which people frequently move from job to job in pursuit of new opportunities.
- Even cancer survivors who have been in remission for years with a good long-term prognosis have trouble finding coverage in the individual market because of medical underwriting and the existence of their preexisting condition.

Clinical Trials: Part of ensuring access to cancer care includes access to clinical trials.

- Each year, thousands of people gain access to the highest-quality cancer care and receive new treatments before they are widely available by participating in a clinical trial. Millions more benefit from the findings. Yet, while more than 1.4 million Americans are diagnosed with cancer each year, fewer than 5 percent will participate in an approved clinical trial.[11]
- Some health insurance companies do not cover routine medical care expenses for patients enrolled in approved clinical trials—or refuse to cover extra scans, doctor visits and drugs to address complications that occur during the course of an approved clinical trial.

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[7] John Gabel, et al., "Trends In Underinsurance And The Affordability of Employer Coverage, 2004–2007, *Health Affairs Web Exclusive*, w595, June 2, 2009.

[8] Himmelstein, et al., "Illness and Injury as Contributors to Bankruptcy," *Health Affairs Web Exclusive*, w563, Febrary 2, 2005.

[9] Lake Research Partners and American Viewport conducted the survey, which was sponsored by the American Cancer Society Cancer Action Network, May 1 through 11, 2009, among a national sample of 1,057 adults age 18 and older, in households with cancer or a history of cancer. Available online: http://www.acscan.org/pdf/healthcare/reports/poll-05202009.pdf.

[10] Karen Schwartz, et al., "Spending to Survive: Cancer Patients Confront Holes in the Health Insurance System," Kaiser Family Foundation and the American Cancer Society, February 2009. Also see the Lake Research Partners and American Viewport survey.

[11] American Cancer Society.

SOLUTIONS: Congress should require health insurance companies to provide coverage to all, with no preexisting condition limitations. In addition, barriers to clinical trials must be removed for all patients—including cancer patients—without regard to the type of health insurance plan. This can be accomplished by (1) a codification in law of Medicare's current reimbursement policy for routine expenses for patients in approved clinical trials, and (2) making needed changes to ERISA, the Public Health Service Act and the Internal Revenue Code to accomplish the same policy for private insurance plans. The issues related to clinical trials could be addressed by including language from the "Access to Cancer Clinical Trials Act" (S. 488) by Senator Sherrod Brown (D–OH).

4. Enhance the quality and value of health care by focusing on prevention, wellness and chronic disease management.

PROBLEM: The U.S. health care system often focuses too much attention on treating people once they become sick, and not enough attention on keeping people healthy or detecting chronic diseases like cancer early, when there are more treatment options and the chances of survival are often greater.

Prevention, Early Detection & Wellness: Prevention saves lives. Applying proven tobacco control strategies could eliminate a third of all cancer deaths.[12] Cancers related to obesity, physical inactivity and poor nutrition could also be prevented. And many of the more than 1 million skin cancers that are expected to be diagnosed in 2009 could be prevented by protection from the sun's rays and avoiding indoor tanning.

For other cancers, early detection is the key to survival. Regular screenings can detect cancers of the cervix, colon and rectum by detecting precancerous growths that can be removed, and can detect breast, colon, rectum, cervix, prostate, oral and skin cancers at early stages when they are most treatable.

- For breast cancer, the 5-year relative survival rate is 98 percent when breast cancer is detected at an early stage, 84 percent for regional disease and 27 percent for distant-stage disease.[13]
- Yet, for women who are uninsured and underinsured, cost is a significant barrier to getting preventative care—only 67 percent of underinsured women over the age of 50 received a mammogram in the past 2 years, compared with 85 percent of adequately insured women.[14]
- For women with health insurance or Medicare, even a relatively small copayment can significantly reduce mammography rates, particularly for underserved populations.[15]

Clinical Effectiveness: Komen supports the use of clinical effectiveness research (CER), which will arm patients and their doctors with the best available information on effectiveness and safety of drugs, devices and diagnostic tests. To that end, a comprehensive national comparative effectiveness research program should better identify the most effective health care options, and ensure information gained through CER is incorporated into clinical practice to better inform decisions made among patients, their health care providers and payers. A CER program should also link data from public and private entities to build upon existing data collection and research capabilities and support the development of "personalized" or stratified medicine.

Coordination of Care and Survivorship Care Planning: A key aspect of chronic disease management is the coordination of care. To that end, cancer patients should have a coordinated plan for treatment and followup from the time they are diagnosed through the years of their survivorship. With a written cancer plan and the opportunity to review it in person with their doctor, cancer patients will better understand the process ahead, monitor their health, and participate in decisions about their care. And a written plan will help coordinate care among a patient's many doctors and providers, reduce medical errors, and ultimately improve patient care.

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[12] American Cancer Society.

[13] American Cancer Society, *Breast Cancer Facts & Figures 2007–2008*, Atlanta: American Cancer Society, Inc. (Available online at http://www. cancer.org/downloads/STT/BCFF-Final.pdf).

[14] Sheila Rustgi, et al., "Women at Risk: Why Many Women are Forgoing Needed Health Care," The Commonwealth Fund, Issue Brief, May 2009. (Available online: http://www.commonwealthfund.org/content/publications/issue-briefs/2009/may/women-at-risk.aspx.)

[15] Amal N. Trivedi, et al., "Effect of Cost Sharing on Screening Mammography in Medicare Health Plans," *The New England Journal of Medicine*, Vol. 358, January 24, 2008, pp. 375–383. (Available online: http://content.nejm.org/cgi/content/full/358/4/375). The study examined 174 Medicare managed-care plans from 2001 through 2004, which included 550,082 individual-level observations for 366,475 women between the ages of 65 and 69 years.

SOLUTIONS: Congress should reduce or eliminate copayments or deductibles for preventative services like diagnostic imaging and screening, and should provide incentives for providers to focus on prevention, wellness and chronic disease management.

5. Address the chronic shortage of cancer care specialists, particularly in underserved areas.

PROBLEM: There is a shortage of cancer care specialists, particularly in underserved areas. This shortage will only intensify as the population ages, which will bring along with it a significant increase in the number of cancer cases each year. Congress clearly recognizes this is an issue. The economic stimulus package passed earlier this year included billions for community health centers, training for the health care workforce and an investment in health information technology.

The promotion of a robust health information technology network could also help alleviate the shortage of cancer care experts, particularly in rural areas. Electronic medical records will ultimately improve health care quality for cancer patients by improving coordination of care. And it also allows for second opinions and reviews of patient records from anywhere in the world.

SOLUTIONS: Congress should include provisions to strengthen the health care workforce by forgiving student loans, providing grants to increase faculty in nursing programs, providing financial incentives to encourage health care professionals to practice in underserved areas, and investing in health information technology. Congress should also encourage partnerships between community hospitals and large cancer centers.[16]

Statement of Albert B. (Al) Baca

The intent of this paper is to explain why our Nation needs a "Single Payer" system to pay for medical care. It is my hope that Sen. Brown will see fit to discuss the points documented in this paper with people whom he talks with.

I would also deeply appreciate it if Sen. Brown's staffers in Washington can speak to the Senate Finance Committee staffers about the contents of this paper. Since the Obama Administration desires to push health care reform in this Congress, such a discussion with Senate Finance Committee staffers would be timely and pertinent.

This medical horror story is about my 44-year-old daughter, Vivian A. (Vandy) Baca, who is almost completely disabled, cannot walk nor stand, draws SSDI, has Medicare and lives at home under the auspices of the State of Ohio Medicaid Home Health Care Waiver Program.

Let me tell you about myself. I am a retired civilian employee of the Air Force. The past 4 years have been very hard on me because of the way that medical care is done in this country. To quote from two radio programs I used to listen to when I was a young kid: "Taint funny McGee" and "What a revolting development this is."

For people outside of the Dayton, OH area who may not know, in 2005, there was a gigantic squabble between Anthem Blue Cross and Blue Shield (BC/BS) and Premier Health Partners—*i.e.* Miami Valley Hospital, Good Samaritan Hospital, and the doctor groups directly associated with each hospital—concerning Anthem BC/BS payment of fees to Premier Health Partners for services rendered.

The bickering lasted for all except 1 week of 2005. During that time many people in the Dayton, OH area suffered. One of those who suffered was my daughter, Vandy. The unfortunate thing is that Vandy is still suffering and she will continue to suffer for a long, long time. She may never quit suffering and return to normal.

There is no doubt in my mind that the year-long squabble between Anthem BC/BS and Premier Health Partners was the direct cause of the medical horror story I am going to tell you. The story is not for the squeamish.

Before I begin my story, I would like to state that because my wife and I are senior citizens, we both have Medicare as our primary medical coverage. I am a retired Federal employee and have BC/BS as my FEHBP insurance which is secondary to Medicare. Therefore, the Premier Health Partner and Anthem BC/BS squabble did not impact us because our FEHBP BC/BS was secondary. My wife and I were lucky. Vandy wasn't.

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[16] Congress could consider building on the NCI's Community Cancer Centers Program, which is a pilot program to provide private medical surgical and radiation oncologists with close links to NCI research and the network of 63 NCI-designated Cancer Centers principally based at large universities. http://ncccp.cancer.gov/.

For those people who are not from the Dayton, OH area, I found something on the Internet that summarizes the Premier Health Partners and Anthem BC/BS squabble for you in a very few words:

Source: Redorbit.com
Posted: Wednesday, 4 January 2006
Title: Premier, Anthem Fight Hurt:

- Premier Health Partners and Anthem Blue Cross and Blue Shield had to settle at some point. They need each other too much.
- Three days before Christmas, the area's largest hospital group and the popular insurer decided that it was time, that a year was long enough to shoot at each other and even at their own feet.

Apparently, each side insisted on shooting itself in the foot for a solid year to prove a point. Was that ridiculous? Yes. Would that have happened under "Single Payer"? No.

Back to the story. In April 2005, Vandy had pneumonia and anemia which required her to be hospitalized. Because of the Premier Health Partners and Anthem BC/BS squabble, Vandy had to go to a hospital other than Good Samaritan Hospital which is close to her doctor's office and which has always been her hospital of choice. While a patient in the other hospital, Vandy contracted a staphylococcal infection (MRSA) which developed into encephalopathy or inflammation of the brain. Vandy spent several weeks in intensive care at the other hospital before being transferred to a nursing home where she was a resident for almost 2 years.

When Vandy arrived at the nursing home, she was in such terrible shape that the other residents and the staff thought she would never survive. But Vandy is a fighter and she did survive. She made progress, too. I would go to the nursing home every day to play memory games such as "name the capitals of the States" with her. Luckily, her mental faculties did come all the way back. However, she didn't get to walk out of the nursing home as she desperately wanted to do. In fact, she still can not walk. Nor can she stand.

If Vandy would not have had to go to the other hospital because of the squabble between Anthem BC/BS and Premier Health Partners, she would not have caught the particular MRSA infection which disabled her. However, I will concede that Vandy might also have caught a staph infection at Good Sam. After all, a hospital is not the best place to be when you are sick.

Wait. There is much, much more to this horror story and why I am so thoroughly disgusted with the way that we, the American people, have let the big insurance companies dictate medical care to us. And as you will see in a few moments, I am equally as disgusted with the way that the U.S. Government, especially the Social Security Administration, has let them.

I have fought bureaucratic battle after bureaucratic battle with the Social Security Administration on behalf of my daughter. Because of that I have become somewhat of an expert on Social Security and Medicare. If I had the energy that I had 25 or 30 years ago, I would offer free advice to people on how to fight Social Security.

I will now delve into the silliness regarding what Vandy has to pay for her prescription medications. I will begin by telling you that Vandy is dual eligible for the Medicare and Medicaid low-income subsidies. Please remember her dual eligibilities as you read the rest of the story.

Vandy's husband, Stanley Styles, has worked at Wright State University as a floor custodian for many years. Stan has carried a BC/BS "FAMILY" plan as his group health insurance during all that time. (Please note that the word "FAMILY" is emphasized.) He also carries the WSU group dental plan and the WSU group vision plan.

In November 2008, Vandy was notified by the Social Security Administration that Stan's BC/BS group health plan's copays rather than her Medicare Part D carrier's copays would have to apply when she ordered her prescription medications. The law is explicit that because her husband's employer, Wright State University, has more than 100 employees, the WSU BC/BS group health plan copays have to apply rather than the Medicare Part D copays.

My question to that is why can't the law be changed? The answer to that is that would be too easy and would make too much sense. Further, why does the law have to assume that larger employers have better health plans for their employees than smaller employers? That is not always the case; which is sad but true.

While Vandy was in the nursing home, I was able to get her qualified for Social Security Disability Insurance (SSDI). She was still living in the nursing home when she began receiving her SSDI payments and became entitled to Medicare. As required by law, the nursing home kept most of Vandy's SSDI payment to apply

against her nursing home expenses. The remaining nursing home expenses were paid by the State of Ohio Medicaid Program. In other words, either Medicare or Medicaid paid for all of Vandy's nursing home expenses, including all of her medications. She certainly didn't have to pay any BC/BS copays for prescriptions.

Back to the story: As stated, in early November 2008, Vandy was notified that the BC/BS copays rather than the Medicare Part D copays would have to apply to her prescription medications. The BC/BS copays are $8.00 for generic drugs, $25.00 for brand-name drugs on formulary and $40.00 for brand-name drugs not on formulary. Since Vandy is required to take about 30 prescriptions a month, her BC/BS copays would have been hefty at the generic rate and out of sight at the brand-name rate.

A pharmacy technician managed to accomplish a "workaround" whereby Vandy's Medicare Part D carrier covered her prescriptions through the months of November and December 2008. I am grateful to the pharmacy technician for doing that.

During November and December, I called people all over the country about Vandy's prescription dilemma. The people I called were at 1–800–Medicare, the SSA national 800 number, the local Social Security office, the SSA Coordination of Benefits office, three SSA Advanced Resolution specialists, several SSA CMS specialists in Chicago, the Ohio Job and Family Services Medicaid Hotline, the Ohio Senior Health Insurance Information Program office, (SHIIP Ohio) and Congressman Boehner's office.

Most everybody that I spoke with advised me that the easiest solution to Vandy's dilemma would be to have her dropped from Stan's BC/BS coverage at work and to let Medicare and Medicaid cover all of her medical expenses. However, I was hesitant to recommend that to her because, if Stan dropped her from his BC/BS group "FAMILY" health plan at work, Vandy would also drop automatically from the WSU group dental and group vision plans.

SHIIP Ohio advised me to inquire: "Since Vandy is bedridden and dual eligible to receive the Medicare and Medicaid low-income subsidies, how come her dual eligibility for low-income subsidies doesn't trump the higher BC/BS copays?" I got absolutely nowhere with that one.

The WSU Benefits Unit told me that my daughter could be dropped from her husband's group health policy at any time. SHIIP Ohio told me the same thing.

Because my daughter's family is strapped financially, there is absolutely no way that they could afford the more expensive BC/BS copays for her prescriptions. So Vandy and Stan decided it would be best to drop Vandy from the WSU BC/BS group "FAMILY" medical plan which also automatically dropped her from the WSU group vision and dental plans. This was done only to avoid paying the much higher BC/BS copays for her prescription medications. PLEASE, note that Vandy and Stan felt that they did not have any other alternative because they simply could not afford to pay the higher BC/BS copays.

Vandy dropped from her husband's BC/BS coverage at work effective 1 January 2009. On that date, Medicare assigned her to a new Medicare Part D carrier which is now covering her prescriptions. Please note that BC/BS does not pay a single DIME on Vandy's prescriptions, even though Stan has a BC/BS FAMILY plan at work which is supposed to cover a good part of his family's prescription costs. Instead the American taxpayer is paying for Vandy's prescriptions. Wouldn't you say that the American taxpayer is getting the shaft? I would.

I am a firm believer that government is at its best when it is guided by common sense. I hope that Vandy dropping herself from Stan's BC/BS coverage at work was the right decision. I am not sure that it was. Let me tell you why:

Vandy recently had to pay $151.00 for a prescription that was not on her Medicare Part D carrier's formulary. The cost of paying for that one expensive prescription "out-of-pocket" wiped out a good chunk of whatever prescription "savings" Vandy and Stan had achieved by dropping her from his BC/BS coverage at work.

Next I want to explain that Vandy recently had to have bariatric surgery to try to lose some weight. The reason for the bariatric surgery is that her doctor and her therapists have told her that unless she loses some weight, she will never have a chance of walking again.

I point out that the bariatric surgery was performed by a "preferred" doctor at a "preferred" hospital.

NOW FOR THE CLINCHER: The American taxpayer had to pick up the entire tab for that bariatric surgery even though Stan has a BC/BS group FAMILY policy at work. IS THAT BRILLIANT?—OR—IS IT JUST PLAIN STUPID?

It makes me sick to think that the poor American taxpayer is getting the shaft while the big insurance company is paying nothing, especially when Stan has a BC/BS group FAMILY policy at work. And the U.S. Government lets them. Is that fair to the American taxpayer? You know my answer.

That must be why the insurance companies "lobby" Congress so hard.

If I sound disgusted, it is because I am.

If, after reading this medical horror story you are a bit uneasy, get busy contacting your congressional delegation to tell them you don't like the way the Nation does its health care business and that you want it changed. Together, we can make a difference.

I thank you for reading Vandy's medical horror story. If you want to contact me to discuss additional aspects to Vandy's medical horror story, please do so. Believe me, I have only skimmed the surface.

Statement of the Association of Professors of Medicine, Association of Program Directors in Internal Medicine, Association of Specialty Professors, Clerkship Directors in Internal Medicine, and Administrators of Internal Medicine

Abstract

In response to a projected physician workforce shortage, the Alliance for Academic Internal Medicine (AAIM) recommends:

- Strategically increasing the number of Medicare-funded positions for primary care specialties to adequately meet the Nation's health care needs. For these new positions, Medicare should support the entire duration of training, which is typically 3 years but is 4 years for combined programs such as internal medicine-pediatrics. In addition, AAIM believes new primary care slots should be added in geographic areas of demonstrated need. Ultimately, all health care insurers should have a role in explicitly contributing to GME funding.
- Enhancing the attractiveness of primary care careers by altering the physician reimbursement system, increasing job satisfaction for current and future primary care practitioners, providing incentives for geographic distribution of primary care physicians to areas of greatest need, and applying innovations to educational models.
- Increasing efficiency in the health care delivery system by broadening the use of electronic health records (EHRs) and other advances in health information technology and capitalizing on the use of physician extenders. Additional options for improving health care delivery should be considered.

While the evidence that the Nation faces a shortfall of physicians is compelling and difficult to refute, increasing GME positions without respect to specialty or practice region would be imprudent. Steps must be taken to ensure access to primary care physicians, better methods for coordinating care, a physician reimbursement system that values the work of the primary care physician, incentive programs for physicians to train and practice in rural areas, adequate financial support for GME, and steps taken to improve the efficiency of health care delivery.

Introduction

After two decades of consistent predictions that the United States will face a physician surplus, leading professional organizations and advisory boards have now altered their calculations and projected that the Nation may soon face physician shortages (1–5). These organizations are calling for teaching hospitals, medical schools, and the Federal Government to respond to predicted shortages (6–8).

The primary determinant of the number of practicing physicians in the United States is the number of graduate medical education (GME) positions or training slots. These positions represent the only pathway to licensure for medical practice in the United States. Since the Balanced Budget Act of 1997 capped the number of federally funded positions in each residency program at the 1996 level, increases to the flow of new physicians into the workforce have been limited despite evidence of growing demand. The shortage of physicians is particularly significant in primary care specialties.

AAIM's recommendations to allow strategic growth in positions in primary care specialties and geographic areas of need would prevent an unregulated increase in positions for highly specialized training programs, which might raise health care costs without adding primary care physicians to address health care needs. However, increasing the number of primary care positions will not result in an increase of physicians practicing primary care unless steps are taken to enhance the attractiveness of primary care careers.

This position paper was created by the AAIM Advocacy Committee, with representation of its five member organizations: the Association of Professors of Medicine, Association of Program Directors in Internal Medicine, Association of Specialty Pro-

fessors, Clerkship Directors in Internal Medicine, and Administrators of Internal Medicine. The committee solicited feedback from the alliance membership before writing the statement. After vetting by the leadership of each organization, the consensus statement was finalized and approved as the alliance position on how to address the projected shortage in the physician workforce. This paper reviews the data that support the conclusion that the United States faces the prospect of a shortfall of physicians, describes certain aspects of these data particularly as they relate to the supply of primary care physicians, addresses the mechanisms necessary for expanding the pool of practicing physicians through increasing Medicare funded GME slots, discusses the expansion of programs that distribute physicians to geographic areas of need, and comments on steps that can be taken to improve the efficiency of physician work.

Physician Supply

COGME issued *Physician Workforce Policy Guidelines for the United States 2000–2020* in January 2005 (9). COGME noted that although the absolute number of physicians would increase by 24% between 2000 and 2020, the population growth would exceed the rate of growth of physicians, resulting in a decrease in the ratio of full-time equivalent (FTE) physicians per 100,000 Americans. COGME also postulated that the demand for physician services will grow as the elderly population increases as a proportion of the total population. The council concluded that U.S. medical school enrollment needed to increase by 15% by 2012 to meet demand.

In June 2006, the Association of American Medical Colleges (AAMC) issued the *AAMC Statement on the Physician Workforce*, which claimed there was "sufficient evidence" to recommend increasing by 30% the number of entry-level positions in Liaison Committee on Medical Education accredited medical schools by 2012 (7). AAMC stated the 30% increase could be accomplished by increasing enrollment at existing schools as well as creating new medical schools. According to the statement, increased funding for GME positions should occur simultaneously to ensure graduating medical students could receive appropriate postgraduate training.

In December 2008, AAMC released updated projections indicating that a shortage of 124,000 FTE physicians will occur by 2025 (10). According to their estimates, 37% of the shortage will be in primary care, 33% in surgery, 6% in medical specialties, and 23% in other specialties. The shortage of 124,000 physicians is based on the assumption that current supply, use, and demand patterns will remain the same for the next 16 years. Since it is unlikely these patterns will remain stable, AAMC also created an alternative scenario assuming a continued increase in utilization rates, changes in work schedules, a moderate expansion in GME capacity, and improvements in productivity, which projects a shortage of 159,300 FTE physicians by 2025.

While academic institutions have responded to the calls from COGME and AAMC with an increase in allopathic medical school class size and the creation of several new medical schools, new Federal funding for additional U.S. GME slots has not been forthcoming, except in a limited way from the Department of Veterans Affairs (VA). Increases to positions funded by other sources, while they exist, have also been minimal (11).

Beyond increasing support to expand GME positions, interest in primary care careers among medical school graduates must also increase to positively affect the supply of primary care physicians. Extensive data support the observation that decreased numbers of U.S. medical school graduates are pursuing careers in primary care. For example, 3,884 U.S. medical students matched into internal medicine residency positions in 1985 compared to 2,660 in 2008 (12). In a recent study by Hauer et al., only 24 (2%) of the 1,177 students in the 11 medical schools participating planned to pursue a career in general internal medicine (13). Conversely, while interest of U.S. seniors in general internal medicine has declined, the proportion of residents choosing specialty fellowships has increased from 50% in 1988 to 80% in 2006 (14). According to Hauer's study, today's medical students prioritize lifestyle issues in career selection and perceive general internal medicine as a low-satisfaction, low-income, and uncontrollable career (13). The potential consequence of declining interest in general internal medicine careers is a decrease in the delivery of preventive measures and appropriate treatment of chronic diseases that often lead to disability and premature death. This consequence has direct implications for the growing number of the elderly in the United States who require coordination of treatments for multiple complex, chronic conditions.

The geographic maldistribution of physicians in the United States also has negative implications for ensuring an adequate supply of physicians. Several studies indicate a shortage most pronounced in rural areas and certain urban neighborhoods (15, 16). A study of 20-year trends in geographic variation of physician distribution shows that an increase in practicing physicians by 51% did not translate into

regional variation of practice location. Despite long-standing public policies, physicians continued to locate in areas of adequate-to-high physician-to-population ratios, further compounding issues for health professional shortage areas (HPSAs) (17).

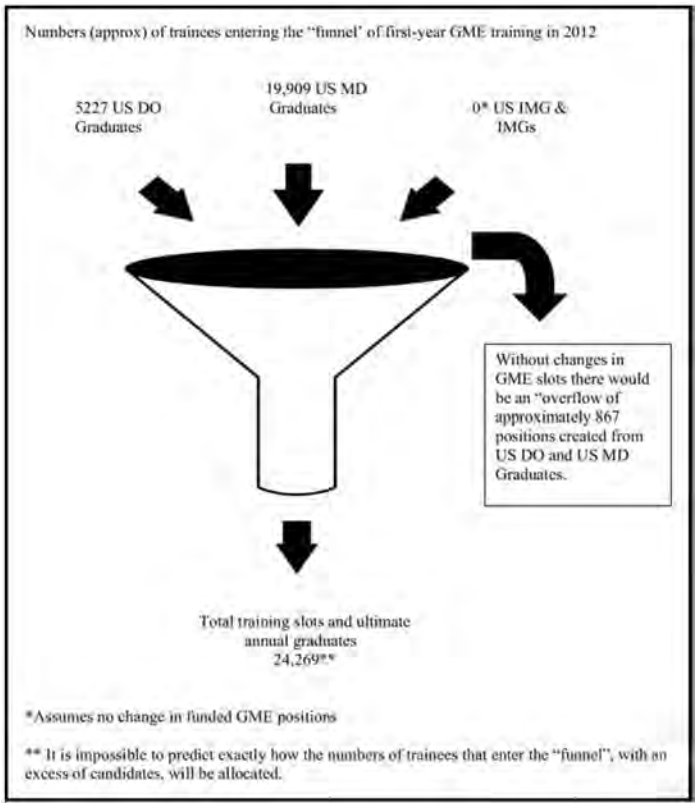
Physician Supply

Assessing the country's future needs for physicians is a challenging and complex estimation of supply and demand. The supply side involves the output from multiple training pathways for initial medical degrees as graduates enter the final common pathway of residency training. Supply is also a product of physician effort and varies in relation to age, gender, and generational or lifestyle preferences.

The largest source of physicians entering the "funnel" of GME is provided by U.S. allopathic medical schools. In 2005, 15,760 graduates of U.S. allopathic schools and 2,800 graduates of U.S. osteopathic medical schools were eligible to enter GME programs (18, 19). A total of 24,269 first-year GME positions in training programs approved by the Accreditation Council for Graduate Medical Education (ACGME) and the American Osteopathic Association were available for these new graduates (12, 20). The gap between the number of available positions and the total graduates of U.S. programs was filled by approximately 6,000 graduates from medical schools in other countries.

Based on 2007 enrollment and class size increases, first-year enrollment into U.S. medical degree programs is projected to increase from 16,488 in 2002 to nearly 19,909 in the 2012 academic year (AY). Similarly, substantial growth in first-year enrollment of osteopathic schools is expected, from 2,148 in AY 2002 to 5,227 in AY 2012 (a 70% increase) (21). As a result, unless the number of first-year positions in GME training increases, not enough positions will exist to accommodate all U.S. medical graduates by the year 2012 (Figure 1).

Figure 1: Funnel of Graduate Medical Education



It is estimated that international medical graduates (IMGs) now account for 24% of the total U.S. physician workforce (22). Although concerns about depletion of the physician supply in IMG home countries also exist, the current demand for physicians in the United States can only be met by the continued training and retention of IMGs. If more residency positions are not funded, increasing the number of U.S. medical school graduates will be a zero-sum game in terms of the number of practicing physicians in the United States (19). Currently, more than a quarter of the Nation's primary care physicians are IMGs.

The supply of physicians is also influenced by the rate at which physicians leave practice. Just as the total U.S. population has aged, the population of practicing physicians has also aged. It was estimated that there would be 99,000 U.S. physicians over the age of 65 in 2008 (19). Furthermore, changing demographics and emerging expectations about professional life by both male and female physicians will lead to increasing numbers of practicing physicians with reduced work hours (23, 24).

Projections from 2007 suggest that the number of practicing physicians in the United States will increase from 733,852 in 2000 to 906,278 in 2010, and will rise further to 988,100 in 2020 (25). However, in spite of the increase in numbers of physicians, the projected increase in the U.S. population will mean that the ratio of active physicians to population (per 100,000) will increase only modestly from 278.5 in 2000 to 293.4 in 2010, and it will remain essentially unchanged for the next decade at 294.2 in 2020. These statistics do not account for the anticipated functional reduction in work capacity anticipated as a result of changing work habits and patterns of practice. Assessing the need or demand of the population for physician services is a complex and controversial topic. However, it is clear that the physician supply must increase to accommodate the growing and aging population as well as the growing number of medical students entering the pipeline.

Responding to Physician Workforce Projections

Recommendation 1: AAIM recommends strategically increasing the number of Medicare-funded residency positions in primary care specialties to adequately meet the Nation's health care needs as defined by COGME. In addition, AAIM believes GME slots should be added in geographic areas of demonstrated need.

According to COGME, meeting the Nation's future physician workforce demand and need will require increasing to 27,000 the number of physicians entering residency training each year by 2015, which would represent an increase of approximately 3,000 positions annually. Based on its recent projections, AAMC has advocated for an increase of 5,000 positions annually over an average of 4 years of training to respond to its recommended 30% increase in medical school class size. A global, unregulated increase in GME positions is unlikely to meet regional or specialty-specific shortages. A deliberate and strategic increase should be considered to justify the creation of new GME slots. AAIM's recommendation for Medicare to fund new positions in primary care includes a call for support for an average of 4 years per position. While training in internal medicine, pediatrics, and family medicine is 3 years, training in combined programs such as internal medicine-pediatrics takes 4 years.

Current data suggest as many as one-half of physicians trained in a specific locale will stay there for their practice careers (17). To allow residents to train in areas of demonstrated need, Medicare GME funding regulations must change to permit resident time spent outside of the academic health care setting to count for purposes of GME funding. Currently, the use of non-hospital training sites is restricted by Centers for Medicare and Medicaid Services (CMS) regulations that require a training program to incur 90% of all costs for a resident or fellow rotating outside of the teaching hospital, which disallows private practitioners and other community faculty from volunteering their time and presents a barrier to increasing training in venues outside of the teaching hospital. Without funding, hospitals stop sending residents to non-hospital settings or use precious limited resources for this training at the cost of other programs. Removing current restrictions and breaking down barriers for reimbursement would increase residents' opportunities to practice in a variety of settings, including rural, inner city, and other underserved locations. Aside from providing experiences in areas where a resident may ultimately care for patients, allowing residents to practice outside of teaching hospitals can also serve as a successful recruitment mechanism for communities in need. While ultimate practice locations of physicians can not be controlled, increases in GME should be made with geographic factors in mind.

The Medicare program provides approximately 40% of total GME funding. The remainder is supported by other sources that vary by institution and State and are often subject to the annual appropriations process (26). An increase in PGY–1 slots to respond to health care needs is only possible with increased funding. AAIM understands the restrictions of State, institutional, and Federal budgets to increase funding for medical education. As a result, AAIM supports a system in which all insurers contribute to GME costs.

As long as Medicare funding is provided for GME positions, the per-resident amounts paid to hospitals must be reassessed. Per-resident amounts for Medicare direct GME payments were originally set in 1984. While adjustments have been made, the per-resident amount has not been altered to account for changes in training. Mandated competency-based education and evaluation as well as duty hour restrictions require significant resources as do health care simulation, centralized oversight of regulatory compliance, and faculty development. These changes and many others that require additional resources and resident time have not been considered in the current GME financing system.

In 2005, CMS redistributed 3,000 unused GME slots to hospitals that demonstrated greatest need. While this redistribution helped more than 350 hospitals mostly in rural areas, it also proved disadvantageous because Congress lowered the percentage of indirect graduate medical education (IME) payments associated with the positions. AAIM recommends any increase in GME positions must include IME payments equal to those provided to existing positions.

For hospitals and institutions with the capacity for additional training positions, funding should remain earmarked for primary care specialty positions and must not be redirected to other specialty slots. In addition, institutions and hospitals must make a commitment to keep current levels of primary care positions to receive funding for additional positions. Any move to decrease current primary care slots and use the funding for other specialty positions or fellowship training will not positively affect the total output of physicians entering primary care. Also, institutions must document their means and ability to add positions with respect to teaching resources.

Enhancing the Attractiveness of Primary Care Careers

Recommendation 2: AAIM recommends enhancing the attractiveness of primary care careers by altering the physician reimbursement system, increasing job satisfaction for current and future primary care practitioners, providing incentives for geographic distribution of primary care physicians in areas of greatest need, and applying innovations to educational models.

If the capacity for GME in internal medicine is enhanced by providing more funding for residency slots, simply increasing the number of graduates from U.S. medical schools without improving the attractiveness of general internal medicine will not produce the desired effect. Without providing incentives for selecting a career as a general internist, larger class sizes will likely increase the number of specialists in a variety of attractive practice disciplines. Education, training, and reimbursement should be restructured to ensure positive exposure to general internal medicine for physicians-in-training and job satisfaction for individuals who choose a career in general internal medicine.

Studies of student career choice highlight lifestyle issues as a high priority in the decisionmaking process. Internal medicine has been identified as a specialty with uncontrollable lifestyle regarding work hours and patient care duties. In 2008, a study noted that clerkship students choosing a career in internal medicine and those choosing careers in other specialties perceive internal medicine residents as less satisfied than residents in other specialties (13). Exposure of medical students and residents to faculty who feel overwhelmed and devalued will inhibit new physicians entering the field of primary care.

Aside from training, a major challenge primary care faces in becoming a successful career option is the current physician reimbursement system. Today's system proves lucrative for procedure-based specialties while primary care and cognitive specialties are inadequately reimbursed for time spent delivering comprehensive patient care. Reviewing the process for determining the current value of physician services should be the first step in ensuring the work of primary care physicians is not devalued. The Medicare Payment Advisory Commission has made this recommendation to Congress along with recommendations to increase Medicare payments for primary care services and establishing a "medical home" pilot project through Medicare (27). The ultimate enhancement of adequate reimbursement by Federal, State, and private insurers for high-quality cognitive care will provide tre-

mendous incentive for physicians to seriously consider primary care as a career of choice.

Understanding job satisfaction for the general internist requires more than examining physician income. Outpatient schedules with inadequate time to carefully evaluate the patient results in less than optimal care and increased frustration for physicians.

Job satisfaction has the potential to increase with adequate professional support. As the number of primary care physicians decline, fewer colleagues will share the clinical load. Increasing use of physician extenders may help to ease the burden of care; however, the prestige of the generalist must also be considered. While physician extenders can help ease the amount of work for primary providers, it is important to note that they are not replacements for physicians who are uniquely situated to identify and treat multisystem issues and complex diagnoses.

Successful distribution of physicians to locations where primary care physicians are most needed will require additional incentives. Financial incentives for loan repayment may be successful in attracting primary care physicians to locations of most need. In addition, focus should be placed on recruiting and providing incentives to potential trainees from underserved areas. Studies show that medical school matriculants from underserved areas or with career plans to serve in such areas are more likely to serve as rural primary care providers than their peers. Programs developed to increase the supply of rural primary care physicians have proven successful (28, 29). While political and other forces that would be needed to make these adjustments will require considerable strategy, these changes would improve the overall health of the Nation if the best graduates were encouraged to consider primary care. Potential strategies at the national level for increasing the number of physicians in HPSAs include enhancing the National Health Service Corps (NHSC) and health professions education programs, passing legislation such as the Rural Training Act to remove regulatory barriers to having residents train in nonhospital and rural settings, and increasing the number of waivers through the J–1 visa waiver program to previous levels. Steps can also be taken at the State level.

The understanding that the primary care physician is essential to access and optimal health outcomes underscores the need to address explanations underlying the current deficiency in the number of these essential providers. Understanding how best to integrate these physicians with other professional colleagues such as nurse practitioners and physician assistants rather than promoting their displacement by these individuals will ultimately lead to the optimal team approach. Focusing on the needs of the future health care workforce is critically important, and national strategies are urgently required to avoid a shortage of primary care physicians. The challenge of appropriate funding will require redistribution of financial resources and reimbursement to reflect the fair cost of delivering high-quality care to the U.S. population.

Improve Health Care Delivery

Recommendation 3: AAIM recommends increasing efficiency in the health care delivery system by broadening the use of EHRs and other advances in health information technology and capitalizing on the use of physician extenders. Additional options for improving health care delivery should be considered.

The projected physician shortage could be mitigated by maximizing the efficiency of physicians. In the future, optimizing efficiency may actually reduce the number of physicians required to provide optimal care. AAIM proposes improving the health care delivery system by promoting widespread use of EHRs, capitalizing on the use of physician extenders, and considering other options for increasing efficiency such as improving access to health care screening.

A study conducted at community health centers concluded that EHRs present a clear value to patients and stakeholders. Patients received better care and payers were likely to reap EHR-related downstream benefits in avoided specialist, emergency room, and hospital spending (30). EHRs help physicians and staff members view, chart, and interact with patients' health information in a timely and accurate manner. While computerized physician order entry systems may prove cost-prohibitive for some institutions, the use of order sets or clinical practice guidelines could also serve to increase efficiency in patient care.

Utilizing physician extenders can also increase efficiency by freeing up the primary physician's time and providing greater continuity of care. In primary care practices, nurse practitioners and physician assistants can improve productivity by providing some direct and indirect patient care, including routine examination and review of medical histories, telephone triage, patient education, counseling, and

health awareness. Physician satisfaction with the use of the physician extender model to increase efficiency is very high (31).

Additional options for increasing efficiency in the health care delivery system should be explored. For example, consideration should be given to regionalizing expensive treatments and applying the certificate of need system globally; improving access to health care screening to reduce the need for future hospitalization; and other innovative measures to enhance efficiency. AAIM believes addressing the physician shortage successfully will take both an increase in the number of physicians and improvements to the health care delivery system.

Conclusion

The Nation is facing a physician shortage that is likely to adversely affect public health. AAIM recommends increasing the supply of Medicare-funded positions in primary care specialties, including internal medicine and internal medicine-pediatrics. National numerical targets should coincide with the physician-to-population ratio adequate to meet the Nation's health care needs as defined by COGME.

The evidence that the Nation faces a shortfall of physicians is compelling and impossible to ignore. At the same time, an unbridled increase in GME positions without respect to specialty or practice region would be imprudent. AAIM believes that selective increases in GME slots can and should occur in primary care. Allowing local communities and their legislators to demonstrate the need for primary care providers could provide a mechanism to address the geographic maldistribution of physicians. In addition, steps must be taken to increase efficiency in the current health care delivery system and enhance the attractiveness of generalist careers, including internal medicine and combined programs such as internal medicine-pediatrics.

AAIM has already begun such efforts with its statement, *Redesigning Residency Training in Internal Medicine: The Consensus Report of the Alliance for Academic Internal Medicine Education Redesign Task Force*. While the Nation seeks to increase the physician supply, it also must examine and implement measures that will improve physician efficiency and effectiveness. Ignoring the imminent shortage of physicians puts the Nation's health and well-being at risk.

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Statement of American Academy of Physician Assistants

Physician assistants (PAs) are one of three health care professions providing primary medical care in the United States today, and are an integral part of health care reform.

- In 2008, over 257 million patient visits were made to physician assistants, and approximately 332 million prescriptions were written by PAs.
- PAs practice in virtually every area of medicine. Between 35%–40% of all PAs practice in primary care. PA education is based on the primary care model of care, providing greater flexibility for PA practice upon graduation.
- By design, PAs always work with physicians. However, PAs make autonomous medical decisions. The physician is always available for consult, but the physician may not be onsite, in the same county, or in the case of the State Department, in the same country or hemisphere. Reimbursement for medical care provided by PAs is separate than reimbursement provided to physicians.
- PAs serve as medical directors in rural health clinics, community health centers, and other federally qualified health centers. In rural and other medically underserved communities, a physician assistant may be the only health care professional available.

- PAs provide first contact, continuous, and comprehensive care for patients throughout the United States. PAs currently manage care for patients in primary care, chronic care, and other areas of medicine.
- Studies show that in a primary care setting, PAs can execute at least 80 percent of the responsibilities of a physician with no diminution of quality and equivalent patient care satisfaction.
- By virtue of PA education in primary care and the ability of PAs to work in all medical and surgical specialties, PAs expand access to care in medically underserved rural and urban communities.
- By design, the physician assistant profession extends the reach of medicine and the promise of health to the most remote and in-need communities of our Nation.

In addition to the need to produce more primary care physicians, it is critical that Congress support expansion of PA programs as they develop strategies for addressing health care workforce challenges.

- Funds should be made available to PA educational programs to increase the PA workforce, which in turn, will extend physicians' ability to provide.
- The Title VII, Public Health Service Act's Health Professions Program is successful in training health care professionals for practice in medically underserved communities. Funding for PA educational programs is woefully underfunded and must be increased.
- The single largest barrier to PA educational programs educating more PAs is a lack of clinical training sites. Attention must be directed to investing in the number of these sites, including loan repayment for preceptors in primary care medical practices and/or the increased use of VA facilities as clinical training sites for PA educational programs.
- Funds must be made available to increase the number of faculty at PA educational programs. Eligible PA students are being turned away because of the lack of faculty and clinical sites.
- Faculty loan repayment, including funding to attract faculty from diverse backgrounds, is also critical for PA educational programs.
- Federally supported student loans and increased opportunities through the National Health Service Corps are key to attracting PA students and clinicians to primary care.
- Graduate medical education funding should be used to support the educational preparation of physician assistants in hospitals and outpatient, community-based settings.

Physician assistants are key to health care reform. However, to be fully utilized, current barriers to care that exist in Federal law must be addressed.

- The Medicare statute must be amended to allow PAs to order home health, hospice, and skilled nursing facility care, as well as to provide hospice care for Medicare beneficiaries. (*A 2009 report by the Lewin Group estimates an overall cost savings through implementation of the four PA Medicare provisions.*)
- Medicaid should be updated to require States to reimburse all covered services provided by PAs under the fee-for-service plan. Additionally, Medicaid should recognize PAs as primary care case managers through managed care plans.
- The Federal Employee Compensation Act needs to be updated to allow PAs to diagnose and treat Federal employees who are injured on the job.
- Physician assistants must be fully integrated into new models of care, including the primary care medical home and chronic care coordination.

In brief, AAPA recommends the following changes to the House Health Care Reform Discussion Draft—

- Explicitly recognize physician assistants as primary health care providers throughout the bill.
- Incorporate the Senate HELP Committee language on reauthorization of the Public Health Service Act's Title VII Program, including a 15% carve for PA educational programs in Title VII training on primary care medicine, an updated definition of PA educational programs, and faculty loan repayment for PA education programs.
- Revise Medicare to allow PAs to order home health, hospice and skilled nursing facility care, as well as to provide hospice care for Medicare beneficiaries. (*A 2009 report by the Lewin Group estimates an overall cost savings through implementation of the four PA Medicare provisions.*)

On behalf of the nearly 75,000 clinically practicing physician assistants (PAs) represented by the American Academy of Physician Assistants (AAPA), thank you for the opportunity to submit written testimony for the hearing record of the House Committees on Education and Labor, Energy and Commerce, and Ways and Means.

AAPA Principles for Health Care Reform

AAPA has a longstanding history of support for universal health care coverage. Among the Academy's key principles for health care reform—

- The AAPA believes the primary goal of a comprehensive health care system reform is to ensure access to quality, affordable, and cost efficient health care for all residents of the United States.
- The AAPA supports a health care system that will provide basic services to all residents.
- The AAPA supports health care that is delivered by qualified providers in physician-directed teams.
- The AAPA supports reform that confronts the limits of care and resources.
- The AAPA believes that fair and comprehensive reform of the medical liability insurance system is needed.
- The AAPA endorses system reform that enhances the relationship between the patient and the clinician.

Physician Assistants

Physician assistants are licensed health professionals, or in the case of those employed by the Federal Government, credentialed health professionals, who—

- Practice medicine as a team with their supervising physicians.
- Exercise autonomy in medical decisionmaking.
- Provide a comprehensive range of diagnostic and therapeutic services, including performing physical exams, taking patient histories, ordering and interpreting laboratory tests, diagnosing and treating illnesses, assisting in surgery, writing prescriptions, and providing patient education and counseling.
- May also work in educational, research, and administrative settings.

PAs always work with physicians. However, this does not mean that the physician is necessarily on site, nor does it suggest that PAs do not make autonomous medical decisions. PAs employed by the State Department, for example, may work with a physician who is a continent away and available for consultation by telecommunication.

PAs are located in almost all health care settings and in every medical and surgical specialty. Nineteen percent of all PAs practice in nonmetropolitan areas where they may be the only full-time providers of care (State laws stipulate the conditions for remote supervision by a physician). Approximately 41 percent of PAs work in urban and inner-city areas. Approximately 44 percent of PAs are in primary care. Nearly one-quarter of clinically practicing PAs practice in surgical specialties. Roughly 80 percent of PAs practice in outpatient settings.

PAs are covered providers within Medicare, Medicaid, Tri-Care, and most private insurance plans. Additionally, PAs are employed by the Federal Government to provide medical care, including the Department of Defense, the Department of Veterans Affairs, the Public and Indian Health Services, the State Department, and the Peace Corps.

AAPA estimates that in 2008, over 257 million patient visits were made to PAs and approximately 332 million medications were written by PAs.

Overview of Physician Assistant Education

Physician assistant programs provide students with a primary care education that prepares them to practice medicine with physician supervision. PA programs are located at schools of medicine or health sciences, universities, teaching hospitals, and the Armed Services. All PA educational programs are accredited by the Accreditation Review Commission on Education for the Physician Assistant, an organization composed of representatives from national physician groups and PAs.

The average PA program is 26 months and is characterized by a rigorous, competency-based curriculum with both didactic and clinical components. The first phase of the program consists of intensive classroom and laboratory study, providing students with an in-depth understanding of the medical sciences. More than 400 hours in classroom and laboratory instruction are devoted to the basic sciences, with over 70 hours in pharmacology, more than 149 hours in behavioral sciences, and more than 535 hours of clinical medicine.

The second year of PA education consists of clinical rotations. On average, students devote more than 2,000 hours or 50–55 weeks to clinical education, divided between primary care medicine and various specialties, including family medicine, internal medicine, pediatrics, obstetrics and gynecology, surgery and surgical specialties, internal medicine subspecialties, emergency medicine, and psychiatry. During clinical rotations, PA students work directly under the supervision of physician preceptors, participating in the full range of patient care activities, including patient assessment and diagnosis, development of treatment plans, patient education, and counseling.

After graduation from an accredited PA program, the physician assistant must pass a national certifying examination jointly developed by the National Board of Medical Examiners and the independent National Commission on Certification of Physician Assistants. To maintain certification, PAs must log 100 continuing medical education credits over a 2-year cycle and reregister every 2 years. Also to maintain certification, PAs must take a recertification exam every 6 years.

The majority of PA educational programs offer master's degrees, and the overwhelming majority of recent graduates hold a master's degree.

Title VII Support of PA Education Programs

The Title VII support for PA educational programs is the only Federal funding available, on a competitive application basis, to PA programs. Unfortunately, the level of support has eroded from the highest level of $7.5 million in FY 2005 to $2.6 million in FY 2007.

Targeted Federal support for PA educational programs is authorized through section 747 of the Public Health Service Act. The funds are used to encourage PA students, upon graduation, to practice in underserved communities. These goals are accomplished by funding PA education programs that have a demonstrated track record of: placing PA students in health professional shortage areas; exposing PA students to medically underserved communities during the clinical rotation portion of their training; and recruiting and retaining students who are indigenous to communities with unmet health care needs.

The Title VII program works.

- A review of PA graduates from 1990–2006 demonstrates that PAs who have graduated from PA educational programs supported by Title VII are 59% more likely to be from underrepresented minority populations and 46% more likely to work in a rural health clinic than graduates of programs that were not supported by Title VII.
- A study by the UCSF Center for California Health Workforce Studies found a strong association between physician assistants exposed to Title VII during their PA educational preparation and those who ever reported working in a federally qualified health center or other community health center.

The PA programs' success in recruiting underrepresented minority and disadvantaged students is linked to their ability to creatively use Title VII funds to enhance existing educational programs. Without Title VII funding, many special PA training initiatives would be eliminated. Institutional budgets and student tuition fees are not sufficient to meet the special, unmet needs of medically underserved areas or disadvantaged students. The need is very real, and Title VII is critical in leveraging innovations in PA training.

Need for Increased Targeted Support for PA Education

Federal support must be directed to PA educational programs to stimulate growth in the PA profession to meet the needs of universal health care coverage. Targeted funding should be directed to—

- The use of Title VII funds for recruitment and loan repayment for faculty in PA educational programs.
- Incentives to increase clinical training sites for PA education.
- Federally backed loans and loan repayment programs for PA students.

Eliminating Barriers to Care in Federal Law

Eliminating current barriers to medical care provided by PAs that exist in the Medicare, Medicaid, and the Federal Employees Compensation Act (FECA) laws would do much to expand access to needed medical care, particularly for patients living in rural and other medically underserved areas.

- AAPA believes that the intent of the 1997 Balanced Budget Act was to cover all physician services provided by PAs at a uniform rate. However, PAs are still not allowed to order home health, hospice, skilled nursing facility care, or provide the hospice benefit for Medicare beneficiaries. At best, this creates a mis-

use of the patient's physician's and PA's time to find a physician signature for an order or form. At worst, it causes delayed access to care and inappropriate more costly utilization of care, such as longer stays in hospitals. For patients at end-of-life, it creates an unconscionable disruption of care. (*A 2009 report by the Lewin Group estimates an overall cost savings through implementation of the four PA Medicare provisions.*)

- Although most States recognize services provided by PAs in their Medicaid programs, it is not required by law. Consequently, some State Medicaid Directors pick and choose which services provided by PAs they will cover. Others impose coverage limitations not required by State law, such as direct supervision by a physician.
- Although nearly all State workers' compensation programs recognize the ability of PAs to diagnose and treat State employees who are injured on the job, the Federal program does not. As a result, Federal workers who are injured on the job may be rerouted to emergency rooms for workers' compensation-related care, rather than to go to a practice where the PA is the only available health care professional.

The Medicare, Medicaid, and FECA statutes create Federal barriers to care that do not exist in State law. The barriers need to be eliminated to promote increased access to the quality, affordable medical care provided by PAs.

Integrate PAs into New Models of Care

AAPA is concerned that health care reform could create new, unintended barriers to care provided by PAs unless special attention is devoted to ensuring that PAs are fully integrated into the medical home and chronic care coordination models of care.

PAs always work with physicians, but in many rural and other underserved areas, the PA is the face of health care. The PA is the medical professional who develops the care plan and coordinates the care. PAs also own and/or provide care in rural health clinics and other settings that may serve as the patient's primary medical home. It is critical that the medical home and chronic care management models of care recognize the ability of PAs to develop and manage medical care plans, without unnecessary limitations. And, it is important that PA-run clinics and practices be eligible for reimbursement from the new models of care.

Medicare Physician Payment Reform

It is critically important that health care reform legislation contains a long-term solution to Medicare's physician payment system. The current system is simply not sustainable, nor is it fair to the health care professionals who provide medical care for Medicare beneficiaries.

American Association of Colleges of Pharmacy

Dear Chairmen Miller, Waxman, and Rangel:

The American Association of Colleges of Pharmacy (AACP) is pleased with the overall intent of the legislative discussion draft released by your three Committees last week. Your combined commitment to increasing all Americans' access to high-quality health care is certainly commendable. The legislation's focus on opportunities for preventing unnecessary illness and keeping our citizens well is an approach that has been too long in coming. Our intent is to work with you and the Committees to make sure this opportunity becomes a reality.

The issue of how we will pay for reorganizing our health care delivery system is certainly important, but it is beyond the scope of our organization's mission. We are fully prepared to assist you in creating a reorganized system that makes the best use of the research, teaching, and service mission of pharmacy faculty. Pharmacy faculty can be of particular assistance, especially in the areas of quality improvement and measurement, wellness and prevention, workforce preparation, and the necessary research that establishes the evidence-base to improve the quality of care patients receive.

Affordable Health Care Choices

We encourage you, in both public and private plans, to make any and all efforts to ensure that patients have access to team-based, patient-centered care as discussed in the 2003 report of the Institute of Medicine, "Health Professions Education: A Bridge to Quality." Quality improvement is predicated on the needs of the patient to be addressed by a community of care. This approach to care delivery also reflects another IOM report from 1994 on primary care

that was authored due to the growing complexity of and interdependencies within health care delivery.

How care delivery is organized is just as important as what care is included in an essential benefits package, whether in a public or private plan.

Therefore, we strongly encourage you to create opportunities for care to be delivered in a collaborative manner, making best use of the knowledge and skills of all health professionals (acting within their individual scopes of practice) focused on the needs of the patient, not the payment expectations of the providers.

This approach will go a long way toward increasing access to the primary type of care, including medication therapy management, that all patients need, especially the chronically ill and elderly. This team-based approach has been successfully employed in several State Medicaid programs including Community Care of North Carolina and integrated health care systems such as InterMountain Health in Colorado and Geisinger Health in Pennsylvania.

Academic pharmacy is actively engaged with the types of delivery system examples above, as well as a host of others including those within family physician offices, ambulatory clinics associated with academic health centers, and increasingly with federally qualified health centers through a patient safety collaborative administered by the Health Resources and Services Administration. The research of pharmacy faculty forms a significant evidence-base supporting collaborative, team-based approaches to care as the standard of care. This evidence-base readily leads to the development of quality measures for plan and provider incentive strategies, important elements in moving toward a reorganization of care systems.

Medicare and Medicaid Improvements

Medicare beneficiaries and Medicaid eligibles form a significant population that benefits from strong care coordination. Regardless of whether the difficulties of accessing care are due to frailty or ability to pay, efficient and effective management of both clinical and community-based services is essential to help improve outcomes and reduce overall costs.

We strongly support provisions within the discussion draft that direct care to be delivered in a much more comprehensive and coordinated fashion.

We ask that these provisions more stridently state the need for care coordination, especially at transitions of care and for the chronically ill taking multiple medications, to include medication therapy management services.

With medications contributing a significant cost to any health plan, including Medicare and Medicaid, the integration of clinical pharmacy services, including medication therapy management, across the continuum of care is integral to improving medication-associated outcomes and controlling costs.

We recommend that your proposed medical home pilot be expanded to be the standard of care for both Medicare and Medicaid patients.

This coordinated, team-based approach has the ability to focus care on the needs of a disease-specific patient population as well as a general community/service area. This is due to the recognition that including the appropriate community-of-care providers focused on the needs of the patient population being served improves health outcomes and can reduce costs associated with care delivery. Academic pharmacy is actively engaged with these policy concepts. Faculty are currently working with hospitals to reduce readmissions due to medication-related problems that should have been addressed at discharge. Pharmacy faculty work with family physicians, their patients, and their patients' caregivers to improve the management of prescribed medications, which improves medication-related outcomes and prevents medication-related problems that may lead to emergency room visits or hospital admissions.

This team-delivered care can be accomplished within a variety of contexts including those that utilize telehealth which makes your interest in increasing the access to telehealth all the more important to remain in final legislation.

Elderly and chronically ill populations account for a significant cost to any health plan or delivery system and assistance with the management of their medication use has been shown to improve health outcomes, reduce unnecessary care across the continuum of care, and reduce the overall cost of care delivery.

AACP supports the establishment of a Center for Comparative Effectiveness. We recommend that the national research agenda include the comparison of practice patterns.

This is important in developing the evidence-base associated with support for team-based, patient-centered approaches to care delivery. For example, team-based, patient-centered care is important in improving the management of the chronically ill and patients at transitions of care. The results of this type of research are much more amenable to the development of quality measures to assist providers in the delivery of evidence-based care.

We ask you to clearly state that the results of comparative effectiveness research should not necessarily be focused on payment issues that have the potential to reduce provider participation in research networks required for this type of work.

Inclusion of all the stakeholders in the development of this national research agenda will be important. Therefore, legislative language should clearly state that all health professionals, not just physicians, are expected to have a seat on the Commission.

We strongly support the expansion of prevention and wellness programs and services into the Medicare and Medicaid programs.

The Committees should stress the importance of increasing access to all public health interventions across a wide range of health professionals, including pharmacists. Expanded access to prevention and wellness programs and services through a wide range of health professionals increases the chances that a patient will make the behavioral change necessary to become more responsible for their individual health and that of their community.

Public Health and Workforce Development

Increasing access to high-quality care at an affordable price will require a substantial reorganization of our health care delivery system. As we know, the United States spends more and receives less compared to other industrialized nations when it comes to many common population health measures. The final division of the discussion draft does little to support the reorganization of health professions education toward the creation of professionals prepared to collaborate and provide culturally competent, team-based, patient-centered care, supported by informatics.

The Committees could do much more toward this end by reauthorizing the Public Health Service Act Title VII health professions programs and requiring all the programs to be interprofessional in nature to the extent possible.

Until the Federal financial support for health professions education is focused on meeting the IOM recommendations stated in its 2003 report, "Health Professions Education: A Bridge to Quality," efforts to move toward an interprofessional health professions education model will languish since Federal policy may give the impression that it is not of high importance.

The Institute of Medicine defined primary care back in 1978, revised the definition in 1984 and again in 1994. The rationale for the 1994 revision was to create a definition "that recognizes two important trends: the greater complexity of health care delivery and the greater interdependence of health professionals." http://www.nap.edu/openbook.php?record__id=9153&page=5.

The 1994 IOM definition reflects primary care as a concept incorporating the "main, chief, or principle" aspects of health care delivery and moves beyond the "first-contact" concept that suggests an initial interaction and then triage to the appropriate level of care. http://www.nap.edu/openbook.php?record__id=9153&page=9.

"Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community." IOM 1994 http://www.nap.edu/openbook.php?record__id=9153&page=15#p20003779ddd0000023.

Over several decades, the United States Congress, recognizing the benefit to both individuals and communities of increased access to primary care, passed key legislation that authorized programs intended to increase access to primary care. The need to provide rural and underserved communities access to primary care was the rationale for establishing the National Health Service Corps. Increasing the supply of primary care providers created programs authorized under Title VII of the Public Health Service Act. Both of these Federal programs are focused on who is eligible to provide primary care. The legislative language makes primary care the responsibility of certain health care professionals. Both of these programs were established prior to the widespread appreciation, supported by IOM primary care definition revisions, of the multidimensional aspect of primary care.

The effectiveness of these programs is further questioned in light of the 2003 IOM report that indicates that health care professionals competent in team-based, patient-centered practice may be one opportunity to close the quality chasm. The Na-

tional Health Service Corps program, with its placement of those health care professionals deemed primary care providers through statute, makes no attempt to recognize the multidimensional aspect of primary care. It focuses solely on a health care professional. The negative aspects of this focus can and frequently does leave the designated provider isolated both from providers of his or her own profession, but more importantly, from those providers with whom he or she might establish a team-based, patient-centered approach to primary care delivery in keeping with the IOM's current definition of primary care.

There are Title VII programs that, at least legislatively, recognize that the complexity of our health care system creates significant need for health care professionals to be educated through interprofessional approaches that establish team-based care as an acceptable and appropriate expectation upon graduation.

The area health education centers (AHEC), geriatric education center (GEC), and HIV education center programs all address an area of national significance—primary, geriatric and HIV care, respectively—the quality of which is improved by increasing the competence of health professions students to practice as teams focused on the needs of the patients for which they provide care. What is of concern is that the currently operating programs that Congress established to address past issues of national significance are not being readily considered as opportunities, through reauthorization and recommitment, for addressing new (or incompletely addressed) issues that impact the ability or willingness of our Nation's health professionals to provide recommended care more than 50% of the time that is evidence-based, culturally appropriate, and that recognizes both individual and community determinants of the patients health status.

Therefore, the Committees should first consider how existing health professions education programs, such as those authorized within Title VII, could, through reauthorization and recommitment, more readily address the development of team-based approaches to care, as well as test the assumptions of the benefits of this approach to quality, cost, and access.

One recommendation would be for all Title VII programs, to the extent possible, support interprofessional education of health professionals that is focused on team-based, patient-centered approaches to care.

The focus of that care could easily address health care issues that remain important to the Nation as a whole, such as primary, geriatric, and HIV care, as well as addressing new issues such as chronic illness, medication therapy management, and wellness and prevention. Such an approach would reduce the opportunity for duplication of programmatic intent, increase buy-in to change from existing stakeholders, and build a team-based approach to policy development between current program and new proposal stakeholders.

Academic pharmacy is a rich resource that has provided much of the medication-related evidence-base used to support many of the provisions within the proposals offered by your Committees, as well as those in the Affordable Health Choices Act. Pharmacy faculty remain committed to working with your Committees to ensure that new evidence is readily transmitted to policymakers and health care professionals so that our Nation's health care system continues to meet the needs of the patients it serves. Please do not hesitate to contact me to discuss how AACP and its members can be of assistance.

Sincerely,

William G. Lang IV, MPH
VP Policy and Advocacy
American Association of Colleges of Pharmacy

Statement of the American Farm Bureau Federation

The Ways and Means Committee, Energy and Commerce Committee and Education and Labor Committee recently released a health care reform discussion draft. The draft document suggests bold new programs such as a health insurance exchange, a public health insurance option, a personal responsibility coverage requirement and an employer requirement to provide coverage. Many items in the discussion draft are of interest to our Nation's farmers and ranchers.

Farm Bureau supports health care reform that improves and builds on our current health care delivery system. We believe that health care is primarily the responsibility of individuals and support efforts to provide all Americans with access to quality and affordable health care. We support the promotion of personal wellness, fitness and preventive care as basic health goals. We oppose compulsory

national health insurance and any national health plan and favor instead tax incentives and market reforms that will expand health care coverage. Farm Bureau supports direct government financial assistance for those unable to pay for their own health care.

Rural Health Care

Farm Bureau believes that any health care reform must address the disparities that exist between rural and nonrural communities. There continues to be a critical shortage of health care facilities and qualified health care professionals in rural areas. According to the Department of Health and Human Services, 20 percent of Americans live in rural areas while only 9 percent of physicians in America practice in those settings. In addition, many rural residents depend on small rural hospitals that face unique health care delivery challenges due to their size and case-mix. Transportation needs are also pronounced among rural residents, who face longer distances to reach health care. As a result, data shows rural residents are less likely to receive recommended preventive services and report, on average, fewer visits to health care providers.

Farm Bureau supports equitable Medicare payment rates to rural hospitals and physicians as one way to preserve and expand health care services in rural areas and supports rural access protection provisions contained in the discussion draft. Prior to 2003, Medicare reimbursements for rural providers were lower than those for urban and suburban providers disadvantaging those who live in nonmetropolitan areas. Since then, the inequity has been corrected through a series of temporary legislative fixes that need to be made permanent. This is especially critical if Medicare reimbursement rates become the basis for establishing payments for other service providers and health care professionals as proposed.

Farm Bureau believes that Health Information Technology (HIT) has the capacity to transform our Nation's health care delivery system into a higher-quality more efficient system. The discussion draft contains an important new initiative to expand and enhance Medicare beneficiary access to telehealth services. Such programs will aid the many rural Americans who are unlikely to enjoy the benefits of HIT due to the current lack of access to advanced telecommunications services in their communities. We caution against provisions that would penalize rural areas that are technically unable to rapidly employ health Internet technology.

Farm Bureau supports government programs and incentives that encourage health care professionals to practice in areas without adequate medical care, many of which are in rural America. We support provisions contained in the draft proposal that would increase scholarships and loans to students who agree to provide health care services in medically underserved areas after graduation.

Individual Requirements

Health care reform must not only address access but also cost. Farming and ranching businesses operate on tight profit margins and are cyclical, with unprofitable years nearly as common as profitable ones. Health insurance costs are an ongoing and significant expense for farmers and ranchers and for this reason we oppose compulsory health insurance in the form of an individual coverage mandate.

A high proportion of farmers and ranchers are self-employed individuals, and as such purchase their own health insurance. We are concerned that prescribing national minimum benefit requirements will increase the price of insurance. When coverage is out of reach because of cost, imposing a 2 percent tax on adjusted gross income will only create greater financial hardship for our Nation's farms and ranches and the families they support. The discussion draft allows individuals and their dependents to keep current coverage and indefinitely continue their health insurance policies allowing them the option to continue coverage that they can currently afford.

Farm Bureau supports tax incentives that help individuals pay for health care and afford health insurance for their families. We recommend continuation of the tax deduction for health insurance premiums paid by the self-employed and, because many farmers and ranchers pay as much or more in self-employment taxes as they do in income taxes, we recommend that a deduction also be allowed against the 15.3 percent self-employment tax. We support eliminating the 7.5 percent adjusted gross income threshold so that all medical expenses are deductible and expanding tax incentives for health savings accounts (HSAs). We are opposed to proposals to limit the deductions for HSAs and out-of-pocket medical expenses.

Employer Requirements

Any health care reform passed by Congress must not unduly burden farm and ranch businesses who employ others or impose costs that they cannot afford. As stated before, farming and ranching businesses operate on tight profit margins and

are cyclical. Requiring employers to provide insurance coverage or pay a tax equal to 8 percent of payroll will put added financial strain on already struggling farm and ranch businesses. Any new tax is troubling because, like insurance premiums, payment will be due whether or not a farm or ranch business turns a profit. For this reason, we do not support an employer mandate to "play or pay."

Farm Bureau supports tax credits to help farmers and ranchers who struggle to provide insurance for their employees. The discussion draft proposes an important employer exemption for certain yet-to-be-defined small businesses and would create tax credits for small employers to help with insurance costs. It also contains an important 5-year grace period for current group health plans. Farm Bureau supports both a small employer exemption and tax credits and asks that small farm and ranch employers not be disqualified from eligibility because they hire seasonal or temporary workers.

Many farms are small businesses with large labor needs for only a very short period of time. For example, a small farmer with 50 acres of cherries might have no full-time employees other than family members and yet hire 60 or 70 workers for 2 or 3 weeks per year. It will be counterproductive to the goal of expanded coverage to deny tax credits to small businesses that temporarily exceed employment thresholds. For small farm and ranch businesses, the administrative and financial burden of providing a health care program for temporary or seasonal workers would be truly overwhelming.

There is also uncertainty about whether or not affordable short-term coverage will be available for temporary or seasonal agriculture workers, some of whom may be employed on multiple farms or ranches for just a few days each. In cases where a seasonal or temporary worker has multiple employers, there are questions about who would be responsible to purchase health insurance and how coverage would be coordinated to avoid duplication and unnecessary expense. Farm Bureau believes seasonal and temporary workers should be exempt from employer provided health coverage requirements.

Market Reforms

The discussion draft proposes the creation of a health insurance "exchange" to make it easier for individuals and employers to compare and purchase insurance products. Farm Bureau believes that an exchange will increase the availability, quality and affordability of health care without the creation of a public insurance option. Farm Bureau supports efforts to foster health care competition but believes that such an exchange should not preempt State regulation or the authority of States to determine coverage requirements.

Another market reform supported by Farm Bureau is the creation of voluntary regional insurance purchasing cooperatives to expand the availability of insurance coverage. Pooling arrangements would allow business owners to join together to purchase health insurance at lower rates, expand health care options and lower administrative costs. It is important to Farm Bureau that such cooperatives remain subject to State regulation.

Sugar-sweetened Beverage Tax

Farm Bureau is concerned about the proposal to use a sugar-sweetened beverage excise tax to fund health care reform. We oppose taxes on any agricultural commodity to fund health care programs. The obesity problem in this country is rooted in many factors, including a lack of exercise and poor nutrition education. Taxing sugar-sweetened beverages is an oversimplified attempt to address a health issue that goes far beyond consumption.

Statement of the American Society for Clinical Pathology

On behalf of the American Society for Clinical Pathology (ASCP), we commend you and the Committee for its leadership and efforts to reform health care delivery in America. ASCP concurs with you about the need and urgency to reform the way health care is provided in the United States. Moreover, it is imperative that efforts to reform health care address many of the long standing inefficiencies and inequities that have plagued our health system for years.

The ASCP is a 501(c)(3) nonprofit medical specialty society representing 130,000 members nationwide. Our members are board certified pathologists, other physicians, clinical scientists, certified medical technologists and technicians, cytotechnologists, and educators. ASCP is one of our Nation's largest medical specialty societies and is the world's largest organizations representing the field of laboratory medicine and pathology. As the leading provider of continuing education for pathologists and

medical laboratory personnel, ASCP enhances the quality of the profession through comprehensive educational programs, publications, and self-assessment materials.

ASCP would like to begin by offering some comments on self-referral, an issue that has received some attention in discussions regarding what should be involved in health care reform but not with the breadth and scope we believe is necessary. Following these comments, we offer ASCP's views on a number of the policies options that have been brought up in congressional discussions surrounding health care reform.

Self-Referral

ASCP firmly believes that health care reform discussions to date have not adequately explored the impact of self-referral on the increasing utilization of medical and health care services and the need for Stark law reform, specifically as it relates to the exclusions contained within the law's in-office ancillary services exception (IOASE). ASCP is very concerned about the proliferation of a number of arrangements designed to enable referring providers to profit from their referrals. Over the last few years, a number of physician group practices have increasingly sought to exploit "so-called" loopholes in the IOASE to capture the reimbursement for anatomic pathology services.

Last year, CMS inadvertently opened the door for additional self-referral billing abuses. We have seen over the last few years a significant increase (41 percent between 2002 and 2007) in charges for and utilization of anatomic pathology services (CPT code 88305). We believe much of this increase is caused by self-referral. In fact, it was CMS' concern about abusive billing practices for anatomic pathology services that prompted a recent multi-year effort to revise the agency's anti-markup rule.

As CMS noted in its proposed rules implementing the Stark I law, self-referral, markups and certain abusive contractual arrangements can distort rational medical decisions, lead to the overutilization of health care services and higher medical costs for patients and third-party payers, and "cause unfair competition by freezing out competitors" unwilling to engage in such practices. These arrangements can also adversely affect patient welfare as well as undermine patient trust in the medical profession. Patients most likely to be affected by these inappropriate practices are often uninsured and those covered by private payers that have not adopted safeguards similar to those designed to protect the Medicare program from abusive billing practices.

In 2007, the Department of Health and Human Services Office of the Inspector General (OIG) launched an investigation into anatomic pathology-related self-referral. OIG published three audits of physician group practices to examine their utilization of anatomic pathology services after entering into business arrangements to capture pathology reimbursements. These arrangements typically utilized a "pod lab" or other contractual joint venture arrangement to obtain the revenues intended for the performance of the technical and professional components of anatomic pathology services.

The OIG audits reveal an alarming increase in the utilization of anatomic pathology services once these group practices were able to capture the pathology-related revenues. In the year after the three urology practices entered into arrangements allowing them to profit from their referrals, their utilization of pathology services increased 699%, 230%, and 26%, respectively. One urology group practice increased its per patient utilization of pathology services from one unit of service to almost 9 units of service. With Medicare reimbursing the examination of a biopsy specimen at about $110 per specimen this represents a cost increase of almost $900 *per patient*.

In addition, the OIG audits reveal that all of the audited physician groups billed significantly more biopsies than the area Medicare carrier paid on average to other providers—124%, 65%, and 58%, respectively. It is difficult to justify such significant increases in utilization over a 2-year period on changes in "clinical practice," considering the comparison with the billing practices of other area providers.

When CMS first started to examine these billing abuses, much of its efforts were focused on "pod labs." These arrangements were described in a 2005 Wall Street Journal article. Since then, and due in part to CMS' initial efforts to curtail these abusive arrangements, new arrangements known as in-office histology laboratories have been established by a number of physicians ordering anatomic pathology services to enable them to exploit the IOASE under the guise of "enhanced patient care."

The IOASE was intended to allow referring physicians to bill for services that are provided during a patient visit. Anatomic pathology services, however, are not ancillary services in that the proper processing of biopsied tissues is time consuming and cannot be performed during the patient visit. As anatomic pathology is not truly an

ancillary service, ASCP strongly encourages the Committee to remove anatomic pathology from the Stark Law's IOASE.

Physician Quality Reporting Initiative:
Allowing Participation in a Maintenance of Certification Program

ASCP strongly supports amending the Physicians Quality Reporting Initiative (PQRI) to allow physicians participating in maintenance of certification (MOC) program to receive PQRI incentive payments. As a certification agency for nonphysician clinical laboratory professionals we can attest to the important role that such programs can have on quality. Another reason we believe that allowing for participation in a MOC program is warranted is the concern that inter-specialty payment differentials could steer the next cadre of physicians away from specialties that lack approved quality measures, raising the prospect of shortages within these specialties. Given the difficulty of developing quality measures for all physician specialties and subspecialties, we believe allowing for participation in a MOC program is appropriate.

ASCP supports incentive payments for physicians participating in initiatives to improve quality, such as the PRQI. While we have concerns about what we believe are design flaws with the program, we believe that patient care is best enhanced by the extension of the PQRI incentive payments. One of our concerns with the PQRI relates to those physician specialties or subspecialties that are not served by an approved quality measure, such as molecular pathology. Consequently the payment structure of PQRI can adversely affect the reimbursement prospects of certain physicians through no fault of their own. We do not believe that this is fair, especially since options under consideration by Congress for the incentive program call for cutting physician reimbursement in 2013–2014 for those physicians that do not participate in the program. Allowing physicians to participate in MOC programs removes this problem with the PRQI.

Transparency and Evidence-Based Decisionmaking for Imaging Services:
Transparency in Self-Referrals

ASCP is concerned about the limited scope of proposals to require physician disclosure of financial interest in certain imaging services provided to patients through the IOASE. ASCP believes that it is clear that abuse of the IOASE is occurring. While Congress' interest on this issue seems to be focused largely on self-referral related to imaging and physician-owned hospitals, self-referral, especially as it relates to abuse of the IOASE, is a growing problem for a number of physician services.

If Congress truly wishes to rein in utilization increases resulting from self-referral, it must act to amend the in-office ancillary services exception to remove those services from the list that are not truly ancillary services, such as anatomic pathology.

Promotion of Adherence to Appropriateness Criteria for Imaging Services:
Transparency in Self-Referrals

ASCP appreciates congressional interest and efforts to curb abusive billing practices, such as abuse of the IOASE. While we appreciate the intent of this proposal to address self-referral of imaging services by providing lower differential payments to ordering providers, this proposal will ultimately fail to stop billing abuse, overutilization, and its accompanying increases in health care costs.

So as long as the differential payment still provides the ability for a referring provider to profit from his or her referrals, self-referral will likely continue. We believe that it would be more effective to reexamine the Stark law's IOASE or to reexamine certification of need requirements. Some of the services that are currently listed in the in-office ancillary services exception, such as pathology, are not truly ancillary services—services that can be performed on the patient during a patient visit. For example, anatomic pathology services require extensive and time-consuming processing that prevents the analysis of biopsied tissue during a patient visit. We strongly recommend removing anatomic pathology from the IOASE.

Chronic Care Management Innovation Center

With regard to proposals to establish a Chronic Care Management Innovation Center at CMS, ASCP is concerned about proposals to utilize a "standard process that would be developed to evaluate the design and performance of payment models under consideration for broad-scale testing." Our concern here is that the criteria that may be most appropriate to evaluate one demonstration project, may not be appropriate for other projects. We are particularly concerned about the criteria that may be adopted to assess quality during a demonstration. For example, during one

recent demonstration project, CMS relied on a measure akin to accreditation status, which fails to allow for a quantitative assessment of the facilities performance during the course of a demonstration project.

The Sustainable Growth Rate

ASCP believes that the Sustainable Growth Rate (SGR) should be repealed this year and replaced with an updated system that reflects increases in physicians' and other health professionals' practice costs. A realistic budget baseline for future Medicare payment updates that accurately reflects the anticipated costs of providing physicians with positive updates under a new update system in lieu of SGR-related cuts should be incorporated into the Federal budget.

Should Congress and the Administration decline to repeal the SGR this year, it should adopt a transitional approach that does the following:

- Establish by law a roadmap for complete replacement of the SGR by 2015.
- Provide stability and predictability with positive, funded updates from 2010–2015 set by statute and linked to the Medicare Economic Index (MEI) for each year until a replacement takes effect.
- Establish a realistic baseline for Medicare spending on physician services that eliminate the assumption that SGR-driven cuts will be implemented, thereby greatly reducing the score assigned to legislation to repeal the SGR.
- Use regulatory authority to remove physician-administered drugs from the SGR from 1996 on to help reduce the cost of repeal.
- Use regulatory authority to adjust the Medicare Economic Index to include all the costs of a current medical practice and use realistic productivity assumptions.

Encouraging Health IT Use and Adoption in Support of Delivery System Reform Goals

Laboratory medicine and pathology is responsible for 60–70 percent of all patient diagnoses and treatments, and yet it is responsible for less than 2 percent of overall Medicare spending. Pathology and laboratory medicine's contributions are regularly overlooked. Pathology and laboratory medicine, along with pharmacy and imaging, is one of the areas of health care best positioned to contribute to Health Information Technology systems and Electronic Health Records (EHRs). Much, if not most, of the data that will likely be contained in patient EHRs will be pathology and laboratory test data.

We suspect that much of the EHR records submitted by hospitals to qualify for Medicare EHR incentive payments will come from the hospital clinical laboratory, possibly even when the hospital has contracted out for much of its laboratory services. Moreover, since an independent clinical laboratory owned and operated by a pathologist appears to be eligible for the Medicare EHR incentives, it seems odd, and unfair, that other independent clinical laboratories would not be able to qualify for the incentive program. We believe that this could slow the adoption of HIT/EHR. As a result, ASCP encourages the Committee to allow all independent clinical laboratories to qualify for EHR incentive payments.

Physician Payment Sunshine

ASCP supports transparency in the relationship between providers and manufacturers; however we do not believe that this proposal has sufficient breadth. ASCP believes that physician self-referral is a major issue and one that is responsible for a large share of the increases in health care costs, particularly with respect to increased utilization of health care services per patient. As a result, ASCP believes that provider submission of payment and ownership information should be extended to physicians ordering medical services through other physicians, providers, or entities with or in which they have an ownership or financial interest.

One of our concerns has been the increasing utilization of anatomic pathology services by physicians in a position to profit from (markup) their referrals. We suggest that as part of the reform process, CMS be required to revise its Medicare claims forms to better capture information that would reveal when providers or entities, such as independent clinical laboratories, are billing for services by a provider or group practice that has an ownership or other financial interest in that laboratory or entity. We believe that this latter proposal will help shed more light on the problems that can be caused by pod labs and in-office histology (technical component) laboratories, both of which can facilitate physician self-referral. Moreover, these entities may be responsible for the significant increases in charges and utilization of anatomic pathology services (CPT 88305).

Developing a National Workforce Strategy

ASCP believes there is an urgent need to develop a national workforce strategy. ASCP shares the concerns expressed by the American Association of Medical Colleges (AAMC) that physician shortages could impede our Nation's health care reform efforts. Recent findings from AAMC's Center for Workforce Studies project that an enrollment increase of 6,000 in medical and osteopathic schools between 2002 and 2013 would not be enough to ameliorate the estimated shortage of as many as 100,000 physicians or more in the coming years. Furthermore, medical school enrollment increases will not lead to net increases in the physician supply without a corresponding increase in residency training positions.

In addition, ASCP does not believe sufficient attention or funding is being provided for documented allied health professions shortages, such as for clinical laboratory professionals. A recent report on allied health personnel shortages (including nursing) in California was conducted by Health Workforce Solutions for the Campaign for College Opportunity. The report concluded that the profession experiencing the greatest need was technologist-level laboratory practitioners. Unfortunately, over the last few years many of the accredited clinical laboratory programs training our next cadre of laboratory professionals have closed, further eroding our Nation's ability to address staffing shortages. With laboratory professionals responsible for performing the laboratory tests that account for 60–70 percent of medical diagnoses and treatments, increased government attention to this shortage is in the Nation's best interests.

Health Insurance Benefit Options

We urge Congress to make sure that when legislating the benefits required for insurance plans, that the list of covered services includes clinical laboratory diagnostic testing and screening. It is necessary to include laboratory services to ensure that all insurance plans provide coverage for these services. Laboratory services are essential for prompt and effective patient diagnoses and treatments. Further, clinical laboratory testing is a key component of preventive medicine and failure to specifically cover these services could undermine the Committee's previously stated goals to emphasize prevention and wellness.

Promotion of Prevention and Wellness in Medicine

Given the importance of laboratory testing to early, more affordable diagnoses and treatments, we believe it is necessary to specifically add the performance of appropriate clinical laboratory testing as a central component of a Medicare comprehensive health risk assessment and personal prevention plan.

Incentives to Utilize Preventive Services and Engage in Healthy Behaviors

Regarding congressional proposals to remove or limit cost-sharing (copayment, deductible or both) for preventive services covered under Medicare and rated "A" or "B" by the U.S. Preventive Services Task Force (USPSTF), we do not believe that USPSTF should solely be tasked with such determinations. Other groups such as the Advisory Committee on Immunizations Practices, Institutes of Medicine, the Centers for Disease Control and Prevention, National Institutes of Health, medical specialty associations, patient care groups, scientific societies and the Clinical Laboratory Improvement Advisory Committee should be added.

We note that the USPSTF's recommendations do not call for annual screening of individuals 30 and older who are at risk for having or developing type 2 diabetes mellitus or screening all patients with diabetes mellitus for chronic kidney disease annually, both of which is recommended by the American Association of Clinical Endocrinologists. We believe that such screening is justifiable not only from a proper patient care perspective but also on cost benefit grounds.

Moreover, we believe that it would be beneficial for recommendations from the USPSTF and the aforementioned groups to be reviewed and approved by the National Quality Forum consensus standards process for inclusion in CMS' pay-for-performance incentive program.

ASCP also believes that patient care would be enhanced by broadening the current composition of the USPSTF, which is comprised solely of primary care physicians, to include other specialties and public health professionals.

Adjusting Reimbursement for High-Growth, Over-Valued Physician Services

ASCP believes that physician and other health care services, such as clinical laboratory tests, should be rationally and adequately valued. While the proposal to adjust reimbursement may have merit, we have concerns about several congressional proposals that have received attention. Unless reform clearly allows for readjusting reimbursement for those services that are currently undervalued, these reforms will

lack rationale and have the potential to adversely affect access to important health care services. An effort that focuses solely on those services that are overreimbursed could limit access to essential services as providers may elect not to provide those services that are underreimbursed.

Modifying Beneficiary Contributions:
Making Beneficiary Contributions More Predictable

ASCP is concerned about the discussions to apply a 20 percent copay to all Part B Medicare services, such as clinical laboratory services. We believe applying a copay to clinical laboratory services is ill-advised for several reasons. First, because laboratory services are ordered by the patient's physician and not the patient, a copay on laboratory services would not likely result in sufficient savings, which is part of the rationale for a copay. Additionally, laboratory services are a key component of preventive medicine and applying a copay to these services could undermine the Committee's previously stated goals to emphasize prevention and wellness. It would shift an entirely new cost burden, approximately $24 billion, to Medicare beneficiaries.

We note that the Institute of Medicine (IOM) considered this issue as part of its 2000 report *Medical Laboratory Payment Policy* and noted that "cost sharing could create a barrier to appropriate use of laboratory services for chronically ill and financially disadvantaged beneficiaries, which could ultimately lead to greater program costs if deferred testing delays diagnosis and leads to more costly treatment." IOM recommended against imposing a copay on clinical laboratory services, concluding that because of the administrative costs and burdens . . . , cost sharing for laboratory services is inconsistent with its goals for a laboratory payment system that ensures beneficiary access and maintains administrative simplicity."

ASCP appreciates this opportunity to provide comments on the Committee's efforts toward health care reform. If you have any questions about our comments, please do not hesitate to contact Matthew Schulze, ASCP's Senior Manager for Federal and State Affairs, at (202) 347–4450 or by email at matthew.schulze@ascp.org.

Statement of Paul Crist

Americans for Medicare in Mexico, A.C. is an organization formed in Mexico by American citizens living either full-time or part-year in Mexico, who support and promote a Medicare Demonstration Project in Mexico. These individuals continue to vote and participate in other civic activities as U.S. citizens, as allowed under State and Federal elections laws.

The need to cap spending and to find innovative reforms that reduce Medicare program costs is well documented. Actuarial data predicting a looming deficit and eventual insolvency of the Medicare Trust Fund make it ever more urgent to find savings as the percentage of seniors in the U.S. population increases and health care costs continue to climb.

Based on data from a number of sources, a strong argument can be made that providing Medicare benefits to eligible beneficiaries in Mexico would result in substantial savings to the Medicare Trust Fund.

Mexico is home to *at least* 800,000 American citizens (and many estimates exceed 1 million). Based on recent demographic studies, over 200,000 of these people are 60+ years old, and thus at or near eligibility for Medicare benefits. In addition to these full-time, year-round seniors living in Mexico, an estimated 40% to 60% more live in Mexico for part of the year (under tourist visas).[1]

Besides a moderate climate and warm and welcoming Mexican people, the cost of living is attracting thousands of retirees south of the U.S. border every year. In most of the well-known, popular, and safe American communities in Mexico, such as San Miguel de Allende, Lake Chapala, and Puerto Vallarta, retirees can live comfortably on a modest income. Even a U.S. Social Security check is enough to get by on. According to one survey of expatriate seniors, the median household income for this group is only US$35,000.[2]

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[1] International Education and Research Center. *Preliminary Report #1. U.S. Expatriates Residing in Mexico.* Mexico DF, 2008.

[2] Dr. David C. Warner. *Medicare in Mexico: Innovating for Fairness and Cost Savings.* University of Texas, LBJ School of Public Policy, Austin, TX. 2007.

Lack of access to the Medicare benefits for which they've paid is the top concern for seniors living in Mexico or considering retiring there. For seniors who have paid into the Medicare Trust Fund during their entire working lives, it is unfair to shut them out from coverage based on where they live. Many choose Mexico because they find it increasingly difficult to manage on a fixed retirement income in the United States, so the decision to retire to Mexico is frequently an economic one.

Further, obtaining private insurance in Mexico is extremely difficult for anyone with a preexisting condition (which describes most seniors). Even high cholesterol or blood pressure can shut the door on insurance coverage. And for those over 75, private insurance is essentially unavailable in Mexico.

This testimony will show why providing Medicare to eligible seniors in Mexico is a win-win proposal.

Health care costs in Mexico are a fraction of those in the United States, while large majorities of seniors report high satisfaction with the quality of care. Lower-cost health care services provided in Mexico means Medicare wins by saving money. Seniors in Mexico win, because they'll have access, where they live, to the high-quality services they've paid for during their working years.

Medicare Program Cost-Savings Analysis for a Demonstration Project Providing Medicare Benefits to Eligible Beneficiaries Residing in Mexico

Based on data from a number of sources, a strong argument can be made that providing Medicare benefits to eligible beneficiaries in Mexico would result in substantial savings to the Medicare Trust Fund.

According to a report by the Kaiser Family Foundation, Medicare spent on average $6,255 per beneficiary on health items and services in 2005.[3] The following chart from that study, based on the CMS Medicare Current Beneficiary Survey, details the changes in Medicare spending between 1997 and 2005. It highlights unsustainable cost increases for Medicare (53.2% increase), for beneficiaries (53.0%), and for third-party payers (73.4%) during the period.

Cost increases for all payers (Medicare, third-party, and beneficiaries) are at an unsustainable level. Medicare must look to every available innovation for cost savings for all three payer groups.

Per Capita Out-of-Pocket Spending by Medicare Beneficiaries on Health Care Services and Premiums, 1997 and 2005

	1997		2005		Difference, 1997-2005		Percent increase, 1997-2005	Share of growth, 1997-2005
Number of beneficiaries	39.7 million		43.4 million					
	Spending amount	Share of total	Spending amount	Share of total	$	%		
Total (health services and premiums)	$9,943	100.0%	$15,237	100.0%	$5,294*	–	53.2%	100.0%
Medicare spending	$4,452	44.8%	$6,255	41.1%	$1,803*	-3.7%*	40.5%	34.1%
Third-party payer/other spending	$2,843	28.6%	$4,930	32.4%	$2,087*	3.8%*	73.4%	39.4%
Out-of-pocket spending (premium plus nonpremium spending)	$2,648	26.6%	$4,052	26.6%	$1,404*	0.0%	53.0%	26.5%
Breakdown of out-of-pocket spending								
Premium spending	$968	36.5%	$1,576	38.9%	$609*	2.4%*	62.9%	43.4%
Non-premium spending	$1,681	63.5%	$2,476	61.1%	$795*	-2.4%	47.3%	56.6%
Facility (LTC and SNF)	$740	27.9%	$804	19.8%	$64	-8.1%*	8.6%	4.5%
Prescription drugs	$314	11.9%	$612	15.1%	$298*	3.2%*	94.8%	21.2%
Medical providers and supplies	$310	11.7%	$581	14.3%	$271*	2.6%*	87.2%	19.3%
Dental	$153	5.8%	$225	5.6%	$72*	-0.2%	47.1%	5.1%
Outpatient hospital services	$74	2.8%	$145	3.6%	$71*	0.8%*	95.5%	5.0%
Inpatient hospital services	$69	2.6%	$90	2.2%	$20*	-0.4%	29.3%	1.4%
Home health	$20	0.7%	$19	0.5%	-$1	-0.3%	-2.7%	0.0%

NOTES: LTC is long-term care. SNF is skilled nursing facility. * indicates difference between 2005 value and 1997 value for each estimate is statistically significant at .05 level.
SOURCE: Kaiser Family Foundation analysis of CMS Medicare Current Beneficiary Survey Cost and Use files, 1997 and 2005

For the approximately 200,000 seniors living in Mexico, the provision of Medicare benefits would result in substantial savings to the Medicare Trust Fund, to beneficiaries, and to any third-party payers providing Medicare Supplementary Policies

[3] Tricia Neuman, Juliet Cubanski, and Anthony Damico. *Medicare: Revisiting "Skin in the Game" Among Medicare Beneficiaries; an updated analysis of the increasing financial burden of health care spending from 1997 to 2005.* Henry J. Kaiser Family Foundation. February 2009.

to this group. It would also resolve a serious issue of access and utilization of health care services by this group of seniors, thus improving health outcomes.

In September 2008, the Mexican government published the results of a survey of expatriate U.S. and Canadian residents in Mexico.[4] In that survey, which sought to identify the major obstacles faced by immigrating foreigners into Mexico, 80% of respondents were U.S. citizens. Nearly half (48.8%) of respondents were 61 years of age or older, and 76.5% were retired. Over two-thirds (71.3%) were year-round residents and 28.8% were part-year residents in Mexico.

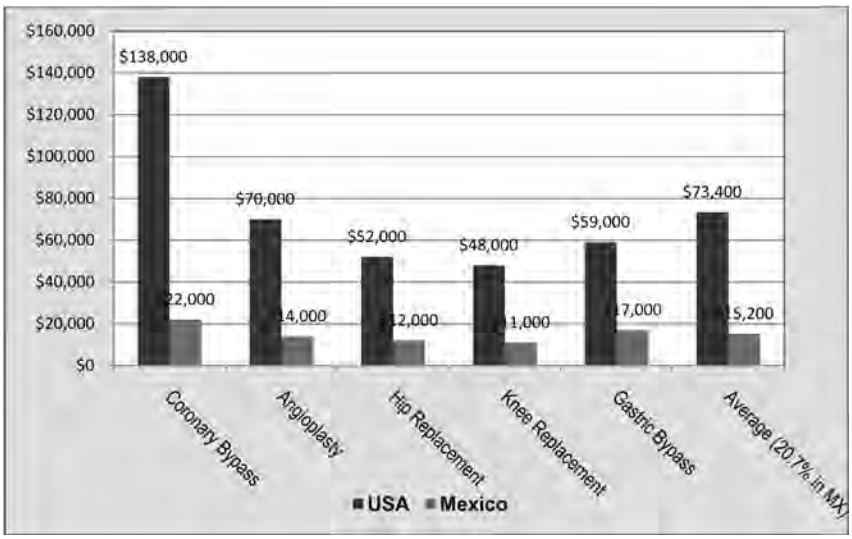
Over half of the respondents (56.8%) indicated some difficulty with obtaining medical coverage in Mexico, with 17.0% indicating extreme difficulty. And 66.1% had paid some amount in medical expenses out-of-pocket, despite having coverage in the United States, while 9% claimed never to have visited a doctor in Mexico.

Nearly eighty-five percent (84.8%) felt that health care costs were lower or much lower than in the United States, while 67.3% felt that service was as good as or better than that available in the United States. And 82.5% believed that if Medicare benefits were available in Mexico, more Americans would retire there.

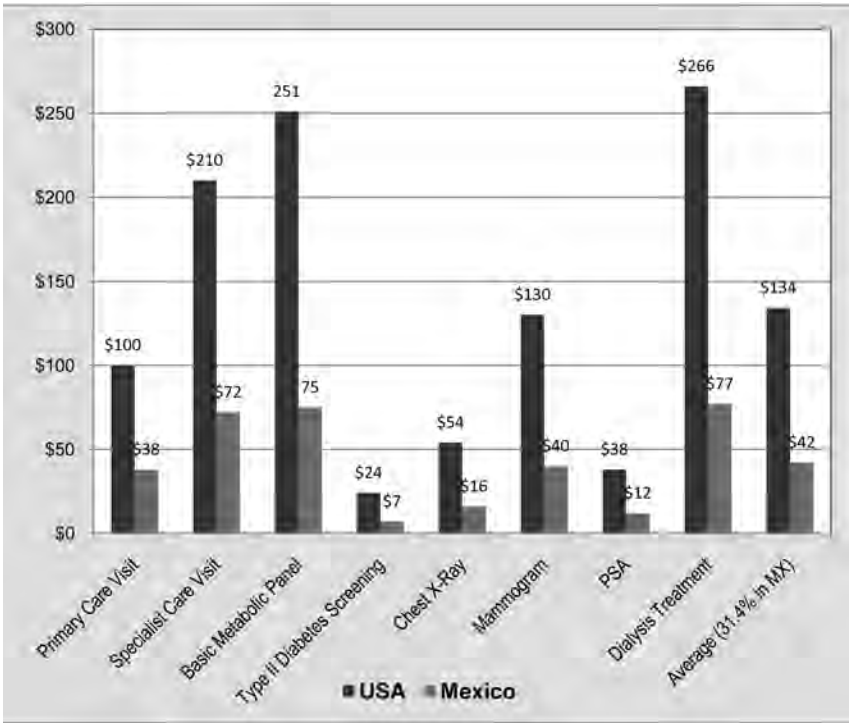
Thus, the overwhelming consensus of expatriate seniors living in Mexico is that:

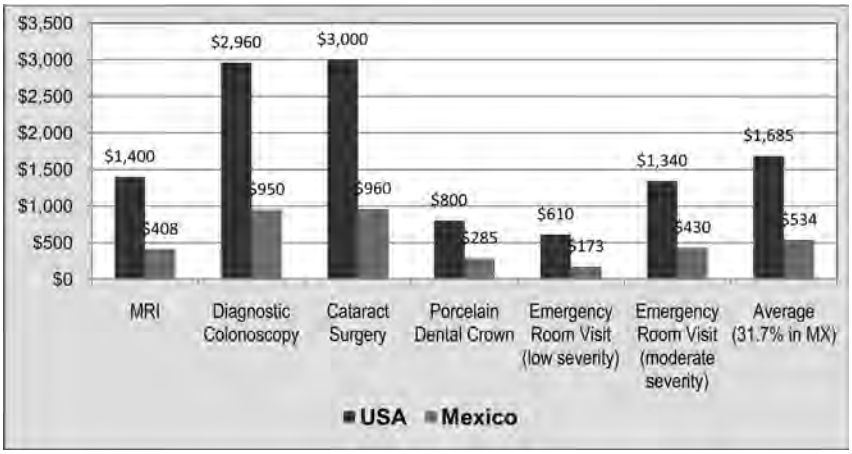
- **Obtaining health care coverage in Mexico is difficult for non-Mexican citizens, particularly seniors.**
- **Health care costs are substantially lower in Mexico than they are in the United States.**
- **Quality of care is as good as that available in the United States.**

The perception of seniors responding to this survey, regarding costs, is supported by solid evidence. Based on our investigations of health care costs for specific, common medical services and procedures, the cost of health care in Mexico does not exceed 35% of that in the United States, and is probably even lower. Obtaining average costs for medical services is difficult, as prices vary widely both in the United States and in Mexico, but the following findings make a powerful case that costs are much lower in Mexico (see charts, below and next page).



[4] Dr. Rodrigo García Verdú. Resultados de la Encuesta de Percepción entre Ciudadanos Estadounidenses y Canadienses Residentes en México. Secretaria de Hacienda y Crédito Público; Unidad de Seguros, Pensiones, y Seguridad Social. September 2008.





As the preceding charts show with regards to the cost of medical services, it is not just the perceptions of expatriate residents that confirm lower costs in Mexico. Costs range from 70% to 80% lower in Mexico for common procedures.[5] And on aver-

[5] Prices for these procedures and services are compiled from a variety of sources, including various online sources and information provided by individual Mexican and U.S. health care providers. In the case of major procedures described in the first chart, prices include estimated post-operative hospital stay. Part of the large difference is the very high cost of hospitalization in the U.S. relative to Mexico.

age for a broad "basket" of treatments and procedures, Mexican health care costs certainly do not exceed 35% of U.S. costs.

Without doubt, the requirements of additional medical and financial record-keeping, certification to international standards and improved administration will add some costs to Mexican health care providers, and place some upward pressure on medical services pricing in the market. However, both the Mexican government and the health care industry are already pursuing these innovations. Modest cost increases associated with improved administrative capacity are already a fact in most urban markets in Mexico.

Even in the unlikely scenario that Mexican prices climbed to 50% of U.S. prices, the potential for Medicare savings would still be large.

Consider the following:

1. Assume only 20,000 enrollees in a Medicare Demonstration Project in Mexico.
2. Assume the worst case scenario that Mexican health care costs climb to 50% of U.S. costs.
3. Using the 2005 Medicare per-beneficiary spending, as shown in the Kaiser report previously cited.
4. Assume that currently, 64% of Mexico's expatriate seniors are traveling back to the U.S. for major medical care, but would remain in Mexico for care if it were covered there.[6]

Number of Enrollees	Country Location	Per-Beneficiary Medicare Cost	Utilization Rate	Total Cost
20,000	U.S.A.	$6,255 (based on 2005 spending as shown in the previous chart)	64%	$80,064,000
20,000	Mexico	$3,127 (50% of above per beneficiary cost)	100%	$62,540,000

Thus, these calculations show a worst case scenario, in which:

- **Health care costs in Mexico increased to 50% of U.S. costs; and**
- Medicare utilization rates in Mexico are 100% of enrollees, compared to an estimated 64% now using Medicare by traveling back to the United States.

Saves $17,524,000 per year, or a 21.9% cost savings to Medicare!

However, the savings are likely to be larger. If enrollees in the Mexico Demonstration have a greater tendency to seek early diagnosis, preventive care, and wellness management, a portion of the high-cost inpatient care they are now obtaining in the United States could be eliminated. Because seniors in Mexico are currently paying for outpatient services out-of-pocket, it is almost certain they are now foregoing early care that would mitigate later inpatient treatments and procedures. With a Medicare Part B option available in Mexico, more seniors will seek early interventions, reducing costs and resulting in improved health outcomes. When hospitalization is required, Medicare Part A coverage in Mexico will provide the high-quality care that seniors deserve and Medicare requires, while saving substantial cost.

What is a "Medicare Demonstration Project?"

Short Answer: A Demonstration Project is the legal name for a Medicare pilot project, or experiment, in a Medicare program innovation. Since Medicare has never operated outside the United States, a Demonstration Project is required to prove that it can be done. The experiment seeks to prove that it is administratively feasible; that it will be budget neutral or cost saving; that it will result in improved health outcomes for participating beneficiaries, etc.

We are seeking congressional authorization for a Demonstration Project because the current legislation does not allow for CMS to implement Demonstration Projects outside of the United States.

More Detail

Historically, Federal policymakers have understood the need to test new ideas in the complex Medicare and Medicaid programs. Research and demonstrations projects whether initiated by States, health services researchers, providers, health plans, CMS, or Congress often lead to models or reforms available or mandated nationwide.

[6] Dr. David C. Warner. *Medicare in Mexico: Innovating for Fairness and Cost Savings.* University of Texas, LBJ School of Public Policy. Austin Texas. 2007.

Therefore, Federal law permits the Secretary of Health and Human Services to waive certain provisions of the Social Security Act and associated regulations as needed to conduct demonstration projects in Medicare, Medicaid, or both Medicare and Medicaid. Waivers are purely discretionary unless congressional legislation mandates a specific project.

Medicare Waivers Under Sections 402/222

Under Sections 402/222, the HHS Secretary may waive Medicare statutes and rules to demonstrate new approaches to provider reimbursement, including tests of alternative payment methodologies, demonstrations of new delivery systems, and coverage of additional services to improve the overall efficiency of Medicare or to improve health outcomes for beneficiaries. (Sections 402/222 refer to section 402[a] of the Social Security Amendments of 1967, as amended by section 222[a] of the Social Security Amendments of 1972.)

Any organization or individual may propose a Medicare waiver project. This includes providers, health plans, State Medicaid agencies, and health services researchers. CMS maintains an open invitation for outside parties to propose Medicare demonstration projects and the necessary waivers. However, the bulk of Medicare waiver-based demo projects are congressionally mandated in legislation or initiated administratively by CMS. CMS-initiated Medicare demonstration projects are often developed at the behest of the HHS Secretary, the White House Office of Management and Budget (OMB), the Medicare Payment Advisory Commission (MedPAC), or the Office of the Inspector General.

Unlike many Medicaid waiver-based projects, most Medicare waiver projects tend to be genuine demonstrations projects with a careful research design and evaluation methodology.

Once approved, Medicare waiver projects are administered by CMS either directly, through contractors (e.g., Medicare administrative contractors, Medicare Advantage plans), or (rarely) through States. Except for operational waivers, CMS evaluates each demonstration project. Major Medicare demonstrations, including congressionally mandated projects, are evaluated by independent health services researchers hired by CMS.

Every proposed Medicare waiver program must be budget neutral to the Federal Government. That is, Medicare under the requested waivers must be projected to cost the Federal program no more than expected spending without the waivers. There is no set methodology—economic or actuarial—for determining Federal budget neutrality.

Authority to issue waivers under §§ 402/222 rests with the HHS Secretary. However, all Medicare waivers, regardless of size and scope, require the prior review and approval of the White House Office of Management and Budget (OMB). OMB may require changes, additional terms and conditions, or reject the proposed waivers.

Medicare waiver projects initiated by CMS are typically operated for 3 or 5 years, depending on how much time is needed to test the policy change. Congressionally mandated waivers vary in length, with most 3 to 5 years in length and some indefinite.

A Brief Look at Health Quality Indices in the United States and Mexico

In two separate surveys, overwhelming majorities of seniors living in Mexico report high levels of satisfaction with the quality of care available in Mexico.[7] But is that an adequate measure to determine the quality of available health care in Mexico?

Another way to assess quality of care may be a comparison of some common indices used to compare health care systems and quality among countries. These comparisons also have certain limitations, however. For example:

- Differences in health care spending per capita can result in substantial variation in indices of infant mortality, life expectancy, and other measures. In wealthy countries, a larger portion of the population may have access to services than in poorer countries, which can skew per capita spending statistics. Further, higher spending is not always a guarantee of better health outcomes. Thus, per-capita spending statistics must be considered in the context of differences in wealth; differences in income distribution; and cultural differences.

[7] Medicare in Mexico: Innovating for Fairness and Cost Savings, a study led by Dr. David Warner of the University of Texas, LBJ School of Public Policy; 2007. Also, Resultados de la Encuesta de Percepción entre Ciudadanos Estadounidenses y Canadienses Residentes en Mexico, a survey for the Mexican government, undertaken by Dr. Rodrigo García Verdú, an economist with the Ministry of Finance.

- Differences in first-year infant mortality are affected by the percentage of births in hospitals or attended by trained health personnel. In a poorer country, more births occur in the home or unattended by health professionals, skewing the statistics. As a consequence, infant mortality differences between countries may not necessarily reflect differences in quality of care when health professionals are involved.
- Similarly, differences in life expectancy may be reflective of wealth and income disparity, with associated access and utilization of health care services, rather than real differences in the quality of care available in the formal health care system.

Nonetheless, commonly used indices can be helpful guidelines in assessing differences in quality of health care available between countries, with the proviso that indices are a snapshot that does not take into account differences in wealth, income, income distribution, educational levels, and culture. Given the significant differences that exist between the United States and Mexico on these factors, the indices reported by the World Health Organization for Mexico compare favorably with the indices for the United States.

Data from the World Health Organization Statistical Information System Interactive Database of Core Health Statistics for 193 Member Countries

	Per Capita Total Expenditure on Health (Purchasing Power Parity in U.S. $) 2006 data	Physician Density per 10,000 population 2006 data	Healthy Life Expectancy 2003 data	Life Expectancy (for persons born between 2005–2010) 2006 data	Infant Mortality (deaths during the first year/ 1000 live births) 2006 data
U.S.A.	$6,714	26.0	69.0	79.0	7
Mexico	$756	20.0	65.0	74.0	29

The above data reveal some interesting things:

- A huge difference in per capita total expenditure on health care has only a small effect on either healthy life expectancy or life expectancy for those of the current generation being born.
- Differences in physician density per 10,000 population are not large.
- Infant mortality rates are much higher in Mexico. However, certain infant mortality statistics for Mexico are not readily available:
  - Rates for attended or hospital births for Mexico are known to be much lower in Mexico than in the United States. This can be expected to result in higher infant mortality in Mexico.
  - Infant mortality rates among the highest wealth and education quintiles in Mexico are not available. Attended and hospital births among these groups would be substantially higher than the national average, and this would likely be reflected in much lower infant mortality for births among these population sectors.
  - Infant mortality in Mexico has been reduced dramatically. In 1990, the rate was 42/1,000 live births. Government programs increasing prenatal care and education, expanding access to health services for expectant mothers, and economic growth have expanded access to health care services generally.

In sum:

- **World Health Organization indices appear to show that Mexico is achieving reasonably good health outcomes at very low cost.**
- **Expatriate Americans' perceptions about the quality and cost of health care in Mexico are very favorable.**
- **Cost comparisons show that health care services cost less than 35% of those in the United States.**
- **CMS could achieve substantial savings, improve health outcomes, and increase beneficiary satisfaction by providing eligible beneficiaries access to high-quality care in Mexico via a Medicare Demonstration Project.**

Submitted by Paul D. Crist, President,
Americans for Medicare in Mexico, A.C.

Association of Ambulatory Behavioral Healthcare

Dear Mr. Rangel and Committee Members:

The Association of Ambulatory Behavioral Healthcare (AABH) is providing Public Comment by way of this letter on issues related to the **Health Reform in the 21st Century: Proposals to Reform the Health System**. We thank you for the opportunity to comment on this issue.

The AABH is a national membership organization of Partial Hospital Programs (PHP) and Intensive Outpatient Programs (IOP), outpatient hospital treatment providers, free standing treatment providers, administrators, doctors, psychologists, nurses, program directors, and front line therapist and support staff who serve as educators, case managers, political advocates, and treatment providers of individuals with mental illness and substance use (M/SU).

The AABH feels that the use of Partial Hospital Programs (PHP) and Intensive Outpatient Programs (IOP) to treat mental illness and substance use (M/SU) conditions are proven methods of care and money saving options to inpatient and emergency care for these individuals and should be considered as the primary option to manage these conditions effectively and economically.

The AABH supports the PHP and IOP treatment programs concept within the M/SU continuum of care, flanked by outpatient/assessment services and inpatient/acute services. Medical necessity guidelines determine eligibility for PHP and IOP treatment and reflect an acuity level only slightly less severe than inpatient treatment.

In general, PHP and IOP treatment is effective when deemed medically necessary by the treating physician to avert inpatient hospital treatment. The patient must be experiencing noticeable impairment in self-care and must be unable to fulfill expected life functions. Patients may also be referred to PHP or IOP as a step-down from more expensive inpatient treatment to facilitate base-line functioning. PHP and IOP services are known for their ease of accessibility, and low cost treatment for individuals with acute and chronic mental illness.

PHP and the less intensive IOP treatment, engages the patient in diagnostic assessments, symptom management and coping skills education, crisis intervention and relapse prevention, and relies on best practices and performance benchmarking to provide information as to the efficacy of the treatment programs.

The continuance of PHP and IOP services within the continuum of care is vital, as it allows for patients to be treated in the less restrictive and a considerably less costly level of care, to be treated in the community in which they live, and takes steps to prevent decompensation of symptoms establishing a more positive quality of life.

The AABH supports reform efforts that assist and establishes integration of the best knowledge and expertise available for M/SU treatment and prevention services into the health care reform planning process.

The AABH fully supports utilizing the already proven and effective interventions provided through outpatient programs such as PHP and IOP for treating M/SU conditions while new and innovative interventions are being sought. M/SU treatment benefits already well exceed costs—for every dollar spent on M/SU treatment, we estimate that $7 in future health care spending can be saved. PHP and IOP care will save money.

Partial Hospital Programs (PHP) and Intensive Outpatient programs (IOP)

Since as early as 1968, PHPs have been providing mental health and substance abuse treatment for the Nation's chronic and disabled mentally ill. Although not widely used until the mid 1990s, the PHP was developed as a less costly and more accessible treatment option to in-patient hospital care. As the M/SU patient is treated in the environment in which he lives, he is able to live in a stable environment and receive outpatient treatment close to his home. The savings are significant when the efficacy and cost of a long-term PHP care is set against the efficacy and cost of short-term hospital or emergency care.

Partial Hospital Programs (PHP), and the less structured Intensive Outpatient Programs (IOP), are ambulatory, active and time-limited M/SU treatment programs that offer therapeutically intensive coordinated and structured clinical services within a stable therapeutic milieu. "Partial Hospital and Intensive Outpatient" implies psychosocial milieu treatment with group therapy as the primary treatment modality. While specific program variables often differ, all PHPs and IOPs pursue the general goals of stabilizing clinical conditions, reducing symptoms and impairments, averting inpatient hospitalization, reducing the length of a hospital stay, and providing medically necessary treatment for individuals who cannot be effectively treated in a less intensive, strictly outpatient level of care.

All PHPs and IOPs attempt to employ an integrated, comprehensive and complementary array of evidence-based treatment approaches. Programs are designed to serve individuals with severe symptoms and functional impairments resulting from M/SU disorders. They are also intended to have a positive clinical impact on the individual patient's support system and therefore the individual's recovery environment. Treatment services may be provided during the day time, evening time and on some occasions, on the weekends.

PHPs and IOPs may be free-standing, part of a mental health organization, or a department within a medical health care system. One of the unique strengths of a PHP or IOP is its applicability to a diverse array of circumstances such as clinical conditions, patient populations, treatment durations, treatment settings, etc.

PARTIAL HOSPITAL PROGRAMS and Intensive Outpatient Programs ARE INTENDED TO BE COST EFFECTIVE AND:

- Provide the M/SU patient a way of managing their illness in an environment that allows them to remain in their homes and communities;
- Provides Continuum of Care options, as these patients require psychiatric care of some type for their entire lives;
- Provide options, other than inpatient hospitalizations, which are far more restrictive, far more costly, and far less effective;
- Provide a cost savings, as untreated mentally ill patients will eventually end up in hospital emergency departments, jails, prisons, or become part of the growing homeless population.

The concept of PHP and IOP is to maintain patients with chronic behavioral disorders in a controlled environment, providing psychotherapeutic and pharmacologic support on a daily basis, without requiring an inpatient hospitalization. Patients admitted to a PHP or IOP must be under the care of a physician; patients must provide written informed consent for treatment; must require comprehensive treatment due to a M/SU disorder which severely interferes with multiple areas of daily life, including social, vocational and educational functioning.

Patients appropriate for the PHP or IOP level of care comprise the following:

- Discharged from an inpatient hospital treatment program;
- In lieu of continued inpatient treatment; or
- Patients who, in the absence of partial hospitalization, would require inpatient hospitalization.

Patients admitted to a PHP or IOP are provided comprehensive treatment and utilize the same services as inpatient psychiatric care at a greatly reduced cost; the treatment directly addresses the presenting symptoms and problems and consists of clinically recognized therapeutic interventions including individual, group, and family therapies and activities pertinent to the patient's illness. Medical and psychiatric evaluations and medication management are integral to treatment.

Admission Criteria to a PHP and IOP

M/SU patients should be treated in the least intensive and restrictive setting that meets the needs of their M/SU illness. If patients do not require a 24-hour per day level of care, as provided in an inpatient setting, the PHP outpatient level of care is the perfect setting to prevent inpatient hospitalization. The M/SU patients being treated in a PHP or IOP receive active treatment through a combination of services such as psychotherapy, occupational, activity therapy and medical interventions as necessary.

Patients admitted to a PHP or IOP must have an acute onset or decompensation of a covered Axis I mental disorder which severely interferes with multiple areas of their daily life and will have a degree of impairment that is severe enough to require a structured program.

Services Provided in a PHP or IOP

- Medically necessary diagnostic services related to M/SU.
- Individual or group therapy; Occupational therapy.
- Drugs and biologicals that cannot be self-administered.
- Individualized activity therapies that are essential for progress toward treatment goals.
- Treatment plans noting how each therapy fits into the treatment of the patients illness.
- Family counseling to assist the family members in helping the patient.
- Patient education where activities are related to the care and treatment of the patient.
- Diagnostic services for the purpose of identifying problem areas.

M/SU conditions are tied to physical health and can be addressed like other chronic and acute conditions in order to provide efficacious health care. Ignoring one is likely to compound the other. However, for people that need M/SU treatment services the services vary widely. An effective health care delivery system must provide:

- Providers who are paid for providing services with desired outcomes;
- A comprehensive range of services;
- The full continuum of care, including PHP and IOP services;
- Service to those with both acute and chronic condition;
- Service to a wide and varied population—some will present themselves, some will be delivered into the system, and some the system will need to seek out and serve.

Summary: PHP and IOP Included in Health Care Reform

PHPs and IOPs have evolved over the years until their current status as an instrumental part of the behavioral health continuum. Clients are referred both as an alternative to inpatient hospital care as well as a step-down from inpatient hospital care. PHPs and IOPs are particularly successful with first episode of care patients and utilize an educational format combined with group therapy, medication management, and specialized therapies to assist people in understanding their diagnosis and initiating a path toward recovery. Most programs are managed and adhere to strict medical necessity guidelines which determine individual eligibility for care.

While reform must successfully deal with the medical needs of the many healthy individuals, the greater challenge is to ensure that a reformed system better serves the medical and M/SU chronic care and prevention needs of a small fraction of the population that consumes a disproportionate number of services.

The AABH supports reform that goes beyond the current standards and practices of the meeting patient's needs and is looking to be involved in assisting in the crafting of new and innovative methods of care that are not only less costly but also more effective. Currently providers are paid for providing services rather than producing desired outcomes. There are significant disparities in health and health outcomes as they exist across sectors of society. Individuals, health practitioners, and policymakers make decisions based on a limited evidence base regarding which practices work effectively for which groups or individuals. In addition, the current system focuses heavily on expensive acute care for physical and M/SU illnesses to the detriment of an approach that can prevent and/or stabilize disease well before acute care is ever needed.

In conclusion, we want to make sure that health care reform includes the provisions of PHP and IOP services for M/SU in health care plans, as they maintain a fundamental alternative to inpatient care for the seriously ill M/SU patient in acute crisis, while providing a supportive community-based setting that maintains the continuation of family and community support. This gives the patient the opportunity to maximize treatment gains through completion of homework assignments, reconnect with community services, seek out employment options, and be involved in activities that develop strengths and enhance resiliency and recovery.

Again, we would again like to thank you for this opportunity to share our comments. The AABH continues to work with other organizations and governmental agencies towards an integrated health care system where the M/SU patient will be able to receive a multitude of services including treatment in a PHP and IOP economically.

Sincerely,

Larry Meikel—*President of the Board*
JoAnne Mandel—*Co-Chairperson; Public Policy Committee*
AABH Board of Directors
Public Policy Committee

Statement of Becton, Dickinson and Company

BD is a leading global medical technology company that develops, manufactures and sells medical devices, instrument systems and reagents. The Company is dedicated to improving people's health throughout the world. BD is focused on improving drug delivery, enhancing the quality and speed of diagnosing infectious diseases and cancers, and advancing research, discovery and production of new drugs and vaccines. BD's capabilities are instrumental in combating many of the world's most pressing diseases. Founded in 1897 and headquartered in Franklin Lakes, New Jersey, BD employs approximately 28,000 people in roughly 50 countries throughout

the world. The Company serves health care institutions, life science researchers, clinical laboratories, the pharmaceutical industry and the general public.

BD appreciates this opportunity to provide input on landmark health care reform legislation. ***One of our highest priorities is to provide incentives within the Medicare payment system that would reward hospitals for preventing health care-associated infections ("HAIs").***

Policy Request. **Include specific HAI prevention interventions as quality measures under value-based purchasing authorization in health reform legislation.**

The Department of Health and Human Services ("HHS") recently finalized its *HHS Action Plan to Prevent Health Care-Associated Infections* ("Action Plan"), which provides a roadmap for a 5-year, national HAI prevention strategy. BD supports this comprehensive prevention effort as part of health care reform and quality of care improvements by the Obama Administration. Specifically, BD supports efforts to achieve the Action Plan targets for HAI prevention, including reducing invasive methicillin-resistant *Staphylococcus aureus* (MRSA) infections by 50% by 2014 and reducing *Clostridium difficile* (C. *diff.*) infections by 30% by 2014, as measured by case rate per patient days.

Many health care and Medicare payment reform proposals have included the establishment of a Medicare hospital value-based purchasing ("VBP") program. According to recent proposals from Senators Baucus and Grassley as well as the Centers for Medicare and Medicaid Services ("CMS"), a VBP program would increase or decrease hospitals' DRG payments depending on their success at achieving, or improving upon, certain quality performance measures. ***To ensure that the HHS-established HAI prevention targets are achieved, the Action Plan's targets and process and outcomes metrics should be incorporated into any Medicare VBP framework as quality performance measures.*** VBP payments to hospitals then would be conditioned, in part, on hospitals making annual progress toward their HAI prevention goals, creating a strong incentive for every hospital to take steps to reduce HAIs.

Background. **VBP Creates Incentives to Reduce High Rates of Preventable HAIs**

According to the Centers for Disease Control and Prevention, HAIs caused by MRSA, C. *diff.*, vancomycin-resistant *enterococcus* (VRE) and other infectious pathogens are one of the top 10 leading causes of death in the United States, accounting for approximately 99,000 deaths annually. Furthermore, in addition to thousands of lost lives, HAIs cost the U.S. health care system an estimated $20 billion each year. Yet many of these infections are easily preventable.

We must strengthen HAI prevention efforts. Prevention of HAIs would improve the quality of patient hospital care, save thousands of lives, and at the same time lead to billions of dollars in savings. The Action Plan signals a renewed national commitment to reducing HAIs. However, successful implementation of the Action Plan depends on an enforcement mechanism to ensure that hospitals implement infection control policies and take other precautions to prevent HAIs. Without specific incentives, such as VBP, hospitals may not achieve the Action Plan prevention targets, and HAIs will continue to be a major cause of death and a significant driver of health care system costs.

In a recent announcement, the American Hospital Association, the Federation of American Hospitals and the Catholic Health Association embraced VBP in the context of health care reform. As Congress considers developing the framework of this program, it is important that HAIs be included as one of the conditions or clinical performances areas considered in determining hospital payments. According to a recent survey by the Association for Professionals in Infection Control and Epidemiology, more than 40% of hospital infection control programs have experienced budget cuts over the last 18 months. Incorporating HAIs into the VBP framework would establish a platform for providing hospitals with the resources they need to support efforts to prevent infections.

VBP has been considered in health care and Medicare payment reform proposals on numerous occasions. Most recently, the Senate Committee on Finance, in a health care reform Policy Options paper released in April, proposed establishing a hospital VBP program that would build on the success of the current Reporting Hospital Quality Data for Annual Payment Update ("RHQDAPU") program and "move beyond paying for reporting on quality measures and activities, to paying for hospitals' actual performance on these measures." This proposal follows a 2007 VBP white paper from CMS proposing that a portion of the hospitals' DRG payments (2–5%) be contingent on meeting certain quality goals.

Furthermore, in the Medicare hospital inpatient proposed rule for FY2010, CMS acknowledged the "growing concern regarding hospital acquired infections" and discussed the possibility of adopting new quality measures for potential future use in the RHQDAPU program, which could include HAIs.

Attached to this statement is a proposed amendment to the most recent available congressional discussion draft of a value-based purchasing bill. We hope that this draft amendment will provide the Committee with a concrete example of the type of legislative language that we are proposing.

FOR FURTHER INFORMATION, PLEASE CONTACT:

Paul Seltman
Director, Public Policy and Government Relations
BD

Proposed Amendment to 2008 Value-Based Purchasing Discussion Draft

Include Health Care-Associated Infections in Value-Based Purchasing Authorization

The Senate Finance Committee released a discussion draft of a value-based purchasing proposal in 2008. We recommend the following changes (in **bold**) to section 2 of the proposal to include prevention of health care-associated infections as a quality measure under the value-based purchasing authority.

SEC. 2. HOSPITAL VALUE–BASED PURCHASING PROGRAM.

(a) Program.—

(1) In general.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

"(n) Hospital value-based purchasing program.—

"(1) Establishment.—

"(2) Measures.—

"(A) In general.—The Secretary shall select measures for purposes of the Program. Such measures shall be selected from the measures specified under subsection (b)(3)(B)(viii).

"(B) Requirement for fiscal year 2012.—For value-based incentive payments made with respect to discharges occurring during fiscal year 2012, the Secretary shall ensure the following:

"(i) Conditions or clinical performance areas.—Measures are selected under subparagraph (A) that cover at least the following ~~four~~ **five** specific conditions or procedures:

"(I) Acute myocardial infarction (AMI).

"(II) Heart failure.

"(III) Pneumonia.

"(IV) Surgeries, as measured by the Surgical Care Improvement Project (formerly referred to as 'Surgical Infection Prevention' for discharges occurring before July 2006).

"(V) Health care-associated infection prevention metrics and targets, as established in the Department of Health and Human Services' *HHS Action Plan to Prevent Health Care-Associated Infections* or any successor plan.

"(ii) HCAHPS.—Measures selected under subparagraph (A) shall be related to the Hospital Consumer Assessment of Health Care Providers and Systems Survey (HCAHPS)."

Statement of the Breyer Foundation

America's health care system is fueled with innovation and pioneering discoveries leading to the cure, treatment and intervention of the most challenging diseases in the history of man. The unique economic structure of this country weaves the interconnection of the different factors that feeds and sustains the economic growth and promotes the discoveries of new ideas that changed the history of science and medicine. With this advancement comes the compassion and the struggle of every physician, health care provider and educator to reach out to all the people in disseminating new knowledge and cure. Since America is still considered quite a young country in comparison to the rest of the world, such efforts remained to be perfected and polished to reach the optimum potential that this system and country can achieve. Our ultimate goal is to be free of the burden of health care cost and provide the best quality health care for all the people in this country. Such goal can be achieved through some of the following key features:

- Improvement of the quality of life through an effective preventive care program, free preventive care coverage for all;
- Empowerment of the people through knowledge, access and control of their own health care portfolio;
- Effective communication and efficient dissemination of new discoveries, best clinical practices and treatments, and other information that promotes the improvement of the quality of life of the patients and growth of the system as a whole;
- Economically sustainable health care system powered by the inherent strength of the different stakeholders, and the alignment of their mutual interests that promotes synergistic growth—a win-win for all;
- Preserve the best of the current system—flexible option;
- Health saving system that builds foundation toward financial independence of health care cost;
- Provides solution to the financial problem of Medicare;
- An equitable, timely and quality health care system that addresses the needs of all Americans, including the 47 million uninsured;
- Effective and efficient Central Network System (CNS) design that eliminates unnecessary bureaucracy;
- Promotes innovation, collaboration and economic growth;
- Offers incentives such as tax exemptions or credits instead of tax increase;
- Promotes personalized medicine and depositories of effective treatment protocols and guideline;
- Works effectively in rural and urban areas of America;
- Provides real solution in eliminating health disparities representing all racial groups in America;
- Empowers each individual with the right to choose and the right to life;
- Eliminates barrier for the health insurance access of people with preexisting conditions.

Basic Implementation Principles

Sustainable Health Care System Model: The fundamental and basic structure of the health care system is based on the alignment of the interest of the different stakeholders that promotes synergistic growth. A system based on a delicate combination and balance between the negative and positive rights of an individual and his/her responsibilities to the welfare of other stakeholders engaged in the system. The system is based on understanding the fundamental factors that will provide incentives to the different stakeholders to perform their optimum task and contribution in the system with minimum enforcement and barriers.

Emphasis on Preventive Care (Benefits to ALL): Insurance for all will not be able to resolve the health care needs of the poor. As most of the current 47 million uninsured are eligible to a basic Medicaid system but cannot and/or will not access this system until absolutely necessary through our Emergency facilities. An annual preventive care visit to a physician could dramatically decrease the need of Emergency visits for all Americans.

A free annual preventive care visit to a physician should be a major component of all standard insurance benefits for Americans. Although it is quite understandable that difficulties exist for the poor and underserved groups from factors such as transportation, time and lost wages, it is, however, essential to note that their well-being and health is their responsibility and their actions impact the rest of the Nation. Thus with the rights comes the responsibility for the underserved groups to take advantage of the free preventive care visit available for them in this program. The program subsidizes the insurance cost of the people below a certain poverty level. The subsidy is renewable every year and initiated through their first annual free preventive care visit to a physician. A decrease in the cost and number of major catastrophic care would eventually decrease the burden in the insurance companies and our entire health care system, thus providing the people a better leverage in reducing insurance premium.

A portable medical electronic record for the system will keep track of the enrollment and medical history of individual participants. This will address the need of people who have no permanent residence and relocate more often than average Americans. Repetitive tests due to lack of health record history for the uninsured and homeless is one of the major contributions for high health care cost. Security in the access of these records will be ensured in order to protect the rights and privacy of the patients. All access to these health records by a third party (physicians, nurses, etc.) will be based on patient's consent (or authorized family members in cases of patient's incapacity to make a decision). These records will be maintained

in the Central Network System (CNS), a fully independent agency, using a system with a defined security structure to prevent access of unauthorized individuals to sensitive information. Insurance companies and employers will not have access to health results and risk assessments of the individuals. The Central Network System will facilitate the communication of benefits and service between the patient-physician and insurance companies. Access to insurance provider and enrollment to the CNS program could be accomplished in the physician's office through automated, online and national standardized forms.

Equitable and Affordable Insurance with Variable Options to Meet Participant's Needs (Financing, Benefits to Patients) (One size does not fit ALL!): Standard features such as ***free annual preventive care*** (including dental, vision, mental health, health education credit and assessment, etc.) visit and a component of a catastrophic care to cover the needs of an individual over the span of his/her lifetime. These standard features will be included in the minimum standard benefit reflecting the needs of the majority of Americans, as evaluated over a period of time, with additional options available, tailored to individual's need. Entry to the program is independent of preexisting condition. CNS, the Federal and State government will leverage the cost of these premiums for the people in order to optimize the cost savings of the system.

Small business owners and their employees, self-employed individuals, employees of large corporations and Federal Government, and the current uninsured can choose between the different providers and options in the insurance exchange. The overall base premium (for all options) should reflect additional 20–30% of a cumulative individual health savings account (IHSA) components that would provide the participants with additional reward savings in meeting and maintaining his/her annual health and wellness goals. The IHSA account will be maintained and managed for the individual (in similar manner as the retirement account) and the program by an independent Central Network System. Interest from the trust fund (with sufficient funds) could be used to pay future insurance premium for the individual. Individuals could transfer the benefits/trust funds to their heir after their death.

Eighty percent of uninsured individuals in the United States live in households with an employed individual. Breyer's plan will extend the tax exemptions and coverage to secondary families such as parents and children in student status. Tax exempt and credit structure will be set up and optimized to provide incentives for an individual (and their employers as an optional partner) to sponsor and buy in affordable insurance to uninsured secondary family members living in the same household. Children will be covered by the parent's insurance while in student status and 1 year grace period after school (while finding an employer-sponsor). Such option would provide not only affordable insurance to approximately 20%–34% of our uninsured but will also provide enrollment of these individuals in the individual health savings account (IHSA) and additional tax credit to sponsors.

Breyer's plan does not require mandatory health insurance. Uninsured who are in high income brackets (20%–25% of uninsured) who choose not to buy insurance through the program will have to provide a set savings bond of at least $20,000–$50,000 to cover a future catastrophic incident. Since a portion of the individual health savings account in Breyer's model goes as donation to the underserved and uninsured, this approach will ensure a fair system where the individual donation will go to help the poor and uninsured and not the rich who skip paying insurance and later on will get the benefit from other people's sacrifice and efforts.

A defined and clear guideline will be established consistent with taxable income and tax payment/credit structure to ***provide subsidy to insurance coverage for individuals who are below the 400% poverty line***. Unemployed individuals will be covered in this subsidized insurance program. Financing will be provided through a portion of the individual savings (20 cents for every dollar saved) acquired through leverage with ***insurance companies (lower premium)*** and ***pharmaceutical industries (lower drug cost)***. A small copayment (between $20–$50) will be established depending on the poverty level above 200%. The program will not require any out-of-pocket expenses from individuals, such as increase in taxes, but will provide tax exemptions and credit on the IHSA and donated funds to the uninsured. (Please see the **Breyer's Model**).

Veterans and their families who are not eligible for veteran hospital benefits (since VA health benefits are limited to war related injuries) will be able to enroll in the private insurance program and, with the consent and support of the Department of Veterans Affairs, can access the state-of-the-art facility of the VA Med-

ical Centers or go to other hospitals of their choice. A Federal program will be available for Federal employees through choice of different private insurance and options. Culturally appropriate ***financial and infrastructure support will be provided to the Native American Indian Health System***.

Benefits to Participating Hospitals, local clinics and other health care institutions: All private and public hospitals, local clinics and other health care institutions who participated in the various programs of Breyer's plan (preventive, cost reduction through effective, efficient and quality health care) will receive subsidy for their uninsured enrolled in the program.

Individual Mandate: Insurance is not mandatory to everyone. However, to prevent high-income individuals from skipping the insurance premium cost and taking advantage of the system's benefit in times of need, individual savings bond (at a minimum of $20,000), to cover catastrophic incident, would be required for high-income individuals (based on taxable income adjusted to the cost of living for a given State) who selected not to buy insurance in the program.

Employer Requirements: Employer will be provided a tax exemption for employee-sponsored benefits and additional tax credit for extending sponsorship to secondary family members. Employers will receive the savings proportional to their contribution in the employees' overall insurance premium. A similar formula as specified in the Breyer's model will be applied in their contribution to the uninsured and in their corresponding tax credit.

Expansion of Public Program (Solution to Medicare Bankruptcy): A portion of the current stimulus fund of $630 billion and leftover Medicare funds for 7 years (Medicare funds left until 2017) could be used to subsidize individuals above 65 years of age who are currently in Medicare while the rest of the population can slowly transition their Medicare contribution to their IHSA for their own individual health care benefits. Thus providing a solution to the unsustainable structure of Medicare and a path for independence of future health care cost for the individual. (A more detailed and optimized system (amount and timing) could be acquired and simulated with a given software resources/program).

Premium Subsidies to (Benefits to) Employers: Tax exemption and credit will be available to employers for employee's benefits. No tax increase but additional savings that can be used to enhance employee's benefits. Small businesses and self-employed individuals would be able to access an affordable insurance premium that is currently just available to large corporations and Federal programs. CNS programs would be available to employees to improve health and work performance.

Benefit Design: An annual preventive care (includes services that the American Medical Association and/or other medical associations considered essential in early prevention of diseases, i.e. vision, dental, mental health, podiatry, mammogram, lab tests, pre-natal care if applicable, etc.) is free for ALL. A minimum standard benefit of equivalent or greater value from the benefits currently enjoyed by a majority of Americans (such as the Blue Cross/Blue Shield Standard Plan and the Standard Federal Employees Health Benefit Program, FEHBP). Additional options are available for long-term disability and types of long-term care services. An additional component of the standard plan would be an optional tax credit and/or benefit for (preventive) health and wellness education program and assessment.

Benefits to Private Insurance: A guaranteed insurance of close to 330 million Americans every year. National support through CNS and all stakeholders for preventive care and efficient, effective and quality health care improving the health and quality of life for all. Support from CNS, Federal and State agencies, scientist and health professionals through depositories of effective clinical practices, more standardized cost of medication and services, innovative approach and effective treatment will be available resources to all. Additional public support programs for nutrition and wellness classes for the poor through existing programs, e.g. USDA food stamps and nutrition programs. CNS will coordinate programs with CDC, VA, NIH and other national health associations to expedite the dissemination of programs that will enhance risk assessment, prevention and treatment of various disorders. Together with various public and private organizations CNS will provide an efficient bridge in the translation of new discoveries and best practices from a bench to clinics and hospitals. These programs will drastically reduce administrative and catastrophic health care cost for insurance companies.

Benefits to Pharmaceutical Companies: Twenty-five percent of the cost for pharmaceutical company's drug discovery and development is focused on marketing and dissemination of information. CNS will facilitate the dissemination of new dis-

coveries in new drugs and technologies through its participating hospitals, physicians and health professionals, remarkably reducing the cost of marketing and dissemination for the company. Such activities will be done in coordination with the participating public agencies such as FDA, NIH, CDC, etc.

CNS will also provide a national depository or listing of clinical trials for new drugs and technologies so as to provide options for individual participants to access innovative approach, medication and studies throughout the Nation. It would be the individual's choice to participate in any of the listed clinical trials based on the health benefits that study would provide. This connection will be facilitated by CNS through close communication with the Food and Drug Administration and other collaborating agencies (CDC, NIH and other public and private agencies) that would provide accurate and reliable information to everyone regarding the risk and health benefits of the discoveries. This would reduce the inefficiencies in the recruitment and retention of participants in evaluating the effectiveness of treatments and other intervention procedures. Reduction in the administrative, evaluation and dissemination cost for the development of drugs will help pharmaceutical companies in reducing the cost of medication in this program.

Benefits to Physicians and Health Professionals: CNS will work with NIH, CDC and other public and private agencies to provide resources, medical information and technical support for physicians in urban and rural areas regarding new and effective treatments and discoveries. Telemedicine and ready access to specialists will be provided through this network. CNS will also help facilitate the transition of technology and approach to personalized medicine. Inter-individual biological differences exist and thus there will be no mandatory protocol. Best clinical practice protocols and results of effective treatment studies would be available in CNS depositories in order to guide physicians in making informed decisions. Breyer's plan promotes an integrated approach on health care through collaboration and communication between physicians and health care professionals beyond geographical barriers, all within the goal of providing the optimum care the patient deserves. Physician's decision based on well-founded and supported knowledge, and readily available support from other experts in similar and complementary fields will reduce the uncertainty and risk involved in malpractice lawsuits.

An efficient communication infrastructure between the different health institutions and professionals will also provide further support for CDC and NIH in promoting and implementing studies that would resolve some of the problems in the health of the American people. Breyer's plan of a centralized network will provide efficient infrastructure and further support on CDC's and NIH's initiatives for more comprehensive NHANES and Framingham studies that would provide more information on the prevalence, risk and effective treatment of different diseases in various ethnic groups in the Nation. Understanding of the risk and prevalence of the different disorders such as cancer, diabetes and other diseases would enable health care professionals to better implement preventive care and treatment.

Physicians in remote areas do not have ready access to the state-of-the-art discoveries in medical treatment and technology. CNS' depository will be the means to bring this innovation to the rural and remote areas through training, support to physicians and other health professionals, while utilizing as much of the existing resource and infrastructure.

State Benefits and Function: Since each State has different demographics, resources and infrastructure, CNS will work with local State health agencies to design and implement programs depending on the States' resources and infrastructure. The dynamic changes and flux in the different resources and needs of each State will be closely monitored by State agencies. Corresponding adjustment in the national CNS system will be performed based on the State quality assessment-feedback and national process optimization approach. Progress and effective health care reform from each State will be evaluated based on their starting baseline. Private insurance and service options may differ between States but the same guidelines (in overall cost and benefits) will be observed.

Cost Containment: CNS will leverage the reduced cost of insurance premiums and drugs for 330 million Americans. A minimum standard insurance premium will be established equivalent or higher in benefits to the current standard Blue Cross/Blue Shield or Federal Employee Benefit Plan (with free annual preventive care). Several payment plan variations and options of this standard plan would be available to address the financial needs of the people. Additional savings will be maintained by CNS and will be placed in individual accounts through participation and accomplishments in the preventive care programs. Participating hospitals that report an effective, efficient and quality health outcome for their patients get the cor-

responding savings through subsidy to their uninsured. Results and outcome for cost effective and quality care for patients can be evaluated through multiple followup and efficient recording of health results of patients. Thus electronic medical data and history will guide not only the physicians in prevention and diagnosis but also provides the patient a portable medical record and control of their own health. Information summaries and results of available studies in the service cost, effectiveness of existing treatment and medication will be available to patients, physicians and other health professionals for their review and evaluation. Strict penalties will be placed on fraud and corruption in the system. The CNS in collaboration with agencies in State, Federal, and private institutions will set up guidelines, routine audit checks and oversights of each participating group in this system.

Health Disparities: CNS will work with the U.S. Census, CDC and NIH towards programs such as NHANES and Framingham studies to evaluate the risk, prevalence and effective interventions for various diseases for all the groups (African Americans, Asian Americans, Caucasians, Latinos, Native American Indians, Pacific Islanders) represented in the American population. Oversampling of groups will be implemented in order to provide statistically valid health information, especially for small underrepresented ethnic groups.

Central Network System: The Central Network is independent of any entity (Government, insurance and health care providers) and provides not only insurance leverage but also effective communication (personalized medicine), treatment, clinical, scientific guidelines and services in coordination with other private and public agencies—an integrated approach necessary to run a complex system. CNS' structure will consist of an oversight board consisting of representatives from all stakeholders and external advisers.

Statement of Budd N. Shenkin, M.D.

The Obama Health Insurance Reform in Perspective

I'm glad to see that the first step of the Obama Health Plan (OHP) will rest on creation of a health insurance "exchange," where consumers are presented each year with a menu of alternative plans at predetermined standardized levels of benefits, offered by various companies. Since there will be government subsidies to make at least the basic plan affordable to everyone, insurance will probably become nearly universal, and job mobility should improve. It seems that, after all this time, the problem of the availability of health insurance to individuals will be largely solved. This will mark a good and important first step, tactically very smart to take, in fixing health care and making insurance available.

But it is only a first step. As everyone knows, the whole system needs revision, to make it relatively efficient, fair, less costly, higher quality, and progressively gaining ground in all these aspects instead of losing ground. The basic problems lie in the nature of the insurance system, the cost and organization of hospitals, pharmaceuticals and medical devices, and reliance on specialists instead of primary care. So, while the OHP's first step is a great one, it needs to lead to bigger changes in the way the system functions as a whole. Which I think it will.

The key to understanding the current insurance system is this: How do the companies make their money? Competition in and of itself is not a good thing if the way they compete doesn't redound to the benefit of the public. To simply celebrate the existence of competition qua competition is to celebrate ideology rather than what competition is supposed to deliver.

I wish I knew more about insurance companies so I could write with a deeper factual background, but here is the way it seems to me. First of all, they compete by underwriting. In the individual market they assess health and age status; in the group market they assess utilization history and probabilities; in both cases they then price their products accordingly, and deny applications, raise premiums, or restrict coverage. (This is called experience-rating; if a company would give the same price to all comers, this would be called community-rating). The companies that underwrite most artfully make the most money. In addition, since benefits are not standardized, the companies that can write their plans most cleverly also win. Unfortunately, the underwriting enterprise winds up making coverage either unobtainable or exorbitant to many people who thus become uninsured.

Insurance companies also strive for profits in other ways. In the large company sphere they provide administrative services; if they can do this most efficiently, they win. They negotiate with care providers, especially physicians and hospitals, to variable effect, bending to the pressure of hospitals with a lot of market power, making

others bend to them when the insurance company is more powerful. Market power is more influential than straight cost-accounting. What a company loses in one market they gain in another. If they lose to hospitals, they make it up by short-changing the atomized physicians.

Insurance companies can also profit by the way they pay providers, or don't. If they declare some services "included" with other services, they can avoid paying for both, although both might have perfectly valid CPT (service descriptor) codes. They can deny claims on obscure bases. Some insurance companies have been convicted of setting "payment denial" objectives for their staff. They can delay payments and make money on the float.

Unfortunately, what they have not been able to do to a significant extent is to assert control over utilization, nor to improve quality, because they are too far away from the functioning of the system, and too far away from their own expertise, to do so. Overall, the culture of the health insurance companies has been such that none have been described as particularly good citizens, looking out for the health of the Nation, coming up with schemes that would advance the health care industry and do better for people. In fact, quite the reverse.

It is clear, then, that when it comes to health insurance, the OHP has more to reform than accessibility to a policy. The first step will be to establish the "exchange." The second will be to eliminate the ability of the companies to reject applicants, and establish community-rating premiums with governmental subsidies to avert adverse selection. (Hal Luft of the Palo Alto Medical Foundation Research Institute has suggested that establishing a Major Risk Pool is a way of achieving this.) While these changes will save insurance companies the overhead costs of underwriting, they will also mean that a major *modus operandi* of the health insurance industry will be altered. They can still make money by establishing contracts with providers that rest on their market power; they can still make money by denying claims; they can still make money by being efficient in administrative operations. But they will have to stop making money by experience-rating individuals and groups, and by cleverly designing plans to their own advantage.

The OHP will of necessity solve the insurance accessibility problem. What it then needs to do is to influence the insurance companies to focus their profit motive to add to the public good by making their own internal operations more efficient, and inventing ways that make the system as a whole better. The issue is, would inclusion of the public option make that objective more possible?

The Question of the Public Option

Given that there will be a health insurance exchange, and given that there will be community-rating, the biggest controversy right now is: ***should there be a so-called public plan on the menu?*** A public plan would be one sponsored by government—proponents want it to be the Federal Government, others would like it to be States, or even other entities such as "cooperatives." I have called this option the BGP, the Big Government Plan. (Which it wouldn't be if it were to be the ill-advised cooperatives.) All agree that there would need to be a level playing field so that competition between public and private plans would be fair, and there are many suggestions on how to do this. This is the question I pose and answer today. I think we can only answer the question by reflecting on the nature of the health insurance industry, which is why I started this post as I did.

Let's first look at what is being said. The May 28, 2009 issue of the New England Journal of Medicine contains three invited articles on the subject. One is by *Jacob Hacker*, a liberal strongly for the BGP; one by *Mark Pauly*, a free-marketeer from the Wharton School who accepts a BGP to make reform politically viable; and the third by the canny veteran health economist *Victor Fuchs*, who thinks the BGP would be irrelevant. Two weeks later in the June 11 issue of the Wall Street Journal, *Karl Rove* stated the hard Right's objections to the BGP as the pathway to socialism, and the next day in the WSJ *Stephen Burd*, CEO of Safeway, didn't address the BGP at all, but gave the preventive medicine approach to fixing America's health care problem. These are our texts for today.

Hacker strongly supports a BGP, while acknowledging that public entities are generally rigid, and private ones are "more flexible and more capable of building integrated provider networks." He looks to the BGP "to provide: stability, wide pooling of risks, transparency, affordable premiums, broad provider access, and the capacity to collect and use patient information on a large scale to improve care." He also thinks the BGP would have lower administrative costs (the government more efficient than private business?); will be able to receive better volume discounts (this would violate the level playing field provision, and just who would these discounts come from, and for what?); and would be nonprofit (OK, but what would the incentive be, then? Virtue?).

Pauly, the free-marketeer, thinks that a very wide array of choices on the menu would bring public support, and many provisions to allay the advantages of size and the possible political domination of the BGP, would make the OHP politically viable. Interestingly, he puts forward the idea of having *two distinct government plans in each area!* I think this is a great idea—it gives a sense of where the incentive to the public plans would come from. We have experience with this format in California Medicaid, where in our counties, for instance, patients can choose either the local initiative (county health department) plan or the private Medicaid plan, and so can providers.

Pauly also brings up the old issue of Any Willing Provider—could the BGP(s) choose not to let a duly licensed physician, say, join the plan? How could a governmental entity do this? Yet, if the BGP had to admit providers and the private plans didn't, wouldn't that give an advantage to the private plans? Likewise, if care were to be delivered in networks that contracted with the BGP, how could the BGP choose to contract with one group but not another? I think the answer here would have to be that each provider would have to have access to at least one plan, with the BGP as the contractor of last resort. More could be proposed here, but let's go on.

Fuchs says that the three biggest challenges of health care are the uninsured, cost, and quality, and he doesn't see how a BGP would impact any of them. Insuring everyone will require a subsidy and compulsion, and a BGP is not needed for either. Neither cost nor quality have been positively affected by either Medicare or Medicaid, so why should another BGP have any effect?

Moreover, says Fuchs, who would join a BGP? Medicare and Medicaid are already set for the elderly and the poor. Thirty percent of the populace are covered by large companies who self-insure, the administration of their plans contracted out to the health insurance companies for provider network supply and payments. The BGP would have nothing to offer these companies. Twenty-five percent of the populace are covered by smaller employers that contract with private health insurance companies. Again he argues, what would a BGP have to offer them? Since these contracts for care are generally experience rated rather than community rated (that is, one price for all despite historical medical care utilization), only the high utilizers would want to go to the BGP, thus giving the BGP adverse selection, and taking the bloom off their rose. (I think community-rating is in the works, given the nature of an exchange.) Currently 5.9% are individually insured, and these would go to the BGP. Fifteen percent of the populace are uninsured, of which three-quarters, or 12%, are too sick or too poor to buy policies, and the remaining 3% choose not to. Fuchs doesn't see the value of a BGP for these people either.

I don't agree with Fuchs here. First of all, I think we have to get to community-rating for everyone, with risk adjustments made as Hacker suggests. Secondly, even by Fuchs' analysis tens of millions of people would sign up with the BGP.

Rove asserts that we don't need a BGP because we already have enough competition. This is a purely ideological argument (surprise!) that doesn't look at the quality of the companies, nor at the results. Private insurance companies have a terrible history. Their innovations are generally pseudo-innovations, and the ways they choose to make money are not productive to the Nation as a whole—underwriting, refusing care, reneging on coverage, gaming providers who submit bills, etc.

His second argument is that the public option will pay providers less than private companies will (not clear this is so), and thus cause other providers and patients to subsidize the BGP, the old transfer game that hospitals play.

His third argument is "crowd out," that in contrast to Fuchs who thinks hardly anyone will choose the BGP, Rove avers that so many will choose it that private companies will be stifled. As both Hacker and Pauly assert, however, if the playing field is indeed made fair, this will probably not be the case. And if it turns out to be as Rove fears, would that not be a testament to the underlying vapidity of the current private companies and their practices? If they can't beat the government that's a pretty low bar.

Rove's fourth argument is also Fuchs', that Medicare and Medicaid are too expensive and do not lead to efficiencies, so the BGP would do the same. It's true that government is not good at innovation and cost control.

Fifth and finally, Rove asserts that a governmental monopoly will be unresponsive and a bad, socialistic option. This is the Trojan Horse or Slippery Slope argument—BGP today, National Health Service tomorrow. Well, the point is then to make the playing field level, and as Pauly suggests, let there be competing governmental entities.

Burd, finally, makes a non-BGP point, an argument that reminds me of the "Legalize Marijuana" solution to the California State budget crisis in its indirect approach. Burd says that Safeway has kept medical costs stable for the last 4 years

by giving their employees incentives to avoid tobacco, reduce obesity, and keep blood pressure and cholesterol in normal bounds. The better health of the group has led to lower costs. It strikes me that only smaller, private insurance groups could handle this kind of innovative approach, and thus beat the BGP in competition.

Conclusion

So, given that the OHP can make health insurance accessible by simply establishing the exchange, but that it needs to do more to "fix" health care, does there have to be a BGP option? The answer is clearly yes. In fact, Pauly's suggestion of having **two** BGP's available on the menu would make the most sense—perhaps one a Federal and one a State program.

If a BGP is on the menu, everyone agrees that the playing field needs to be made level. Community-rating and risk-adjustment could be accomplished by the Luft Major Risk Pool plan. The NEJM articles have cogent suggestions on other leveling procedures. More specifically for part of the means to this, the BGP needs not to undercut rates. I would suggest that the BGP start out with 130% of Medicare rates for primary care, 100% of Medicare for selected specialists (some, such as general surgery, would need to be higher; some, such as imaging could be lower).

The temptation for health insurance companies would be to continue their operations as they have practiced them in the past. The more the OHP can deny them profit from old, nonproductive practices, the more they will have to find new means to make profit. Denied profit possibilities from underwriting and clever plan design, they would be tempted to continue to deny payments and care, and to assert market power where possible to glean profit. The presence of the BGP would blunt their ability to force poor contracts on relatively weaker providers. If properly designed, the BGP would force the private plans to compete for the allegiance of providers by ceasing those practices.

What would be left for the insurance plans to do? They would benefit if they were truly efficient in administration, practiced prevention as Burd suggests, aligned with groups that were themselves innovative in the way they delivered care, etc. We would look for innovation from the private sector as we always have. They would have the advantage over the BGP by not having to contract with all providers; if the insurance company and providers shared their profits, both would have incentives.

In addition, the presence of the BGP would act as a safety net. Everyone in every part of the country would have insurance available in a traditional way. If a private company tried to innovate and failed, the BGP would be there to pick up the pieces for the enrollees with that failed company. Also in addition, if small or large companies chose the BGP over private companies, so be it. And with several BGP entities available, they would themselves have a competitive incentive and measuring stick to work against.

Some say that a BGP is necessary to "keep the insurance companies honest." Clearly, left to itself, the industry has not been trustworthy. I hope that I have shown to some extent how the BGP would function in keeping the private plans honest.

Finally, it is important to note that the point of the BGP would not be to be innovative—that's not something the government is good at, at least not for a long time. (See the OEO experience from the 60's, for instance, on how innovation can begin and then be stifled.) It should be solid even if stolid, the safety net for everyone; honest, straightforward, maybe unimaginative, but present. The BGP should also be a lowest common denominator, in the sense that if the BGP can do something, then there is no reason other plans can't do it, too.

Statement of the Friends Committee on National Legislation

Chairman Rangel and Members of the Committee:

Thank you for your combined work and expertise to produce the tri-committee discussion draft. We believe that this plan sets up a structure that could succeed in making high-quality comprehensive health care available and affordable for everyone in the United States. We offer a few comments and recommendations here to strengthen the plan and to further ensure that no one is excluded from health care coverage for lack of ability to pay or other reasons.

The Friends Committee on National Legislation is a Quaker lobby in the public interest. Working in Washington since 1943, the Friends Committee promotes a vision of a society that lives well with itself and others. We share a Quaker belief

in the essential integrity and decency of human beings, and support public policies that elicit and build on these strengths.

In these comments, we lift up four critical elements of the tri-committee draft: The public plan, subsidies, preventive care, and regulation of the private health insurance market.

A Successful Launch for a Public Health Insurance Plan

The House tri-committee draft describes a public insurance plan that would meet or exceed the requirements of all plans in the Health Care Exchange, which would be available, initially, to uninsured individuals and employees of very small employers.

We strongly support a public insurance plan, because of its potential availability to all health care consumers, and because of its eventual effect on the private market. A comprehensive standard public plan will set the bar for the private insurance market to meet. However, in order to have these desired effects, **it is important that the public plan be launched to a *broad demographic of potential participants***. Large employers and currently insured individuals should be free to offer or opt for the public plan, along with those who may have been excluded from health insurance by prior existing conditions or high premiums relative to income.

A robust launch accomplishes several intended goals, by:

- Offering real competition in the marketplace, at a level and of a nature that will affect the business decisions of private companies that also hope to attract large employer buyers;
- Including participants who represent a wide range of health care needs, not be weighted toward those with greater needs and fewer resources;
- Lowering the cost of administration per participant, relative to a plan that includes only individuals and small employers;
- Providing health care providers with a built-in incentive to participate in the public plan; and
- Alowing the plan to begin operating with a strong financial base.

We are concerned that launching the plan to a relatively limited population that has not been well served by the current health insurance system will hamper the chances for the public plan's success. We urge the three Committees to make the plan available both within and outside of the Exchange, to currently insured and uninsured individuals and groups.

Subsidies to Make Health Care Affordable to All

We strongly support income-based subsidies, delivered through the tax system or in other ways, to make health care affordable for non-elderly people who have incomes above the (expanded) Medicaid eligibility level. The tri-committee draft proposal sets tiers of subsidies between 133 percent and 400 percent of the poverty level, ending with a standard that an individual or family should spend no more than 10 percent of income on health care. The draft essentially defines "affordable" as 10 percent of income, which we accept.

However, at 401 percent of the poverty level, a family could easily be required to spend a much higher percentage of income—perhaps 18 percent or more—on health care premiums alone (ignoring, for the moment, out-of-pocket expenses). We unite with the comments of your first witness in the June 24 hearing, Professor Karen Pollitz of the Georgetown Health Policy Institute, who suggested that the **10-percent-of-income standard be applied without regard to an income cap**. The anomalies that might occur with relatively high-income families receiving subsidies could be addressed by specifying that the subsidies apply only to standard plans that offer what the public plan offers. Applying the 10-percent-of-income rule uniformly above 400 percent of poverty would eliminate the "cliff" that would almost inevitably occur just above any cap on subsidies. As a result, the Committees could better achieve the goal of making health care affordable to all consumers.

Preventive Care Prevents Costly Intervention

We appreciate the inclusion and recognition of preventive care as a valuable component of the health care system. Besides its intrinsic value in contributing to the overall health of the U.S. population, preventive care and wellness programs will save money for the government and for individuals.

We are aware of the CBO's critique of the cost-effectiveness of prevention programs. This critique, and indeed, that of a few of our respected colleagues, misses the point of investments in preventive and wellness programs. These analyses incorporate two errors:

(1) They look for a payoff in 10 years. While many prevention and wellness programs produce profound improvements in health status within a few years (weight loss, blood pressure decrease, cholesterol control, etc.), the dramatic cost savings (lack of a need for expensive medicines or surgical interventions) do not occur until later in life and are, indeed, difficult to catalog and calculate. Numerous long-range studies have shown the effectiveness of nutrition and behavioral changes; cost accounting that reaches beyond 10 years should be able to recognize and incorporate these savings.
(2) These analyses are based on an inaccurate understanding of preventive care and wellness programs. Prescribing drugs to control high blood pressure, cholesterol, and other diseases is a type of treatment, not prevention. These drugs are prescribed only for individuals who already suffer from common chronic diseases, and they tend, if successful, to minimize the need for further intervention.

According to the Milliken Institute, the combined cost of the top seven modifiable chronic diseases (cancer, diabetes, hypertension, stroke, heart disease, pulmonary conditions and mental disorders) exceeds $270 billion per year in direct care costs. A modest focus on prevention, early intervention and behavior changes can save about 80 percent of that cost annually. Preventive care and wellness programs address underlying conditions of obesity and physical inactivity and can and should be promoted broadly on a cost-effective basis to the public.

Fair Play: Regulating the Private Health Insurance Market

The private health insurance industry has benefited greatly from tax exemptions provided to both the employer and the employee for employer-provided health benefits. The Federal Government has every right to insist that, to qualify for this benefit, health care plans must meet certain criteria.

To qualify for tax advantages offered in the employment context, any such plan should be required to meet certain standards, including a defined comprehensive package of medical, mental health and prescription services with no exclusions for prior existing conditions, age, or gender; no termination of individual insurance for expenditures by the insurance plan; no lifetime caps; and a maximum yearly out-of-pocket cost for participants.

Rates for the standard package should be the same for all participants, with adjustments permitted for family coverage and for broad geographic areas (i.e. States or regions, not redlined neighborhoods). Discounts for health predictors such as non-smoking or healthy weight could be permitted. But rate adjustments for age and other uncontrollable conditions should be minimized. Even the 2 to 1 ratio for age permitted in the House plan would result in unrealistically high premiums for older, but not Medicare eligible, individuals and heads of households. An unrealistically high premium means the exclusion of certain demographic groups.

ERISA-qualified private plans—the standard private plans that qualify as an employee benefit—should also be required to be made available to the individual market, at the same rates.

The Tri-Committee Plan has two real options to catalyze change in the health care marketplace. One is by competition from a strong, widely available public plan. The other is by allowing a tax advantage only from employer-sponsored plans that meet the same criteria as the public plan, including breadth and depth of coverage, and rules governing guaranteed issue, renewability and rates. The Tri-Committee Plan is almost there. We believe that this plan, with some strengthening, can make an historic difference in health care availability and indeed in the health of this Nation.

Thank you for the work that you and your staff have devoted to this important undertaking and for the opportunity to share our reflections and recommendations.

Letter by Richard Kirsch

Dear Chairman Rangel and Chairman Stark:

Health Care for America Now (HCAN) appreciates the opportunity to comment on the draft House tri-committee health care reform legislation that is designed to address the critical health care issues that have plagued the American health care system for far too long. HCAN is a national grassroots movement powered by 30 million people and more than 1,000 organizations working to win a guarantee of quality, affordable health care we all can count on. The draft legislation put forward by

your Committees shows that we can achieve the President's goal of quality, affordable health care for all this year.

Your draft bill is an excellent example of what can be accomplished when Members of Congress work together to do what is best for the people they represent. It provides quality, affordable coverage for all, requires shared responsibility by individuals, employers and government, and expands health insurance coverage choices, including being able to retain one's coverage, have additional private plan options, and a public health insurance option designed to lower costs and keep insurance companies honest.

HCAN strongly supports the provisions in the draft bill that make health insurance and health care services more affordable. In particular, premium assistance, reduced cost-sharing, and application of an out-of-pocket cap are central to making health care accessible to low-income individuals and families. Also, we commend you for your leadership in extending assistance in purchasing health insurance to working families who have seen health costs increase four times faster than wages. Given the significant range in the cost of living across the country as well as the variance in the cost of health insurance coverage, these provisions are vital to ensuring that persons in all corners of our country are able to afford health insurance. Establishing true affordability is particularly important given that the draft bill requires individuals to obtain health insurance coverage.

While the draft bill establishes a framework for achieving quality affordable health care for all, HCAN believes it should be strengthened in several critical areas:

- In order for the public health insurance plan option to be effective, it must be truly robust with a strong national network of providers from the start.
- The employer responsibility requirements should match the average contribution large employers currently pay.
- Health insurance must be affordable in terms of premium and cost-sharing and protect Americans from medical debt and bankruptcy.
- Individuals should not be required to have coverage that is unaffordable and inaccessible; coverage for all must mean coverage for everyone.
- Medicaid and CHIP need to be strengthened and new protections need to be put in place to ensure the benefits and cost-sharing protections of these programs are maintained.

Public Health Insurance Plan Option

HCAN commends the Committees for including in the draft a national public health insurance option, which is critical to reforming our health care system. So long as the playing field is not tilted against it, a public health insurance plan option will promote competition and efficiency, provide stability and advance innovation. More broadly, the public health insurance plan option will foster payment and delivery system reforms, remedy disparities in access to care, and guarantee that quality, affordable coverage will be there for individuals and families no matter what happens to their jobs or their health.

HCAN, however, is concerned that the public plan as proposed may not be large enough to compete on a level playing field with large national insurers, which have many built in advantages and considerable experience in State and regional markets. The American Medical Association reports that 94 percent of insurance markets in the United States are now highly concentrated. In many State markets, one insurer already controls more than half and often more than two-thirds of the market. Two companies alone control more than one-third of the private health insurance market—WellPoint with 35 million insured and United Health Group with 18 million insured. The Health Insurance Exchange will include these well-established plans and other major players, which will make it very challenging for a new entrant such as a public plan to enter the market. Therefore, we believe several improvements are needed to the draft bill to ensure the public health insurance option can compete on a level playing field with private insurers.

Recommendations

- **Ensure broad provider participation.** Private insurers have had decades to build their provider networks. To ensure broad participation in a public plan start-up, the Committees should ensure that all providers (hospitals, institutional providers, physicians and other practitioners) that currently participate in public programs also participate in the public health insurance plan. However, physicians and other health practitioners should retain the ability to opt out after a sufficient period that allows the plan to get established.

- **All employers must be allowed to join the exchange.** HCAN is concerned that the Exchange, and through it the public health insurance option, is restricted to employers with 10 or fewer employees in the first year and 20 or fewer employees in the second year. Allowing larger small businesses to join the Exchange in the first 2 years—for instance up to 100 employees—would give them access to more affordable health care options and create a much larger market that would increase the number of people insured both with private and public plans. While it may be necessary to give the Commissioner the authority to determine the schedule for phasing-in medium and large employers, the bill should specify that all employers eventually will be able to access the Exchange and the public plan. With more enrollees a public plan would be more viable in a very competitive insurance environment.

Employer Responsibility

HCAN believes that employers (including public employers) should be required to fund a meaningful portion of their employees' and dependents' health care costs. Employer responsibility is a necessary prerequisite for individual responsibility requirements. Ensuring continued employer involvement in our health care system is also critical to the affordability of the package as a whole.

We commend the Committees for recognizing the importance of a strong employer responsibility requirement. The draft bill also requires proportionate contributions for those employees who work less than a full-time schedule. HCAN offers the following recommendations to strengthen the employer responsibility provisions in the draft bill.

Recommendations

- **Employer responsibility should match average contribution requirements made by employers today.** HCAN believes large employers should be responsible for funding at least 80% of the cost of individual coverage and 75% of family coverage for the defined benefit, which are the current average employer premium contribution levels for employer-based health insurance. The employer contribution under the draft falls short of this goal—72.5% for individual coverage and 65% for families.
- **The contribution amount should be applied to plans employers are currently offering.** The contribution percentages in the draft apply not to the benefit plan offered by the employer but to the "lowest cost plan that meets the essential benefits package." Instead, we believe the contribution amount should be applied to plans employers are currently offering, or else the minimum required employer contribution may be significantly less than it would otherwise be if the coverage actually offered was the basis for the requirement.
- **Contribution requirements should be based on a sliding scale.** The Committees should also scale the contribution requirements for small and medium employers based on wage levels, part-time and full-time employment and number of employees. It is important that the contribution for part-time employees be scaled so that employers do not have an incentive to create part-time employment and thus avoid the employer's share of the responsibility.
- **Accountability measures need to be in place to ensure compliance.** There should also be an accountability mechanism in place for employers who alter employee status, such as by hiring people as "independent contractors" instead of employees, for the purpose of evading insurance obligations.
- **Employers should be responsible for covering their own workers.** The legislation should ensure that employers who cover the employee of another employer as a dependent should receive reimbursement equal to the noncovering employer's contribution. Dependent children of working parents should be assigned to the paying employer as they are now.
- **Definitions of family should be expanded to include gay, lesbian, bisexual and transgender families.** For the purposes of determining access to health insurance coverage, subsidies and related Federal tax treatment of health care benefits, definitions related to "family" should be extended to ensure inclusion of lesbian, gay, bisexual and transgender families, families headed by domestic partners, and recognize multiple family structures and diverse kinship networks.
- **Establishment of a reinsurance program that encourages employers to continue to provide coverage to pre-Medicare retirees.** A requirement that individuals purchase coverage could result in employers dropping coverage for pre-Medicare retirees since reform does not require them to continue such coverage. This is similar to the challenge Congress faced with respect to ensuring that employers continued prescription drug coverage when the Medicare Modernization Act (MMA) was adopted in 2003. We appreciate the proposal to

establish such a reinsurance program to help ensure that coverage provided by employers and VEBAs to pre-Medicare retirees will be affordable (Section 501). This provision represents a positive step in addressing the health care needs of a vulnerable population. However, we recommend that the Committees make it a permanent program with sufficient funding.

- **All workers should have access to coverage.** Employers who pay into the system should be assured that their workers have access to coverage, helping to ensure that their workforce remains productive. As written the bill would exclude certain immigrants from affordable credits even where the employer is "paying." The House should explore mechanisms to ensure that all workers of employers who are "paying" can benefit from that contribution and can have access to affordable coverage; in such cases it can be structured so that it is the employer's payment, and not a Federal payment, that is being used to make the coverage affordable.

Affordability/Individual Responsibility

HCAN commends the Committees for the affordability and shared responsibility provisions of the draft bill that place the burden on the health of our Nation with individuals, employers and the government. We are pleased with the affordability credits that recognize that low- and moderate-income families need protection from both high premiums and high out-of-pocket costs. A sliding scale that phases out at 400% of the Federal poverty level is the minimum level necessary to assure consumers that coverage will be affordable. Similarly, HCAN strongly supports the study, by the Commissioner, of geographic variation in the application of the FPL. HCAN believes this report should be completed 12 months prior to year one. This information is necessary to establishing regionally-adjusted FPL limits that would more efficiently target subsidies to families that need them the most.

HCAN, however, is concerned that the public plan as proposed may not be large enough to compete on a level playing field with large national insurers, which have many built in advantages and considerable experience in State and regional markets. The American Medical Association reports that 94 percent of State insurance markets in the United States are now highly concentrated based on U.S. Department of Justice criteria. In many State markets, one insurer already controls more than half and often more than two-thirds of the market. Two companies alone control more than one-third of the private health insurance market—WellPoint with 35 million insured and United Health Group with 18 million insured. The Health Insurance Exchange will include these well-established plans and other major players, which will make it very challenging for a new market entrant such as a public plan. Therefore, we believe several improvements are needed to the draft bill to ensure the public health insurance option can compete on a level playing field with private insurers.

Recommendations

- **Provide cost-sharing credits to individuals and families with qualified employer coverage and allow individuals to apply their cost-sharing credits to their employer-sponsored coverage.** Some individuals and families will face high costs relative to their income because their employer satisfies the "play" requirement or their income is above 400% FPL. These individuals and families should receive cost-sharing credits in the year following any year during which they reach their out-of-pocket maximums in an effort to protect families from the risk of financial ruin and bankruptcy. Additionally, credit-eligible full-time (and part-time) workers who are likely to decline the employer offer should be allowed to apply their credit to the employer offer rather than enroll in the exchange.
- **The individual mandate should not apply to everyone unless everyone has access to affordable coverage.** While HCAN supports provisions of the bill that incentivize individuals to obtain coverage, there is a lack of congruence between the exceptions from the tax and the guarantee of affordability, threatening to leave millions of individuals in the double bind of being penalized even though they lack access to affordable coverage. Health care should be provided to all people who pay taxes and contribute to the system and everyone should be required to pay their fair share.
- **Oppose expensive verification and documentation procedures.** HCAN is concerned that the positive impact of several reform proposals on the table may be undermined by additional measures that would severely restrict access to health coverage by mandating new, expensive verification and documentation procedures. The best way to reduce costs in our health care system is to ensure that people do not have to follow a long paper trail to get to the doctor and that everyone shares the costs of a new system.

Medicaid and CHIP

HCAN believes the Medicaid protections and standards given to people below the Federal poverty level should be extended to those with incomes up to 200% FPL, including no premium contribution requirements and only nominal cost-sharing requirements. Additionally, HCAN believes that individuals who are in groups currently with cost-sharing exemptions or caps should maintain this protection. The Committees' bill makes substantial improvements in coverage and access to low-income persons. For instance, the Committees' commitment to ensure that every newborn and infant born in the United States have health coverage is a significant step toward improving child health.

Recommendations

- **Increase Medicaid protections to 200% FPL.** HCAN supports the House tri-committee bill's increasing the across-the-board Medicaid eligibility to 133% FPL with full Federal funding. However, we urge that this limit be increased to as close to 200% as possible.
- **Cover legal immigrants.** We are very disappointed that the draft does not support coverage for legal immigrants in Medicaid. In particular, HCAN supports requiring States to cover otherwise eligible legal immigrants in Medicaid at the same levels as citizens, without waiting periods. We urge similar coverage for legal immigrants, without a waiting period, in Medicare.
- **Increase access to primary care.** We strongly support the provision to increase Medicaid provider rates in primary care to Medicare payment levels by 2012 and believe this will improve access to important health services. We also encourage consideration of increasing Medicaid outpatient provider rates for specialty services in a similar manner.
- **Preserve cost-sharing protections for children.** HCAN appreciates a number of positive provisions regarding children's health, including coverage of well-baby, well-child, dental and vision services. However, it is important to continue the cost-sharing exemptions or caps currently provided for children in CHIP. If those affordability protections are discontinued after 2013, children could be worse off.
- **Preserve EPSDT for CHIP children.** Children enrolled in CHIP in 13 States and the District of Columbia are currently guaranteed EPSDT benefits through their Medicaid expansion CHIP programs. Those children will lose access to these vital protections if moved into the Exchange, unless benefits in the Exchange can be made comparable.
- **Cover all children and pregnant women.** Low-income immigrant children and pregnant women should be eligible for Medicaid and CHIP regardless of their citizenship or immigration status.
- **Streamline enrollment procedures.** HCAN believes the enrollment process must be simplified across Medicaid and other insurance options. For example, the Committees should consider applying the 12-month continuous coverage provision currently proposed for the credit to Medicaid as well.
- **Increase protections to ensure seamless delivery of services covered by Medicaid and not covered by other insurance options through the exchange.** HCAN has serious concerns regarding the provisions that after 5 years would give States the option to provide access to the exchange for people eligible for Medicaid. These concerns include, among others, that stronger protections need to be established concerning the seamless delivery of services covered by Medicaid, the affordability of insurance on the exchange (even with subsidies) and procedural protections available to Medicaid participants that may or may not be available to those insured through the exchange. We look forward to working with the Committees to resolve these issues and make this proposal work for all stakeholders.

Addressing Health Disparities Under Health Care Reform

This draft demonstrates the strong commitment of the three Committees to achieving health equity for communities across the country. Health disparities populations—including racial and ethnic minorities, immigrants, women, the lesbian, gay, bisexual, and transgender (LGBT) population, people living in rural and tribal areas, and others—have historically experienced differences in disease incidence, health outcomes, and access to health care, and these differences continue to persist in the Nation's health care system under the status quo. The proposals included in the draft legislation make substantial, meaningful investments in achieving equitable health outcomes for all people living in the United States and its territories.

Please see the attached analyses, which provide section-by-section recommendations to achieve the greatest impact for health disparities populations. The first

("Attachment A") includes recommendations for health disparities populations broadly, while the second ("Attachment B") details recommendations with respect to immigrant populations.

Recommendations

Coverage

- **Family-based approach should apply to administration of affordability credits.** The bill generally takes a family-based approach to application and enrollment in health coverage, which helps reduce paperwork and which ensures that individuals and their dependents can get the coverage they need. A similar approach should be employed in administering the affordability credit. An affordable credit eligible individual should be able to include any dependents seeking coverage on the application for an affordable credit, without subjecting those dependents to the same individual eligibility determinations. Additionally, affordability credits for families should be set at levels that reflect the true cost of obtaining family coverage, which is on average 2.7 times more expensive than individual coverage.
- **Eliminate blanket exclusion for all persons with "non-immigrant visas."** The blanket exclusion of all persons with "non-immigrant" visas would deny access to affordable coverage to a broad range of individuals who are authorized by law to live, work, and remain in the United States, such as survivors of trafficking, domestic violence and other serious crimes who are cooperating in prosecuting these crimes (T and U visa holders), persons with fiancé petitions (K visa holders), citizens of "compact of free association states" (Micronesia, Palau, Marshall Islands) and others.
- **Reform must be consistent with and responsive to the Federal Government's trust responsibilities to American Indians and Alaska Natives.**
- **Government findings that impact the health of a community should be publicly released.** Finally, in order to foster a more transparent policymaking process, HCAN encourages government decisions that impact the health of a community to be evaluated, and the findings publicly released, on the potential positive and negative health effects of these decisions.

Public Health Infrastructure

- **Increase support for community health centers.** A robust public health system, at a minimum, invests in health planning, undertakes prevention strategies, conducts disease surveillance and management, increases health literacy, and fosters a health care safety net through community health care workers and clinics. HCAN strongly supports increased investments in the community health center network. Community health centers will continue to serve as critical access points for many people living in underserved communities.

Prevention and Wellness

- **Best practices must be "evidence-informed" rather than "evidence-based."** We applaud the Committees' focus on community-based research and stakeholder input to develop and disseminate best practices, and recommend that the standard for these practices be "evidence-informed" rather than "evidence-based" unless and until sufficient new research on health disparities has been conducted.

Data Collection

- **Data collection must be based on uniform categories.** HCAN strongly supports the establishment of uniform categories for the collection of race and ethnicity as specified by OMB Directive 15, including the five racial categories and dichotomous question of Hispanic ethnicity, as well as the development of standards for collecting primary language data. Congress should require health plans and other entities to collect disaggregated data on ethnic subpopulation and tribal affiliation whenever possible. To ensure transparency, HCAN urges the Committees to authorize and fund regular analyses of this data in order to track the Nation's progress in narrowing gaps in health care access and quality and health outcomes, with a special emphasis on historically marginalized populations.
- **Standardized data must be collected across the entire health care system.** Standardized, disaggregated health care data must be systematically collected and reported across the entire health care system in order to measure, track, and hold accountable our system's progress toward eliminating racial and ethnic health disparities in health coverage, health care, and health outcomes. While HCAN staunchly supports the proposed requirement that plans partici-

pating in the Exchange report data to the Commissioner for the purpose of identifying and remedying disparities, we urge the Committees to broaden the scope of this proposal by requiring *all* health plans—public and private—to collect this data from enrollees and report to a centralized system.

Language Access and Cultural Competency

- **Health plans should provide culturally and linguistically competent health care services based on CLAS standards.** All health plans, public and private, operating inside and outside of the Exchange should be required to provide health care services that are culturally competent and linguistically appropriate. Additionally, plans should be required to apply the culturally and linguistically appropriate services (CLAS) standards within all aspects of health services.
- **Language access services should be an essential benefit and reimbursed under all public coverage.** HCAN urges the Committee to include language access services—such as qualified medical interpretation and translation—as an essential benefit. Additionally, these services should be reimbursed under all public coverage programs, including both Medicare and Medicaid, at adequate reimbursement rates—with a minimum of FMAP of 75%.
- **Codify Executive Order 13166.** HCAN urges the Committees to codify Executive Order 13166 to reinforce the prohibition of discrimination in health care settings based upon patients' national origin.
- **"Individuals with limited English proficiency" should be specified as a vulnerable population to whom exchange-participating health benefits plans should be targeted.**
- **Include adequate funding for workforce diversity initiatives.** HCAN supports the Committees' efforts to increase the number of health care professionals from underserved communities, and hopes that Congress will make adequate investments in these programs in order to achieve the greatest impact on the workforce.

The National Health Insurance Exchange

HCAN commends the Committees for including provisions that require the Exchange to solicit and negotiate bids and contracts for coverage through the Exchange from qualified health benefit plans. HCAN offers the following recommendations to strengthen the exchange provisions in the draft bill.

Recommendations

- **State exchanges should have the ability to negotiate with qualified health benefits plans.**
- **Ensure notice of exchange and affordability credits.** The provisions on outreach and enrollment by the Exchange would be improved if existing COBRA/HIPAA requirements were amended to require notice of the availability of the Exchange, including the availability of affordability credits. For those who have lost employment-based coverage through loss of a job or loss of a spouse, the availability of the Exchange and affordability credits can help those individuals to meet their individual responsibility for coverage in an affordable way despite the loss of a job or a spouse to death or divorce.
- **Privacy protections.** HCAN urges the Committees to include provisions protecting the privacy of those covered by the Exchange so that information collected by the Exchange cannot be shared with other government agencies and used for other purposes. The Social Security Administration has strong privacy protections that assure that information provided to the Social Security Administration is not shared with other government agencies.

Comprehensive Benefits

HCAN commends the Committees for including an "essential services" benefits package and creating the Health Benefits and Advisory Committee (HBAC) to recommend benefits beyond those listed in the draft bill. HCAN offers the following recommendations to strengthen the essential benefits package and the HBAC.

Recommendations

- **Terms for members of the Health Benefits and Advisory Committee (HBAC) should be specified and staggered to protect its independence.** HCAN supports the Committees' establishment of an independent Health Benefits Advisory Committee (HBAC) to recommend an essential benefit package beyond the broad direction provided by the legislation. Decisions about the specific services and items that must be covered should be made by health experts who

are charged with shaping a benefit package grounded in science and guided by established standards of medical care. HCAN urges the Committees to establish terms of service for HBAC members and to stagger the terms so that all of the positions do not come open at a single time. This will guard against the possibility that the appointment process might in the future be used to impose a political agenda, which would undermine the medical judgment, expertise and independence of the HBAC.

- **Comprehensive dental coverage must be an essential benefit.** Comprehensive dental care is an essential part of health care throughout the lifespan, and such services may be especially important to the well-being of people who have been subjected to domestic violence that includes battering resulting in broken bones in the jaw or damage to teeth.

Insurance Regulation

HCAN commends the Committees for including new insurance regulations that will prohibit insurers from excluding coverage based on preexisting conditions, refusing to renew plans, and prohibit them from being able to charge people different premiums based on their gender, health status, or occupation; while limiting the percent difference insurers can charge based on age. HCAN offers the following recommendations to strengthen the insurance regulations provisions of the draft bill.

Recommendations

- **Identify a decisionmaking body charged with setting standards to determine "clinical appropriateness."** While the Discussion Draft would prohibit a qualified health benefit plan from imposing "limits unrelated to clinical appropriateness," without further clarification, insurance companies would ultimately have the unfettered discretion to determine what "clinical appropriateness" would allow them to impose service limits.

HCAN recommends a minor modification to Division A, Title I, Subtitle C, Section 123(c) (p. 23) to require the Health Choices Commissioner, the Health Benefits Advisory Council or some other independent entity (other than insurance companies) to issue objective standards to guide the use of a clinical appropriateness standard to impose any coverage limits.

- **Structure cost-sharing limitations to protect against particularly onerous deductibles.** We strongly support the inclusion of significant cost-sharing protections. HCAN is concerned, however, that the bill fails to address deductibles, which likewise impose significant barriers to care when deductibles are too high, and are especially burdensome for low-income individuals. HCAN recommends modification of the language regarding cost-sharing in Division A, Title I, Subtitle C, Section 122(c)(2)(C) (p. 26) ["In establishing cost-sharing levels for basic, enhanced, and premium plans under this subsection, the Commissioner shall, to the maximum extent possible, use only copayments and not coinsurance."]. We encourage you to discourage the use of deductibles in addition to coinsurance, and to make clear that, to the extent any deductibles are part of any cost-sharing scheme, they should be set at sufficiently low levels to ensure that they do not impose cost-related barriers to accessing health care services.
- **Add key notice and reporting requirements to prevent insurers from inappropriately limiting enrollment under the capacity exemption.** We commend the Committees for including many important insurance market regulations for Exchange participating plans. HCAN, however, is concerned that without further clarification, insurance providers may inappropriately use a "capacity limitation" exception to limit enrollment if they find that a plan is attracting higher-cost enrollees. To avoid the inappropriate use of exceptions to enrollment requirements, we recommend language modification to Division A, Title II, Subtitle A, Section 204(b)(4) (p. 61) to clarify that:

> Contracts with Exchange participating issuers would expressly indicate and quantify any capacity limitations; for those contracts that do address capacity limitations, the Commissioner should ensure that adequate alternative insurance plan options would be available under each benefit tier through the Exchange in the event that such capacity limitations are reached; a reporting requirement "trigger" for insurance issuers to notify the Commissioner in advance of reaching capacity limitations that would allow enrollment limitations.

Delivery System Reform

We applaud the Committees for considering innovative new health care delivery system structures, and support the premise that these new payment models are an opportunity to redesign care delivery to encourage better care coordination, greater efficiency, and more patient-centered care. HCAN, however, has several concerns with the current provisions in the bill and offers the following recommendations to improve these provisions.

Recommendations

Accountable Care Organization Pilot Program

Without appropriate safeguards models such as the ACO model could result in perverse incentives for providers to under-deliver care for patients. We are particularly concerned that the underlying focus of the ACO pilot is the achievement of savings in Medicare, with too little emphasis on improving care for patients and holding ACOs accountable for delivering patient-centered care.

- **Change ACO incentive payments to reflect quality.** While we are pleased that the bill calls for ACOs to report on quality measures and "utilize patient-centered processes of care, including those that emphasize patient and caregiver involvement in planning and monitoring of ongoing care management plan," we are concerned about the basis of the ACOs' incentive payments. The bill indicates these payments will be made to ACOs only if the expenditures are less than a target spending level or a target rate of growth. There is no language linking incentives to the delivery of high-quality, patient-centered care. We urge you to build accountability mechanisms into the new payment models to provide a check against providers' potential financial incentives to skimp on patient care.
- **HHS should be charged with identifying and endorsing patient-centered measures.** The Secretary of HHS should be charged with identifying and endorsing patient-centered measures for the services and activities performed by ACOs, that ACOs be required to report on such measures, and that the reporting be independently validated.

Medical Home Pilot Program

- **The pilot program should focus on improving health outcomes for vulnerable populations and delivering appropriate care and should be expanded nationally as quickly as proven successful.** We urge you to improve this section by incorporating into the pilot program an ongoing and continuous process for assessing the performance of medical home practices on measures of patient-centered care. For example, in addition to being required to meet patient-centered standards to be recognized as a medical home, practices should demonstrate on an ongoing basis that they are delivering patient-centered care.

Post Acute Care Services Payment Reform Plan

We support your efforts to encourage better coordinated, integrated and accountable care by addressing avoidable and preventable hospital readmissions. Patients who are rehospitalized after a recent discharge experience greater-than-expected clinical complications, incur higher-than-expected costs, and are less satisfied with their health care. We recognize, however, that a bundled payment for expected services puts hospitals more at risk for costs that exceed the payment.

- **Ensure patient protections are included to eliminate incentives for hospitals to reduce needed care for patients or disregard patient preferences about kinds and sources of post-acute care.** We recommend that the Secretary of HHS be charged with identifying and endorsing patient-centered measures for the services and activities intended to be captured by the bundled payment policy, that any hospital participating in the bundled payment be required to report on such measures, and that the reporting be independently validated.
- **Expand demonstration projects that bundle payments.** HCAN recommends that the introduced bill should expand these demonstration projects into a nationwide pilot program to bundle hospital and physician payments for inpatient care and provide for the development, testing and, if prudent, expansion of shared savings programs within Medicare.

Establishment of National Priorities and Performance Measures for Quality Improvement

We strongly support establishment of a process to identify priorities for performance measures and quality improvement. Without the right measures and measurement, we can't transition to quality-based payment (as opposed to volume-based), we can't assess and eliminate disparities, and we can't tell whether such new payment models as ACOs, medical homes, or bundled payments are actually resulting in better care for patients.

- **National priorities and performance measure should include broad stakeholder involvement.** The Secretary of HHS should draw upon a multi-stakeholder process to inform and make recommendations. Such a process allows consumers and patients to have a meaningful role in shaping and advancing quality measurement.
- **The Committees should include a process for testing and implementation of new purchasing initiatives.** This process should evaluate the use of pay for quality and value-based purchasing initiatives, similar to the approaches contained in the "Affordable Health Choices Act" and the Senate Finance Committee's Delivery Reform options paper.

Prevention and Wellness

HCAN believes the draft bill represents an impressive policy mix aimed at shifting our health care system from disease care to true preventive health care, which reflects HCAN's commitment to quality, cost savings, and equity. HCAN offers the following recommendations to strengthen the quality, prevention and wellness provisions in the draft bill.

Recommendations

- **Increase funding for the Prevention Trust Fund and build on Medicare's pay for reporting initiative.** HCAN believes the Committees should increase funding for the Prevention Trust Fund in the draft bill to the level in the Senate's "Affordable Health Choices Act."

HCAN commends you for your leadership in fashioning this legislation. As the legislative process moves forward, HCAN is eager to work with the Committees to ensure that this excellent draft and the needed improvements reach enactment. We look forward to working with you to address the remaining issues and to move this critical bill through the legislative process. Thank you again for your consideration of these comments.

Sincerely,

Richard Kirsch
National Campaign Manager
Health Care for America Now

ATTACHMENT A

Section-by-Section Review of Disparities Provisions in the Tri-Committee Health Care Reform Bill

I. Affordable Health Care for All

Sec. 123. Health Benefits Advisory Committee

HCAN is pleased that the membership of the Health Benefits Advisory Committee must include experts on health disparities within racial and ethnic minority and disability communities as well as specialists on children's health. HCAN urges the Committee to ensure that the perspectives of other underserved communities—such as women, the LGBT population, and people living in rural and tribal areas—are also represented by the Advisory Committee.

Sec. 143. Consultation and Coordination

HCAN supports the inclusion of Indian Tribes and Tribal governments in the consultation and coordination provisions. The government-to-government relationship between Indian tribes and the Federal Government is a necessary for the health and independence of Indian communities. HCAN encourages the Committees to include language to encourage conferring—not consulting, which infers a government-to-government relationship—with Urban Indian health programs to ensure that that the Federal Government and States fulfill in the trust responsibility to all Indian people.

Sec. 152. Prohibiting Discrimination in Health Care

We strongly support the Committees' commitment to preventing discrimination based on personal characteristics in all aspects of health care delivery and health coverage plans. The Committees recognize that health reform legislation should include broad protections and adequate remedies, including the right to sue, with sufficient resources for enforcement to ensure that each actor in a reformed health care system is held accountable for adhering to nondiscrimination protections.

These regulations promulgated by the Secretary must be rigorously enforced. The enforcement of anti-discrimination laws in health care is indispensable and must include directing sufficient resources to monitor, prosecute, and ensure active compliance with all civil rights laws, and must integrate and prioritize the health issues of communities of color in all relevant agencies of the Federal Government.

Sec. 202(b)(7) Essential Community Providers

While HCAN strongly supports this provision and applauds the Committees for including community providers, we believe that Indian health providers must be specifically included as an essential community provider in order to protect the integrity of the Indian Health Service. Often private insurance plans, and even States, refuse to contract or otherwise work with Indian health providers because Indian patients are poorer and sicker than the general population, thus presenting a high risk. By specifically stating that Indian health providers are designated essential community providers which must be included in any PPO or other reimbursement scheme. Merely allowing an entity to designate Indian health programs as essential providers is not adequate. Tribes have enormous experience, across the country, with the variety of ways they can be excluded as providers by insurance plans. This is why Medicaid protections were included in ARRA Section 5006(d) which simply requires plans to pay Indian programs as in network providers. This type of provision should apply to all plans participating in an Exchange.

Sec. 242. Affordable Credit Eligible Individual

The bill generally takes a family-based approach to application and enrollment in health coverage, which helps reduce paperwork and which ensures that individuals and their dependents can get the coverage they need. HCAN strongly urges the Committees to employ a similar approach in administering the affordability credit. An affordable credit eligible individual should be able to include any dependents seeking coverage on the application for an affordable credit, without subjecting those dependents to the same individual eligibility determinations.

In addition, the blanket exclusion of all persons with "non-immigrant" visas is troublesome, since it would deny access to affordable coverage to a broad range of individuals who are authorized by law to live work, and remain in the United States, such as survivors of trafficking, domestic violence and other serious crimes who are cooperating in prosecuting these crimes (T and U visa holders), persons with fiancé petitions (K visa holders), citizens of "compact of free association states" (Micronesia, Palau, Marshall Islands) and others.

Sec. 59B. Tax on Individuals Without Acceptable Health Care Coverage

The array of health coverage options from which individuals and families may choose must be available to all people living in the United States and its territories. It would be unacceptable if any individual who lacked access to affordable coverage were then penalized for their failure to enroll, yet the exemptions from the tax are not congruent with the guarantee of affordable coverage. For example, many immigrants ineligible for an affordable credit are, due to their "substantial presence" in the United States, defined as "resident aliens" under the Tax Code and are therefore not subject to the exemption for "nonresident aliens" however, rather than expanding the exemptions, HCAN urges the Committees to take as their first priority ensuring that the broadest range of individuals do have access to affordability mechanisms that make it possible to obtain health insurance coverage.

Sec. 1302. Medical Home Pilot Program

We strongly support the creation of a pilot program for community-based medical homes which integrate nonphysician practitioners and community health workers into chronic disease management and public health education. However, HCAN recommends that the Committees adopt an "evidence-informed" standard for medical home guidelines rather than an "evidence-based" standard. Clinical research and evaluation is sorely lacking for many vulnerable populations, such as racial and ethnic minorities, women, and the LGBT community, making an "evidence-informed" standard more appropriate.

Sec. 1401. Comparative Effectiveness Research

Best practices in treatment, services, and medications must be grounded in evidence that is based on the actual populations involved. To ensure that comparative effectiveness research will truly promote improvements in quality care, the Committees should ensure fair representation of all groups in health research that have been historically excluded from health research including women of all ages, races, and ethnic groups, lesbian, gay, bisexual, and transgender individuals, and children. Although the Committees do call for research to include these populations and account for any differences "as feasible and appropriate," HCAN believes that more robust requirements and incentives to conduct research inclusive of these populations are necessary.

Sec. 1801. Medicaid Eligibility for Individuals With Income Below 133 Percent of Poverty Level

HCAN supports efforts to expand Medicaid eligibility to 133% of the Federal poverty level and to nontraditional Medicaid-eligible populations. In addition, we urge the Committees to repeal the 5-year waiting period and sponsor-related barriers for legal immigrants in Medicaid and CHIP by mandating that States cover legal immigrants on the same basis as citizens in these programs as well as Medicare.

Sec. 1802. Requirements and Special Rules for Certain Medicaid Enrollees and for Medicaid Eligible Individuals Enrolled in a Non-Medicaid Exchange-Participating Health Benefits Plan

With respect to the proposed incentive for reducing State matching percentages, the Committees should be cognizant of the fact the way in which States' reduction in uninsured populations will be measured—by the Current Population Survey conducted by the U.S. Census Bureau—does not include data for U.S. territories.

Sec. 1201. Increased Funding [for Community Health Centers]

A robust public health system, at a minimum, invests in health planning, undertakes prevention strategies, conducts disease surveillance and management, increases health literacy, and fosters a health care safety net through community health care workers and clinics. Community health centers will continue to serve as critical access points for many people living in underserved communities. HCAN strongly supports increased investments in the community health center network under health care reform.

Sec. 2301. Prevention and Wellness

HCAN applauds the Committees for developing proposals that recognize the needs, language, culture, infrastructure and practices of the local population and build local capacity to address the health care deficiencies in the community.

We support establishing and funding Health Empowerment Zones which integrate community-based strategies in health care delivery in order to reduce disparate health outcomes in underserved communities.

We also strongly support the Committees' robust investments prevention and wellness programs with a strong commitment to health equity. The creation of the Task Force on Community Preventive Services demonstrate the Committees' commitment to eradicating disparities in health care and health outcomes for historically underserved populations. We applaud the Committees' focus on community-based research and stakeholder input to develop and disseminate best practices, and recommend that the standard for these practices be "evidence-informed" rather than "evidence-based" unless and until sufficient new research on health disparities has been conducted.

HCAN agrees with the Committees' definition of health disparities populations, which recognizes populations that have been historically marginalized from the health care system—including racial and ethnic minorities as well as geographically isolated individuals—and also appropriately allows for the further delineation of subpopulations.

II. Data Collection and Reporting

Sec. 142. Duties and Authority of Commissioner

Sec. 204. Contracts for the Offering of Exchange-Participating Health Benefits Plans

Section 221. Establishment and Administration of a Public Health Insurance Option as an Exchange-Qualified Health Benefits Plan

One of the primary functions of the Health Choices Commissioner will be data collection within the Exchange for the purposes of promoting quality and reducing

health disparities. We support the data collection and reporting requirements to which private health plans in the Exchange are subject in order to realize these objectives. HCAN urges the Committee to clarify that this data should include demographic information about plan enrollees, including race, ethnicity, primary language, ethnic subpopulation, socioeconomic position, sexual orientation, gender identity, gender, and age. Additionally, health plans should report data on key health plan performance indicators (e.g., nonpatient specific claims and outcomes data; consumer satisfaction and disenrollment rates; provider satisfaction; initial and post-resubmission claims denial rates) stratified by demographic characteristics.

Sec. 1709. Assistant Secretary for Health Information

The statistics on key health indicators as determined by the Assistant Secretary should be stratified by race, ethnicity, primary language, gender, age, and other key demographic information. HCAN strongly supports the establishment of uniform categories for the collection of race and ethnicity as specified by OMB Directive 15, including the five racial categories and dichotomous question of Hispanic ethnicity, as well as the development of standards for collecting primary language data. In addition, Congress should require health plans and other entities to collect disaggregated data on ethnic subpopulation and tribal affiliation whenever possible.

Because standardized data collection is a prerequisite to comparing data across plans, HCAN urges Congress to mandate that standardized categories for the collection of race and ethnicity data, as well as other key subpopulation information, for all health plan data collection and reporting. HCAN supports providing States with funding to upgrade data collection systems in order to comply with these standards for data collection and reporting.

III. Language Access and Cultural Competence

Sec. 122. Essential Benefits Package Defined

In addition to the broad categories of services outlined in this section as essential benefits, HCAN urges the Committee to include language access services—such as qualified medical interpretation and translation—as an essential benefit.

Sec. 133. Requiring Information Transparency and Plan Disclosure

HCAN is pleased that health plans must provide timely disclosure of plan documents and any plan changes in plain language, and urges the Committees to require health plans to make these materials available in multiple languages in order to best serve individuals whose English proficiency is limited.

Sec. 204. Contracts for the Offering of Exchange-Participating Health Benefits

HCAN strongly supports the requirement for Exchange-participating health plans to provide for health care services that are culturally competent and linguistically appropriate. We urge the Committees to expand this requirement to all health plans, public and private, operating outside of the Exchange.

Sec. 204. Outreach and Enrollment of Exchange-Eligible Individuals and Employers in Exchange-Participating Health Benefits Plan

HCAN applauds efforts to provide culturally and linguistically competent education and outreach about the Health Insurance Exchange to vulnerable communities by the Commissioner or other appropriate entities. Allowing the Commissioner to partner with community-based organizations and leaders will substantially increase awareness and enrollment.

In addition to the populations identified by the Committees as critical outreach populations—children as well as individuals with disabilities, mental illnesses, or other cognitive impairments—HCAN recommends the inclusion of historically underserved communities, such as racial and ethnic minorities, women, LGBT individuals, and residents of rural and tribal areas.

Sec. 1222. Demonstration to Promote Access for Medicare Beneficiaries With Limited English Proficiency by Providing Reimbursement for Culturally and Linguistically Appropriate Services

Sec. 1223. IOM Report on Impact of Language Access Services

HCAN applauds the Committees' intention to improve Medicare recipients' access to culturally and linguistically appropriate services through a demonstration project as well as provide for an evaluation on the impact of this project. However, there is an existing wealth of research which demonstrates the benefits of culturally and linguistically appropriate care. In addition, Federal public programs such as Medicaid already provide reimbursement for language services on the basis of such evi-

dence. Accordingly, HCAN suggests that the Committees should broaden the scope of this effort and provide reimbursement of these services to the entire Medicare program.

Additionally, ensuring reimbursement for the provision of language services under public coverage programs at adequate reimbursement rates—with a minimum of FMAP of 75%—will give providers some new tools to meet their obligations to take reasonable steps to provide language services to limited-English-proficient patients.

Sec. 2241. Cultural and Linguistic Competence Training for Health Care Professionals

HCAN supports efforts to increase effective cultural and linguistic competency training for health care professionals. We recommend that these education and training programs raise awareness and address the role of gender, social and cultural biases in clinical decisionmaking to prevent nonclinical or nonbiological judgments based on sex, race, ethnicity, sexuality, gender and gender identity, which inappropriately affect the amount and kind of treatment received.

In addition to these programs, HCAN recommends improving funding for the training of interpreters and translators who are qualified to assist limited-English-proficient patients.

IV. Health Care Workforce Diversification

Sec. 2241. Centers of Excellence

Sec. 2242. Scholarships for Disadvantaged Students, Loan Repayments and Fellowships Regarding Faculty Positions, and Educational Assistance in the Health Professions Regarding Individuals From Disadvantaged Backgrounds

Sec. 2243. Nursing Workforce Diversity Grants

Sec. 2244. Coordination of Diversity and Cultural Competency Programs

HCAN applauds the Committees' efforts to increase the number of health care professionals from underserved communities, and hopes that Congress will make adequate investments in these programs in order to achieve the greatest impact on the workforce.

Sec. 2261. Health Workforce Evaluation and Assessment

National Center for Health Workforce Analysis

We support the establishment of these national centers to establish and measure benchmarks for the health care workforce, including Federal programs. We applaud the Committees' requirement for members of the Advisory Committee to include representatives from underserved and underrepresented communities. These benchmarks should reflect the national priority of achieving a diverse workforce with adequate representation of racial and ethnic minorities and other critical populations.

ATTACHMENT B

Summary of Immigration Recommendations to the House Tri-Committee Health Reform Bill

Proposed by the National Immigration Law Center

June 29, 2009

Last week the National Immigration Law Center recently offered several recommendations aimed to improving immigrant inclusion in health care reform. Below is a summary, presented in order of the sections as they appear in the bill.

Expanding Examples of "Vulnerable Individuals" (p. 67)

In the section on "Outreach and Enrollment of Exchange-Eligible Individuals and Employers in Exchange-Participating Health Benefits Plan," adding "individuals with limited English proficiency" to the list of "vulnerable individuals" to whom outreach should be targeted would help insure the likelihood of participation in health coverage by those who are limited-English proficient (as well as hearing-impaired), as follows:

"(1) Outreach.—

Such outreach shall include outreach specific to vulnerable populations, such as children, individuals with disabilities, individuals with mental illness, individuals with other cognitive impairments, and linguistically isolated individuals."

Definition of Affordable Credit Eligible Individual (p. 103)

The draft bill makes affordable credits only to "an individual who is lawfully present in a State in the United States (other than as a non-immigrant described in 101(a)(15) of the INA)." The blanket exclusion of "non-immigrants" leaves out several categories of persons who are authorized by law to live and to remain in the United States, such as survivors of trafficking, domestic violence and other serious crimes who are cooperating in prosecuting these crimes (T and U visa holders), persons with fiancé petitions (K visa holders), citizens of "compact of free association states" (Micronesia, Palau, Marshall Islands) and several other categories of "non-immigrants" who are permitted to live and work here permanently or are on a pathway to lawful permanent residence.

To ensure that lawfully present individuals who are also residing in the United States are eligible:

Sec. 242(a)(1) should be revised to read:

"(1) In General.—For purposes of this division, the term "affordable credit eligible individual" means, subject to subsection (b), an individual who is lawfully residing in the United States."

"Lawfully residing in the United States" is precisely the language used to define which immigrant children and pregnant women are eligible for federally funded health coverage under the recently enacted section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA," H.R. 2). The terminology has been vetted and battle-tested.

Streamlining Coverage for Families (p. 104)

The bill generally takes a family-based approach to application and enrollment in health coverage, which helps reduce paperwork and which ensures that individuals and their dependents can get the coverage they need. A similar approach should be employed in administering the affordability credit.

Sec. 242(a)(2) should be revised to read:

"(2) TREATMENT OF FAMILY.—Notwithstanding any other provision in this Title and except as the Commissioner may otherwise provide, an affordable credit eligible individual may apply for a credit under this subtitle for the purpose of securing family coverage. Individuals seeking family coverage shall include any dependents seeking coverage on the application."

Tax on Individuals Without Acceptable Health Coverage (p. 136)

The political viability of the government enacting an individual mandate imposing a financial penalty on uninsured persons hinges on a question of fairness. If individuals and families subject to a penalty have access to affordable coverage, the public will view it as fair to expect them to fulfill a responsibility to enroll. Unlike the Senate HELP bill, which expressly exempts from penalty "any person for whom affordable health care coverage is not available," the House bill exempts a small number of enumerated groups.

Included among these groups are "nonresident aliens" (p. 138). However, there is no parallel between "nonresident aliens" and the various categories of immigrants lacking access to affordable coverage because under the discussion draft they are ineligible for both Medicaid and an affordable credit. The term "nonresident alien" is not what it implies. It is a term of art in the Tax Code that essentially means a noncitizen who is neither a lawful permanent resident nor a person who has had a "substantial presence" in the United States during the year, a test that gets to physical presence and is unrelated to immigration status. Even undocumented immigrants are considered "resident aliens" for tax purposes so long as they meet the substantial presence test. For more information, see: http://www.irs.gov/taxtopics/tc851.html.

Therefore, under the House bill, millions of immigrants would have no access to affordable coverage and yet would appear vulnerable to being penalized for failing to obtain acceptable health care for themselves or their families. Although the bill does signal that future regulations may enable individuals in this circumstance to apply for a hardship waiver (see p. 142), this does not offer protection sufficient to assuage concerns or controversy over the disjuncture. Immigrant parents with citizen children could be penalized for their own lack of coverage even if they enrolled the eligible children in coverage.

As a practical matter, subjecting low-income immigrants to a tax penalty for failure to secure health coverage that they cannot afford will discourage tax compliance and collection. Approximately 1 million tax returns are filed with Individual Taxpayer Identification Numbers, most of which are assumed to belong to undocu-

mented immigrants taking the extraordinary step of filing personal income tax returns despite their status. The prospect of having a penalty levied could change the equation for many of these individuals.

This problem highlights the need to broaden pathways by which individuals and families are able to secure affordable coverage (and therefore be fairly subject to a penalty if they fail to do so) including:

- Enabling affordable credit individuals to secure family coverage;
- Enabling all low-income children to secure Medicaid and CHIP;
- Exploring mechanisms to ensure that all workers of employers who are "paying" can benefit from that contribution and can have access to affordable coverage; in such cases it can be structured so that it is the employer's payment, and not a Federal payment, that is being used to assist any immigrant worker who is not otherwise affordable credit eligible.

Medicaid and CHIP (Title VIII)

Public opinion overwhelmingly supports access to coverage and care for legal immigrants on the same basis as citizens. Concerns regarding potential push-back from States due to increased expenditures ring hollow given the larger expansions of Medicaid for citizens proposed in the discussion draft, and the fact that almost half the States, including most of the States with the largest immigrant populations, have been providing coverage for immigrants with no Federal match during many of the years following enactment of welfare reform. Restoration of eligibility would provide them welcome fiscal relief. This is the time to provide access to health care for low-income immigrants.

To remove the discriminatory barriers to health coverage for legal immigrants imposed by the 1996 welfare law, including the 5-year waiting period, the restrictive and outdated list of "qualified" immigrants, and sponsor-related barriers, and to ensure timely and effective care for all children and pregnant women, the following sections should be inserted in Title VIII:

"Medicaid"

Section 1903(v) of the Social Security Act (42 U.S.C. 1396b(v)) is amended—

(1) by striking paragraph (4) and inserting the following new paragraph:

"(4)(A) Notwithstanding sections 401(a), 402(b), 403, and 421 of Public Law 104–193, payment shall be made under this section for care and services that are furnished to individuals, if they otherwise meet the eligibility requirements for medical assistance under the State plan approved under this subchapter other than the requirement of the receipt of aid or assistance under subchapter IV of this chapter, supplemental security income benefits under subchapter XVI of this chapter, or a State supplementary payment), and are:

(i) lawfully residing in the United States, or

(ii) children under age 21, including optional targeted low-income children described in section 1905(u)(2)(B), or

(iii) pregnant women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy)."

(B) No debt shall accrue under an affidavit of support against any sponsor of such individual on the basis of provision of medical assistance and the cost of such assistance shall not be considered as an unreimbursed cost.

"Chip"

Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended by striking subparagraph (H) and inserting the following new subparagraph:

"(H) Paragraph (4) of section 1903(v) (relating to individuals who, but for sections 401(a), 403, and 421 of Public Law 104–193 would be eligible for medical assistance under Title XXI."

Conforming Amendment:

42 U.S.C. 1320b–7(f) is amended as follows:

(f) Medical assistance to aliens for treatment of emergency conditions and for medical assistance provided to children and pregnant women.

Subsections (a)(1) and (d) shall not apply with respect to aliens seeking medical assistance for the treatment of an emergency medical condition under section 1903(v)(2) [42 U.S.C. § 1396b(v)(2)] or to children and pregnant women seeking medical assistance under section 1903(v)(4)."

Medicare

Similarly, Medicare should be made available to all lawfully present individuals who are otherwise eligible for the program. The language below on Medicare should be included in the section on Medicare.

42 U.S.C. 1395i–2(a)(3) is amended by striking subparagraph (B) and inserting: "(B) an individual who is lawfully present in the United States."

Statement of Kenneth L. Sperling, Hewitt Associates LLC

Mr. Chairman and Members of the Committee: Thank you for the opportunity to submit our response to the Discussion Draft of the House Tri-Committee Health Reform Proposal, addressing the reform of America's health care system and expansion of health care coverage. 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 18 States plus the District of Columbia.

As the Nation pursues a path leading to universal coverage, we can learn a great deal from the experience of large employers. Employers are the single largest provider of coverage for working Americans and their families, and the system is highly valued by both employers and employees. Nationwide, employer-sponsored health care plans provide health care coverage to 160 million participants. The latest data from the Kaiser Family Foundation from 2008 shows that 99 percent of employers with 200 or more employees offered health benefits in 2008.[1] As we look to expand coverage and improve the health of all Americans, 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.

Hewitt commends the Committee for putting forward a Discussion Draft to enable the collection of further input as the legislative process advances. Our statement focuses on four key provisions in the Discussion Draft, with recommendations on how to avoid disrupting existing employer provided health insurance:

I. Insurance Market Reform
II. Public Health Insurance Option
III. Shared Responsibility
IV. ERISA

Our statement draws from Hewitt's proprietary data and the experience of Hewitt's consultants and actuaries who have extensive knowledge of—and direct experience with—the employer-sponsored health care system. Health care reform is clearly needed and welcomed by large employers if it achieves the objectives of expanding access to high-quality, affordable health care to all Americans. We are pleased to continue to make available our comprehensive data and extensive knowledge of the large employer marketplace, coverage, and cost drivers.

I. Insurance Market Reform

We commend the Committee for developing an extensive reform proposal for the individual and group health insurance markets. We believe that the rating requirements and guarantees of availability and renewability of coverage in the Discussion Draft will broaden access to health care coverage within a framework that generally seeks to continue to support employer-based coverage. Additionally, we strongly support the requirement that all Americans have an individual responsibility to secure acceptable health care coverage when it is both available and affordable.

The employer-sponsored model works well because it allows the pooling of risks and because large-scale group purchasing lowers costs, enabling those who are less healthy to secure affordable coverage for themselves and their families. As proposed, the Exchanges would extend these advantages that employees of large employers currently enjoy to individuals and small groups. Employer-based plans offer coverage that is guaranteed and renewable, typically waives preexisting condition exclusions, and does not increase premiums or limit coverage based on health status. Incorporating an individual coverage requirement into the broader insurance market will level the playing field between large-employer plans and other forms of coverage. It will also provide more coverage choices to Americans.

Proposed Requirements of Health Insurance Plans

Insurance market reforms are indispensable for creating a viable Exchange and a balanced health insurance marketplace. However, Hewitt believes that these re-

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[1] 2008 Kaiser/HRET Employer Health Benefits Survey.

forms should not apply to large employers providing coverage outside the Exchange. Hewitt recommends the Committees consider the following refinements to the proposed reform requirements:

- **Permit rating variations based on tobacco use and adherence to programs promoting wellness and disease prevention.** Large employers have experimented with both of these approaches in an effort to influence employee behavior and reduce the health risk in their populations. We believe employers would support other health insurance programs following similar rating approaches.
- **Reconsider the rebate requirement for insurers whose medical loss ratios exceed the allowable limits.** While insurers should be expected to provide coverage commensurate to the premium payments they receive, the rebate requirement is likely to unintentionally increase costs to all participants. Managing the rebate payments will increase insurers' administrative costs, and insurers may increase their risk charges to build extra reserves to fund the rebate payments.

  At a minimum, employer-sponsored group health plans that are self-insured should not be subject to this requirement because the goal of the rebate mechanism—to preserve affordable coverage to employees and their dependents—is already in practice in the self-insured marketplace. The provisions of ERISA prohibit any excess contributions to be used for any purpose other than benefits for employees and their dependents. Our experience has been that when actual claim costs prove to be lower than expected in a self-insured group health plan, employers reflect the benefit of this favorable experience by not increasing payroll contributions and/or cost-sharing provisions in the following year. To impose onerous rebate requirements on these plans would simply add administrative cost with no substantive benefit. Health insurers that are contracted to provide administrative services under these plans, similar to the third-party contracts in place for the Medicare program, do not receive any additional benefit from favorable self-insured loss ratios.
- **Preserve flexibility for ERISA group health plans outside the Exchange.** Employers are in the best position to determine their employees' health care needs. We recognize and support the idea of an actuarially determined minimum benefit for plans provided through the Exchanges, but recommend that no specific benefit requirements or designs be imposed on large employers outside the Exchange. For this particular group, which already offers near universal group health plan coverage for their workforces, we recommend that the option of sponsoring such plans continue to be voluntary. Accordingly, we suggest that the market reforms not apply to ERISA group health plans.
- **Improve the application of the Grace Period.** Employers will need substantial time to adjust their plans, and it will take time to implement individual and small-group market reforms. To avoid disruption of employer group health plans and added costs, we suggest that the proposed grace period apply to all employer-sponsored plans, including flexible spending accounts (FSAs). We also believe any rules in the Discussion Draft should only be applied after the expiration of the grace period. Additionally, we recommend that any individual enrolled in an employer-sponsored group health plan during the grace period should be deemed to have satisfied the Individual Responsibility requirement in the Discussion Draft.

Health Insurance Exchanges

We support the Committee's suggestion that Exchanges be designed to address access to coverage for small businesses and individuals—precisely the group that could most benefit from this concept.

There is much to be learned from the Massachusetts Connector model, a pioneering Health Insurance Exchange. A May 2008 review of the Massachusetts health care reform plan by the Kaiser Family Foundation estimated the number of people with insurance in Massachusetts has increased by more than 340,000 since late 2006, representing more than half of the estimated 650,000 people who were previously uninsured.[2]

We also strongly support the ability of private entities to facilitate Exchanges because they can best leverage existing processes, technology, and relationships to quickly and efficiently deliver the educational, informational, and enrollment assistance to support the participants of the Exchanges. As such, we also support the non-

[2] *Massachusetts Health Care Reform: Two Years Later*, Kaiser Commission on Medicaid and the Uninsured, May 2008. Others note that at the same time, the costs of the Massachusetts program have risen as well, requiring subsequent and likely ongoing adjustments.

regulatory role that the proposed Exchanges will assume and suggest that oversight and regulation reside at the State or Federal level with independent, nonpartisan agencies.

Benefit Plan Values and Requirements

Hewitt's extensive actuarial and consulting experience with large employers may assist the Committees in defining minimum coverage that would ensure a broad range of medical benefits are provided by the health insurance plans offered in the Health Insurance Exchanges.

We suggest that all health care benefits be subject to a reasonable and objective standard of medical necessity to prevent overutilization of services. This is particularly important in the area of diagnostic imaging and screening. As new technologies have become readily accessible, the industry has seen large increases in cost and utilization without conclusive evidence of commensurate effectiveness.

We have identified several concerns with the Committees' proposed benefit tiers and associated actuarial values and make the following recommendations:

- **Combine actuarial value with a benchmark plan design.**

  We suggest that any proposed benefit levels in employer-sponsored group health plans be determined by combining an overall actuarial value percentage with a reference to a published benchmark plan design. While the overall actuarial value percentage concept proposed in the Discussion Draft is valid, different actuarial models used to determine the percentage of charges paid may vary. This could lead to a cliff effect with plans satisfying or failing the requirements depending on the actuary valuing the plans. Our approach could mitigate this issue by allowing for a small range of overall actuarial values, e.g., the stipulated percentage actuarial value plus or minus 2 percent, combined with referencing a stated actuarial value to a known and public plan design (e.g., the Federal Employees Health Benefit Plan Standard option).

  There is precedent for this approach. Both Medicare Part D and Massachusetts Health Reform minimize the differences in actuarial variation by using a reference plan approach to define appropriate actuarial values. Combining the absolute percentage requirement with a reference plan ensures that various actuarial models are consistent in their measurement. Exhibit 1 provides an illustration of this combination and some examples of reference plans.

Exhibit 1: Illustrative Reference Plans at Different Actuarial Values

Plan Provision	HMO Design Actuarial Value: 95%	PPO Design Actuarial Value: 85%	PPO Design Actuarial Value: 70%
Copayment: Primary Care Physician	$15	N/A	N/A
Copayment: Specialty Care Physician	$25	N/A	N/A
Copayment: Hospital Admission	$200	N/A	N/A
Annual Deductible	None	$300 per individual	$2,000 per individual
Coinsurance (paid by plan)	100%	80% for in-network services	80% for in-network services
Out-of-Pocket Maximum	N/A	$2,000 per individual	$4,000 per individual
Copayment: Generic Drugs	$2	$5	Subject to deductible and coinsurance
Copayment: Preferred Brand Drugs	$8	$15	Subject to deductible and coinsurance
Copayment: Non-Preferred Brand Drugs	$16	$30	Subject to deductible and coinsurance

We also suggest that actuarial value determinations specifically exclude out-of-network providers for any health plan that meets standards to ensure network adequacy. The recent Congressional Research Service paper uses only in-network benefits design in its actuarial value calculations.[3] Under other circumstances, for any plan that does not meet the network adequacy standard and where a significant percentage of care is delivered outside the network (e.g., more than 10 percent), it may be appropriate to include out-of-network expenses in the determination of the plan's actuarial value.

It is also important to define the types of services that should be included in the actuarial valuation. For example, major service categories such as dental, vision, and hearing, and alternative medical services should be specifically identified, as should contraceptives and high-cost biotech pharmaceuticals for the prescription drug benefit.

- **Implement an additional benefit tier.**

  Hewitt has actuarially valued the health care plans of the 325 large employers that participate in the Hewitt Health Value Initiative™ (HHVI), a database containing detailed census, cost, and plan design data representing 13.1 million participants and $51 billion in 2009 health care spending. The data in Exhibit 2 shows that the majority of large employers offer benefit plans that are at least as comprehensive as the Committees' suggested basic plan. Note that less than 2 percent of employees are enrolled in plans with an actuarial value equal or greater to 95 percent, and nearly 4 percent of employees are currently enrolled in plans that would fail to meet the 70 percent actuarial value standard in the Discussion Draft.[4]

Exhibit 2: Comparison of Actuarial Value of Large Employer Plans to the Proposed Basic Plan

Plans with an Actuarial Value of:	Percentage of Employees Enrolled
Less than 65%	0.7%
65–69%	3.0%
70–74%	9.2%
75–79%	18.4%
80–84%	25.4%
85–89%	28.7%
90–94%	12.8%
95% or more	1.8%

We suggest adding an additional benefit tier using an actuarial value of 65 percent to accommodate those individuals and small employers who prefer to enroll in lower-value plans to pay less in monthly premiums. Such a design would provide comprehensive insurance protection against catastrophic loss, while providing a more affordable monthly premium than higher-valued options. Providing this flexibility would avoid forcing individuals and small businesses to provide coverage that they cannot afford and do not feel they need. The Massachusetts health care program includes similar options in their Bronze plans. If a 62 percent tier were adopted, it would permit certain Bronze plan options available through the Massachusetts Connector to meet the minimum value requirement.

Many High-Deductible Health Plans (HDHPs) would fall below this benchmark if contributions made to Health Reimbursement Arrangements (HRAs) or Health Savings Accounts (HSAs) are not taken into account when calculating actuarial value.

[3] Chris L. Peterson, "Setting and Valuing Health Insurance Benefits," Congressional Research Service, R40491, April 6, 2009.

[4] Actuarial value calculated using an assumption of covered expenses paid by the plan.

We strongly recommend that such contributions be considered in determining actuarial value. IRS rules provide guidance for the maximum deductible and out-of-pocket expenses allowed for HDHPs within an HSA. The 2009 limits are a minimum individual deductible of $1,200 ($2,400 family) and a maximum out-of-pocket of $5,950 ($11,900 family). A plan with these deductibles and out-of pocket maximums would have an actuarial value of 71 percent using Hewitt's actuarial model. Any contribution an employer makes to the HSA should also be considered in the actuarial value calculation and would further raise the value. Every $100 contributed to an HSA as part of the plan raises the actuarial value by about 1 percentage point, assuming all coverage tiers are given the same contribution.

- **Apply minimum health benefit standards to total actuarial value and revisit cost-sharing provisions.**

  For employer-sponsored group health plans, we suggest that the standard be based on the total actuarial value of the plan design, not on specific benefit-by-benefit comparisons. The use of total actuarial value should also include certain provisions to prevent "gaming" of the values. For example, for health plans offered in the open market and through the Exchange, we encourage the Committees to take steps to prevent insurers from developing plan designs that meet the total benefit percentage requirements but limit some services in order to prevent high-risk individuals from joining. Total actuarial equivalence is currently used for Medicare Part D employer health plan comparisons, while plans marketed to individuals are required to perform more detailed comparisons. Massachusetts also uses a total actuarial value approach.

  We encourage the Committee to remove the copayment language from the Discussion Draft and allow for both copayment and coinsurance provisions as deemed appropriate by the health plan sponsor. The Discussion Draft suggests that the Essential Benefits Package should use copayments in lieu of coinsurance whenever possible. While copayments are administratively easier for both the individual and the medical provider, this practice removes all transparency around the cost of the service being provided. Employers have successfully used coinsurance designs in prescription drug coverage, for example, to educate employees about the cost of brand-name drugs versus lower-cost alternatives. Using coinsurance provisions, the Medicare Part D program experienced an 88 percent generic substitution rate in its first 6 months of operation that significantly contributed to the favorable cost experience of the program.[5]

  The Discussion Draft allows a variation of up to 10 percent in cost-sharing between basic, enhanced, and premium plans. In our experience with large employers and the options provided to their employees, this range will not be wide enough to allow for meaningful premium differences. In general, there should be an 8–10 percent difference in actuarial value between each plan level in order to offer meaningful choice. Limiting the variation as proposed will not provide this degree of actuarial value difference and corresponding premium savings to the individual.

- **Preserve existing employer plan options.**

  We suggest the Committees be mindful that a wide range of health care plan designs exist today. We recommend that the requirements should be flexible enough to allow employees to keep their existing plans if they so choose. We support the Committee's proposal of a 5-year grace period for group plans. As previously noted, we suggest that the grace period apply for all purposes and to all employer plans, including FSAs. Many large employers offer participants a choice of health care plans with varying employee premium contributions for greater cost-sharing in health care services at point of care. These are often choices of delivery model (HMO or PPO) or choices of plan cost-sharing. This is similar to the Federal Employee Health Benefit Plan Basic and Standard options. Typically, HMO plans have richer benefits, with lower copayments and no deductibles. PPO plans generally have up-front deductibles and coinsurance. Exhibit 3 shows typical plan provisions of HMO and PPO designs, and their associated actuarial values for the network benefit design.

[5] Generic Drug Utilization in the Medicare Part D Program, Office of the Inspector General, Department of Health and Human Services, November 2007.

Exhibit 3: Typical Plan Provisions for HMO and PPO Plan Designs

Plan Provision	HMO Design Actuarial Value: 89%	PPO Design Actuarial Value: 81%
Copayment: Primary Care Physician	$25	N/A
Copayment: Specialty Care Physician	$30	N/A
Copayment: Hospital Admission	$250	N/A
Annual Deductible	None	$500 per individual
Coinsurance (paid by plan)	100%	90% for in-network services
Out-of-Pocket Maximum	N/A	$2,500 per individual
Copayment: Generic Drugs	$10	$10
Copayment: Preferred Brand Drugs	$25	$25
Copayment: Non-Preferred Brand Drugs	$40	$40

Note that the designs shown in Exhibit 3 are representative of typical designs today with 50 percent of large employers offering an HMO plan and 85 percent offering a PPO plan. Both of these designs have lower actuarial values than the proposed Premium option in the Discussion Draft. Other popular plan types include Health Reimbursement Arrangements (19 percent) and Health Savings Accounts (30 percent). In addition, IRS rules provide guidance for the maximum deductible and out-of-pocket expenses allowed for HDHPs with HSAs. The 2010 limits are a minimum individual deductible of $1,200 ($2,400 family) and a maximum out-of-pocket of $5,950 ($11,900 family). Within these limits, a broad range of plan design values could apply. The richest HDHP-qualifying plan, for example, would have a $1,200 deductible and pay 100 percent benefits after that point. The actuarial value for a plan such as this would be 84 percent under Hewitt's actuarial model. Conversely, the leanest HDHP-qualifying plan would have a $5,950 deductible and pay 100 percent benefits after that point, and have an actuarial value of 50 percent. An employer contribution to an HSA would raise the actuarial value, assuming this was allowed in the methodology.

II. Public Health Insurance Option

There has been much debate about the merits of a public health insurance option to compete with private insurance plans. While the Committee has proposed options for a public plan for both individuals and small businesses through the Exchanges, the market dynamics of any public plan will likely extend to large employers outside the Exchanges.

It is well known that private payers are subject to cost-shifting from hospitals and doctors to compensate for below-market reimbursements from Medicare and Medicaid. The Lewin Group estimates that Medicare reimburses hospitals 71 percent of private-plan payments; for doctors it is 81 percent.[6] Structuring a public plan option with payments equal to or slightly greater than Medicare rates would only further exacerbate current cost-shifting. As private-plan costs continue to rise under this pressure, more employers will be squeezed out of the employer health care system as coverage becomes unaffordable. Over time, this cost-shifting cycle threatens to unravel the entire employer-based system.

In light of the risks associated with a public plan and the expected availability of competitive options through the Exchanges, we recommend the Committees remove the public plan as a feature of health care reform. Alternatives to the public plan, such as a trigger mechanism where a public plan is implemented only if targeted goals are not reached within 5 years (e.g., if sufficient competition does not exist in a market) may be appropriate if insurance reforms do not fully meet the needs of individuals in certain markets. Additionally, any public plan triggered by

[6] The Cost and Coverage Impacts of a Public Plan: Alternative Design Options, The Lewin Group, April 2009.

insufficient competition should be required to play by the same rules as commercial health insurance carriers. The Blue Dog Coalition provided a list of minimum conditions that we also support, especially the conditions of free market adherence and a level playing field with private plans.

III. Shared Responsibility

Large employers have widely differing opinions on a proposed employer mandate to provide health insurance coverage. Almost all large employers already offer and subsidize comprehensive coverage, (either voluntarily or through collective bargaining agreements) for employees and their dependents. About half of the total cost of this coverage benefits spouses and children. Large employers tend to absorb a larger proportion of these costs—either because the spouse is not employed, the spouse's employer does not offer coverage, or the large employer's plans are more comprehensive. The 2008 Kaiser/HRET survey shows that 58 percent of employees working for larger employers (those with 200 or more workers) enroll dependents, compared to 47 percent of employees working for smaller employers (those with less than 200 workers). Requiring all employers to provide health coverage would reduce some of the costs borne by large companies for dependent coverage, but a mandate on large employers—who are already offering coverage—seems unnecessary based on the near-universal voluntary participation in this market today.

Further, requiring employers to extend health care benefits to part-time employees would have a severe impact on certain industries that are struggling to survive in the current economy. Employers compete for talent based on their work environments, compensation, benefits, career opportunities, and a host of other factors. The decision to offer health care benefits to a part-time workforce must rest with employers. Alternatively, it would be more appropriate to offer individuals who fall into this category access to coverage through the Exchanges, as well as subsidies based on their income if their employer chooses not to subsidize health insurance benefits.

We recommend that the Committees remove the "pay or play" employer requirements in the current proposal and consider alternative mechanisms to ensure employers retain their current health care benefits. Under a "pay or play" scenario, every employer would have no choice but to carefully analyze its cost to provide coverage with the "pay" alternative—be it a dollar assessment or a percentage of payroll. We believe the result will be a bifurcation of the employer-sponsored system. According to Hewitt's database, large employer health insurance costs are projected to be $8,863 per employee (including dependents) in 2009. However, there is a broad range around this average, with a low of $5,323 per employee to a high of $13,553 per employee. Those with costs above the level of assessment would consider eliminating their employer-sponsored plans, creating adverse selection against the plans in the Exchange and driving up costs for Exchange participants.

The Massachusetts health care program is an example of a "pay or play" approach where most employers have chosen to "play" even though the assessment was relatively minor at $295 per employee. This was primarily because of the administrative complexity of removing Massachusetts employees from large employers' national programs. We believe the result of a national "pay or play" requirement would be dramatically different, as it would provide incentives for many employers to exit health care entirely if the "pay" alternative was sufficiently attractive.

Due to the concerns outlined above and the potential unintended consequences of an employer mandate, we suggest strong consideration of an individual mandate but no employer mandate at this time.

IV. ERISA

Multi-State employers have been able to build uniform benefits programs for all employees regardless of their work location by relying on the uniform Federal regulation offered under ERISA preemption. This allows employers to determine which programs are best for their unique workforce and offer the same programs on a uniform basis in all of the States where they do business. The Discussion Draft proposes subjecting ERISA group health plans to the potential for state insurance mandates if States are willing to contribute toward the costs of those mandates. At the same time, employers become subject to various State rights of action for not meeting the requirements of those mandates. We strongly urge the Committees to reconsider this provision. Weakening ERISA would create a grave risk that large employers would drop their benefits programs as they become overly burdensome and costly to administer.

The Discussion Draft creates a three-tiered system of rights and remedies for employer compliance under Federal health care reform. This system creates three problems for employer group health plans:

- First, the availability of compensatory and punitive damages against an employer plan will, at best, encourage the payment of questionable claims to avoid the costs of litigation. At worst, it will provide an incentive for frivolous litigation. Either outcome will result in increased health care costs.
- Second, it is possible that State and Federal courts will issue conflicting decisions and develop differing bodies of law regarding similar coverage determinations made by employer group health plans, making it impossible to administer group health plans consistently across State lines and from employee to employee. Even for plans that do not participate in the Exchanges and are not subject to State law remedies, Federal courts may rely on decisions made in State courts to reach decisions regarding coverage determinations made by employer group health plans.
- Finally, the public plan option was designed to compete with the private sector on merit, not liability. Employer group health plans will be subject to compensatory and punitive damages that will not apply to the public plan option, which further tilts the playing field in favor of a public plan option.

Conclusion

We applaud the proposals to improve access to affordable health insurance for individuals and small businesses. The creation of Health Insurance Exchanges with insurance market reforms and a viable and competitive insurance marketplace will go a long way toward achieving universal coverage.

We strongly encourage the Committees to reconsider provisions that could draw individuals out of their employer plans and into the individual market or raise employers' costs to unsustainable levels. Inadvertently unwinding the employer-based system would increase, not decrease, overall health care costs, and the effect this would have on a fragile U.S. economy could ultimately turn the public against even the most positive reform efforts.

We hope our observations, data, and suggestions are helpful to the Committees.

Letter from Jaci Mairs, R.N., J.D.

I am a 55-year-old woman, a lawyer who became a registered nurse at midlife and now I am a student again working on a Masters of Nursing in Women's Health. Recently I applied for private health insurance with several companies. I consider myself to be healthy, but was very surprised when my applications were declined due to preexisting conditions. Luckily I have other options. However, many other women are not so fortunate and women in general do not receive adequate coverage by our current health care system.

Women's health care needs are generally greater than men's, particularly during their reproductive years. However, in curious contrast to that, our current system makes it more difficult for women to obtain and afford the health care services they need.

Our health care system is designed to rely heavily on employer-provided health care insurance. This works well when the population is gainfully employed with large employers who provide insurance, and in positions which qualify for insurance. This does not work well overall for women as a gender. Employment statistics tend to overlook the rates of full-time employment versus part-time employment which frequently does not carry health care benefits. Only approximately 40% of all women are employed full-time, whereas more than half, approximately 60% of men are employed full-time. Additionally, many of those women are working full-time work in smaller companies which do not provide health insurance to their employees. The other 6 out of 10 women—those who are either employed part-time or not employed at all—have little access to employer-provided insurance on their own behalf. That majority of women must generally rely on private insurance, public programs, or insurance provided by a spouse (in some instances a significant other).

To make matters worse, private insurance which is available for purchase is likewise biased against women. Many companies charge as much as 1½ times more in premiums for women during their reproductive years than for men. (H.R. 2635, currently pending in the U.S. House of Representatives, would rectify this disparity). Amazingly, the majority of insurance companies exclude coverage for childbearing, and many exclude pap smears and mammograms, major reasons women need health care coverage. Over 10 States permit insurance companies to exclude coverage for FDA-approved contraceptives. And, at least 9 States allow insurance companies to deny applications from victims of domestic violence (while numbers vary, women are the vast majority of victims of convicted domestic violence offenders).

Finally, women overall make less in income than men and therefore cannot afford health care to the same extent. Women employed full-time make approximately 80% that of men working full-time. More working women work part-time, which is generally paid less than full-time work. And, women as a group work fewer hours than men. In a recent survey, more than 50% of all women reported delaying or avoiding health care services as opposed to 39% of men.

I urge this Committee and our U.S. Congress to consider these very significant issues and work responsibly together to finalize and adopt legislation which would create a health care system that guarantees equal and adequate health care for all. Thank you for your consideration.

Jaci Mairs, R.N., J.D.

Jaci Mairs is a registered nurse working on the Perinatal Unit at Truman Medical Center, Hospital Hill, in Kansas City, Missouri, and is also a student at UMKC working on a Masters of Nursing in Women's Health. She is also a licensed attorney and formerly the Court Administrator and Legal Counsel for the Circuit Court of Jackson County, Missouri, for over 20 years. Opinions in this essay are solely those of the author and have not been reviewed or approved by any of the institutions mentioned above.

WOMEN AND THE HEALTH CARE DEBATE

- *Women's health care needs are generally greater than men's, particularly during their reproductive years.*
- *Our current system makes it more difficult for women to obtain and afford the health care services they need.*
- *Our health care system is designed to rely heavily on employer-provided health care insurance.*
- This does not work well overall for women as a gender.
- Approximately 40% of all women are employed full-time, whereas 60% of men are employed full-time.
- Many of those women employed full-time work in smaller companies which do not provide health insurance to their employees.
- The remaining 6 out of 10 women—those who are either employed part-time or not employed at all—have little access to employer-provided insurance on their own behalf.
- That majority of women (60%) must generally rely on private insurance, public programs, or insurance provided by a spouse (in some instances a significant other).

Private insurance which is available for purchase is likewise biased against women.

- Many companies charge as much as 1½ times more in premiums for women during their reproductive years than for men. (H.R. 2635, currently pending in the U.S. House of Representatives, would rectify this disparity).
- The majority of insurance companies exclude coverage for childbearing, and many exclude pap smears and mammograms, major reasons women need health care coverage.
- Over 10 States permit insurance companies to exclude coverage for FDA-approved contraceptives.
- At least 9 States allow insurance companies to deny applications from victims of domestic violence (while numbers vary, women are the vast majority of victims of convicted domestic violence offenders).

Women overall make less in income than men and therefore cannot afford health care to the same extent.

- **Women employed full-time make approximately 80% that of men working full-time.**
- **More working women work part-time, which is generally paid less than full-time work.**
- **Women as a group work fewer hours than men.**
- **In a recent survey, more than 50% of all women reported delaying or avoiding health care services as opposed to 39% of men.**

Statement of Max Heirich

The current emphasis within American health care on ever-more-expensive *disease care* is not getting the job done: It costs too much, it leaves too many people out, and it leaves the health status of the American population far behind that of other industrialized countries. We need greater emphasis on *health-building*—keeping people healthy and helping people at risk for chronic disease improve their health. An effective health care system must deal with disease while also protecting people from environmental health risks (e.g., air pollution, second-hand smoke, toxic wastes, etc.) and it should help create a physical and social environment that encourages health-building. Wellness and prevention efforts address a full spectrum of human needs—physical safety and physical, mental, emotional, social and spiritual well-being.

This paper addresses two questions: First, is there evidence that wellness and prevention programs actually improve health status and save costs? Second, what are critical areas where cost control is needed, and for each, could wellness and prevention projects strengthen person-centered care and provide noncoercive cost control while improving health outcomes? (An appendix lays out seven areas where cost control is needed and identifies prevention and wellness projects relevant to each problem area.)

Obama's proposals for health care reform and bills from the House Tri-Committee and the Senate HELP Committee all include an enlarged budget for wellness and prevention efforts, as did the economic stimulus package. Advocates argue that programs to keep people healthy and to detect disease early will save money. However a recent report from the Congressional Budget Office (CBO) cautions that prevention and wellness proposals will not save money. Moreover, it suggests there is little evidence that prevention efforts actually change health status. Who is right?

CBO is both right and wrong on this one: Much of what passes as "prevention"—e.g., pharmaceutically-based chronic disease management, screenings to identify people with serious health problems such as cancer and diabetes, etc., and preventive care given in doctors' offices (usually at $75 or more per visit)—is useful, but these services are NOT money-savers.

For years people have tried to deliver "preventive" care in doctors' offices, providing vaccinations, disease screenings, and management of chronic illness via prescribing drugs (e.g. statins for cholesterol control). Ron Goetzel, a highly respected, costs-of-prevention analyst, has argued that for cost-effectiveness you need care delivered by less expensive health personnel than MDs, programs that do not rely primarily on use of pharmaceuticals, and programs that intervene in new ways outside medical settings (which have their own built-in costs). Many current prevention efforts are delivered by doctors in medical offices, relying primarily on expensive diagnostic tests and then pharmaceutical interventions or surgery. They may save lives; they do not save money.

More recently, people have tried to implement less-costly chronic disease management via phone or computer, but with limited ongoing success. Low-cost wellness programs have also been tried, featuring self-report surveys of personal health risks, followed up by educational materials and invitations to use a free phone service for more personal health counseling. The impact of these programs also has been limited. The CBO assessment is correct about these kinds of prevention efforts. Most do not save money and many have limited effectiveness. But these programs are not the whole wellness and prevention picture. Innovators have continued to develop new strategies. A growing body of evidence (perhaps not seen by CBO) points to promising demonstrations that both improve health and save money.

The best evidence on the effectiveness of prevention programs comes from the worksite health promotion literature. This literature is also suggestive of the types of prevention programs that are likely to be most successful. These are programs that provide a socially supportive context for lifestyle changes, not simply medical interventions. Michael P. O'Donnell, the critically respected editor of the *American Journal of Health Promotion*, reports: (1) "A systematic scientific review showed that the impact of lifestyle changes on all-cause mortality in coronary artery disease patients compares favorably with cardio-preventive drug therapies." (2) "In a large clinical trial with a population at high risk for developing type 2 diabetes, lifestyle interventions achieved a 58% reduction in onset of diabetes. They were nearly twice as effective in preventing diabetes as pharmaceutical treatment with metformin (which achieved a 31% reduction)." (3) "A large-scale longitudinal study found that people with healthy lifestyles have greater longevity than the general population and end-of-life morbidity is compressed for them." [I.e., they have shorter hospital stays, with less expensive end-of-life care.] Looking more broadly, (4) "Comprehensive scientific reviews identified 378 peer-reviewed studies showing that worksite

health promotion programs improve health knowledge, health behaviors, and underlying health conditions." (5) "The most definitive review of **financial** impact found that 18 [of 56] studies found that a program reduced medical costs, and 14 studies found they reduced absenteeism costs ... 13 studies calculated benefit/cost ratios and all showed that savings from these programs are much greater than their cost, with medical cost savings averaging $3.48 and absenteeism savings averaging $5.82 per dollar invested in the programs. ... A systematic review of 60 scientifically valid studies showed that a comprehensive wellness program, on average, reduces health care expenditures by 26.5%."

The most effective prevention and wellness programs focus on health improvement through lifestyle change. These successful programs do two things: They reach out proactively, encouraging individual changes in health behavior, and they create and strengthen a supporting culture of wellness. Targeted populations improve their health status, lowering disease care use and thus saving money. More is needed to improve Americans' health than lifestyle change alone, however. The public also needs protection from environmental health risks (from air pollution, second-hand smoke and the like). Local public and private actions are needed to create and sustain a culture of wellness by providing social support for becoming and remaining physically active, managing daily stress, and improving nutrition.

The 2009 economic stimulus bill included funds for pilot projects addressing health protection issues. Upcoming health care reform legislation can build on these demonstrations and improve access to primary disease care for currently underserved populations. I am convinced that health-building prevention and wellness programs that are evidence-based and cost-beneficial can become part of a realistic framework for achieving cost control, helping our health care industry evolve into a more effective health care system. (The appendix discusses seven areas where *person*-centered, noncoercive cost-control is needed, and proposes demonstration projects that could be relevant—dealing in new ways with catastrophic-level health care costs, chronic diseases, mental health or trauma, acute care in hospitals, the need for neonatal intensive care and its costly aftermath among low-income mothers, the high cost of dying, and possible ways to simplify hospital administrative costs.)

The House discussion-draft health care reform bill wisely calls for demonstration projects in primary care, prevention, and wellness as a first step. And it welcomes nurse-based primary care and prevention efforts, especially for those making services available to now-underserved populations. The bill also has some omissions, which could be remedied simply. Here are some proposals for strengthening it:

1. Include projects using Integrated Medicine (which combines standard care and complementary and alternative medicine) for potential demonstrations-evaluations.
2. Enlarge Task Force mandates to include identification and evaluation of demonstration projects at worksites, and Integrated Medicine projects in hospitals and primary care (now under way) for outcomes, cost-benefit, and feasibility for wider use. (See appendix.)
3. Recruit effective leaders of these innovative projects to serve on Task Forces.
4. Assign coordination of innovation and assessment efforts undertaken by the Task Forces, NIH, AHRQ, and other governmental groups to the proposed new Assistant Secretary for Health and Human Services. That office would review assessment of outcome effectiveness, and cost-benefit, identifying evidence-based best practices.
5. Give the new Assistant Secretary for Health and Human Services responsibility for developing reimbursement incentives that encourage use of evidence-based best practices. In addition, that office should identify cost-effective *practitioners* of high quality, who would receive full reimbursement for whatever treatment strategy best meets the needs of their individual patients. We want to create patient-centered best practices, not one-size-fits-all care.

Max Heirich, mheirich@umich.edu, professor and research scientist emeritus, U of Michigan, NIH research grantee, co-founder of UM Health Policy Forum, a consultant on prevention, wellness, cost-control and integrated medicine to GM, Ford, Merck, NIH and the White House Commission on Complementary and Alternative Medicine Policy.

GETTING PRACTICAL—AN APPENDIX

Patient-Centered and Noncoercive Cost-Control in Health Care: Making Successful Approaches to Wellness, Prevention and Disease Care Relevant to American Health Care Reform

A. Seven Areas where Patient-Centered, Noncoercive Cost Control is needed:

1. **Patients with "catastrophic costs" for care**
2. **Chronic Disease Prevention and Management**
3. **Mental Health Services and Stress Management**
4. **Hospital Operating Expenses**
5. **Costs for Neonatal Intensive Care Use and Post Care for *Infants of* Low-income Mothers**
6. **The high cost of dying**
7. **Hospital Administration Costs**

B. Pilot projects building on promising demonstrations:

1. Outreach to "catastrophic-cost" patients in a publicly-funded health care option: For an 8-year period during the 1980s, when health benefits costs were increasing at twice the rate of the general inflation, Federal Express discovered that the economist Pareto's prediction applied to their workforce, i.e., that 20% of any population will generate 80% of costs for service to it. Fed Ex hired Options and Choices, a benefits management vendor, to reach out proactively to employees they identified each year as their "Pareto group." Specially trained nurses proactively reached out to them and remained in contact. The nurses helped these employees manage their disease more effectively, provided an impartial sounding board as patients thought through the advantages and disadvantages of various treatment options being recommended, and motivated these employees to work at actively improving their health, coaching and encouraging them as they attempted to do this. This program was well-received by employees. Result: Federal Express kept its health benefits budget increases equal to the general rate of inflation, during a period of time when health benefits costs elsewhere were increasing at twice that rate.

We propose a pilot project targeting a subset of enrollees in a public health insurance plan (i.e., a sample of the 20% of enrollees whose care accounts for 80% of the costs of disease-care utilization). If this could be done with the Federal Express workforce, which is scattered across the country, a pilot project for those in a public health insurance plan should be feasible. Costs for proactive disease-management/wellness outreach services to a "Pareto group" of highest cost users of disease-care services would range between $200–$400 per year per targeted high-cost user, depending on location and difficulty of contacting them. Savings could be substantial, and per capita costs for the pilot group could be compared with per capita costs of the "pareto" catastrophic-cost group of enrollees in the same geographic areas who were not in the pilot study group.

2. Reducing disease-care costs by keeping people healthy: A combined disease-management/wellness program that could be scaled up for much wider use with an entire workforce or a local community. Holtyn and Associates, a health and wellness program vendor, works with a wide range of industries, whose employees come from diverse ethnicities and educational levels of the workforce. They have worked extensively in Michigan and also across the Nation. Holtyn and Associates programs regularly get 75% to 80% or higher participation in health improvement efforts and achieve 50% or more reduction in health risks in these populations within 1 to 3 years. Client organizations have found sharply reduced costs for health benefits, in contrast to peer organizations in their community. Holtyn was the recipient of a CDC grant to develop community wellness programs, and CDC recently sponsored an assessment of another of the Holtyn programs; still other of their programs have won national awards. Currently, in cooperation with Blue Cross/Blue Shield, Holtyn and Associates have jointly developed a protocol to integrate disease-management with health promotion and wellness counseling at worksites. Holtyn's client organizations report cost savings from decreased hospital admission rates (currently by 11%) as employees improve their health. Holtyn is currently working with school system employees in several Michigan communities. As part of a systematic program evaluation by this client, in 2012 data from 12,000 participants will be analyzed by the client's health economists, using state-of-the-art assessment tools, analyzing changes in health status, disease-care utilization, and health benefits costs.

Key ingredients of the Holtyn programs include proactive outreach for health risk assessments; triaged followup for personalized health-improvement by counselors skilled in motivational interviewing; organization of activities that create a "culture of wellness" in a business, neighborhood, or other setting; use of the Internet as part of instruction with clients; and sponsorship of low-cost incentives (e.g., "health lotteries") which motivate participants to participate in ongoing efforts at health improvement in order to qualify for access to incentives. Feasibility for wider use: Holtyn's approach can incorporate a variety of health improvement goals for special population groups, and can be scaled up fairly quickly, with due attention to maintaining quality of the programs. Holtyn has worked closely with the Michigan Department of Community Health to design and implement a training and certification program for wellness vendors in Michigan. In this program, certified wellness vendors screened, counseled and provided education services to over 10,000 businesses and approximately 350,000 employees over a 12-year period. Personnel who developed and supervised this program are still working with the Michigan Department of Community Health. In larger demonstration/evaluation projects, State health department employees could train and certify vendors and assess outcomes. If participants in the demonstration were part of the public health insurance plan, Federal evaluators could assess cost-savings, as well.

3. De-medicalizing stress management for special-needs populations: Working with low-income populations, communities and others dealing with major traumas, including Post Traumatic Stress Disorder (PTSD), the Washington, DC Center for Mind-Body Medicine (Dr. James S. Gordon, psychiatrist, founder and director) has developed a comprehensive program for training health and mental health professionals, educators and community leaders in simple ways to deal with their own stress and psychological trauma and to provide effective programs of self care and mutual care for entire communities. In Kosovo, CMBM trained 600 professionals in ways to deal with trauma and stress using such mind-body techniques as relaxation, meditation, guided imagery, biofeedback, and yoga as well as self expression in words, drawings and movement in a supportive small group setting. This has become central to the entire community mental health system and now serves some 2 million people. CMBM has developed similar programs in Israel, Gaza and post-Katrina southern Louisiana.

The Center initially provides training and support to leaders in relevant institutions—administrators, teachers, clinicians—and then works with them to bring the approach to troubled children and adults. CMBM reports that this model also has been effective and appropriate for use with children and adults who are significantly disadvantaged financially and who often are having difficulty holding a job or succeeding in school: That the techniques and approaches taught give many participants a sense of mastery where they have felt hopeless and powerless; that it allows them to have successful learning experiences which have usually been unavailable to them; and that it provides them with a supportive community which helps them to relieve their immediate stress, and to which they can turn in times of crisis.

We propose one or several pilot programs implementing these techniques with different at-risk populations. One pilot program could work within the VA system targeting military personnel with multiple deployments. Another with long-term unemployed or victims of natural disasters who are enrolled in the public insurance program. Both types of programs would permit evaluation of improvements in health outcomes, improvements in broader social outcomes, and cost-effectiveness.

4. Targeted use of Integrated Medicine in hospitals: Developing optimal healing environments can shorten hospital stays with improved outcomes for patients and staff. In the past 10 years hospitals have become much more interested in the practice of "integrated medicine," which combines traditional scientific medicine with complementary and alternative medical approaches to healing. ("Healing is the process of recovery, repair, and return to wholeness, as contrasted with cure, the eradication of disease."—Samueli Institute). By 2005, 26.5% of American hospitals reported that they were using some form of integrated medical practice. Some allow alternative practitioners to work directly with patients. Others form collaborative teams of medically-trained staff and alternative practitioners that work jointly with patients and their families. Other hospitals have introduced programs that encourage the self-conscious creation of healing intentions among the hospital staff, patients, and their families while still other hospitals restructure the hospital experience itself to optimize healing potential. The Samueli Institute has identified hospital Integrated Medicine practices that show promising results: e.g., a 56% reduction in risk-adjusted mortality among cardiac surgery patients in a hospital that has developed a collaborative teamwork approach; shortened length of stay, improved outcomes, as well as improved staff morale and lessened staff turnover in a hospital

that uses mind/body programs to create a healing intention among staff, patients and family members; and similarly improved functional health outcomes where complementary and alternative practitioners join the treatment team. We recommend pilot projects to evaluate the feasibility of expanding hospital-based Integrated Medicine practices. Pilot projects should implement and evaluate two types of programs: (1) those in which alternative practitioners work cooperatively with traditional practitioners, and (2) those in which hospital employees are trained to use and integrate a variety of alternative techniques into the traditional hospital practice.

C. Pilot projects to implement best practices in additional areas where improved cost-control and health outcomes are needed:

1. Expand participation in WIC programs to reduce need for neonatal intensive care and expensive post-care among infants born to low-income mothers: Several well-designed public health programs now provide psychosocial support, good nutrition, parenting education, and free prenatal medical care for young, low-income, first-time mothers. A variety of high-quality Women-Infant-Children (WIC) programs address these issues. Some show measurable impact on infant and child mortality among women who are enrolled in the program. All of these programs struggle to increase awareness and participation of at-risk pregnant young women. If more expectant mothers participated in these successful, existing programs, there would be significant reduction in health care costs and improved health outcomes. Use of intensive care facilities for low birth-weight babies would decline: as more low-income mothers have good nutrition and prenatal care, their gestation periods are more likely to reach full term. This also would lessen the number of young children with developmental problems, and lower the costs for servicing their special needs. Task Force pilot projects could borrow strategies from the four examples given above, and other sources, to identify kinds of innovations that could increase participation in WIC programs and could encourage creation of demonstration projects that do this.

For example, the Holtyn model might be introduced at a community level, including a featured health lottery, with the health lottery advertised widely on TV (as public service announcements and special reports). Filling out a health risk appraisal would be step one of a two-step process to qualify for participation in the lottery; the second step, which could be scheduled immediately, would involve (free) biometric measurements of your health status, with a brief, personalized health counseling session as it ends, and request for permission to stay in touch, assessing the best ways to do so. The health risk appraisal could be available in public libraries, at the public health department or other service centers where staff can help people with low literacy levels answer the questions. (The health risk appraisal would include two questions for women: "When did you have your last monthly period?" and "Are you pregnant?" to flag women who might be appropriate candidates for WIC referral as part of followup counseling.)

2. De-medicalize end-of-life care costs:

a. Demonstration projects with geriatric patients and their families: Helping clinics and staff develop skills and protocols that encourage patients and their families to assess what is most important to them in maintaining quality of life through its end. These programs would include introduction to living wills, the availability of hospice, and strategies for decisionmaking that are appropriate to the patient's and family's own values about what matters most to them as the end of life approaches. Doing this as part of primary geriatric care could lessen later use of heroic interventions at great cost that delay end-of-life only shortly. Hospice use might increase earlier in the dying process.

b. Demonstration projects with hospital staff who offer end-of-life care, strengthening communication skills and encouraging earlier discussion with patients and their families about quality-of-life choices available to them: A high proportion of Medicare costs are spent trying to delay a dying process which nonetheless occurs within a few days or months. Medical staff make heroic interventions at great cost in an effort to extend life. Often it is only when all interventions clearly have failed that staff help the patient and family address the question of how they would like to spend the remaining time that the patient will have to live. Hospice programs are widely available and are chosen by many patients at the very end. But the kind of communication that helps patients and families look clearly at a dying process that already is underway and that encourages them to decide how they want to use their remaining time often occurs only after heroic interventions that will simply delay a dying process a bit have been exhausted and

failed. Demonstration projects could be encouraged, developed, and evaluated that help staff communicate with end-of-life patients (and their families), to explore what is likely to lie ahead and encourage them to make their own choices about how to balance quantity and quality of time that remains and how to approach the healing aspects of dying as well as living. The Samueli Foundation has identified projects in integrated medicine already in use at some hospitals which help staff and patients deepen their own approach to healing intentions in other contexts. Task Force Demonstration projects dealing with improving quality at the end of life should be evaluated for their effectiveness in providing help and satisfaction to patients and families and for their impact on use of costly, heroic end-of-life interventions. The proposed new Assistant Secretary for HHS should encourage wider use of those approaches which prove to be most useful. This might well reduce end-of-life medical expenditures while improving the quality of life for many dying patients.

3. Simplifying hospital administration costs: Single-payer plans now used in some other countries have strikingly lower costs for hospital administration because they use hospital budgets that reimburse on an annual basis, rather than for individual care episodes. In several countries that have multiple payers for disease care, hospital budgets are set annually through negotiations between hospitals, physicians, and the set of insurers who pay for their services. Annual budgets can be adjusted for individual hospitals, depending on types of services provided, whether it is a teaching hospital, the population mix it serves, and other relevant factors. The various payers then divide these costs among themselves, based on their share of the patient load, adjusted for demographics and health-risk differences in their client base.

In the United States, hospital costs now make up 30% of total health care spending (over $600 billion annually), and hospital administrative costs make up 20% to 30% of the hospital costs, varying from hospital to hospital. In contrast, in Canada, which has hospital facilities similar to those in the United States, but which uses annual budget hospital reimbursement, administrative costs for hospitals average 9 to 11% annually. (Canadians seem to be generally pleased with their hospitals: In 2002, Michigan, New York, and Washington hospitals treated only 154 Canadians who came to border-area U.S. hospitals for elective care. Among "America's Best Hospitals" only one reported treating more than 60 Canadians a year. In a survey of 18,000 Canadians, only 20 had gone to the United States seeking care in the past year.)

Dramatic cost savings could result from such an innovation. However, I think this major a change in reimbursement procedure should be tried in a few States before recommending its use or nonuse more widely throughout the American health care system. Congress could ask the Assistant Secretary for HHS (proposed in the House health care reform bill discussion draft) to encourage a few States to serve as a pilot demonstration testing the feasibility of creating annual budgets for hospitals through negotiations between all the relevant payers and the relevant care providers, and the HHS office could assist in evaluating the impact of reimbursement through annual budgets on hospital administrative costs and total expenditures for hospital care.

Max Heirich, professor and research scientist emeritus, U of Michigan, NIH research grantee, co-founder of the UM Health Policy Forum, author and past consultant on prevention, wellness, cost-control and integrated medicine to Ford, GM, Merck, NIH, and the White House Commission on Complementary and Alternative Medicine Policy, and author of Rethinking Health Care: Innovation and change in America (Westview Press).

Medicaid and Medicare Advantage Programs Association of Puerto Rico

Mr. Chairman and Members of the Ways and Means Committee:

Thank you for the opportunity to provide our comments on the Tri-Committee Draft Proposal for Health Care Reform.

We write as members of the Medicaid and Medicare Advantage Programs Association of Puerto Rico (MMAPA). MMAPA is comprised of the five largest Medicare Advantage (MA) plans in Puerto Rico: Triple-S Salud (SSS), MCS (Medical Card Systems, Inc.), MMM (Medicare y Mucho Maźs), American Health Medicare, Humana Puerto Rico. Together we account for 88.5% of MA enrollees in Puerto Rico.

Puerto Rico relies far more on MA to serve the health care needs of its seniors than does the United States. Almost 70% of the Medicare beneficiaries in Puerto Rico participate in MA, compared to 25% in the States. The population in Puerto

Rico is needier, in terms of both economics and health. Per capita income in Puerto Rico is $13,468, half the per capita income of the poorest State, Mississippi, with a per capita income of $27,702. The Special Needs Plans (SNPs) for dual eligibles in Puerto Rico have an enrollment more than four times greater than the national average (52% vs. 12%). Approximately 88% of women and nearly 79% of men 60 years and older in Puerto Rico suffer from at least one chronic illness, and more than 50% of Medicare beneficiaries have four or more chronic health conditions. The prevalence of diabetes among Medicare beneficiaries is more than 50% higher than the national average, and the prevalence of congestive heart failure twice the national average. These facts, and others we will cite, make the sustainability of MA in Puerto Rico of great importance.

MMAPA fully supports the goals of health care reform that you, your colleagues in Congress, and the President are pursuing. We are particularly enthusiastic about the goal of making the delivery system more effective and efficient, particularly improving access and quality, and about many of the policies you propose to reform the system to this end.

Indeed, we believe that we serve as proof that these reforms will work. The MA program in Puerto Rico has provided an opportunity to put to the test the development of efficient coordinated care plans to serve a population that is very poor and with significant health care needs. Early results of satisfaction surveys and HEDIS indicators reflect that the programs developed by plans are promoting high quality health care and the provision of preventive and wellness services.

MA plans in Puerto Rico provide the following benefits, not available through traditional Fee for Service (FFS) in Puerto Rico:

1. Enhanced access to physicians and hospitals with waiver of deductible and coinsurance.
2. Access to a pharmacy benefit. (The MA program is largely responsible for the access of Medicare beneficiaries to Part D benefits due to the socio-economic status of the beneficiaries in Puerto Rico.)
3. Dental, Vision and Hearing benefits not covered by FFS Medicare.
4. Focus on primary care-based networks and clinical management.
5. Preventive exams not previously covered by FFS Medicare.
6. A real effort to provide beneficiary orientation about prevention and health education, including the management of chronic diseases.

We have made significant progress toward another of your goals: monitoring and reducing waste, fraud, and abuse. MA plans in Puerto Rico have developed administrative programs that have created monitoring tools and processes that the Medicare FFS program does not have, and probably will not be able to develop in the near future. Many recommendations for improving the Medicare FFS program today are related to establishing such administrative programs with providers. One important example is the provision of DME services, where in the past traditional FFS Medicare has encountered critical problems of fraud and abuse.

Between 2004 and 2008 we have made demonstrable improvements in health care delivery and health status for our enrollees. Some examples are: colorectal cancer screenings have increased by 70%; breast cancer screenings by 26%. Hypertension control has increased 24%. Our flu vaccination programs have reduced flu hospitalizations by 60% and flu-related deaths by 80%.

It is in this context of great need, and significant improvements in the health status of Puerto Rico's Medicare population through MA plans, that we say to you that we are deeply concerned about your proposal to reduce MA rates to 100% of FFS costs. We believe that this policy is likely to have negative consequences in many areas of the United States. We know it will have negative consequences in Puerto Rico.

Today, Medicare premiums account for approximately 50% of the total health insurance market in Puerto Rico. A policy change that significantly reduces MA funding will affect the entire health care system of the Island. The proposed reduction is equivalent to a reduction of approximately 10.3% of the total estimated health care expenditures for Puerto Rico in 2009, compared to the impact of 0.5% that the change represents at a national level.

The impact of this policy on the MA plans in Puerto Rico is potentially devastating, due in large part to the fact that the FFS cost calculation for Puerto Rico is seriously flawed and results in a FFS cost figure that is inaccurately and substantially too low. In its June Report to the Congress, the Medicare Payment Advisory Commission (MedPAC) alerts the Congress to possible inaccuracies in the Adjusted Average Per Capita Cost (AAPCC) calculations, the Part A estimates, and the risk scores for Puerto Rico. They identify the major source of these inaccuracies as the fact that only 30% of FFS Medicare beneficiaries in Puerto Rico have Part B cov-

erage (compared with a national average of 97%). We believe that there are several other sources as well, including discounted Part A payments, the absence of the SSI program in Puerto Rico, and the absence of the Low Income Subsidy (LIS) for Part D on the Island.

Under the current calculation, Puerto Rico's FFS cost is so much lower than the average FFS cost for the Nation as to strain credulity. The MA rate for Puerto Rico is already 88% of the national average 100% FFS cost.

We urgently request that you act on MedPAC's suggested solution to the anomalously and inaccurately low FFS cost calculation by affirming that the Secretary of Health and Human Services has the authority to establish a calculation that addresses the special circumstances mentioned in the MedPAC report and others. This would be good policy in any case, but certainly if you propose to reduce Puerto Rico's MA rates to 100% of local FFS, the FFS calculation and resulting cost figure should be accurate. If necessary, after the effective date for this policy, until the problems in the calculation have been addressed and resolved, we request that Puerto Rico's MA rate be based on 100% of the national average FFS cost.

The MA program in Puerto Rico is producing positive health care outcomes for the almost 70% of Medicare beneficiaries enrolled in MA plans. The MA program is allowing for more adequate provider reimbursement, network administration, and the development of clinical management programs. We are implementing your objectives of enhancing preventive care, and coordination and efficiency of all care. A reduction in rates such as you propose would seriously impair our ability to provide these important services and results. We hope that you will help preserve our ability to continue our work on the Island.

We stand ready to provide you with any additional information or assistance you might require. We look forward to working with you to achieve health care reform that will ensure the availability of affordable, effective, and high quality health care for all our citizens.

Sincerely,

MMAPA

Statement of the Medical Banking Project, Legislative Committee

I. BANKS ARE IMPROVING COST, QUALITY AND ACCESS TO HEALTH CARE, TOO!

EMBEDDED WITHIN THE FABRIC OF A $2.5 TRILLION HEALTH CARE SYSTEM IS THE BANKING AND FINANCIAL SERVICES COMMUNITY. This network of organizations process these health care dollars using the most efficient payment system in the world, settling billions of dollars every minute for millions of patients and health care groups who value and demand confidentiality, privacy, speed and efficiency.

This national resource, which could be deployed to solve numerous systemic inefficiencies throughout the health care claim and payment process, moves massive volumes of funds and data in between all the health care stakeholders—providers, payers, employers, consumers and others—both within America and around the world. **Yet in our dialog to move health care into a more electronic environment in America, banks and financial services firms are often sitting outside of the discussion. Why is that?**

Many people equate the banking health care contribution to HSAs alone, yet the reality is that banks currently invest in health care IT so they can move mountains of paper out of the health care system. This conversion to electronic processing allows important data to be available much more quickly to the health care providers and subsequently to consumers. This important function that banks perform today for the health care industry bears repeating: **Our banking system does not only move money, but it also moves data between all the health care stakeholders.**

II. SUPPORTING GREEN TECHNOLOGY AND CONVERTING NEW VALUE TO CHARITY CARE

A missing ingredient in the national dialog to improve our health care system is how **banks can harness and enhance highly secure, existing technology to ramp health care onto the digital platform of the 21st century**. Leveraging proven and secure banking systems, we can dramatically reduce the costly paper

chase in health care, **saving at least $35 billion annually in waste**,[1] and, those annual savings can be used to **supplement the cost of treating the uninsured**.[2] In addition, by moving health care into a real time platform we can save billions of dollars in administrative inefficiency and help to make critical information available instantly.[3] Use of this technology not only supports **a powerful Green Technology platform for America but it delivers exceptional public value as well** by giving providers cost savings to apply to uninsured families and the expansion of health care delivery.

III. DELIVERING HEALTH CARE RECORDS AND HEALTH CARE INFORMATION FOR THE MASSES

Today, online banking is one of the most trusted and well used portals, with over 55 million American households currently online. Americans use online banking with confidence everyday, because banks use some of the most sophisticated identity and access management engines outside of the defense industry. In addition to online banking, many employers lament that if their employees used their online health care portals more, they could learn how to live healthier lives. Linking online banking with lifestyle portals offered by employers could create a cultural shift that is clearly necessary for helping individuals learn about healthier lifestyle practices.

This **"Health-Wealth" portal of the future** opens up enormous possibilities to fast forward eHealth for generations to come in America. Through secure online banking systems that we routinely use to access our money, online banking customers could **access their personal health care records along with other online tools and information that foster better health**. The integration of banking and health care is not just about HSAs, although that is a key program; it is also about **how to engage the consumer to live a healthier lifestyle**. Banks and financial institutions have spent much time and money designing easy-to-use online systems and this base of knowledge can be used to support a major national drive to **optimize community health care**, a key goal of the Obama Administration.

IV. HOW IS THIS NEW FIELD OF "MEDICAL BANKING" BUILDING OUT?

THE MEDICAL BANKING PROJECT has pioneered new thinking that links banking and health care infrastructure to dramatically impact cost, quality and access to health care. **Supported by some 45 corporations, universities and government agencies** (CMS, Veterans Healthcare Administration, Department of Defense, Centers for Disease Control) the Project spearheads industry initiatives that demonstrate the potential of medical banking. These include:

The Gold Seal Program for instilling public trust in medical banking programs. The emphasis of this program is HIPAA privacy and security practices, as well as other critical data protection regulations.

- **The Specialized Payment Platform** for moving massive volumes of paper out of the system. This platform promotes real time payments at point of service, implements key processing standards and enables digital workflows.
- **The Health-Wealth Portal** for aggregating financial and health care resources into the online banking platform. The portal can offer single sign on advantages to the consumer as well as convenience for choosing and financing a person's health care.

As President Obama noted in a major policy speech, fiscal success is predicated upon the health of a community. **Healthier communities are more productive and dynamic, thus banks have an interest in supporting the health care of the communities they serve.** Along with serving their communities, banks offer the health care industry a large opportunity for cost savings and improved effi-

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[1] MBProject Research Report, 2001. The report calculates that the aggregate annual savings of implementing one model in medical banking (the specialized lockbox) is $35 billion. The data are based on the cost to process a payment electronically versus via paper. An earlier study was done in 1994 by the Bankers EDI Council that determined the savings to be $11 per remittance. This level of savings confirms the MBProject study.

[2] MBProject asserts that operationalized savings among providers will supplement uncompensated/charity services. In 2005, PNC Bank commissioned an independent survey to study the effect of better administrative practices using banks. The target group was 135 national health care providers and health care plans (approximately 35 were plans). The respondents indicated they would save between $1 million and $10 million annually using a medical banking platform. Sixty-seven percent indicated they would use the savings for funding indigent and/or charity care.

[3] Institute of Medicine, To Err Is Human, 1999. Adverse drug events that result in death of the patient could be mitigated using current electronic health care records.

ciencies, and therefore it makes perfect sense to align these two critical industry segments to improve American health care.

We would like to offer our assistance to Members of Congress and others to help further understand how the banking community can contribute to the formation of solutions that solve the pressing health care policy issues that are currently being faced by our Nation.

MBProject Members In Good Standing
(as of June 30, 2009)

ACS EDI Gateway, Inc.
BancTec, Inc.
Benchmark Revenue Management, Inc.
Bank of New York Mellon Treasury Services
Canopy Financial
CareMedic Systems, Inc.
Centers for Disease Control and Prevention (CDC)
Centers for Medicare & Medicaid Services
Claimtrust, Inc.
Conmergence
Converge Capital
C Vision, Inc.
DestinationRx
DoD/Telemedicine and Advanced Technology Research Center [TATRC]
Donnell Systems (OCIE)
Edifecs, Inc.
HSA Bank
InstaMed
Internet Payment Exchange, Inc. (IPAYX)
MaxSurge Healthcare Solutions, Inc.
Medical Recovery Services, Inc.
Metavante Corporation
Milliman Inc.
U.S. Dept. Office of Civil Rights
PFPC
PNC Bank
PNC Financial Service Group
PricewaterhouseCoopers, LLP
RemitDATA, Inc.
Revenue Management Solutions, LLC
Sentry Data Systems
Starbourne Communications Design
Sun Microsystems
Systemware, Inc.
The SSI Group, Inc.
Thelma U.S.
TransUnion
TransEngen, Inc.
US Bank
Veterans Health Administration
Wachovia, A Wells Fargo Company
Walt Disney Company
WAUSAU Financial Systems

Mark H. Ayers, National Coordinating Committee for Multiemployer Plans

Greetings:

On behalf of the approximately 26 million American workers and families who depend on joint labor-management, multiemployer health and welfare trust funds for their medical and other health benefits, I am pleased to submit these comments on the recent House Tri-Committee Health Reform Discussion Draft to supplement the record of your Committee's June 24, 2009 hearing.

Let me first congratulate you and the Ways and Means Committee as a whole, along with Chairman George Miller's Education and Labor Committee and Chairman Waxman's Energy and Commerce Committee, for taking on one of the most important challenges confronting our Nation: The need for a national health care sys-

tem that provides universal access to affordable, quality health care, that responsibly controls costs, and that distributes costs fairly, without unnecessarily disrupting established employment-based health plans that are meeting their participants' needs. National, systemic reform has long been an aspiration. Hopefully it will soon become reality beginning with enactment of comprehensive legislation in this Congress.

However, great care must be taken in crafting legislation to avoid harming our members' "Taft-Hartley" multiemployer health and welfare funds. These long-established collectively bargained funds are a large and essential part of the employment-based health plan system that national health reform is trying to preserve. As you know, even the best intended and carefully considered legislation can have unintended, counterproductive consequences.

We have been heartened by President Obama's recent public statements that health reform should ensure that workers "who already have health care aren't suddenly seeing their costs go up to pay for other peoples' costs going down" and that reform should be designed so that "everyone's costs can go down effectively." The President has often said that health reform should only fix what is broken in the health care system, not create solutions looking for a problem or that cause more problems than they fix.

Nevertheless, we have grave concerns that provisions of the Discussion Draft, if enacted into law without changes, would have the opposite effect for our health and welfare funds and the millions of working families who depend on them. It appears that the Discussion Draft may result in substantially higher costs for our health and welfare funds and the covered workers; yet the "small employers" who compete against the responsible employers participating in our funds (over 90% of whom employ fewer than 20 workers and more than half who employ fewer than 10) would continue to escape any responsibility and continue to shift the costs of their employees' health care to our funds and workers. The effect of the Discussion Draft would be to discourage participation in our health and welfare funds by employers and individuals to the serious detriment of the covered workers and their families.

The Importance and Special Nature of Multiemployer Health and Welfare Funds

One of the proudest achievements of collective bargaining over the past 50 years is the thousands of labor-management, multiemployer health and welfare trust funds that provide to covered, union-represented workers and their dependents various benefit coverages, including medical, hospitalization, preventive and wellness care, prescription drugs, dental care, and vision care. These trust funds are often referred to as "Taft-Hartley funds" because they are regulated by the Labor Management Relations ("Taft-Hartley") Act of 1947, as well as by the Employee Retirement Income Security Act ("ERISA") and the Internal Revenue Code ("Code").

These health and welfare trust funds cover workers in industries as diverse as airlines, building and construction, transportation, retail, food, clothing, textiles, service, mining, entertainment, hotel and restaurant, maritime, longshore, and manufacturing. But for these trust funds, millions more working families would be uninsured and at risk for financial ruin in the event of a serious illness. The transient, project-based, mobile and seasonal employment patterns that characterize many of these industries would prevent workers from obtaining health coverage absent a central, pooled fund through which portable coverage is provided to workers as they move from employer to employer.

Multiemployer funds solve the problem of real portability as workers change jobs; they don't have to "take their coverage with them" because they remain in the same health and welfare fund as long as they are employed by contributing employers. Further, many funds have reciprocal agreements so that coverage can be continued even for employment with an employer obligated to contribute to another fund. Without the unifying arrangement provided by a Taft-Hartley fund, frequent changes in employment would make coverage by any one employer infeasible, and most are small so that employers would not maintain an employee health plan on their own, especially for transient workers.

In assessing the impact of any health reform proposal on Taft-Hartley, multiemployer health and welfare funds and their participants, one must be mindful of the special characteristics of, and challenges faced by, these funds, including the following.

Collectively-Bargained Trust Funds: A Taft-Hartley, multiemployer health and welfare fund is established and maintained through collective bargaining between one or more labor unions and more than one employer. As a matter of Fed-

eral law, a fund must be structured as a trust that is a separate legal entity, distinct from its sponsoring union(s) and contributing employers. The fund must be governed by a joint board of trustees on which labor and management are equally represented. Generally, the labor trustees are elected union officials and the management trustees are representatives of contributing employers. But, in performing their fund-related duties, the trustees have a fiduciary responsibility solely to the fund and its participants and beneficiaries, and not to the contributing employers or sponsoring union(s).

Plan Design: Among the board of trustees' responsibilities is structuring the fund, engaging appropriate service providers, and designing the plan of benefits to be provided by the fund to covered workers and dependents ("participants and beneficiaries"). The trustees, of course, rely on professional assistance in performing these duties.

In designing the benefit plan, the trustees take into consideration the fund's available and projected financial resources as well as the needs and wants of the participants and beneficiaries, among other relevant facts and circumstances. This balancing of interests requires a lot of innovation and flexibility to maximize value and adjust to changing circumstances, including the ability to adjust benefits to affordable levels and modify eligibility rules.

Because a Taft-Hartley, multiemployer health and welfare fund is a legal entity unto itself, the fund's administration is wholly separate and distinct from any individual employer's operations or human resources functions. For example, a fund has no involvement in a contributing employer's payroll operations including income tax withholding or payroll tax payments. The cost of fund administration is paid entirely from the fund's assets by the trustees, not by any contributing employer.

Funding: A Taft-Hartley, multiemployer health and welfare fund is financed by collectively bargained employer contributions and investment of its pooled reserves. Financing methods can vary from industry to industry according to employment patterns, cash flow, and financial structures in an industry. In many industries, like building and construction, contributions are required at a set rate for each hour worked in employment covered by the collective bargaining agreement and submitted to the fund monthly. While there are industry-based variations (some assess contributions based on days, weeks or shifts worked rather than hours, for example) contributions are almost always based on the activity levels of each employer's covered workforce. The contribution rate is generally set in the collective bargaining agreement for the term of the agreement (sometimes allowing for re-openers in special situations).

Even though contributions are calculated based on each participant's work, the contributions made for any particular participant may bear no correlation whatsoever to the actual cost of that participant's or his family's coverage by the fund. Taft-Hartley funds create multiemployer pools over which costs are spread without a determination as to the cost of each contributing employer's employee group. That aggregate cost (plus the costs of fund administration, reasonable reserves, and coverage for nonworking participants) must be covered by total employer contributions based on the participants' covered employment. Typically no distinction is made between employers based on the differing demographics of their respective workforces.

Typically, in the bargaining process between the union(s) and employers, the health and welfare fund contribution rate is just one of multiple "money issues." In essence, once a total amount of compensation per hour is negotiated, that sum has to be allocated among wages, health and welfare fund contributions, pension fund contributions, and other employee benefits. The reality, not just economic theory, is that workers trade off wages for health and welfare fund contributions, recognizing that they and their families need the coverage. That is, the workers collectively pay for their own health and welfare coverage, although the law treats the contributions as employer contributions. Very few, if any, workers want to give up take home pay for more health coverage than they need. This process makes workers very sensitive to the cost of their and their families' health care.

Eligibility Rules: Health and welfare funds necessarily have eligibility rules for determining whether a worker and/or dependent is eligible for benefits during any given period of time. Funds have developed various industry-specific systems for maximizing coverage, taking account of the employment patterns of the industry and the funds' financing needs. Typically, these systems feature eligibility periods during which a worker's covered employment with any contributing employer builds credit toward eligibility in a future period (e.g. covered employment in the first calendar quarter earns the worker benefit eligibility for claims incurred in the second quarter). Since eligibility is based on the level of covered work in a prior period,

sometimes individuals are not actually working in covered employment during their period of coverage. This pattern of establishing eligibility after the necessary contributions are received by the fund is essential to the structure of Taft-Hartley funds.

It is common for covered employment to fluctuate and for workers to have temporary periods of underemployment or unemployment in the normal course of an industry's employment pattern. When no or insufficient covered employment with a contributing employer is available for a worker, he and his family may lose eligibility under the fund unless the fund provides means for bridging gaps in employment. Many funds, particularly in the building and construction industry, maintain "hours bank" arrangements under which some of a worker's hours of covered employment are "banked" and used to pay for benefit eligibility during periods of unemployment.

Some funds allow workers to self-contribute to make up a shortage in hours of covered employment during an eligibility period. And, of course, the health and welfare funds also offer self-paid COBRA continuation coverage for participants and beneficiaries who lose eligibility.

During times of high unemployment, like now, the funds face a major challenge to maintain unemployed workers' and dependents' eligibility without current employer contributions to finance the coverage. And too often the worker exhausts a fund's system for bridging gaps in employment before finding new covered employment. When that happens, a fund's trustees may try to address the situation by modifying the continuation of coverage rules; but that is only possible if the fund has accumulated and maintained sufficient reserves of assets.

ERISA Preemption: There are thousands of Taft-Hartley, multiemployer health and welfare funds in the United States. Many of them are multi-State in coverage; that is, they cover workers employed in two or more States. This is largely attributable to mobile work patterns, expanding union geographical jurisdictions, and changes in collective bargaining structures. Some funds provide regional coverage, others provide national coverage. The geographical scope of health and welfare funds is expected to increase over time as funds merge to increase their purchasing power and contain costs.

Multi-State coverage by health and welfare funds would not be feasible without the uniform, Federal regulatory scheme provided by ERISA and related laws and, in particular, the protection provided by ERISA preemption against multiple, conflicting and costly State laws. As Congress wisely determined in enacting ERISA, dual Federal and State regulation of even intra-State funds would be counterproductive.

Most Taft-Hartley health and welfare funds are fully or partially self-funded. That is, benefits are paid by the fund from its pooled assets, rather than by an insurance company. Many of these funds carry"stop loss" insurance to spread the risk of catastrophic claims.

On the other hand, some funds still purchase insurance policies for all or some of the benefits. The fund negotiates and pays the group premiums to the insurance company for the eligible participants and beneficiaries, and the benefits are paid from the insurance company's assets.

The proliferation of burdensome State mandated benefit laws, as well as insurers' need for profit and other insurance related costs, drove many funds from the group insurance market and into self-funding. State laws became a problem for insured funds once the U.S. Supreme Court misinterpreted ERISA's preemption provisions as allowing States to regulate the content of insurance contracts including contracts with ERISA-regulated health plans.

Administration: Some Taft-Hartley, multiemployer health and welfare funds, particularly larger funds, are self-administered; that is, they employ an in-house staff to perform all of the administrative functions such as collecting contributions, determining eligibility, processing and paying benefit claims, handling appeals, recordkeeping, and reporting and disclosure. But, many contract with third-party administration companies, or have "administrative services only" contracts with insurance companies, for all or some of the fund's administrative functions. Many also contract with insurers or other organizations that maintain provider networks or group purchasing arrangements.

Importantly, all of a health and welfare fund's administrative costs are paid from the fund's pool of assets; the same pool from which benefits are paid. In other words, a dollar paid in administrative costs (including regulatory compliance) is one less dollar available for paying benefits.

Retirees: Taft-Hartley, multiemployer health and welfare funds commonly provide coverage to retirees, particularly for pre-Medicare retirees, although many also provide supplemental coverage for Medicare eligibles. Retirees self-contribute to the funds for a portion of this coverage normally, but their cost is often subsidized by the contributions made for active workers; that is, the retirees contribute less than the actual cost of their coverage.

Retiree coverage is becoming rare in nonunionized private sector employment, and many workers are compelled to remain actively employed just for health insurance coverage. However, many Taft-Hartley health and welfare funds cover workers in industries, like building and construction, who engage in physically demanding labor and become unable to continue working in covered employment before the age of Medicare eligibility. Pre-Medicare retiree health coverage is very important to these workers. But, subsidized retiree coverage is also expensive for the funds and active workers; a higher collectively bargained contribution rate for active workers' covered employment is needed to support the retiree coverage.

Unfair Competition and Cost-Shifting: Taft-Hartley, multiemployer health and welfare funds are especially harmed by unfair cost-shifting. First, the funds are charged higher prices by providers or otherwise forced to subsidize the uncompensated medical care provided to uninsured workers and their dependents by hospitals and other providers. Second, a fund's contributing employers are commonly competing against nonunion employers that do not maintain employee health plans and whose employees are uninsured. These irresponsible, nonunion employers have an unfair cost advantage over union employers that contribute for their employees to the health and welfare funds. This unfair competition by nonunion employers results in a loss of the covered, union employment that generates contribution income for the health and welfare funds and benefit eligibility for the workers and their families. This unfairness is exacerbated by the fact that the uninsured, nonunion workers and dependents receive uncompensated medical care, the cost of which is shifted to employee health plans including health and welfare funds.

Faced with persistent, systemic health care cost inflation over the past 20 years, Taft-Hartley, multiemployer health and welfare funds have endeavored to develop innovative means for cost containment including preferred provider arrangements, promoting preventive care and wellness, engaging in disease management, and forming group purchasing coalitions to maximize bargaining power.

These serious efforts have made a difference. But, they have not been enough to contain costs sufficiently because most of the causes of inflation in health care costs are beyond the funds' control, like unfair cost shifting by irresponsible employers and by government programs. As a result, health and welfare funds have been compelled to press the collective bargaining parties—actually, the active workers—to shift more wages into health and welfare contributions.

The fact is that national, systemic reform legislation is needed to deal with unsustainable health care cost inflation. And, true universal health insurance coverage is an essential element of that reform.

Discussion Draft and Multiemployer Health and Welfare Funds

Costly New Mandates and Restrictions: Application of the benefit and regulatory mandates of Title I to a multiemployer health and welfare fund (a group health plan that is a multiemployer plan under section 3(37) of ERISA), especially to a self-funded health and welfare fund, would substantially increase the costs of the fund's benefits and administration. Higher costs to the funds for benefits, administration, and legal compliance necessarily translate into a greater portion of the workers' pay package being dedicated to health and welfare fund contributions and less in cash wages. There is no other source of revenue to offset higher health plan costs than the workers' pay, as explained above.

The health and welfare funds are not insurance companies motivated by profit; to the contrary, the funds are nonprofit, tax-exempt trusts. The funds are not single employer health plans whose terms and conditions are unilaterally set by company executives and that can draw on the company's treasury whenever they need money. To the contrary, our health and welfare funds are pools of workers' money governed by a joint labor-management board of trustees who are legally required to operate the fund for the sole and exclusive benefit of the participants and beneficiaries.

Participation by an employer in a health and welfare fund, and its compliance with its collectively bargained contribution obligations to the fund, must be deemed to satisfy any employer responsibility ("play or pay") requirement. And, coverage by a health and welfare fund by a participant or beneficiary must be deemed to satisfy any individual responsibility mandate.

Some multiemployer health and welfare funds might eventually wish to purchase coverage for their participants and beneficiaries through the Health Exchange. They should be permitted to do so, once the Exchange is opened to large employers. And, if any fund does so, it will thereby choose to assume the costs, mandates and responsibilities associated with Exchange participation.

Health Choices Commissioner: The Discussion Draft would create an expansive new regulatory regime and Federal agencies (e.g. Health Choices Commissioner) on top of the existing, complex regulatory regime of ERISA, multiplying the regulatory and administrative costs that a health and welfare fund's participants and beneficiaries would have to bear. The Commissioner, in particular, would be granted very broad, discretionary power to regulate the benefit programs and operations of the funds, and impose unlimited additional obligations and costs.

Opting-Out of Funds: Multiemployer health and welfare funds are very concerned about any legislation that would entitle individual participants to opt-out of fund coverage so they can buy coverage through a Health Exchange. We are absolutely opposed to such an opt-out if the participant's exercise of such a right could be construed under the law as relieving an employer of its collectively bargained obligation to contribute to the health and welfare fund or as requiring the employer to make a payment to the Health Exchange or government agency in addition to paying contributions to the health and welfare fund.

Such leakage would undermine the financial foundation of health and welfare funds, and the fundamental labor law concepts of exclusive bargaining representation and mandatory subjects of bargaining. Younger, healthier, unmarried workers would be incentivized by the legislation to opt-out of their health and welfare funds and buy cheaper coverage through the Health Exchange. The pool of higher risk covered lives left in the funds would be costlier to cover, of course.

This draining effect would be exacerbated if individual workers would receive government subsidies to buy coverage through the Health Exchange.

As noted above, multiemployer health and welfare funds are creatures of collective bargaining. The workers as a group, through their union as the exclusive bargaining representative, negotiate a collective bargaining agreement that requires the employer(s) to contribute to the health and welfare fund for the work performed by all employees covered by the agreement. An individual employee is not permitted to exempt himself from the collective agreement, cut his own deal with the employer, and relieve the employer of its obligation to contribute to the fund for the work performed by the employee.

Moreover, any requirement that the opt-out individual's employer pay an assessment to the Health Exchange or other entity, in addition to complying with the employer's obligation to contribute to the health and welfare fund would incentivize employers to bargain out of the fund.

Employer Responsibility—"Small Employer" Exemption: We strongly support enactment of Federal legislation that would require *all* employers to contribute significantly to the cost of providing health care coverage for their workers and the workers' families. As noted above, the cost of health care for the workers of irresponsible employers and their dependents is being shifted to health and welfare funds and their participants and, through them to the small employers who must compete with those firms. Moreover, these free-riding employers enjoy a big, unfair competitive advantage over responsible employers that contribute to our health and welfare funds. In other words, the workers covered by our funds are being required to pay the health care costs of their nonunion competitors by the current system.

We are pleased to see that the Discussion Draft would require employers to "play or pay." However, we are alarmed to hear that the Committee intends to exempt "small employers" and extend the exemption to employers who have less than 25 employees. Such an exemption would allow, indeed encourage, the unfair competition and cost-shifting that led us to support national health care reform.

As noted above, many, if not most, employers participating in multiemployer health and welfare funds are small employers; often with fewer than 10 employees. To exempt the business competitors of our employers from any responsibility for their employees' health coverage would be to grant irresponsible employers a great competitive advantage over responsible small employers. This would discourage employers from remaining in or joining our health and welfare funds.

In addition, a "small employer" exemption would provide even more financial incentives for employers to misclassify workers as "independent contractors" and avoid any "play or pay" responsibility.

Government Subsidies: The individual and employer subsidy programs that would be created by the legislation should be designed to (a) enable workers and

dependents (participants and beneficiaries) to keep their health and welfare fund coverage and (b) encourage employers to continue participating in and contributing to the funds.

We read the Discussion Draft as providing for subsidies for employers who obtain health plan coverage for their employees outside of the Health Exchange, including employers that contribute to multiemployer health and welfare funds. If this is, in fact, the drafters' intent, we applaud it, but ask for an opportunity for input on how to make the subsidy program effective in a multiemployer fund context.

With regard to individual subsidies, we read the Discussion Draft as providing such subsidies only for individuals who buy health plan coverage through the Health Exchange. We urge that any individual subsidy be extended to participants and beneficiaries in multiemployer health and welfare funds that would otherwise qualify by virtue of their income level.

We applaud the Discussion Draft's commitment to provide for a subsidy program for pre-Medicare retirees. A great many of the workers covered by our health and welfare funds, particularly in the building and construction industry, are physically unable to continue working at their trades until Medicare eligibility age.

The individual "COBRA" subsidy program under the American Recovery and Reinvestment Act of 2009 is helping to maintain health and welfare fund coverage for unemployed workers, and the Medicare Part D subsidy program is helping retirees to maintain their prescription drug coverage under our funds. Both of these programs were designed to be workable for our funds and participants. Similar, widely available subsidy programs for active workers and pre-Medicare retirees should be included in health reform legislation. We would be pleased to discuss with the Committee's staff how such programs can be designed to be workable in the multiemployer fund context.

There are other aspects of the Discussion Draft on which we have comments and concerns. But, in view of the Committee's strict guideline for submissions, let me conclude by again congratulating you for taking on the daunting task of crafting national, systemic health care reform legislation. We look forward to the Committees, the House, and eventually the Congress passing reform legislation that helps multiemployer health and welfare funds and their millions of participants and beneficiaries. We would be pleased to assist you in working out any details of legislation as relates to our health and welfare funds.

If you have any questions concerning this matter, please feel free to contact NCCMP Executive Director Randy DeFrehn at (202) 756–4644.

Respectfully,

MARK H. AYERS
Chairman

Statement of the National Yogurt Association

Chairman Rangel, Ranking Member Camp and Members of the Committee, thank you for the opportunity to offer testimony in opposition to the proposed enactment of a sugar-sweetened beverage excise tax to finance comprehensive health care reform.

As the voice of the yogurt industry, the National Yogurt Association (NYA) is the national nonprofit trade organization representing the manufacturers and marketers of live and active culture (LAC) yogurt products as well as suppliers to the yogurt industry. NYA sponsors scientific research regarding the health benefits associated with the consumption of yogurt with LACs, and serves as an information resource to the industry and general public.

The yogurt industry is committed to improving its customers' health through the unique properties of its products. In addition to containing many essential minerals and vitamins, yogurt with LACs offers the additional benefits of assisting digestion and boosting the immune system.

If Congress moves to enact an excise tax on sugar-sweetened beverages to finance health care reform, drinkable yogurt (i.e., smoothie-style drinks made with yogurt) containing LACs should be excluded due to their many health benefits.

Yogurt Drinks Are Positive Lifestyle Options

Obesity is widely acknowledged to be a serious risk to public health, and excessive sugar consumption has been linked to rising obesity rates. However, some products that contain sugar, including drinkable yogurt with LACs, have public health benefits that outweigh the negatives associated with the added sugar they may contain.

NYA members strive to produce food products that deliver the valuable health benefits of yogurt with LACs. Drinkable yogurt products are a convenient way for adults and children who consume these products to get the minerals, vitamins and LACs they need. Flavoring yogurt drinks in ways that appeal to consumers' taste allows more people to benefit from their many beneficial health properties.

Yogurt Drinks Are Nutrient Dense

Yogurt drinks are nutrient-dense foods that contain many essential minerals and vitamins, including riboflavin (vitamin B2), vitamin B12, phosphorous and potassium. In addition, yogurt drinks are often a good source of protein and calcium, which is important to developing and maintaining strong, healthy bones. The 2005 Dietary Guidelines for Americans notes that studies on milk and other milk products, such as yogurt, showed a positive relationship between the intake of milk and milk products and bone mineral content or bone mineral density.

Benefits Associated With Live and Active Cultures (LACs)

In addition to the high nutritional value offered by yogurt drinks, research indicates that the LACs in yogurt drinks may offer additional health benefits. Many yogurt drinks are cultured with standard yogurt cultures, *Lactobacillus bulgaricus* and *Streptococcus thermophilus*. However, many yogurt drinks on the market today contain other LACs including *Lactobacillus acidophilus*, *Bifidobacterium bifidus*, *Lactobacillus casei* and *Lactobacillus GG*. These cultures aid in the digestion of food and the absorption of nutrients.

Research also suggests that certain specific strains of these "probiotic" LACs may play an active role in preventing gastrointestinal infections, fighting certain types of cancer, boosting the body's immune system and reducing nasal allergies.

Yogurt Drinks Are a Good Alternative for Those Who Are Lactose Intolerant

Many yogurt drinks are produced using the same cultures as refrigerated cup yogurt. Research has confirmed that, during the fermentation process carried out in producing yogurt from milk, lactase enzyme generated by the LACs breaks down lactose in milk and remains present through consumption, thus allowing those who are lactose (milk) intolerant to eat yogurt without certain side effects such as bloating and diarrhea.

Lactose intolerance is relatively common among certain ethnic populations, particularly those of Asian, African and Native American descent. The high rate of lactose intolerance in these populations partly explains the Institute of Medicine (IOM) finding that Asians and African Americans are especially at risk for low intakes of dietary calcium. The IOM has recognized that individuals with lactose intolerance are able to tolerate yogurt better than milk, and noted that in public comments, yogurt, soy milk and tofu were frequently requested as calcium-rich options.[1]

Conclusion

Yogurt drinks with LACs provide consumers with a dietary option that delivers a unique combination of properties with definite positive health benefits. They are a rich source of many necessary vitamins and other key nutrients, and provide individuals who are lactose intolerant an alternative source of these vital nutrients, such as calcium.

NYA recognizes the challenge facing the Committee in finding funding streams to pay for health care reform. However, given the many health benefits of yogurt drinks with LACs, these products should be excluded from the proposed excise tax on sugar-sweetened beverages. Yogurt drinks provide health benefits to consumers, and should not be subject to the proposed tax and categorized along with products of lesser nutritional value.

NYA appreciates the opportunity to offer this testimony.

Respectfully Submitted,

Kraig R. Naasz,
President and CEO
National Yogurt Association

[1] IOM, "WIC Food Packages: Time for a Change," at 119 (December 2005), *available at* http://www.fns.usda.gov/oane/menu/Published/WIC/FILES/Time4AChange(mainrpt).pdf (last accessed May 22, 2009).

Letter From the Nurse Practitioner Roundtable

Dear Chairmen and Ranking Members of the Tri-Committee:

The members of the Nurse Practitioner Roundtable (American Academy of Nurse Practitioners, American College of Nurse Practitioners, National Association of Pediatric Nurse Practitioners and National Organization of Nurse Practitioner Faculties) would like to thank the Members of the Ways and Means Committee, the Energy and Commerce Committee and the Education and Labor Committee for their thoughtful undertaking of the issues of Health Care Reform in their currently proposed legislative draft which we have reviewed. We wish to express our support of the comments submitted by the nursing community under separate cover, and would like to take this opportunity to thank you for the improvements included in this bill that specifically address issues of importance to nurse practitioners and their patients.

We are particularly appreciative of your recognition of nurse practitioners as primary care providers in many venues, including the medical home. We are also appreciative of your recognition of the worth of nurse-managed centers and school-based clinics by providing funding for these clinics that provide a valuable service, particularly to the uninsured.

There are, however, some sections where unchanged language could impair the ability of nurse practitioners to provide their full scope of services, thus limiting patient access and incurring increased costs. Below are sections that we would appreciate having adjustments made that would clarify and strengthen our ability to provide health care to the citizens of our Nation. An appendix of suggested language adjustments is attached.

I. Preserving Patients' Choice

Many patients elect to see a nurse practitioner for their primary care. Certain sections in this draft retain language that would obstruct patients from making that choice by referring to physician offices:

Division A. Affordable Health Care Choices, Title I, Subtitle C, Section 122(b)(4) Essential Benefits Package (p 24)

We would suggest adding "health care professional" to the list of allowable settings in the essential benefits package. This wording is consistent with (b)(3) of this section and the beginning of the sentence in (b)(4).

Division B. Medicare and Medicaid Improvements, Title II, Subtitle B, Section 1221 Ensuring Effective Communication in Medicare (p 333–334)

Nurse practitioners are major providers for the underserved populations, many of whom have language disparities. It is important that they be included in any feasibility studies for support for LEP activities, not just physician offices. We suggest adding practitioners (as defined by 1842(b)(18)(c).

Division B. Medicare and Medicaid Improvements, Title II, Subtitle C, Section 1235 (p 362)

It is important that nurse practitioners be authorized to sign orders for life sustaining treatment. While the language in this section appears to be inclusive, the lack of specificity for who would be authorized to write this order is concerning. If the language in this section cannot be changed, we would request that the expectation that nurse practitioners are among those authorized to sign such orders be included in report language.

Title III, Division B, Section 1308(a)(4)(B) Coverage of Marriage and Family Therapist Services and Mental Health Counseling Services (p 414)

We would suggest substituting the words "with other health care providers" in the title and in line 15, adding attending or primary care physician "or nurse practitioner," since nurse practitioners are often a referring health care provider for marriage and family therapy and would be the attending or primary care provider for referred patients.

Title III, Division B, Section 1308(a)(4)(B) Coverage of Marriage and Family Therapist Services and Mental Health Counseling Services (p 419)

We would suggest substituting the words "with other health care providers" in the title and on page 419 in line 1, adding attending or primary care physician "or nurse practitioner," since nurse practitioners are often a referring health care provider for mental health counseling and would be the attending or primary care provider for referred patients.

II. Ensuring That Proposed Programs and Studies Capture the Full Scope of Primary Care Services

New health delivery and quality improvement models and studies of these models must include nurse practitioners in order to obtain an accurate picture of health care delivery in the United States. We are appreciative of the inclusion of Nurse Practitioners in the Medical Home proposals in this legislation, noting that nurse practitioners are uniquely equipped to handle the demands of a patient-centered care-coordination model. We ask that you incorporate the following additional changes in other proposed health care delivery models to include nurse practitioners as providers and that data is collected on the quality and efficiency of nurse practitioner care and used to further health care reform:

Division B, Title III, Section 1301 Accountable Care Organization Pilot Program (p 368)

Advanced Practice Nurses (APRN) need to be included in the piloting of this program. APRNs play a valuable role in cutting costs while providing quality health care. Nurse practitioners widely practice as primary care providers, often in underserved and rural areas with outcomes equivalent to their physician colleagues. APRNS need to be added to the word physician throughout this section and explicitly referenced in report language for the Secretary.

Division B, Title IV, Subtitle A, Section 1401 Comparative Effectiveness Research (p 429–430)

Nurses and nurse practitioners are the backbone of the health delivery system, yet their representation is not evident in the proposals for comparative effectiveness. We recommend that practicing nurses, including nurse practitioners, be included in membership on the oversight commission described in this section.

Division B, Title IV, Subsection C. Quality Measurements. Section 1441: Establishment of National Priorities and Performance Measures for Quality Improvement (p 553)

The need for all health care providers, including nurses and nurse practitioners, to participate in the development of national priorities and performance measures for quality improvement and data reporting is critical. We ask that emphasis be placed on that inclusion in the report language for this legislation.

III. Program Savings

We are particularly concerned about the section that speaks to a requirement for a face to face encounter with a physician in order to be certified eligible for home health care. This perfunctory and unnecessary activity is perpetuated by the fact that home health agencies cannot accept nurse practitioners' referrals for home health care. Instead nurse practitioners must find a physician to authorize/certify their patients eligible for home nursing care, even though they can be the attending provider for that patient once the home care is certified.

Division B. Medicare and Medicaid Improvements. Title VI, Subtitle C, Section 1639 Face to Face Encounter with Patient Required Before Physicians May Certify Eligibility for Home Health Services Under Medicare (p 633)

This provision, as written, adds tremendous and unnecessary cost to the Medicare system which could be alleviated by authorizing home health agencies to accept certifications from nurse practitioners and other qualified health care providers. We would recommend that in this section, nurse practitioners be authorized to certify patient's eligibility for home care services, thus reducing the need for additional face to face encounters with physicians. If such a requirement is still necessary, then both physicians and nurse practitioners would be required to have a face to face encounter with any patient they certify for home care services. This revision would reduce costs tremendously, since nurse practitioners could certify patients eligible for home care at a lower reimbursement rate without requiring an additional unnecessary encounter with a physician at a higher rate of reimbursement.

IV. Assuring Access to Quality Health Care Providers

We appreciate that the Tri-Committee has recognized that health care reform cannot focus solely on health care coverage. It is important that patients of all ages receive health care services from the providers of their choice.

Division B. Medicare and Medicaid Improvements. Title I, Part 3, Subtitle C, Section 1152 (p 235)

Bundling for payment for post acute care services must take into account fair payment for services by a variety of providers. The proposed legislation states that

among the details to be considered in a post acute care payment reform is whether physician services should be included in the bundle. It is our recommendation that nurse practitioners be treated in the same manner as physicians in this payment plan.

Division B, Title VIII, Part 3, Section 1825. Inclusion of Public Health Clinics Under the Vaccines for Children Program (p 697)

The importance of immunizing children cannot be forgotten. Resources for providing vaccines should be all inclusive in order to provide the best coverage possible. We therefore recommend that nurse managed clinics and school based clinics be included in this program as well as rural health clinics and public health clinics.

Division C, Title II, Subtitle A, Chapter 1, Section 2201 National Health Service Corps (p 773 et seq)

We wish to thank you for your support of additional funding for the National Health Service Corps (NHSC). The NHSC plays an essential role in bringing primary care services to underserved areas. Many nurse practitioners and the communities they serve have benefited from this program and with enhanced funding many more will be able to complete their educational programs and provide needed health care services. We would ask that in report language, HRSA be instructed to return to its original policy of allowing pediatric nurse practitioners to qualify for NHSC scholarships, as well as the loan repayment program.

Division C, Title II, Chapter 2, Subpart XI, Section 2213 Training in Family Medicine, General Internal Medicine, General Pediatrics, Geriatrics and Physician Assistantship (p 745)

Nurse practitioners are missing from this section that provides for the development of primary care training programs for physicians and physician assistants. As you know, nurse practitioners have a long and successful track record for serving as primary care providers. However, their funding source in Title VIII is often not realized and they can be overlooked when funding increases for primary care education are considered. We ask that Title VIII (42 U.S.C) be amended with the same language with reference to nurse practitioner preparation.

Division C, Title XXXI, Subtitle C, Section 3131 Task Force on Clinical Preventive Services (p 805)

The cornerstone of nurse practitioner practice is health promotion and disease prevention. Nurse practitioners have been demonstrated to be experts with highly successful outcomes in health promotion and disease prevention interventions. It is with this in mind that we recommend that nurse practitioners be included on the Clinical Preventive Services Task Force and on the Community Preventive Health Services Task Force. If language cannot be changed within the bill, then we highly recommend and request that this recommendation be made in report language.

Division B. Medicare and Medicaid Improvements, Title VIII, Part 3, Access, NEW SECTION 1826 (end of p 697)

Since its inception, nurse practitioners have been identified as primary care providers at State's discretion in the primary care case management program. This has led to barriers in recognition which could be resolved by including Section 2(a) of the Medicaid Advanced Practice Nurses and Physician Assistant Act of 2009 which will be reintroduced by Representative Olver. (See attached).

We thank you for the opportunity to provide comment on the Tri-Committee Draft of the Health Reform Bill. We applaud your efforts and the constructive recommendations being made in this bill to provide access to high quality, cost effective care to the citizens of this Nation. Nurse practitioners stand ready to help in this effort. We cannot do that, if barriers to practice and access are not removed. We thank you for the recommendations you are making and ask that you seriously consider the additional recommendations we are making in this letter and the attached Appendix of line changes.

Sincerely,

American Academy of Nurse Practitioners
American College of Nurse Practitioners
National Association of Pediatric Nurse Practitioners
National Organization of Nurse Practitioner Facilities

Statement of Steve Slagle, Promotional Products Association International

Chairman Rangel, Ranking Member Camp, and Members of the Committee, thank you for holding public hearings on this vitally important topic.

My name is Steve Slagle, and I am President and CEO of the Promotional Products Association International (hereinafter "PPAI"), the international trade association representing an industry comprised of over 22,000 promotional products companies, many of whom are small businesses.

Our members market logoed items (e.g., ink pens, coffee mugs, legal pad portfolios, USB thumb drives, PC mouse pads, etc.) to manufacturers of prescription drugs, as well as medical device and medical supply companies, who in turn, distribute these logoed items to physicians as a form of advertising, not as gifts. Consequently, I write to you in opposition to the *Physician Payments Sunshine Provisions* in your proposed draft (i.e., Division B, Title III, Subtitle D, pages 560–575.).

Specifically, PPAI objects to the "unreasonable" $5 de minimis exclusion contained in the draft proposal (*Id.* at 573). Conversely, PPAI supports a "reasonable" de minimis exclusion (*e.g.*, $25) similar to the one proposed in the 110th Congress stand-alone bill (*i.e.*, *H.R. 5605*).

As you know, these draft provisions require manufacturers and distributors of covered drugs, devices, biologicals, or other medical supplies under Medicare, Medicaid, or CHIP, to report payments or other "transfer of value" to physicians and other health care entities. The intent of these provisions is to provide greater transparency of the financial relationships between physicians and drug and/or medical device/supply companies as such relationships may influence prescribing practices and/or research, which in turn, affects health care costs.

The draft, as currently written, would require manufacturers of drugs, devices, biologicals or medical supplies to physicians to report payments or other transfers of value where the aggregate amount transferred exceeds $100 in a calendar year. Unfortunately, the draft does not provide a "reasonable" de minimis exclusion (e.g., $25) for each transfer of value. As a result, a logoed item valued at $5 or more must be tracked by our customers in order to determine when and if the $100 annual aggregate limit has been met, thereby triggering the reporting requirement.

Although PPAI supports the intent of the proposed draft, our members are deeply concerned that this legislation will have the unintended and adverse economic impact on our industry by effectively restricting and prohibiting the distribution of promotional products to health care professionals. To avoid the administrative burdens of recordkeeping and reporting in order to comply with the mandate of these provisions, it is highly foreseeable that our customers (e.g., pharmaceutical companies, medical device and/or supply companies, etc.) will simply discontinue purchasing logoed items and shift their marketing budgets to other advertising mediums (e.g., print, radio, television, Internet, etc.). Again, promotional products are a form of *advertising* and are not compensation, gifts, honoraria, etc.

Logoed items of relatively nominal value (i.e., $25 or less) do not unduly influence professional behavior of health care professionals in the manner that this legislation is intended to curb. If so, then the solution to such behavior influences best lies in the ethics curriculum and training of medical students, as well as the continuing educational requirements of health care professionals.

Promotional products are tangible forms of advertising that help keep the brand name in front of the recipient over time, reinforcing the advertising message with each use. Promotional products convey important marketing, advertising and communication messages and are no different from any other element in the advertising and marketing mix (e.g., television, radio, print mediums), except for the high message recall they deliver.

This advertising medium is one of the most, if not the most, cost-effective methods for small businesses to market their products and services. Restricting their use results in economic hardship for these small businesses and limits their ability to reinforce personal relationships with their customers, clients and prospects. In this period of economic uncertainty, now is more important than ever for small businesses to provide a personal connection with their customers.

Such a costly and administrative burden on our customers will cause them to discontinue using promotional products as part of their advertising and marketing campaigns. This will have a lasting and devastating effect on the promotional products industry.

Without a reasonable de minimis exception (i.e., $25), this legislation will lead to severe job loss in the promotional products industry, as well as substantial business closings to companies that rely heavily on a customer base of prescription drug manufacturers, medical supply, and medical device companies.

Without including a reasonable de minimis exception (i.e., $25) in this legislation, Congress will actually add to the number of uninsured Americans by shrinking if not eliminating an industry made up of small businesses who actually provide health care to their employees, and who are already struggling to survive in this economic downturn.

For the reasons stated above, PPAI strongly encourages you to amend the draft proposal by substituting a "reasonable" de minimis exclusion (i.e., $25) per transfer of value. Please note that an "unreasonable" de minimis exclusion (i.e., $5) would have an equally profound impact on promotional product companies as if there were no de minimis exclusion at all.

Again, thank you for allowing the public to review and respond to your proposed draft. We hope that you will take our viewpoints into consideration as your prepare your actual legislation for introduction and legislative activity.

If we can be of any assistance to you in this regard or otherwise, please do not hesitate to contact us.

Statement of RNG Consulting, Inc.

"An investment in knowledge always pays the best interest"—Benjamin Franklin.

The purpose of this proposal is to introduce an alternative to the existing way in which health information is communicated to the patient. It should be emphasized that this proposal is meant to compliment doctor/patient interactions and not be viewed as an alternative to seeking personal medical treatment. The two areas of focus are as follows:

- Preventative medicine: A focus on maintaining health vs. treating illness.
- Disease state information: Assisting the patient in dealing with a diagnosis and information on avoiding further complications.

The Internet is used by millions of people as a source of information. Often information dealing with health is not based upon evidence-based medicine. There are many sources that are unreliable. There are also many sources that are too technical. Most of the information is in the form of the written word rather than the spoken word. This proposal is for RNG Consulting Inc. to develop a government-sponsored site that will provide patients access to reliable medical information. This site will use video format to relay information to patients to compliment doctor visits. These videos will be categorized by therapeutic area and include counselling by Medical Specialists. The Specialists will be thought leaders and effective communicators in their area of expertise. Preventative and disease management information will be provided to the patient in a timely manner at a low cost.

The way in which a family doctor communicates disease state information to a patient has many limitations, such as:

- The doctor's knowledge of and comfort with the condition. Medical information is changing at an increasingly rapid pace and not all doctors take advantage of continuing education programs.
- The doctor's ability to communicate in a way that educates and motivates the patient. The patient should leave the office feeling empowered and confident.
- There are time limitations in the doctor's office. A patient needs time and counselling to develop the skills needed to manage their condition. Physicians often do not have the time necessary to provide this information.
- The patient may need several visits to absorb the information being communicated. Emotions play a part when discussing health and often information must be repeated.

The above limitations cost millions in health care dollars. Video-based information on the Internet will be cost effective. It will not require more spending. It will be smarter spending. Having an alternate, reliable source of information will allow physicians to spend more time on diagnosis and patient management.

By implementing this form of communication, there will be immediate and significant reductions in health care costs. Ways in which savings could be realized are as follows:

- Information communicated to the patient will be evidence-based. The cost of pursuing inaccurate, unsubstantiated information will be lessened.
- Patients could obtain information immediately following diagnosis, thereby bridging the time it may take to personally see a Specialist. The patient would be better educated by the time they saw the Specialist and therefore be able

to have a more productive visit. They would be better prepared with appropriate questions.

- Many patients are limited in their access to Specialists, depending upon where they live. High-quality information will be available without the cost of transportation and time spent in travel. Disease could be managed more efficiently and effectively.
- An informed patient will be better equipped to avoid the complications of their condition and reduce costs associated with those complications. This supports the government priority to create incentives for people with chronic illnesses to receive treatment and help get people to focus on their own health.
- The cost of repeated visits to the family doctor would be reduced. If information required by the patient was not recalled the first time it was delivered, the patient could "revisit" the virtual Specialist.
- Family doctors could also view the videos and increase their knowledge base and develop skills for motivating patients to manage their health.
- Many websites are currently being managed by pharmaceutical companies, associations, health care facilities etc. By streamlining the information, millions of dollars could be saved. This shared responsibility will reduce waste and encourage care coordination. This would help save dollars and slow the rise in health costs.

The time is right for this method of communication. We have seen the effectiveness of video presentations on the Health Reform website. When the President is speaking to the video camera, the public feels as if he is addressing them personally. The same result could be obtained with virtual visits to a Medical Specialist.

The public is keenly aware of the need for Health Reform and the time is right to introduce alternatives to the way health care is currently being delivered. The White House paper stated "we can agree that if we want to bring down skyrocketing costs, we'll need to modernize our system and invest in prevention." Web-based videos support these White House priorities.

There is an aging population of baby boomers. This population is approaching a stage in life when health care needs typically increase. This population is familiar with the Internet and is information hungry. Web-based virtual physician visits will help contain increasing costs to the medical system.

The website would be developed with a focus on the therapeutic areas that account for the most visits to the doctor, i.e., blood pressure, arthritis, diabetes, etc.

Using the example of diabetes, some of the current challenges are as follows:

- The doctor may not have the time to explain what the diagnosis means and the severity of the complications if blood sugars are not controlled. The patient may suffer from fear and denial of the diagnosis. They may not understand that complications can be avoided if they aggressively manage their disease. They have questions that often require additional visits to the doctor. They may use the Internet as a source of information but may not visit reputable sites.
- If a patient is referred to a Specialist, there could be wait times and limitations due to the cost and distance of travel.

The alternatives, using web-based videos are as follows:

- Immediately following diagnosis, the patient would have the opportunity for a virtual visit with the Specialist.
- A Specialist is experienced in communicating with patients in an effective and compassionate manner. They encounter patient resistance on a regular basis and know how to overcome it. They are able to create a sense of urgency without scaring the patient. Family doctors would also be able to increase their knowledge base and communication skills by emulating the Specialists.
- There would be links to lifestyle management (diet and exercise), specific information on disease management (proper blood glucose monitoring, appropriate use of prescriptions including insulin) and complications (foot care, eye health, kidney disease, cardiovascular disease, sexual health). A government-sponsored site would provide reliable, evidence-based medical information.
- The patient is able to revisit the virtual Specialist as many times as necessary in order to gain a sound understanding of their disease. An educated patient will manage their diabetes more effectively, thereby limiting complications.

Web-based video supports the following statement from the May 11/09 letter to the President from health care stakeholders . . . "Billions in savings can be achieved through a large scale national effort of health promotion and disease prevention to reduce the prevalence of chronic disease and poor health status, which ultimately leads to unnecessary sickness and higher health costs."

In conclusion, our proposal will save millions of health care dollars, provide increased access to health information and disease prevention information and supports the government's goals for rapid, cost effective change in health care.

RNG Consulting Inc. was founded in 2009. E. George Donaldson is the Director and Ruth A. Donaldson is the V.P. of Business Development. We have more than 39 years of experience in the health care industry and have expertise in medical education, conducting medical advisory boards, patient support systems, sales and marketing. We have the experience, knowledge and passion that is necessary to implement this proposal.

Statement of Rochelle J. Ascher, Executive Intelligence Review

EIR, the magazine founded by Lyndon H. LaRouche, Jr., has done an extensive study of the proposals for health care "reform" being proposed by the Obama Administration. As a result of our research, we have determined that the fundamental premises of the program, as represented by OMB Chief Peter Orszag, his health advisor Ezekiel Emanuel, and the President himself, are identical to those which underlay the genocidal program for eliminating the "unrehabilitable sick" in the Hitler regime.

A historical review documenting this analysis immediately follows.

There can be no compromise with the premises of this program. If it is successful, it will lead to genocide, and not only in health care, since OMB Chief Orszag has already announced that after health care, he intends to "reform," (i.e. slash) Social Security next. Thus, as the first step to reversing direction, the Obama health plan must be totally scrapped.

Instead, Congress must return to the policy laid out in the Hill-Burton Act of 1946, which mandated the provision of the necessary logistical foundation—in terms of hospital beds and personnel—to ensure adequate medical care for the U.S. population. The Hill-Burton approach was essentially dumped in 1973, when a bipartisan grouping in Congress endorsed President Nixon's legislation beginning the establishment of Health Maintenance Organizations, the for-profit institutions which now control the bulk of the health care provision for the American population. Under the HMO regime, the physical infrastructure required for the health of the American population has been slashed, and the quality of care as well.

Lyndon LaRouche has repeatedly led the charge against the HMO wreckers, and in support of an updated Hill-Burton approach. In 1992, the Democrats for Economic Recovery/LaRouche in '92 committee issued a 25-page pamphlet, "Solving the Health Care Crisis," against the HMOs. In 1996, LaRouche led a campaign under the banner, "'Managed Health Care' Is a Crime Against Humanity." In 2000, LaRouche's political action committee issued a national 16-page dossier titled, "Ban the HMOs Now! Before They Get You and Yours," providing draft legislation to revoke the HMO enabling acts. LaRouche has also endorsed the single-payer plan put forward by Rep. John Conyers, as coherent with his approach.

Today, there can be no more delay. The Nazi-like plan of cost-cutting against "useless eaters," which the President has put on the table, must be dumped, and the Hill-Burton approach adopted, without delay.

Hitler's T4 Program Revived in Obama's Health Care "Reform"

In July of 1939, a conference of medical professionals was held in Berlin, Germany. Participating were the professors and chairmen of the departments of psychiatry of the leading universities and medical schools of Germany, many of them, the most respected professionals in their fields. The subject? What would be the criteria for determining what patients would be considered to have "lives unworthy to be lived," and what was the most "practical and cheap" manner of removing them from being burdens on the health care system—by death.

Thus, the bureaucratic machine began to be cranked up for what is known as Adolf Hitler's program of genocide through "euthanasia," a program which killed hundreds of thousands of non-Jewish Germans, and eventually, millions of Jews and non-Germans as well. That program, which had already begun years before, against concentration camp inmates and handicapped children, was officially put into effect in October 1939, when Hitler penned his own personal, and secret, authorization for the program, under the title, "The Destruction of Lives Unworthy of Life":

> "Reichsleiter Bouhler and Dr. Brandt are charged with the responsibility for expanding the authority of physicians, to be designated by name, to the end that patients considered incurable according to the best available human judgment of their state of health, can be accorded a mercy death."

To carry out this program, Hitler and his fiendish Nazi associates would fully utilize the "professional" apparatus which had been put in place, as well as the popular, British-eugenics-spawned ideology which had been increasingly dominant in Germany since Hitler seized power with the aid of powerful British-Wall Street financiers. The killing would proceed with the utmost "cost-effectiveness" and professionalism, in order to save funds for the Nazi state's preferred projects, and not waste them on "ineffective" medical treatments.

If that sounds familiar, it should. For the proposals which the Obama Administration has currently put on the table, follow them in virtual lockstep:

First, the "experts" decide what is "effective" care, with "cost-effectiveness" foremost in mind, ruling out "inappropriate" treatments.

Second, these standards become the law, in terms of what medical care will be paid for.

Third, other experts efficiently implement those decisions, through the existing hospital apparatus.

The result, as in Nazi Germany, is that millions are, with the stroke of a pen, consigned to death.

The T4 Program

The T4 program, which was established following Hitler's secret order, took its name from its Berlin office address, Tiergarten 4, which address housed the coordinating organization for the program, the Reich Work Group of Sanatoriums and Nursing Homes. In charge were Philip Bouhler, Chief of the Chancellory, and Dr. Karl Brandt, Hitler's personal physician and chief medical officer of the land.

Their first task was to devise the questionnaires which would be used to categorize the targetted institutionalized populations. Four categories were specified:

1. Patients suffering from specified diseases who are not employable, or are employable only in simple mechanical work. These included schizophrenia, epilepsy, senile diseases, therapy-resistant paralysis, feeble-mindedness, and the like.
2. Patients who have been continually institutionalized for at least 5 years.
3. Patients who are criminally insane.
4. Non-German patients.

While including these categorizations, the questionnaire overall gave the impression of a rather neutral statistical survey, which also delved into the patients' biographies, their financial situations, and the like. (See {EIR}, June 5, 2009, page 12). It was accompanied by a questionnaire for the institution in which the patient was housed, which asked about staffing, beds available, and budgetary questions. A significant stress was also put on detailing the patients' abilities to work.

The first questionnaires went out in October 1939, the month Hitler signed his order, to State hospitals, and other public and private institutions where mental patients, epileptics, the mentally retarded, and other handicapped persons resided. The responsibility for filling them out, often in a very short period of time, fell on the physicians at those institutions.

The questionnaires were then sent to panels of three or four psychiatric experts, who indicated their opinion about whether the patient (whom they had never seen, much less examined, and whose medical history they were unfamiliar with) was to live or die. Each "expert" made his or her decision independently, and passed on the questionnaire to the next.

The choice for the experts was effectively only one of two options: A plus sign in red, which meant death; or a dash in blue, which meant life. Occasionally, a psychiatrist would put a question mark in the space provided.

The questionnaires were then sent to a chief expert, who passed the final judgment. At this "higher" level, there was no alternative other than life or death. In fact, the "senior expert" was not bound by the recommended decisions. From his judgment, there was no appeal. From that point on, it was merely a matter of sending back the decision to the relevant institution, where the final dispensation of the patient was carried out, and, if so ordered, sending him or her to one of the designated "killing centers."

These centers were supervised by medical personnel, who oversaw the killing, and were responsible for devising the fraudulent death certificates which were sent to the families of those who had been determined to have lives "not worthy to be lived."

Councils of Experts

Shift now to today, where we are in the first phases of the Nazi euthanasia program (called "reform") being promoted by the Obama Administration and its behavioral psychologist "experts." It starts with the dictum that there are insufficient resources to provide medical care for all, especially those at the "end of life," or not able to be "effectively" rehabilitated. In other words, the Nazi assumption that there are lives "not worthy to be lived" (or, not worth spending our money on, if you will). At least according to the priorities for spending which the Administration has set—i.e., the banks must be saved first.

The second step is for the Administration to set up those "panels of experts" who will determine the criteria for who will get medical care, and who won't. Already, the so-called Obama stimulus package has created one such panel, the Federal Coordinating Council for Comparative Effectiveness Research. This 15-member council is comprised of highly credentialed "experts," many of them medical doctors, who are tasked with "coordinating research" on the relative values of treatments. While explicitly claiming that the Council will not directly pronounce judgments on treatments and payments, it is clear that the research that they are supervising is intended to do precisely that.

Particularly ominous is the fact that one of the Council's members, Dr. Ezekiel Emanuel, is trained in "bioethics," a discipline dedicated precisely to determining criteria for deciding who should live, and who should die. Emanuel has a long history of promoting policies of cutting "marginal" care, as well as promoting living wills.

Crucially significant as well, is that Obama's head of the Office of Management and Budget, Peter Orszag, has already set out his genocidal judgment that around 30% of current health care services and procedures are unnecessary.

The model for their work, as reflected in statements by many of the relevant officials, is the British National Institute for Health and Clinical Excellence (NICE), the Orwellian-named agency which has central control over what medical care will be provided to British subjects within the British National Health Service. NICE's directives have systematically denied Britons quality care, on the basis of its being "too expensive," and have singled out, especially, the elderly, for being undeserving of intensive medical care.

The Comparative Effectiveness Council is clearly only the beginning of the genocide—if this Nazi plan is not stopped cold. Let's look at a number of other proposals. One has been made by former Sen. Tom Daschle, the man whom President Obama wanted to appoint Secretary of Health and Human Services, and special health czar in the White House (his appointment was derailed over tax problems). Daschle's plan, as laid out in his 2008 book {Critical: What We Can Do About the Health Care Crisis}, centers around the creation of an all-powerful Federal Health Board, which would be able to act {without political interference,} as the Federal Reserve does in the monetary system.

Daschle's Federal Health Board would have a board of governors ("clinicians, health benefit managers, economists, researchers, and other respected experts") which would command a huge staff of analysts that would come up with policy diktats in the areas of health insurance and medical care. The board would determine which treatments are, in its view, "the most clinically valuable and cost effective." They would promote "quality," by "using evidence-based guidelines and cutting down on inappropriate care." In addition, the Board would "align incentives with high-quality care," an obfuscatory term which means paying doctors to keep costs down, and withholding payments for unapproved (read: "expensive") procedures.

Daschle calls the Federal Health Board a "standard setter," but, in fact, it would become the dictator as to who lives, and who dies.

Paralleling Daschle's proposal is a piece of legislation which was introduced by Sen. Jay Rockefeller (D–W.Va.) on May 20. Rockefeller proposes that the Medicare Payment Advisory Commission (MedPAC, created in 1997), move beyond its current mandate to advise on rates of payment for the 44 million enrollees in Medicare, to set lists of approved treatment standards, and enforce compliance with regulations on health care delivery and reimbursement. Rockefeller's press release states that he wants MedPAC to be made up of "independent experts," as an "executive agency modelled after the Federal Reserve."

He adds: "We must take Congress out of its current role. . . . It is inefficient and ineffective; we are not health care experts, and being a deliberative body means that we cannot keep pace with the rapidly transforming health care marketplace."

President Obama has personally expressed approval of this proposal, which he said would have already saved $200 billion, if the dictatorship had been in place.

Knew or Should Have Known

When the Nazi doctors, and others, were tried for crimes against humanity and genocide at the Nuremberg Tribunal after World War II, many claimed that they only had the most noble intentions; others, that they were only following orders. In fact, they were wittingly serving as "expert" or bureaucratic cogs in a mass-murder machine, of whose outcome they were fully aware.

While there is no doubt that the degeneration of our culture, in terms of the valuation of life, has proceeded quite a distance over the last decades, thus preparing our population to accept Nazi euthanasia today, the apparatus parallel to that which Hitler set up {can still be stopped}. It must be done now—before the medical and economic "experts" carry out genocide again.

Appendix

{The following draft legislation was put forward by Lyndon LaRouche's Committee for a New Bretton Woods in May of 2000. It still forms the core of what must be done today.}

The Proposed 'Right to High Quality Health Care Act'

{Declaration of Purpose:}

The purpose of this legislation is: (a) to affirmatively establish the right of every person to the highest quality health care available; (b) to abolish Health Maintenance Organizations, Managed Care Organizations, and the practice of managed care by health insurers; and (c) to reassert the principles of the Hill-Burton Act (42 U.S.C. Section 291 et seq.) as the primary policy governing U.S. health policy.

This Act is necessitated by the immediate crisis in the health conditions in the United States, where millions of citizens are denied access to necessary health care services due to the financial practices of Health Maintenance Organizations, Managed Care Organizations, the practice of managed care by health insurers, and the lack of adequate medical facilities in many communities in the country. This has created a health care emergency in the United States.

Under the Preamble to the United States Constitution, the Federal Government is required to "promote the General Welfare," thus necessitating immediate action by the Federal Government to address this health care emergency.

The lack of access to adequate health care, and the practices of the Health Maintenance Organizations and Managed Care Organizations, are in violation of Article 25 of the Universal Declaration of Human Rights of the United Nations, and Article 12 of the International Covenant on Economic, Social, and Cultural Rights, which establish the universal right to adequate health care, and require governments to take steps to assure access to quality medical care. The United States is a signatory to these declarations and covenants.

The practice of denying needed medical treatment to certain persons in order to cause their death, was prosecuted as a crime against humanity by the United States in the post-World War II Nuremberg Tribunals.

{Section 1}

A. It is hereby established and affirmed that every person has a right to the highest quality health care available.
B. Any practices by health insurers, that deny any person the right to the highest quality health care available, for financial, or any other reasons, are hereby prohibited.

{Section 2}

A. 42 U.S.C. Section 300e, et seq., providing for the establishment and operation of Health Maintenance Organizations, is hereby repealed.
B. It shall be unlawful to operate a Health Maintenance Organization, Managed Care Organization, or any health insurance program that practices managed care, or seeks to control costs by limiting necessary health care services provided to patients.

{Section 3}

A. It is hereby reaffirmed that the provisions of the Hill-Burton Act, 42 U.S.C. 291 et seq., are the governing principles for U.S. health care policy.

Submitted by:

Rochelle J. Ascher,
{Executive Intelligence Review}

Letter by Ron Manderscheid

Universal coverage is a foundational issue for national health reform. Currently, about 8 million children (10%) and 38 million adults (about 20% of those under age 65) are without coverage. Up to another 20 million adults may be added to this group as a result of the current fiscal recession, although the American Recovery and Reinvestment Act of 2009 will offer this latter group some temporary relief.

Underinsurance is also being considered. Most Americans have very little insurance coverage for health promotion or disease prevention interventions. Most also have very little coverage for substance use conditions.

Without universal coverage to address the needs of those who are not insured or underinsured, large amounts are spent inappropriately each year on hospital emergency room visits. To demonstrate this contrast, a visit to a doctor may cost $100, while a visit to an emergency room may cost $1,000. Clearly, an insurance system that promotes the former is a better investment.

Other features of national health reform being considered include creation of a medical home that would reduce care fragmentation; incorporation of public health measures that will address personal and population health promotion and disease prevention; and new financing strategies to pay for reform.

Over the past several months, I have prepared a series of pieces on national health reform for The Manderscheid Report published by Behavioral Healthcare. These are identified below.

I encourage the Committee to take positive action on National Health Reform, including prevention and care for mental and substance use conditions.

Ron Manderscheid, Ph.D.
Bloomberg School of Public Health
Johns Hopkins University

The Manderscheid Report in Behavioral Healthcare:

- December 2008: Change is coming!
  We must ensure our agenda is on lawmakers' radar.
- January 2009: Aiming for a healthier population by 2020
  Moving our fields toward prevention, early intervention, and population health.
- Online Exclusive January 2009: Making 'health' a noun
- February 2009: Promoting universal coverage.
  Become an advocate for universal health insurance.
- March 2009: Focusing on populations' health.
  Population health insurance would focus on prevention instead of illness.
- Online Exclusive March 2009: Celebrating 50 years of SRCMHS' leadership and innovation.
  The annual conference always has been ahead of the curve.
- April 2009: Stepping back from deinstitutionalization?
  The jury is still out, but new data show some disturbing trends.
- May 2009: Time to stop being one-dimensional.
  We're focused on disease while neglecting health.
- Online Exclusive May 2009: A hearth for our health.
  Health promotion can be the 'hearth' within a medical home.

Letter by Nancy Schwab, Wendy Warner, Bill Berlinghof, Catherine Borowiec, Mark Schmid, Connie Guldin, and Mike Fritz

June 13, 2009

To: Members of Congress

We, the small business owners listed below, want you, our elected representatives in Congress, to know that the Health Savings Account program has been a tremendous value to our firms and our workers. We have been able to significantly lower our health care premiums from what was offered by other plans, improve our benefit package and help ourselves, our families and our employees to save for their health care needs. Also, our workers are now more involved in making their own important decisions about the health care they need for themselves and their families.

Our agent, Ross Schriftman (who has his own H.S.A.) has informed us of the pending changes that are being proposed in the Senate Finance Committee and the

House Ways and Means Committee. These changes will restrict and possibly even eliminate our ability to offer the kind of health care benefits we have come to enjoy.

Limiting contributions to the deductible will reduce the amount of money we and our staff can put aside to meet our long-range health care needs. This change will break the Administration's pledge that people can continue to keep the same health plan they have under the health care reforms taking place.

The proposed changes may also result in our employees paying taxes on contributions made to their accounts. Why on earth would anyone in Congress want to do this to American workers?

Requiring us to substantiate what our workers use their funds for will put tremendous administrative burdens on our small firm and create an unfavorable relationship with our workers who don't want us watching over their shoulders concerning their own personal savings accounts. Please don't put us in such a difficult position.

We can not afford to go back to higher premium plans so we may be forced to drop our health plans. This will result in more people having to rely on whatever government programs are available for their health care or go without health insurance. We know that this is not the intention of the President or of Congress.

Please do not change what is working. Allow us to continue to enjoy the health benefits that we have.

Thank you for your consideration.

Sincerely,

Nancy Schwab, *Owner*
The Artful Framer and Westside Gallery

Dr. Wendy Warner, OBGYN, *Owner*
Medicine in Balance

Bill Berlinghof, *Owner*
Renaissance Ceramic Tile and Marble

Catherine Borowiec, *Secretary/Treasurer*
Neurotech Solutions, Inc.

Mark Schmid, *Owner*
Penn Turf Management

Connie Guldin
Guldin Painting

Mike Fritz, *Manager*
A.T. Cigars, Inc.

P.S. Attached is Ross' written testimony to the PA House Insurance Committee several years ago demonstrating the following of H.S.A. for the average American worker and the potential increased revenue that the Federal Budget can realize when employers switch to these lower-cost plans.

Statement of The Alliance for Academic Internal Medicine

The Alliance for Academic Internal Medicine (AAIM)—the organization that represents program directors, administrative leaders, and faculty and staff responsible for the training of over 22,000 residents and almost 10,000 fellows in the specialties of internal medicine—would like to thank the House Committee on Ways and Means for the opportunity to submit this statement for the record.

For the past several months, congressional Committees, including the House Committee on Ways and Means, have worked tirelessly to research and evaluate potential solutions to solving the problems behind the Nation's desperate need for health care reform. Achieving affordable, accessible, and high-quality health care is at the core of the reform debate. However, in order to fully and effectively implement any potential health care reform policy, it is necessary to recognize the severe physician shortage the United States currently faces, particularly in primary care.

According to the Association of American Medical Colleges, by 2025, there will be a shortage of at least 124,000 physicians by baseline projections. The physician population in shortest supply is primary care physicians. The shortage will continue to worsen as the demand for primary care physicians increases far more rapidly than the supply under current standards.

Primary care physicians are critical to the health care delivery system and the health and wellness of the Nation. They are the "first contact" physicians responsible for providing comprehensive, coordinated, and continuous care for a patient's health care needs. Services provided by a primary care physician include care for all stages of life, acute care, chronic care, preventive service, and end-of-life care.

In response to a projected physician workforce shortage, AAIM recommends:

- Strategically increasing the number of Medicare-funded positions for primary care specialties to adequately meet the Nation's health care needs. For these new positions, Medicare should support the entire duration of training, which is typically 3 years (or 4 years for combined programs such as internal medicine-pediatrics). In addition, AAIM believes new primary care slots should be added in geographic areas of demonstrated need. Ultimately, all health care insurers should have a role in explicitly contributing to GME funding.
- Enhancing the attractiveness of primary care careers by altering the physician reimbursement system, increasing job satisfaction for current and future primary care practitioners, providing incentives for geographic distribution of primary care physicians to areas of greatest need, and applying innovations to educational models.
- Increasing efficiency in the health care delivery system by broadening the use of electronic health records (EHRs) and other advances in health information technology and capitalizing on the use of physician extenders. Additional options for improving health care delivery should be considered.
- Without a robust and equipped primary care physician workforce, the Nation's health care system will become increasingly fragmented and inefficient. As a result, access to high-quality and affordable health care will not be possible. The Nation's health and pocketbooks cannot afford to suffer any longer.

Statement by Cori E. Uccello, American Academy of Actuaries

Chairman Rangel, Ranking Member Camp, and distinguished Members of the Committee:

As Congress examines the details of proposals to reform the health system, the American Academy of Actuaries'[1] Health Practice Council appreciates this opportunity to submit written testimony outlining the key issues that need to be considered when evaluating whether a reform proposal will lead to a viable health insurance system.

The Academy's Health Council has identified three key criteria for whether particular reform approaches will lead to a sustainable health care system with increased access to affordable health insurance. In particular:

- For insurance markets to be viable, they must attract a broad cross section of risks;
- Market competition requires a level playing field; and
- For long-term sustainability, health spending growth must be reduced.

This statement provides the considerations underlying each of these key factors as well as comments on whether the provisions in the Tri-Committee health reform draft proposal conform with these criteria.

Insurance Markets Must Attract a Broad Cross Section of Risks

For health insurance markets to be viable, they must attract a broad cross section of risks. In other words, they must not enroll only higher-risk individuals; they must enroll people who are lower risks as well. If an insurance plan draws only those with higher than average expected health care spending, otherwise known as adverse selection, then premiums will be higher than average to reflect this higher risk. Adverse selection is a byproduct of a voluntary health insurance market. People can choose whether or not to purchase insurance coverage, depending in part on how their expectations for health care needs compare to the insurance premium charged. The higher premiums that result from adverse selection, in turn, may lead to more lower-risk individuals opting out of coverage, which would result in even higher premiums. This process is typically referred to as a premium spiral. Avoiding

[1] The American Academy of Actuaries is a 16,000-member professional association whose mission is to serve the public on behalf of the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

such spirals requires minimizing adverse selection and instead attracting a broad base of lower-risk individuals, over which the costs of higher-risk individuals can be spread. Attracting healthier individuals will ultimately help keep premiums more affordable and stable.

How the various rules and regulations that apply to health insurance markets are defined can affect the degree of adverse selection. In particular, guaranteed-issue provisions, which prohibit insurers from denying coverage based on health status, can exacerbate adverse selection concerns by giving individuals the ability and incentive to delay purchasing insurance until they require health care services. Likewise, limiting or prohibiting premium variations by health status or other characteristics correlated with health spending can raise the premiums for younger and healthier individuals, relative to what they would pay if health status could be used as a rating factor. This could cause younger and healthier individuals to opt out of coverage, leaving a higher-risk insured population.

Increasing overall participation in health insurance plans, especially among lower-risk individuals, could be an effective way to minimize adverse selection. One way to achieve higher participation is to require individuals to have insurance coverage. Other types of incentives are also available to increase participation, including: limiting open-enrollment periods with penalties for delayed enrollment, subsidizing premiums, and instituting automatic enrollment (i.e., opt-out rather than opt-in provisions). The Medicare program includes some of these incentives. Nevertheless, an effective and enforceable individual mandate would likely achieve higher participation rates than these types of voluntary incentives. To be effective, however, penalties (or incentives) associated with an individual mandate need to be meaningful relative to the premium levels.

Relevant Provisions in the Tri-Committee Health Reform Draft Proposal

The Tri-Committee health reform draft proposal contains many provisions that would impact the extent to which insurance markets would attract a broad cross section of risks. The proposal would require guaranteed issue and renewal for all health insurance coverage and would also limit premium variations to reflect age, geographic area, and family size. Furthermore, any premium variations by age would be limited to a 2-to-1 ratio between the highest and lowest premiums.

Implementing these changes without making other changes to the incentives to purchase insurance coverage would exacerbate the extent of adverse selection, especially in the individual health insurance market. Individuals with higher than average health needs would be more likely to purchase coverage, while those with lower than average health needs would be more likely to forgo coverage, and the result would be higher premiums on average, relative to current premiums.

However, the draft proposal also contains incentives for lower-risk individuals to purchase coverage. In particular, the proposal would require that individuals obtain coverage or pay a financial penalty of up to 2 percent of adjusted gross income. Employers would be required to offer and contribute to coverage for their employees or pay a fee based on 8 percent of payroll. In addition, premium subsidies would be available for low-income individuals and families to purchase coverage as well as tax credits to certain small businesses.

The premium subsidies and coverage mandate would help to mitigate adverse selection arising from more restrictive issue and rating rules. It is important to recognize, however, that the impact of such requirements would vary across States, depending on their current market rules. For instance, in States that allow underwriting and premium variations by health status, the uninsured population may be less healthy, on average, than the insured population. Moving to guaranteed issue and prohibiting premium variations by health status would result in increased coverage among the less healthy population, potentially raising average premiums. The individual mandate would help moderate premium increases by ensuring that the healthy maintain (or obtain) coverage in those States.

In contrast, in States that already prohibit underwriting and limit premium variations by health status or other factors that are correlated with health spending, the uninsured population may be healthier, on average, than the insured population. The individual mandate would increase the participation among lower-risk individuals, potentially lowering average premiums in those States.

The effect of reform options, generally, on States with high-risk pools can also be complicated by whether the high-risk pool enrollees are incorporated into the individual market or whether the high-risk pools remain in place, even temporarily. According to the National Association of State Comprehensive Health Insurance Plans (NASCHIP), as of December 2007, 34 States had high-risk pools enrolling about 200,000 individuals in the aggregate. These high-risk pools act as the insurer of last resort for otherwise uninsurable individuals, and the eligibility rules, covered bene-

fits, cost-sharing requirements, plan administration, and funding can vary considerably by State. Premiums for individuals are typically capped at a certain percentage above the individual market premium for a similar benefit package, and the remainder of the cost is funded by the State. The Tri-Committee draft proposal indicates that individuals in State high-risk pools could potentially qualify as meeting coverage requirements. However, States may choose to discontinue their high-risk pools after the implementation of comprehensive national reform.

The impact of an individual mandate can also vary by when it is implemented, compared with other market reforms. The Tri-Committee's draft proposal does not explicitly specify the timing of the implementation of the individual mandate compared with the imposition of guaranteed issue and modified community rating rules. To help ensure the enrollment of low-risk individuals, thereby minimizing adverse selection, it is important that the individual mandate be imposed in conjunction with the move to stricter issue and rating rules, not after.

With respect to the degree of premium rate compression required in the draft proposal, achieving universal coverage through coverage mandates or other means reduces or eliminates altogether adverse selection in the health system as a whole by age, health status, and other characteristics that are correlated with health spending. If universal coverage could be achieved, it would be less necessary, from a plan solvency standpoint, to vary premiums by risk characteristics. The question of how to distribute the costs across the population would then become an issue of balancing the tradeoffs between individual financial equity and social equity. The draft proposal prohibits any premium variations except for those by age, geographic area, and family size. Moving to a narrow limit on premium variations by age, such as the proposed 2-to-1 limit, could result in dramatic premium changes, compared to what individuals are facing currently. In particular, younger individuals in States that currently allow underwriting and wider premium variations by age could see much higher premiums than they face currently (and may have chosen to forgo). The premium may also be high compared to the penalty of 2 percent of adjusted gross income, potentially reducing the effectiveness of the individual mandate. A broader allowable range in premium variations by age may cause less disruption, especially for younger individuals.

Even if adverse selection is minimized in the health insurance system as a whole, some insurance plans could end up with a disproportionate share of high-risk individuals. One way to avoid adverse selection between plans is to ensure that all plans competing for the same participants operate under the same rules. An issue particularly relevant to this discussion relates to whether large groups would be eligible to purchase coverage through the Health Insurance Exchange. According to the draft proposal, initially only individuals and the smallest firms would be allowed to purchase through the Exchange. In subsequent years, however, larger firms would be allowed to purchase through the Exchange. An adverse selection concern arises if eligibility for the Exchange is extended to large firms which would normally self-insure. In particular, large firms with higher than average health spending could potentially benefit by joining the Exchange, whereas firms with lower than average health spending would continue to self-insure. Such adverse selection would increase the average premiums for those in the Exchange. It may be more appropriate to limit eligibility for the Exchange to firms that would not normally self-insure.

Another issue related to potential adverse selection between plans is that plans could be at risk for financial losses if they enroll a disproportionate share of participants with above average health spending, especially when premiums are not allowed to vary by health status or other risk factors. Such threats to a plan's financial health could provide insurers an incentive to develop strategies to avoid enrolling less healthy individuals. To avoid these incentives and help ensure plans receive payments that are adequate relative to the risks they are bearing, the draft proposal includes a risk adjustment mechanism to adjust plan payments to take into account the health status and other risk characteristics of plan participants. This would help minimize the impact of adverse selection between plans in the Exchange. Nevertheless, it is important to recognize that risk adjustment mechanisms cannot fully mitigate the impact of adverse selection. In addition, some type of reinsurance mechanism could limit insurers' downside risk by protecting against unexpected high-cost claims.

Market Competition Requires a Level Playing Field

For health insurance markets to be viable, plans trying to enroll the same participants must operate under the same rules. If one set of plans or insurers operate under rules that are more advantageous to high-risk individuals, then they will migrate to those plans; lower-risk individuals will migrate to the plans more advan-

tageous to them. In other words, the plans that have rules more amenable to higher-risk individuals will suffer from adverse selection. Over time, the premiums for these plans will increase to reflect this, leading to more adverse selection and threatening the viability of those plans.

For example, if a regional health exchange or connector is created, and plans are offered inside and outside the exchange, the rules governing plans inside and outside of the exchange need to be the same. Otherwise either the plans inside the exchange or outside the exchange could get a disproportionate share of higher-risk individuals, depending on which set of plans is subject to rules that are more advantageous to those in poorer health. Level playing field issues arise not only with respect to health insurance exchanges, but also if insurance is allowed to be purchased across State lines or if a public plan option is offered alongside private plans.

From an actuarial perspective, creating a fair and competitive marketplace requires several elements.

- *All plan options must operate under the same rules.* The issue and rating rules as well as any benefit package requirements must be the same for all health plans. In addition, any premium subsidies must be available for all plan options and any default enrollment mechanisms need to allocate eligible participants between all participating plans. Adhering to the same rules and regulations will help minimize selection between the plans, and will help ensure competition is based on efficiencies and quality of care rather than on differences in enrollee risk characteristics.
- *Premium rates must be actuarially sound.* Premiums must be adequate to cover claims incurred, all related operating expenses, cost of capital charges and a risk charge. To ensure plan solvency in the event that plan expenditures exceed premiums, private plans are required to carry capital/surplus (an excess of assets over liabilities) to cover potential deficits and to fund major investments in support of infrastructure. Premiums include a risk charge to absorb minor adverse fluctuations in claims and/or expenses from expected, and to accumulate target surplus (that is, a level of surplus appropriate to the risk). The danger of not having such mechanisms is that deficits in any given year would cause increases in premiums needed in subsequent years, above those needed due to increased health spending. Capital charges reflect the cost of obtaining operating capital.

To ensure that any public plan premiums are self-supporting, and not reliant on general tax revenues, deficit spending, or intergenerational transfers, the public plan should include both a risk charge and a premium rate stabilization fund. Under this approach, public plan premiums would include capital charge and risk charge mechanisms to pay for the cost of capital and to fund a stabilization fund. A risk charge may look like a profit, but it is actually a cost of doing this business.

- *Provider payments must be comparable for all plans.* This is a particular issue if a public plan option is available. Setting a public plan's provider payment rates dramatically lower than those for private plans could help control plan costs, but could also result in cost shifting to private plans and reduced access to providers. Public plan provider payments should be set to balance the tradeoffs between ensuring adequate access to care and controlling plan costs.
- *Any State requirements must apply equally to all participating plans.* States place a variety of other requirements on private health plans, and these would need to also apply to a public plan option for the playing field to remain level. For instance, many States assess health plans to fund high-risk mechanisms, regulatory activities, and guarantee funds. States also require a variety of other nonbenefit requirements on health plans, ranging from consumer protections to market conduct examinations and audit and actuarial certification requirements. These requirements would need to apply to all participating plans, whether private or public, as appropriate.

Relevant Provisions in the Tri-Committee Health Reform Draft Proposal

The Tri-Committee health reform draft proposal would establish a Health Insurance Exchange, and would create a new public plan option to be offered through the Exchange. Individuals would be able to purchase qualified coverage through the Exchange, and the ability for employers to purchase coverage through the Exchange would be phased in gradually by employer size, beginning with the smallest employers. Except for grandfathered coverage, qualified health insurance coverage would no longer be available in the individual market outside of the Health Insurance Exchange.

The public plan would need to follow the same market rules and benefit requirements that apply to private plans. Although the stated intention of the public plan option is for it to be self-sustaining through premiums, it is unclear whether the draft proposal's provisions would ensure that. The draft reform proposal states that the premium rates shall include a contingency margin. But if this margin includes only a risk charge and not a capital charge, any ongoing costs of capital will not be reflected in the premium. In addition, the creation of a rate stabilization fund is not included in the draft proposal.

The public plan option would also undermine the level playing field requirement that provider rates be comparable to the rates used by private plans. The draft proposal specifies that provider payments in the public plan would be set at Medicare rates (with 5 percent bonuses for certain providers), at least initially. This would create serious concerns regarding cost shifting to private plans as well as access to care issues for those enrolling in the public plan if providers refuse to see patients at the reduced rates. Even the largest private health insurance plans have commercial provider contracts significantly higher than 5 percent above Medicare rates, in almost all geographic markets.

For Long-Term Sustainability, Health Spending Growth Must Be Reduced

According to National Health Expenditure data from the Centers for Medicare and Medicaid Services, health care spending increased 6.1 percent in 2007. Although this is the lowest growth rate in a decade, it far exceeds the general rate of inflation, and exceeds the growth in the overall economy as well. If health spending continues to grow at this pace, as projected, health insurance premiums will continue to increase as well. Unless health care costs are controlled, efforts to achieve universal coverage could be undermined. Reining in health insurance premiums in the near term will be meaningless if rising health spending returns premiums to their original levels within a few years and continues to rise rapidly thereafter. To have the potential for sustainable success, health reform proposals need to include mechanisms that will control the rate of health spending growth. And because there is mounting evidence that the money being spent for health care is not providing enough value and that the vast variations in health spending across the country aren't correlated with variations in health care outcomes, spending growth should be addressed within the context of quality and value reforms.

Several factors contribute to the growth in health spending, and there are options to address many of them, each offering promising opportunities to improve quality while reducing costs. The introduction of new technologies and treatments can increase health care spending by increasing utilization, particularly of higher-intensity services. More comparative effectiveness research should be conducted to better ensure that new technologies and treatments truly add value over their added costs. Another driver of health spending growth is the misalignment in current provider payment systems between provider financial incentives and the goal of maximizing the quality and value of the health care provided. Instead, the most common provider payment mechanisms reward more care, and more intense care. Restructuring provider payment systems could result in more coordinated, cost-effective, and higher-quality care.

Comprehensive insurance benefits, by lowering the cost of care to the insured, can also result in increased utilization of health care services. Although some utilization increases are for necessary care, some are for care that is unnecessary or of limited benefit. Plan design features such as cost-sharing requirements can be used to encourage more effective use of health care services. However, any incentives to make insureds, particularly those with chronic conditions, more sensitive to benefit costs should be balanced so that individuals are not discouraged from seeking needed care. Value Based Insurance Design (VBID), a relatively new concept in insurance benefit design, attempts to better target cost-sharing requirements so they more effectively encourage needed care, yet discourage unnecessary care.

Relevant Provisions in the Tri-Committee Health Reform Draft Proposal

The Tri-Committee health reform proposal includes provisions that would shift the health care payment and delivery systems from rewarding quantity of care to rewarding quality of care. The proposal includes many cost containment and quality improvement strategies focused on the Medicare program and the public plan option, including provider payment and delivery system reforms that provide incentives for coordinated and cost-effective care. A comprehensive and coordinated approach to addressing quality and costs is needed to fundamentally transform the health system to ensure its long-term sustainability.

Conclusion

The American Academy of Actuaries' Health Practice Council has identified three key considerations that are vital when determining whether particular reform approaches will lead to a sustainable health system with increased access to affordable health insurance. In particular, for insurance markets to be viable they must attract a broad cross section of risks; market competition requires a level playing field; and for long-term sustainability, health spending growth must be reduced. As Congress moves forward on a health reform proposal, it should ensure that its provisions adhere to these criteria.

Statement of the ERISA Industry Committee

The ERISA Industry Committee is an association committed to the advancement of the employee retirement, health, incentive, and welfare benefit plans of America's largest employers. ERIC's members provide comprehensive health benefits directly to some 25 million active and retired workers and their families. ERIC has a strong interest in proposals that affect its members' ability to continue to deliver high-quality, cost-effective benefits.

We must change the way we pay for and deliver health care in the United States. Reining in health care costs is absolutely essential to this country's future economic success. ERIC strongly supports reforms to the Nation's health care system that will increase its efficiency, reduce costs, and extend health care coverage to those who are uninsured or underinsured.

ERIC has thought deeply about this subject. In 2007, we released *A New Benefits Platform for Life Security* that lays out our vision of a conceptual framework for overhauling our national approach to providing health and retirement security. Many of the positions we staked out in this *Platform* have been incorporated into proposals currently under consideration in Congress.

Three basic principles are of fundamental importance to change and must be considered as we move forward.

1. ***Do no harm.*** The current voluntary employment-based system provides health coverage to 170 million people, about 61% of the non-Medicare population. This system has served both employers and employees well. Employers have the flexibility they need to tailor their plans to the needs of their workforce while also aggressively pursuing the innovative changes that have led to substantial advancements in so many arenas, including the fields of wellness and prevention. Employees strongly support their employer provided benefits and benefit significantly from this system. They enjoy access to high-quality care with guaranteed issue, limited preexisting condition exclusions, a uniform premium structure, and the other advantages afforded participants in the large risk pools of group plans. Any health care reforms should build on the strengths of this system.

2. ***Control costs.*** The relentless increases in the cost of health care threaten the viability of U.S. corporations in a global economy, while the upward spiral in the costs of Medicare and Medicaid threatens our national solvency. In addition, a substantial portion of the health care we now consume, perhaps as much as 20% to 40%, has no value. The centerpiece of health care reform must focus on reducing these costs. Reform that fails to focus on cost control will not only ultimately prove ineffective but will undermine health care coverage.

3. ***Expand access.*** Forty-sevem million Americans do not have adequate access to health care. Of those, approximately half are unable to afford coverage. History will not judge kindly an affluent society that ignores this problem. We must remember, however, that inadequate access is aggravated, if not caused, by the high level of cost. Our effectiveness in solving the access problem depends on restraining the growth of health care costs.

With these foundation principles in mind, we lay out what ERIC can support in a responsible health care reform initiative:

1. ERIC strongly supports a **competitive, pluralistic health care system** in which employers and individuals have choices among several health plans that compete on the basis of quality, cost, and effectiveness. There is an urgent need to eliminate the significant waste in the current health care delivery system, establish a foundation for responsible cost management in the future, and systematically ensure quality health care for all Americans. Too many reforms pursued in the past have made changes at the edges of health care delivery when funda-

mental structural changes are needed. ERIC believes that a properly designed, responsibly regulated pluralistic system will be able to correct the deficiencies in the current system and produce significant improvements in costs, quality, and access.

2. ERIC's *New Benefits Platform* supports the establishment of an **insurance exchange or gateway** that provides a fair and equitable method for the distribution of insurance products. If exchanges are established, they should follow uniform national standards.

3. **Employers should be given broad flexibility regarding how they choose to provide health benefits to their employees and their families** but should be protected from systematic adverse selection by the plans in the exchange. Employers should be given the option of choosing to continue in the current system and arrange for and sponsor their own health plan alternatives. At the same time, employers should have the flexibility to provide financial resources to their employees to purchase health plans through the insurance exchange from among competing health plans. The employer should not be required under any circumstance to provide financial resources to employees to purchase insurance through an insurance exchange when the employer has chosen to continue in the current system. To allow this would create systematic adverse selection problems that could ultimately result in the demise of the employer-based system. This is inconsistent with the stated objectives of the President to support the continuation of the current system.

4. **Incentives in the current financing system must be changed from risk avoidance to responsible cost management.** The foundation principle of a fair and equitable financing system for health care must be that the cost of disease and injury must be distributed across all plans offered through the exchange. In the end it is the expectation that health plans offered through the exchange should be strongly incentivized to differentiate their products and premiums based on efficiencies generated by better administrative practices derived from improved payment systems, disease management, utilization management, case management, lifestyle management and other innovative initiatives designed to lower cost, increase quality and improve accountability. Large employer plans have pursued these goals with notable success.

5. **Transparency and accountability of both providers and health plans must be improved.**
   - There has been much discussion on the need for better provider transparency in terms of both cost and quality. We are fully supportive of these initiatives.
   - There has been less discussion about the need for better **health plan** transparency and accountability. It is widely recognized that the practices of some private health plans create an enormous frustration to both consumers and providers of health care. Medicare does provide a good example of more consistent administration of health plans. In a restructured system, it will be important to establish mechanisms where there can be standardization and full transparency of administrative practices of health plans that are offered through the exchange. This might include disclosure of health expense loadings, the number and cost of denied claims, the efficiency of claims administration and other administrative practices, and consumer assessments of each health plan.

6. ERIC strongly supports **payment reform**. There is strong evidence that financial incentives must drive the changes that are desired. President Obama's Budget Director, Peter Orszag, recently stated that, for example, "nearly 30% of Medicare's cost could be saved without negatively affecting health outcomes if spending in high and medium cost areas could be reduced to the level in low cost areas." In both the private and public sectors, we must stop rewarding providers for doing more and instead incentivize them to provide high-quality health care that delivers true value to the American consumer. It is irresponsible to perpetuate a system in which between 20% and 40% of the health care delivered has no value. Payment reform is essential to this objective.

7. Every citizen should be required to obtain health care coverage, **with standards established at the Federal level**. Because a significant portion of the population is unable to afford adequate coverage, ERIC would support subsidies to assist financially disadvantaged individuals.

We must also call attention to the areas in current legislative proposals where the "Do no harm" principle is most at risk.

Taxation of Benefits

Several proposals have been made to curtail the favorable tax treatment for employees of employer-provided health benefits. One proposal would eliminate the exclusion entirely. Others would impose a cap based on the value of health insurance, an individual's income, or a combination of the two.

ERIC has serious concerns with limiting the ability of an employee to exclude from income the value of employer-provided health insurance. If this exclusion were curtailed, many large employers would follow one of two approaches. Some would redesign their plans to meet the new cost standard in the legislation, below which taxation would not be imposed. This would necessarily mean that their employees would be provided with less generous health coverage.

Other employers would choose to keep their existing plans; if the value of the plan exceeded the standard in the legislation, employees would face taxation on the "excess" value. If this were to occur, employment-based insurance would suffer. Young, healthy employees would either seek to exit their employers' plans in search of cheaper coverage rather than pay taxes on a more expensive plan or pressure their employers to reduce coverage. If younger workers sought cheaper coverage elsewhere, an employer plan that once had a favorable and balanced risk pool would now be left with an older, sicker, more costly population whose premiums would eventually become unsustainable. Loss of a large, viable risk pool would greatly diminish an employer's ability to offer efficient and innovative health care coverage to its employees. As the cost of providing benefits increased, more employers would exit the system.

There are also equity and administrative issues associated with a tax cap that need to be carefully assessed. We are concerned that if a cap is to be imposed, it not discriminate against individuals by virtue of higher premium costs due to geography, the demographic composition of the group, or because they happen to work for a small firm.

A Public Plan

ERIC has several serious concerns with the creation of a public plan that would compete with the current private marketplace. Although at present we do not know how this new plan would be structured, we have profound reservations with the prospect of a public plan modeled after Medicare. Medicare does provide an example of an efficient, consistent, and fair claims administrator; there are also examples of consistent, fair claims administrators among private health plans. Medicare is not, however, a sterling example of what a restructured financing system should look like. In fact, Medicare has perpetuated some of the cost problems that we have in our current health care system by rewarding those who provide more care, regardless of value.

Our most fundamental concern with a public plan based on Medicare, however, is the potential for even greater cost-shifting than exists today. Right now ERIC members subsidize the cost of Medicare. This includes both administrative and claim costs. One example of the administrative subsidy relates to the fact that Medicare does not pay anything for transaction fees associated with the electronic movement of claims from providers to Medicare intermediaries. These transaction costs are not free. They must be absorbed by other paying customers, including employer plans.

Moreover, according to most providers, Medicare's reimbursement rates do not cover their costs. Contrary to what many people say, these rates are not negotiated, they are mandated. Providers argue that in most cases they accept these rates because they want to continue treating patients that have been treated all of their lives. Hospitals argue that they have no choice. They believe that they survive only because they are able to charge higher rates to private plans and other customers. In short, the provider shortfall from Medicare is shifted to the private sector, a practice that is unacceptable in a reformed system.

At the end of the day, ERIC's position is that if a public plan could be fairly fashioned, it must not be structured in such a way that employer plans end up bearing the burden of additional cost shifts. Health care costs are already rising at an unsustainable rate. Increased cost-shifting would trigger the warning light that causes employers to rethink whether they can afford to provide high-quality health care to their employees. An exodus of employment-based plans from the Nation's health care system would diminish the development of practices to improve the quality of health care and the pursuit of innovative strategies to bring health care costs under control that are core strengths of the employment-based system.

Employee Opt-Outs

We are also concerned about the adverse selection that would be experienced if individual participants in employer-sponsored plans were permitted to opt out of the employer plan and into a public plan, especially if the employer were compelled to pay for the individual's participation in the public plan and/or finance any subsidy given low-income individuals who opted out. If permitted, an opt-out would undermine the demographic fairness of a large risk pool that is a feature of employer plans. Over time, young, healthy employees would seek cheaper coverage outside of the employer's plan, and older, sicker employees would remain in the plan. Eventually, employer plans would become havens for employees with the worst risk profiles, and this would be reflected in ever-higher premium costs. At some point, employers would no longer be able to provide affordable coverage to their workers.

Employer Mandates

Employer mandates, especially their manifestation in the "pay-or-play" penalties currently under discussion, have the potential to seriously harm employer-sponsored plans. ERIC members generally provide high-quality benefits with generous employer contributions; thus, it would appear that a "pay-or-play" requirement would have little or no relevance for us. As we have learned from the experience in Massachusetts, however, this is not always the case, and—as is so often true in life—the devil is in the details. For instance, if the employer mandate only required that employers offer a set minimum package of benefits to employees that met a specified, modest actuarial value, then many—but not all—major employers would meet that bar. But if the mandate were to require that all full-time employees were to be covered, and full-time were defined as working 25 hours per week, many other employers would drop below the bar. If the mandate were to further include no cost-sharing for prevention or wellness and full coverage of mental health benefits, others would drop out.

Employer mandates by definition restrict our ability to devise and operate health care plans that best meet the needs of our employees. Mandates increase costs and limit flexibility. Coupled with punitive regulatory regimes, employer mandates will discourage employers from continuing to provide quality, affordable health care to their employees. This is not an idle threat; one need look no farther than the Nation's moribund defined benefit plan system to see the effects of overly complex rules and regulations.

Preemption

It is absolutely essential that ERISA's preemption doctrine not be breached. Without the national uniformity made possible by ERISA's preemption doctrine, large multistate employers simply could not offer quality health care coverage to their employees. Its importance was recognized by the original sponsors of ERISA as critical to ensuring that employers provided sound and secure benefits. Any future legislation must continue to accord preemption and national uniformity of regulation a similar priority.

Conclusion

ERIC is committed to the goal of reforming the Nation's health care system in a responsible manner that will extend health care to those without it and that will reverse the current fatal escalation in the costs of health care. Equally important is that this reform be accomplished without undermining the system that currently offers quality health care to 170 million satisfied Americans.

ERIC intends to continue to play a constructive role in this debate.

Statement of The Senior Citizens League

On behalf of the approximately 1 million members of The Senior Citizens League (TSCL), a proud affiliate of The Retired Enlisted Association (TREA), thank you for the opportunity to submit a statement regarding health care reform. TSCL consists of active senior citizens, many of whom are low income, concerned about the protection of their Social Security, Medicare, and veteran or military retiree benefits.

Our members are very concerned with the rising cost of health care. According to a recent survey that TSCL conducted in early 2009, some 41 percent of seniors responding said they occasionally cut back on visits to the doctor in the past year due to the economy. Another 21% said they "frequently" did so. With skyrocketing Medicare premiums and out-of-pocket expenditures, coupled with predictions of no cost-of-living adjustment (COLA) for 2010 and 2011, TSCL is highly concerned that many seniors, or their caregivers, will be forced to choose between life-saving medications or paying for groceries or other bills.

Making health care affordable and accessible for all Americans—young and old—is of the utmost importance. However, we realize that there is an enormous pricetag associated with this vision. President Obama's Administration presented a "down-payment" of approximately $634 billion over the next 10 years in its proposed budget for fiscal year 2010. Of this total, an estimated $316 billion is expected to come from changes to Medicare payments and reducing fraud. With this in mind, TSCL encourages Members of Congress to support including the following items in any health care reform package.

TSCL and its supporters believe that substantial savings to the Medicare program could be gained with a few adjustments to current examples of waste, fraud and abuse. Many groups, including the Government Accountability Office (GAO) and Inspector General, have reported that the Federal Government is overpaying the Medicare Advantage (MA) insurers by about 14% or more. First, payments to Medicare Advantage plans should be reevaluated by Congress. Additionally, the Centers for Medicare and Medicaid Services (CMS) should complete drug plan and MA plan audits as required by law. Plans should be required to refund overpayments, if any, to affected Medicare beneficiaries.

TSCL also believes that provisions, such as those in Senator Mel Martinez's (FL) *Seniors and Taxpayers Obligation Protection (STOP) Act*, would prevent the loss of billions of dollars from Medicare through prevention of waste, fraud and abuse. For example, the GAO estimates that improper payments for Medicare Fee-for-Service and Medicare Advantage totaled $17.2 billion in fiscal year 2008.[1]

TSCL believes that additional savings could result if consumer access to affordable prescription drugs **is made possible by Food and Drug Administration (FDA) approval of the importation of safe prescription medications from selected countries**. During the 110th Congress, the Congressional Budget Office (CBO) estimated that, if enacted, Senator Byron Dorgan's (ND) *Pharmaceutical Market Access and Drug Safety Act* would result in a $5.4 billion reduction in direct Federal spending for prescription drugs and a $5.2 billion increase in Federal revenues over 2009–2017. The CBO also estimated that this legislation would reduce total drug spending in the United States by $50 billion over 10 years.[2]

TSCL adamantly opposes means testing and encourages Congress and the Administration to not expand it to Medicare Part D premiums. Monetary funds from a one-time high-income (e.g., property sale, lump sum distribution of a pension account, etc.) or retirement savings should not be used to determine higher-income-based Medicare premiums for persons who would not normally be required to pay the higher fee. Because Part D plan premiums vary tremendously, implementation may be extremely difficult. Another challenge that could present itself is protecting beneficiaries' sensitive tax information from misuse by private health plans.

In 2009, approximately 2.2 million affected seniors[3] pay at least $38.50 and up to $211.90 per month in addition to the standard monthly premium of $96.40.[4] This is the first year that beneficiaries pay fully phased-in higher premiums. Despite a 'break' in 2009, the standard Medicare Part B premium has increased from $45.50 per month in 2000 to $96.40—that is 111.8%! This percentage does not take into account the increases in premiums due to means testing. TSCL is supportive of legislation that would eliminate the means test applied to Medicare premiums. During the 110th Congress, Rep. Nita Lowey (NY) introduced H.R. 4330, which would have eliminated means testing for Medicare Part B premiums.

TSCL also supports legislative action that would either reduce or eliminate the coverage gap, often referred to as the 'doughnut hole.' For 2009, seniors falling into the gap must pay $3,454 in out-of-pocket expenses before Part D coverage begins again. When premiums, deductibles, and copays are factored in, in premiums, deductibles, and copays, the beneficiary must spend $4,350 out-of-pocket before catastrophic coverage. Unfortunately, there are few Part D plans that offer gap coverage, and those that do typically cover only generic prescriptions.[5] The beneficiary that takes a brand-name medicine for which there is no generic or that takes a

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[1] "Progress Made but Challenges Remain in Estimating and Reducing Improper Payments." Testimony of Kay L. Daly before the Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security, Committee on Homeland Security and Governmental Affairs, U.S. Senate, April 22, 2009.

[2] "Pharmaceutical Market Access and Drug Safety Act Frequently Asked Questions," www.dorgan.senate.gov/issues/families/rx/faqs/.

[3] "CMS Announces Medicare Premiums, Deductibles for 2009," CMS, September 19, 2008.

[4] http://www.ssa.gov/pubs/10161.html. March 9, 2009.

[5] "Medicare Part D 2009 Data Spotlight: The Coverage Gap," Kaiser Family Foundation, November 2008.

costly specialty tier drug is often forced to choose between taking their meds and paying for other necessities.

Senator Bill Nelson (FL) introduced the *Medicare Prescription Drug Gap Reduction Act of 2009*, which, if signed into law, would amend the Medicare portion of the *Social Security Act* to reduce the Part D doughnut hole due to savings resulting from negotiated prescription medication prices. The Federal Government would be able to do such negotiations under the umbrella of Department of Health and Human Services (HHS), with its Secretary acting as a liaison/negotiator.

Included in the *American Recovery and Reinvestment Act of 2009*[6] was approximately $1.1 billion for Comparative Effectiveness Research (CER). Although language was included that stated CER should *not* be used by Medicare and private insurers to deny care or leave patients with uncovered costs, TSCL believes that this should not be overruled by health care reform legislation. Beneficiaries rely on Medicare to cover all medically necessary costs. Changing the "medically necessary" policy could prevent seniors from getting certain types of care that impose much higher new costs on sick patients.

Take for example virtual colonoscopies. CMS ruled that virtual colonoscopies will not be covered because there was "insufficient evidence" to conclude that virtual colonoscopy "improves outcomes in Medicare beneficiaries."[7] However, the public may be interested in receiving more information about available treatment options. Some patients may find it less invasive and thus be more willing to undergo the treatment. On the other hand some specialists say virtual colonoscopies may expose patients to more dangerous levels of radiation than conventional methods. This information, which is of the greatest use to patients, was never even mentioned in general media stories on this coverage decision.

If taxpayer supported research is made public, it holds the potential to save lives and some people may prefer safer forms of treatment when possible. However, TSCL fears that without proper oversight, CER could be used by Medicare and private insurers, to deny treatment on the basis of cost-effectiveness—despite the fact that patients may not have the same reaction to the same prescribed treatment. As such, TSCL recommends that legislators and the Administration ensure that CER is easily accessible by the entire U.S. public, and that it is used to help patients and their health care providers make informed decisions regarding medical treatment.

Another concern that many groups, including TSCL, and some legislators have is that CER may lead to age-based health care rationing. Presently, there is nothing set in stone that mandates limiting health care to persons on the basis that he/she is too old to receive such a treatment and should accept the condition as something that comes with age. There are, though, hospitals that have adopted a type of health care rationing on the basis of their legal status or whether or not the patient has an outstanding payment balance.[8] Extending this practice to senior citizens is something that could happen and some argue should happen to help the Federal Government cut costs. TSCL believes that medical treatment should not be denied to anyone on the basis of his or her age. Again, CER managed by a Federal health care board should be primarily used to help—not deny—care as doctors, patients, and their families make informed decisions about the available treatment for that individual.

TSCL also strongly opposes changes to Medicare that would increase costs for beneficiaries. According to a recent TSCL survey, the overwhelming majority of respondents said they are highly concerned about Medicare reform proposals that would increase out-of-pocket costs and at the same time would restrict what Medicare supplements or Medigap plans are allowed to cover.

Currently, most Medigap plans cover almost all of the deductibles and cost-sharing. Seniors and the disabled purchase the plans precisely because they need protection from the large out-of-pocket costs that Medicare does not currently cover.

Nevertheless, several budget options to control Federal spending on Medicare, cited in testimony in February to the Senate Committee on Finance by the Congressional Budget Office would:

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[6] Public Law No. 111–5.

[7] "Cost Effectiveness of Colorectal Cancer Screening With Computed Tomography Colonography," Medicare and American Cancer Society, April 23, 2007. "Medicare Blow to Virtual Colonoscopies," Andrew Pollack, *The New York Times*, February 13, 2009, http://www.nytimes.com/2009/02/13/health/policy/13colon.html?__r=1&scp=1&sq=Medicare%20Blow%20to%20Virtual%20Colonoscopies&st=cse.

[8] "Rationing Health Care Among the Uninsured: Practice Becomes More Common at U.S. Hospitals," Robert Bazell, Chief Science and Health Correspondent, NBC News, February 24, 2004.

- Impose a new $500 deductible for an estimated three-quarters of Medicare beneficiaries.[9]
- Mandate coinsurance for certain services such as home health care that currently are not subject to cost sharing.
- Prohibit Medigap plans from covering the new deductible and restrict plans to covering only 50% of cost-sharing.

Beneficiaries could potentially face up to $2,888 in out-of-pocket expenses (not counting premiums) in 2011 and the maximum out-of-pocket would increase every year after that.[10]

The Senate Finance Committee recently released a document, *Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options*, which addressed these same budget proposals to alter Medicare co-insurance coverage. These proposals would prevent seniors from receiving the full supplemental coverage for their Medicare co-insurance and cost-sharing that they pay for and rely on today. Increasing out-of-pocket costs for supplemental coverage will only exacerbate the financial problems encountered by seniors who are trying to make ends meet and could lead to more hospital admissions if seniors avoid necessary visits and screenings. Additionally, the media is full of stories about seniors who have been forced to file bankruptcy due to uncovered Medicare costs.

Seniors and the disabled already spend a larger portion of their incomes on health care than younger Americans. Thus, TSCL believes it would be poor policy to finance an expansion of health care coverage to younger Americans by shifting higher costs to the oldest and sickest family members.

TSCL also supports extending "hold harmless" protection to beneficiaries who receive Medicare Part D. The CBO is predicting no Social Security Cost of Living Adjustment for 2010 and 2011.[11] TSCL is concerned about Medicare drug plan premiums increasing (in addition to Part B for some beneficiaries) in years when there is no Social Security COLA. The "hold harmless" provision prevents the vast majority of beneficiaries from receiving smaller Social Security checks in years when Medicare Part B premiums exceed the COLA. Currently, "hold harmless" protection applies only to Medicare Part B as there is no provision protecting the Social Security benefits of those who receive their coverage through Part D and have premiums deducted from their benefits. Assuming most drug plans will increase premiums, TSCL estimates that at least 6.3 million beneficiaries enrolled in Part D plans would see a reduction in Social Security benefits because of the increases.[12,13]

TSCL would also support an "emergency COLA," paid out of Social Security payroll taxes, to Social Security beneficiaries to offset the increase in Medicare premiums. This would help to preserve beneficiaries' current and future buying power and potentially lower overall beneficiary Part B premium costs. To prevent inequities among beneficiaries TSCL supports an "emergency COLA" for all Social Security recipients.

The "emergency COLA" could be set at a level that would cover the cost of Part B premium increases for beneficiaries. This would potentially mitigate a very stiff projected jump in Part B premiums. If no action is taken, Medicare Trustees estimate that Part B premiums for beneficiaries not covered by the "hold harmless" provision would increase from $96.40 per month in 2009 to $104.20 per month in 2010, and $120.20 per month in 2011.[14] Providing an "emergency COLA" eliminates the need for the "hold harmless" provision for Part B in 2010 and the beneficiary portion of the cost of premiums could thus be spread over 42.4 million rather than just approximately 10 million.

There are countless additional provisions that will be debated, but one thing remains certain—beneficiaries should be protected and their health should come first. Protecting Medicare for current and future retirees is essential, and TSCL respectfully requests that any proposed changes impacting America's senior citizens be carefully considered.

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[9] "Options for Expanding Health Insurance Coverage and Controlling Costs," Statement of Douglas W. Elmendorf, Director, Congressional Budget Office, Before the Senate Committee on Finance, February 25, 2009.

[10] Budget Options Volume I, Health Care, Congressional Budget Office, December 2008.

[11] A Preliminary Analysis of the President's Budget and an Update of CBO's Budget and Economic Outlook, Congressional Budget Office, March 2009.

[12] Medicare Trustees Report, May 12, 2009.

[13] Medicare Premium Withholding, GAO, July 15, 2009.

[14] Medicare Trustees Report, May 12, 2009.

Statement of Larry S. Gage,
National Association of Public Hospitals and Health Systems

The National Association of Public Hospitals and Health Systems (NAPH) greatly appreciates this opportunity to submit a statement for the record in connection with your June 24, 2009 hearing on Health Reform in the 21st Century. Specifically, we would like to share with you our comments on the Tri-Committee bill under consideration at that hearing, with particular attention to the role of NAPH members and other safety net hospitals and health systems in a reformed health care system.

We would like to begin by extending our support to this Committee, as well as to the Congress and the Administration, for their historic efforts to reform our Nation's health care system. In particular, we support your goal of extending comprehensive health coverage to all Americans. For far too long, tens of millions of vulnerable individuals have been unable to access affordable health care coverage. These people not only fail to benefit from the knowledge and care made possible by the advances in American medicine, but do not even have ready access to basic preventive and primary medical, dental, and behavioral health care.

We also would like to acknowledge the many sound substantive policies lying at the heart of the Tri-Committee bill. The initiatives you have proposed address many weaknesses that underlie the existing delivery system, including fragmented care, wide disparities in the type and quality of services available to different populations, and workforce training that does not align with our system's needs. NAPH supports Congress' efforts to promote integration and care coordination, to address disparities in care, and to invest in primary care training.

We also deeply appreciate that the Tri-Committee bill preserves critical support for safety net hospitals—and in particular Disproportionate Share Hospital (DSH) payments—thereby protecting the vulnerable patients that these hospitals serve currently and will continue to serve under a reformed system. Just as there is widespread agreement that health reform should include increased investment in community health centers—an approach that NAPH supports—a similar investment in ensuring a viable safety net beyond primary care is equally critical. As coverage expands, many newly-covered patients will have gone long periods of time without care. We can anticipate pent-up demand not only for primary care services, but also for resulting specialty and acute care services for which patients are going to need to be referred. Strong community health centers and safety net hospitals will both be required to provide newly-insured and other vulnerable groups with meaningful access to health care.

We would like to focus our testimony on the role of safety net hospitals under health reform. Simply stated, America will continue to depend on safety net hospitals and health systems even if we are able to extend health coverage to all. Massachusetts health reform was premised on the belief that the need for safety net hospitals would decline once health reform took hold. Policymakers had assumed that when previously-uninsured individuals enrolled in the new coverage options, they would begin using a broader network of providers and that the new insurance payments would encourage competition for these patients. This assumption proved false, these patients have continued seeking care at safety net hospitals, and the State has scrambled to find new support for these providers before the unforeseen losses arising out of health reform completely undermine the State's health care safety net.

This statement will briefly describe NAPH, and then will address the following four topics:

- The role of safety net hospitals and health systems in health reform, including the use of coordinated care networks.
- The ongoing need for DSH payments under health reform.
- Graduate medical education.
- Other Medicare payment issues.

NAPH

NAPH members include over 140 of the Nation's largest metropolitan area safety net hospitals and health systems. Located across the county, our members include hospitals and systems such as the Alameda County Medical Center, Hurley Medical Center, and the New York City Health and Hospitals Corporation. These systems have traditionally served as the primary source of care for many low-income populations, including Medicaid recipients, patients unable to access insurance, and individuals who find their health coverage inadequate. On average, roughly 60 percent of patients served by NAPH members are enrolled in Medicare and Medicaid, and

another 20 percent are uninsured. Although NAPH members account for only 2 percent of hospitals nationwide, they provide 20 percent of the Nation's uncompensated hospital care. The amount of uncompensated care provided by NAPH members has increased significantly in the last year due to the economy, underscoring the need for comprehensive health reform that provides meaningful coverage and access to care to all Americans. In the last quarter of 2008, NAPH members experienced a 10 percent increase in uncompensated care costs compared to the same quarter of 2007, an average per-hospital increase of $3 million.

The Role of Safety Net Systems in Health Reform

Enacting comprehensive health reform legislation will be only the first step to achieving universal coverage. The Tri-Committee bill does not envision full coverage initiatives commencing until 2013, and the health reform initiatives of Massachusetts, Maine, Vermont and others confirm that the process of expanding health coverage to all Americans will take several years. During this time, the need for safety net hospitals likely will expand, rather than contract. In fact, any coverage expansion's success will hinge, in part, on using safety net hospitals and health systems to engage low-income and other hard-to-reach populations, ensuring that these individuals take advantage of the new, affordable coverage opportunities.

During the transitional years, safety net hospitals will continue providing high-quality services to all those seeking care, regardless of insurance status. Many people likely will remain uninsured during health reform's initial years, and safety net systems likely will continue treating a disproportionate number of these patients.

Given safety net health systems' uninsured volumes, they also are uniquely positioned to facilitate enrolling the uninsured into new coverage vehicles. To the extent that health reform expands Medicaid eligibility in certain States, those States likely will rely on safety net hospitals to identify newly-eligible patients. Safety net hospitals also will serve as entry points for individuals not eligible for public coverage, but who can enroll in subsidized and unsubsidized private coverage. Given our members' deep knowledge of their patients' unique needs, safety net health systems will be able to facilitate enrollment in the most suitable plans, whether that be Coordinated Care Networks (described below) or other plans offered by private or nonprofit insurers through the Health Insurance Exchange.

Coordinated Care Networks (CCNs) have the potential to serve as a vehicle for transitioning to a reformed health care system and for ensuring that the newly-insured receive ongoing care that addresses their unique needs. Attached to this statement is NAPH's proposal to develop CCNs. CCNs would be integrated health care delivery systems for low-income populations, voluntarily formed by public and private safety net providers. CCNs would provide support for integrated delivery systems to coordinate the full range of care—primary care to hospital and post-acute care—for low-income individuals and families, including Medicaid patients, Medicare beneficiaries (including dual eligibles), the uninsured and those who may be newly covered under health reform. CCNs would focus on improving both quality and efficiency of care for these vulnerable patient populations, and would ensure that their enrollees continue to have a range of necessary "wrap-around" support services that may not be needed by the rest of the population. Given the high costs associated with treating low-income and other targeted populations, safety net systems, through CCNs, also would be prime testing grounds for incentives to improve quality and efficiency.

As proposed, CCNs would be public or private nonprofit legal entities representing consortia of safety net providers, such as public hospitals, federally qualified health centers, children's hospitals and others. They would be eligible to contract directly with various payers under health reform to provide integrated care to their respective enrollee populations. CCNs could also, at their option, choose to offer or develop health plans built around their network and contract with Medicare, Medicaid, CHIP, or the newly-formed Exchange.

In many ways, CCNs would deliver the services already available through safety net systems. Our proposal, however, would provide a needed national framework to recognize integrated, multi-provider networks and systems already developed by safety net providers in many parts of the country, and to develop and extend their "best practices" for care coordination to other communities. They would work in concert with many of the other important initiatives included in the Tri-Committee bill, such as accountable care organizations and medical homes. Quality can be improved and costs reduced by getting patients to the right place, at the right time, with the right level of care, with the right provider, with the right outcomes, and the right financial incentives. Through CCNs, the Federal Government would have a mechanism through which to encourage this sort of integration and coordination. NAPH developed this proposal from successful models implemented by several safety net

hospitals, including ones from south Florida to New York City, San Francisco to Richmond, Virginia. Based on the success of these models, we urge you to consider incorporating the concepts imbedded in this proposal into your health reform efforts.

Finally, safety net systems will continue their leadership in addressing disparities in health, access, and quality often faced by low-income and minority populations. NAPH members, including the University of California Davis Health System and Nassau County Medical Center in New York, have devoted significant resources to create programs that target disparities in care. Denver Health's experience demonstrates that disparities can be eliminated. Seventy percent of Denver Health's patients are members of minority groups. Yet a recent study in the Journal of Urban Health found that at Denver Health, disparities in care did not exist among racial or ethnic groups for the likelihood of receiving various cancer screenings and having properly managed chronic conditions. NAPH supports the requirement that all plans participating in the Exchange would have to provide culturally and linguistically appropriate services and communications, a first step towards broadly eliminating disparities. We also support your proposal to increase Medicaid funding for translation services.

The Ongoing Need for DSH Payments

NAPH strongly endorses the DSH policy reflected in the Tri-Committee bill. Both Medicare and Medicaid DSH payments will continue at their current levels into the foreseeable future, with HHS reporting on both programs by July 1, 2016.

Federal and State governments have a significant interest in ensuring the ongoing viability of safety net hospitals in a reformed health care system. Large numbers of low-income and other vulnerable patients will continue relying on safety net hospitals, as will the general population. Many newly-covered patients, as well as low-income patients already with health coverage such as Medicare, will continue seeking the specialized care that these hospitals provide. Many NAPH members offer wraparound services designed to address vulnerable populations' unique needs, such as translation, transportation, and social work services. Similarly, even with a goal of coverage for all Americans, many are likely to continue falling through the cracks, remaining uninsured and underinsured post-health reform. For example, the Congressional Budget Office estimated that upwards of 33 million Americans would remain uninsured under the Health, Education, Labor and Pensions (HELP) Committee's portion of the Senate's health reform legislation. Even in Massachusetts, the uninsured rate continues to hover around 2.6 percent. Some groups, particularly undocumented aliens, simply will not be eligible for coverage under health reform, and will continue seeking care at safety net systems. For these reasons, safety net hospital uncompensated care costs may remain relatively high compared to other hospitals' post-health reform.

The virtual certainty that many low-income patients will continue seeking care at safety net hospitals means that Congress will need to maintain existing levels of Medicare DSH support. We appreciate your decision to maintain Medicare DSH payments. Congress originally established the Medicare DSH program to offset the heightened costs associated with treating large numbers of low-income Medicare patients. Over the years, Congress acknowledged that Medicare DSH also helps ensure access to care for vulnerable patients, including low-income Medicare beneficiaries. The Tri-Committee bill acknowledges that Medicare DSH has been extended to also support hospitals' uncompensated care burden by requiring a report on the distribution of Medicare DSH as it relates to hospital uncompensated care. In Massachusetts health reform, safety net hospital systems provided more care to low-income patients post-reform and were reimbursed significantly below costs for that care (60 to 70 percent of costs). Including inpatient and outpatient care, NAPH members lose money on treating Medicare patients, so we believe that the need for Medicare DSH will continue after reform has been implemented.

NAPH supports your decision to maintain existing Medicaid DSH payments, too. Medicaid DSH is critical for safety net hospital's financial stability, directly reimbursing uncompensated care expenses and any Medicaid shortfalls. Although we support your use of Medicaid as a building block to reform, we expect shortfalls associated with this program to worsen unless States improve their payment rates. We also urge you to extend the 340B program to the inpatient setting, which should further reduce costs associated with treating this population and provide savings to safety net hospitals and the Medicaid program.

In summary, NAPH strongly supports the approach to both Medicare and Medicaid DSH outlined in the Tri-Committee bill—rejecting arbitrary predetermined cuts in DSH and establishing a thoughtful process by which the DSH programs can be restructured once health reform is fully implemented and only after hospital

losses on the low-income and uninsured populations are substantially reduced. NAPH thanks the Committee for its ongoing support for DSH and its deep understanding of the important role played by safety net hospitals in securing access to care for low-income, vulnerable populations.

Graduate Medical Education

NAPH supports the Tri-Committee bill's multi-pronged approach toward strengthening our health professional workforce, and its clear recognition of workforce development's prominent role in health reform. Our current graduate medical education (GME) infrastructure fails to train an adequate number of primary care physicians. We face impending shortages in many other health professions, particularly nursing (although the nursing crisis has been delayed by the ongoing recession). Large areas of the country remain underserved, and only through gap-filling programs like the National Health Service Corps are we able to ensure that residents in these areas have access to basic medical care.

One pressing need is to train more physicians, particularly primary care physicians. Health care reform may aggravate the need for physicians in certain areas, as seen in Massachusetts where health reform has demonstrated the need for primary care physicians to serve the newly insured. Eighty-five percent of NAPH members are teaching institutions, and their diverse patient populations ensure that physicians training at their facilities learn to deliver culturally competent care and to treat the specialized needs of minority and other vulnerable populations early in their careers.

NAPH was pleased to see that the Tri-Committee bill did not propose funding a coverage expansion with reductions to Medicare or Medicaid GME payments. Rather, your bill strengthens these programs by enabling increased training in the outpatient setting and codifying Medicaid's role in funding GME. Funding for GME activities comes almost exclusively from public payors. Medicare makes direct GME (DGME) payments for direct training costs, including salaries for residents and supervising physicians, and indirect medical education (IME) payments compensate teaching hospitals for the increased cost of providing care in teaching hospitals. Many Medicaid programs include either DGME or IME payments or both to pay Medicaid's share. Private insurance rarely makes specific DGME or IME payments. With little other support for their teaching mission, Medicare and Medicaid GME payments are essential to safety net teaching hospitals.

NAPH urges the Committee to consider expanding the overall number of physicians trained annually. This country suffers not only from shortages of certain types of practitioners, particularly in primary care, but, in many areas, from an overall shortage of practicing doctors. Your proposal to redistribute unused GME positions to fund new primary care positions is a good first step. However, we urge the Committee to consider more sweeping proposals, such as the one introduced by Representative Schwartz, that would increase the overall number of funded GME positions.

Other Medicare Payments

NAPH is pleased that the Tri-Committee bill includes a permanent fix to Medicare physician payments. The current payment system, which requires temporary 'patches' on an annual basis, does injustice to the many physicians who devote their time and energy to treating Medicare beneficiaries.

NAPH urges this Committee to exercise utmost caution prior to making other significant changes to Medicare hospital payments. On average, 23 percent of the inpatient services provided by NAPH members is to Medicare beneficiaries. These patients account for 20 percent of our members' revenues, a significant amount, albeit relatively lower than many other hospitals'. We are concerned that several of the provisions in the Tri-Committee bill may result in significant reductions to Medicare payments. In particular, we are concerned that the proposed productivity adjustment to the market basket increase may result in extremely low payment updates. This adjustment, coupled with CMS' proposal to further reduce inpatient payments over the next 3 fiscal years, may even result in negative payment updates. We also are concerned about the scope of the proposed readmissions policy, and urge the Committee to work with the industry to refine it. We thank you, however, for providing additional support to high-DSH hospitals to address patient noncompliance with discharge instructions.

NAPH thanks you for your monumental reform effort and looks forward to continuing to work with you to see meaningful health care reform happen this year.

Coordinated Care Networks:
Delivery System Reform for Vulnerable Populations

Proposal of The National Association of Public Hospitals and Health Systems

June 3, 2009

I. OVERVIEW OF PROPOSAL

The National Association of Public Hospitals and Health Systems (NAPH) asks the Congress to include in national health reform legislation a provision extending explicit Federal recognition of Coordinated Care Networks (CCNs).

CCNs would be integrated health care delivery systems voluntarily formed by public and private safety net providers. This proposal would provide a needed national framework to recognize integrated, multi-provider networks and systems already developed by safety net providers in many parts of the country, and to develop and extend their "best practices" for care coordination to other communities.

A number of integrated safety net delivery systems have made significant strides toward coordinating care for their vulnerable patient populations, including safety net networks in communities from south Florida to New York City, San Francisco to Richmond, Virginia.

The goals of the proposed CCN program would be multi-faceted:

- To provide support for integrated delivery systems to coordinate the full range of care—from primary care to hospital and post-acute care—to low-income individuals and families, including those who may be newly covered under health reform.
- To provide mechanisms for improving both quality and efficiency of care for such vulnerable patient populations.
- To provide a range of necessary "wraparound" support services for these populations that may not be needed by the rest of the population.
- To provide networks of safety net services for those individuals who may continue to fall through the cracks following implementation of health reform, and
- To provide ways under health reform to continue to ensure the availability of communitywide safety net services, such as emergency and trauma care, needed by everyone.

This proposal should be a companion provision to current delivery system reforms under consideration by Congress, such as Accountable Care Organizations.

II. ELEMENTS OF CCN PROPOSAL

While it is important to provide sufficient flexibility to enable CCN's to be responsive to the specific needs of their communities, the establishment of national guidelines as part of health reform will greatly enhance the ability of such systems to meet the goals set out above.

Networks and CCN Health Plans. Federal law would authorize CCNs to be established (on a voluntary basis) as public or private nonprofit legal entities representing consortia of safety net providers, such as public hospitals, federally qualified health centers, children's hospitals and other providers. CCNs would be eligible to contract directly with various payers under health reform to provide integrated care to their respective enrollee populations. CCNs could also, at their option, choose to offer or develop health plans built around their Network that could contract with Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), and participate in the Exchange.

Federal Criteria. The Secretary would be authorized to develop a set of criteria that a provider network would have to meet in order to be certified as a CCN. NAPH's proposal would link CCN certification to additional support funding (described in the discussion of payment below), providing a significant incentive for existing and new hospital systems to commit to providing a scope of services and incorporating innovations that HHS determines are critical to improving the delivery system for vulnerable patients. Examples of such criteria may include:

Comprehensive Range of Services
Enhanced Support for Primary Care
Coordination Between Primary and Specialty Care
Comprehensive Care Management
Community-Based, Accessible Care
Assurance of Emergency Care
Outreach and Enrollment

Prevention and Wellness Care
Transitional Care
HIT Requirements
Accountability Requirements

Vulnerable Population Focus. The proposed provision would encourage the development of CCNs in communities whose residents include significant numbers of low-income individuals and families and other vulnerable patient populations that suffer from inadequate access to care and disparities in their health status. Potential target populations include: low-income newly insured, residual uninsured, Medicaid and CHIP enrollees, low-income Medicare beneficiaries and individuals who are dually eligible for Medicaid and Medicare.

Comprehensive Range of Services. To receive a Federal CCN designation, CCNs would be required to offer a comprehensive range of primary, specialty and acute care services, as well as support services (such as nutritional counseling, transportation, language services, and other social services), consistent with broad Federal requirements. The precise scope of services would be defined by each CCN and approved by the Federal Government, allowing for variation by CCN and by community to meet local needs. Specialized CCNs might be developed to provide a set of services tailored to meet the needs of specific populations, such as the chronically ill, Medicare-Medicaid dual eligibles, or migrant workers.

Payments for Services. The proposed provision would authorize a range of ways in which payments could be made for services provided by CCNs, which could vary by program and by population. Health Exchange plans could negotiate market rate reimbursement for CCN services they cover, but to the extent that a CCN's federally-approved scope of services exceeds the services covered by a plan, the CCN would receive Federal wraparound payments to provide these noncovered services to Network patients. CCNs would receive case management services payments and could develop innovative payment incentive systems, for example to share in cost-savings with Exchange plans or public payers. FQHCs participating in CCNs would continue to receive FQHC payments from public payers. CCNs also would receive Federal payments to provide services to those who remain uninsured.

Added Value. CCNs would be required to demonstrate their value in a reformed system by participating in quality reporting, quality-based incentive payments and other quality initiatives. Demonstration programs could test innovative payment mechanisms and delivery system designs, with successful demonstrations rapidly expanded and unsuccessful ones terminated.

Start-Up Funding. Direct grants and contracts would be made available for start-up and capital (including HIT) necessary to meet the certification requirements to ensure adequate availability of CCNs.

Creation of a HHS Coordinated Care Network Center. NAPH proposes creation of a Center that would certify CCNs, provide ongoing technical support, share CCN best practice models, and evaluate the effectiveness of the CCN model and related demonstrations.

III. PROJECTED POPULATIONS SERVED

NAPH projects that a range of important populations would be served under this proposal whose needs (and communities) may not otherwise be adequately addressed under health reform.

Those populations could include:

- *Newly insured.* CCNs could ensure continuity of care and sufficient support services so that coverage translates into actual access by contracting with Exchange plans or creating their own Exchange plans. Exchange Plans that receive premium subsidies for low-income enrollees should be required to contract with CCNs operating in their geographic region, unless a CCN declines to participate or places unreasonable conditions upon its participation.
- *Current Uninsured During Transition.* CCNs could serve a critical role in assisting their transition into a reformed health care system by beginning to implement delivery system reforms, providing care management and improving care for these low-income populations.
- *Medicaid and CHIP.* CCNs could serve Medicaid and CHIP populations either as providers or by forming CCN health plans and participating as managed care plans. If these populations are moved into Exchange plans, Medicaid and CHIP programs could also contract with CCNs and CCN health plans for certain wraparound services, such as EPSDT services.

- *Dual Eligibles.* CCNs, in particular those with a specialized scope of services (such as for treating people with chronic disease or long-term care CCNs) could serve as a basis for innovation and experimentation in providing care to the chronically ill in this population.
- *Medicare.* CCNs could continue to serve Medicare patients as a unique provider type and CCN health plans could participate in the Medicare Advantage program. CCNs could also play a role in bringing the uninsured who would qualify for any temporary Medicare buy-in into the health care system and providing critical care coordination for this population known to suffer from a higher burden of multiple chronic diseases.
- *Remaining Uninsured.* CCNs could be a vehicle to provide cost effective, affordable care to the remaining uninsured after reforms are fully implemented and to provide continuous care to those who cycle on and off coverage due to administrative obstacles or for other reasons.