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COMPREHENSIVE HEALTH CARE REFORM DISCUSSION DRAFT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

JUNE 23, 24, & 25, 2009

Serial No. 111–54

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COMPREHENSIVE HEALTH CARE REFORM DISCUSSION DRAFT, DAY 1

TUESDAY, JUNE 23, 2009

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 9:39 a.m., in Room 2123, Rayburn House Office Building, Hon. Frank Pallone, Jr., [chairman of the subcommittee] presiding.

Present: Representatives Pallone, Dingell, Green, DeGette, Capps, Schakowsky, Baldwin, Matheson, Barrow, Matsui, Christensen, Castor, Sarbanes, Murphy of Connecticut, Space, Sutton, Deal, Whitfield, Murphy of Pennsylvania, Burgess, Blackburn, Gingrey, and Barton (ex officio).

Staff Present: Karen Nelson, Deputy Committee Staff Director for Health; Purvee Kempf, Counsel; Sarah, Despres, Counsel; Jack Ebeler, Senior Advisor on Health Policy; Robert Clark, Policy Advisor; Tim Gronniger, Professional Staff Member; Stephen Cha, Professional Staff Member; Allison Corr, Special Assistant; Alvin Banks, Special Assistant; Jon Donenberg, Fellow; Camille Sealy, Fellow; Karen Lightfoot, Communications Director, Senior Policy Advisor; Caren Auchman, Communications Associate; Lindsay Vidal, Special Assistant; Earley Green, Chief Clerk; Jen Berenholz, Deputy Clerk; Miriam Edelman, Special Assistant; Ryan Long, Minority Chief Health Counsel; Chad Grant, Minority Health Counsel; Brandon Clark, Minority Professional Staff; and Aarti Shah, Minority Health Counsel.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. The hearing of the Health Subcommittee is called to order. And I will start by recognizing myself for an opening statement.

Today we are meeting to examine a discussion draft on comprehensive health reform. The subcommittee will also convene to receive testimony tomorrow and Thursday.

In addition, the full committee will meet tomorrow morning to hear from the Secretary of Health and Human Services, Kathleen Sebelius.

Comprehensive health reform is a goal that has alluded reformers, Democrats and Republican alike, for over a century. As a result, the problems that plague our healthcare system have contin-

ued to grow worse. The ranks of the uninsured continue to swell. The cost of insurance and medical care continues to skyrocket. The quality of care delivered becomes more and more erratic.

After years of failing to address these problems, we find ourselves in a situation where our broken health care system is a clear and present danger, in my opinion, to the economic health of this nation. Government budgets are being overrun by the mounting costs of health care, crowding out funding for other key services. American businesses are disadvantaged as they try to compete in the global marketplace, and American families are being driven into bankruptcy by ballooning medical debt or forgoing critical care altogether.

President Obama understands that these problems require urgent action, which is why he has called upon Congress to pass comprehensive health reform legislation this year. And health reform is an issue that generates great interest and controversy. That certainly we know. And while we may not all agree on a common solution, I think we also know that we can't let this opportunity pass us by.

Maintaining the status quo and allowing these problems to continue to fester is no longer an option. Nor can we simply resign ourselves to making marginal improvements as we have done in the past. The time has come for comprehensive reform, and the discussion draft we are reviewing this week is a starting point for that debate.

The discussion draft envisions a world where every American family has access to affordable and quality health coverage. Those who are currently unable to access coverage through our public programs, employers or the individual market will now be able to do so through a reformed insurance marketplace that guarantees access, quality and affordability. People who already have health coverage will be able to keep their coverage and their choice of doctors.

But health reform isn't just about improving coverage and access; it is also about improving the public health. Too many people are suffering from preventible illnesses and conditions, such as cardiovascular disease, respiratory diseases, and obesity-related illnesses. Accordingly, we must change the way we think about medical treatment by focusing on preventive care, as well as the quality of care being given. And this discussion draft aims to do just that.

There are a lot of other important details about the discussion draft that I am not mentioning, which I hope will be explored over the course of the next 3 days. I just want to speak directly to those who will stand in opposition to our efforts. For those who have legitimate concerns with the draft, I simply urge you to talk to us about your ideas. We want to work with those of you who are truly interested in being constructive participants in enacting health reform this year. But for those who stand in opposition simply for opposition's sake, I urge you to rethink your position. After a century of inaction, the American people want to see change. They want to see health reform enacted, and we intend to deliver it to them. Thank you.

And now I will yield to our ranking member for the day, the gentleman from Texas, Mr. Burgess.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. Thank you, Mr. Chairman.

It seems like I have been waiting my entire career for just this time. I gave up a 25-year medical practice to run for Congress, and I didn't do so to sit on the sidelines with really what could be the biggest change in our system since the enactment of Medicare almost 45 years ago.

And here we are this morning calling up 10 panels to walk us through a legislative proposal released late last week, and it is pretty skimpy on some of the details. Now, I recognize what a draft is, and I understand that a draft means that everything is not completed, but for a draft that mentions "fee" 54 times, "tax" 58 times and "penalty" 98 times, isn't it odd that we have nothing as pertains to financing this legislation?

So, Mr. Chairman, will we have a legislative hearing on the actual bill that this committee might markup when that bill becomes available? I feel like we ought to emphasize the care part of health care, and this debate continues to be defined by two words, "cost" and "coverage." Yet we need to know how many people are covered under this proposal, or how much it will cost, or how we are going to pay for it.

Mr. Chairman, will you commit that we will at least have a CBO score on the bill that we will mark up, since we do not have one on this bill?

Now, everyone if the CBO were here to testify, which they are not, will they be able to tell us how much this bill will cost in the outyears? Every change in the Tax Code, every cut in spending that achieves savings only gets us out 10 years. From there on out, it will mean Congress will be having to find tens of billions of dollars a year to keep whatever program we enact, to keep that going.

And most importantly, as I said, coverage does not equal access. What does this bill do for patients? What does this bill do to ensure that we will have an adequate supply of physicians?

Now, Mr. Chairman, the President said in his break out— after one of the break out sessions last March, that he wanted to find out what works. He said it again at the American Medical Association last week. I applaud him for having an open mind. I wish this committee, I wish this committee had the same type of open mind.

You just said you want to work with people who are willing to work with you. Why, then, Mr. Chairman, have we been excluded from the drafting of this bill only to receive it, again, late last week and in a very incomplete form?

Now, I was hopeful and I am still hopeful that we can write a bipartisan bill. Since no Republican has been consulted thus far, the totality of this bill, I think that is a disservices to our constituents. I think that is a disservice to Americans.

Mr. Chairman, we do stand ready to work with you when it is possible; and when it is not, we stand ready to try to educate you where you are wrong. And that is what this process should be about. But it should be done in the arena in the full light of day and not behind closed doors in the dark of night. That is how our constituents are best served. That is how the American people are

best served, and certainly for America's patients and doctors, we should do no less.

I would yield back the balance of my time.

Mr. PALLONE. Thank you.

May I just mention, Dr. Burgess was sitting in as the ranking member, so I gave him the 3 minutes or close to it. But because we want to hear from the witnesses today and we have so many, I am asking members to try to limit their remarks to 1 minute today.

Hopefully you got notification of that, because remember, not only the Health Subcommittee members are able to participate today; any member of the Energy and Commerce Committee is able to give an opening statement or participate. So that is why we limited it to 1 minute.

Next is the gentlewoman from Colorado, Ms. DeGette.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thank you, Mr. Chairman.

I will just point out to my friend from Texas, here we are in the light of day, and we are going to have 3 days of hearing on this draft.

And I want to thank you, Mr. Chairman, for doing that.

This is a monumental undertaking, and it is going to take everybody's wisdom and advice. I want to talk about a couple of things that we all care about in this bill. I think we are all going to have to do that today because it is such a comprehensive bill.

First of all, automatic enrollment of newborns into Medicaid will ensure that all children have access to necessary immunizations and well-child visits during the first and most important year of life.

Secondly, primary care workforce incentives and training programs, like student loan repayments and higher reimbursements for primary care, will help with the workforce we need.

And finally, a strengthened infrastructure for health care quality will let us pay—let us identify and track key health indicators.

I want to agree with you for the need for prevention, and I just want to close by saying, we are either going to pay now or we are going to pay later, and I suggest we focus on Americans' health.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you.

The gentleman from Georgia, Mr. Gingrey.

OPENING STATEMENT OF HON. PHIL GINGREY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. GINGREY. Thank you, Mr. Chairman.

Mr. Chairman, I want to ensure that every American has quality health care.

Unfortunately, this legislation will do nothing but ensure that millions of Americans lose the coverage they currently have. By including a government health plan and a mandate that every American purchase health insurance, this bill guarantees that the only

insurance plans available to Americans and businesses are those that are designed and sold by government bureaucrats.

For those that argue that the government plan will merely compete, studies have shown that such a plan will drive out competition and indeed become a monopoly.

This, the bill before us argues, is the responsible thing to do. By way of government-made products, mandates, taxes and partisan politics, this legislation will take quality market-driven health insurance away from millions of Americans and lead inexorably to a single-payer national health care system.

We can do better, Mr. Chairman. The minority party has some well-studied ideas for improving the affordability, the access and availability of health care.

So far, the majority party in the House has turned a deaf ear toward working in a bipartisan manner. For the sake of the American people and those patients I cared for, for over 30 years, I urge you to listen carefully to all voices, and I yield back.

Mr. PALLONE. Thank you.

Vice Chair of the subcommittee, the gentlewoman from California, Mrs. Capps.

OPENING STATEMENT OF HON. LOIS CAPPS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mrs. CAPPS. Thank you, Chairman Pallone.

And thank you, Chairman Waxman and Chairman Emeritus Dingell, for your excellent leadership and the hard work that you and your staffs have put into this draft legislation.

As a nurse turned Congresswoman, this debate is one I have waited for, for a very long time. We have had many hearings on this topic, bipartisan hearings, and I thank you for that opportunity, that it really, truly is coming from all the people we represent.

Our Nation's health care system is in shambles, and with legislation, we will finally take the most important steps we can to fix it. We will put the emphasis on wellness instead of just illness. We will give patients greater choice and protection in the health insurance market. We will make sure that everyone has access to the care they need and deserve.

It is going to take a long time, some difficult choices, and perhaps a few pennies to get it underway. But we must act, and we must act now. The price of inaction is simply too high. I look forward to this coming week and the discussions we will have on how to perfect this legislative proposal.

I yield back.

Mr. PALLONE. Thank you.

The gentlewoman from Tennessee, Mrs. Blackburn.

OPENING STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Mrs. BLACKBURN. Thank you, Mr. Chairman.

As I have said so many times in this committee, what is on the table for us to consider is in essence the Tennessee TennCare experience all over again. And for those of you who do not know, that

was Tennessee's attempt at an executive order program of the Governor's Office. This was their attempt at Medicaid managed care. The plan, that plan is what our Democrat Governor in Tennessee recently called, and I am quoting him, "a disaster."

Eventually that program consumed every single penny of new revenue in our State. I was a State Senator tasked with funding that program. That program nearly bankrupted the State of Tennessee. It is not a model for future success. It is a model for a looming fiscal disaster.

And I have no clue who the majority thinks is going to pay for this thing. I have no idea where they think they are going to get the money for this. Let me tell you, go look at the 10 care records. We cannot afford this program. There is no money to pay for it. You cannot borrow enough money to pay for this program.

In Tennessee, we know that this public option always costs more than initial projections. Cost overruns were through the roof. Patients are always going to choose free rather than out-of-pocket care. Employers will force their employees onto the system. That is why you are going to see more than 120 million Americans moving off of private insurance if this goes through. Sound the alarm bell. This is not——

Mr. PALLONE. The gentlewoman, I just wanted you to know you are a minute over.

Mrs. BLACKBURN. Mr. Chairman, I thank you for that, and I think this is an incredibly serious situation. And I thank you for your patience.

Mr. PALLONE. Thank you.

I am trying to keep people to a minute. I am not going to stop you if you go a little over.

Mrs. BLACKBURN. It is fine. I apologize.

Mr. PALLONE. All right.

The gentleman from Utah, Mr. Matheson.

OPENING STATEMENT OF HON. JIM MATHESON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF UTAH

Mr. MATHESON. Thank you, Mr. Chairman. I will do my best with a minute.

We use the terms cost, access and quality a lot around here, but we really do need to focus on all three. That is what we are trying to do here. I think this is the most complex piece of legislation we are going to work on in our careers. And just maintaining the status quo is not an option. Our health care system is driving up costs in a way, both the public sector and the private sector. We can't sustain the path we are on.

I fear this discussion has focused so much on access, we are not also looking at the unproductive system we have now. There is so much money in our health care system today that is spent in irrational ways. There are so many perverse incentives built into our health care system. And if we want to achieve what our President has asked us to do, which is to bend the curve, the cost curve, the plots where costs are going, if we want to achieve that, that is where we can really accomplish something as a group.

So I encourage this committee, as we look at this legislation, to look for ways to make our health care system more efficient, get

rid of perverse incentives. And if we do that, I think we will secure a better future regardless of how we structure the plan.

Thanks, Mr. Chairman. I yield back.

Mr. PALLONE. Thank you.

The gentleman from Pennsylvania, Mr. Murphy.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY OF PENNSYLVANIA. Thank you, Mr. Chairman.

And I am thankful we are finally moving forward on this. Certainly there is not a member in this room on either side of the aisle, no matter what one's political leanings, who is not totally dedicated to reforming our health care system as many of our witnesses are, too.

The question is, which direction? From the time I arrived in Congress in 2003 and through my time before as a State senator, I focused my energies on trying to reform this system. Just on the issue of hospital-borne infections alone since I have been in Congress, 350,000 people have died, hundreds of thousands more from other errors. And we have spent hundreds of billions of dollars in wasted health care.

Our current system of $2.4 trillion wastes about $700 billion a year. Our Medicare and Medicaid system are filled with problems. We need to address those first. But don't take my word for it. Take Members of Congress's word for it. In the 110th Congress, 452 bills were brought forward by Members of Congress to reform Medicare and Medicaid. Members of Congress signed up to cosponsor those 452 bills 13,970 times.

Members of Congress think we have trouble if the Federal Government is going to run a health care system. We are not there. A bill that looks at who pays for premiums and co-pays is not health care reform. A bill that looks for taxes to pay for these things is not health care reform. A bill that reduces costs by reducing payments to physicians and hospitals is not health care reform.

We have to reform that system. We have the talent and the ability to do that. And I hope that as we progress in the coming weeks on this health care reform system, we truly can look at focusing on outcomes and not quantity and really make health care more affordable and accessible for millions of Americans who right now can't afford it.

Thank you. And I yield back.

Mr. PALLONE. Thank you.

The other gentleman from Georgia, Mr. Barrow.

Mr. BARROW. I will waive an opening.

Mr. PALLONE. The gentlewoman from the Virgin Islands, Mrs. Christensen.

OPENING STATEMENT OF HON. DONNA M. CHRISTENSEN, A REPRESENTATIVE IN CONGRESS FROM THE VIRGIN ISLANDS

Mrs. CHRISTENSEN. Thank you, Mr. Chairman.

And I want to begin by using this opportunity to recognize the fair and open way in which the Chair Emeritus Dingell, Chairman

Waxman and you, Chairman Pallone, have conducted the process of getting us to this point today and to thank you and your staff.

The bill acknowledges that insurance is not enough and takes steps to promote prevention and wellness, to expand services and to eliminate health disparities. We appreciate and applaud your efforts.

But if we are to truly transform our system, we will continue to push the committee to go further. One specific area where more progress is needed is in the treatment of the territories. Just as we will willingly and proudly fight and die in every war and conflict in defense of our Nation, we believe that we deserve the same access to health care as every other citizen and legal resident of the United States. We understand "universal health care" to mean universal health care.

And finally, I believe that the health and well-being of every person living in this country is important enough and vital enough to our Nation's productivity, competitiveness, strength and leadership that passing a meaningful and effective health care reform bill should not require an immediate offset for every provision. Prevention saves. It saves lives first of all, and it saves money as well.

Thank you, and I yield back.

Mr. PALLONE. Thank you.

The gentleman from Ohio, Mr. Space.

OPENING STATEMENT OF HON. ZACHARY T. SPACE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. SPACE. Thank you, Mr. Chairman, for your time and your tireless work on behalf of American consumers.

We stand before a debate so historic and significant that it arises but once every several generations, and that stake is an issue of no less importance than the health of the American citizen, along with the health of the American economy. For, even though we boast of the most sophisticated health care, technology, and talented health care professionals in the world, their services are often out of reach of the average working American.

Today I offer three areas of critical importance where improvements must be made. First, we must grow and nurture our rural health care workforce to ensure the same quality of care is offered to all residents of this country regardless of where they reside.

Second, we must make quality affordable health care a reality for every resident of this country by making reforms that capture the power of the free market, harnessing what is best about market forces.

And third, we must change how we treat chronic diseases, taking more steps to encourage prevention and managing care of those that they afflict. An investment on the front end will only result in a higher quality of life for those who suffer from chronic diseases and cost savings of billions of dollars to our health care system.

Just as history has judged our efforts to battle for democracy abroad and put men on the moon, we, too, shall be judged for our response to this critical moment in history. We truly cannot afford to fail.

I yield back.

Mr. PALLONE. Thank you.

The gentlewoman from Illinois, Ms. Schakowsky.

OPENING STATEMENT OF HON. JANICE D. SCHAKOWSKY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Ms. SCHAKOWSKY. Thank you, Mr. Chairman, for moving us closer to getting where we all want to be, and that is the goal of comprehensive reform of our health care system.

I want to thank Chairman Waxman and Chairman Emeritus Dingell who have provided wonderful leadership.

This is a historic moment. Americans are counting on us for guaranteed access to affordable quality health care and we have to ask now—act now. People are forgoing care, families are falling into bankruptcy, businesses are struggling to make ends meet. I want to focus on two provisions.

First and most important, the public health insurance option. Consumers need a real choice, and the insurance market needs real competition. A robust public option provides both. It is essential to meaningful reform.

Second is the inclusion of the nursing home quality and transparency act no-cost legislation, which as the title says, will improve quality and transparency, helping nursing home residents and their families. There are so many important provisions in this bill and I look forward to moving it and at long last creating an American health care solution that meets America's health care needs. I yield back.

Mr. PALLONE. Thank you.

The gentleman from Texas, Mr. Green.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Mr. Chairman.

I want to thank you for holding this series of hearings on the health reform discussion draft. I am pleased we are starting the process on addressing the issues facing the 47 million uninsured individuals in our country. There is a lot of good things in the discussion draft that I know we will hear about and we will talk about over the next few days.

One of the issues that I would like to point out is something I have been working on with a number of members on our committee that the discussion draft doesn't include, the elimination or the—over a period of years, the 24-month disability waiting period for disabled individuals under 65 for Medicare. Unfortunately, once again, we leave these individuals out in the cold. Currently 1.8 million individuals are stuck in a 24-month waiting period. Of those individuals, 39 percent are uninsured, and 13 percent will die before they endure that 2-year wait.

Congress deliberately created the waiting period in 1972 to keep Medicare costs down. And I believe the 24-month waiting period is a shameful example of how we refuse to cover disabled individuals whose medical treatment is deemed too costly. I sponsored ending the Medicare disability waiting period for 5 years, and each year, we were unable to move the bill because it is too expensive. And again in this draft, we refuse to address the issue. So the reform

drafts would allow some of the individuals to obtain a government subsidy to purchase insurance through the exchange. And if they live through the 24-month waiting period, once they receive their disability determination, they can then switch to Medicare.

Why would we want disabled and chronically ill switching insurance coverage and possibly switching physicians? And I am not sure the exchange will provide these disabled individuals of the complex medical treatment and coverage for equipment that they need. And I strongly urge the committee not to push aside those who endure that 24-month waiting period, even after you wait to get a disability determination from Social Security just for monetary concerns. We can eliminate that waiting period over a period of years and show that we do recognize the problems the disabled have.

And I yield back my time.

Mr. PALLONE. Thank you.

The gentlewoman from Wisconsin, Ms. Baldwin.

OPENING STATEMENT OF HON. TAMMY BALDWIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

Ms. BALDWIN. Thank you, Mr. Chairman.

And thank you to our witnesses for being here today. We have before us what is an amazing accomplishment, the work of many years of research and analysis and a collaborative effort of this diverse committee. It is difficult to overstate the importance of our task. We have been in this position before, but this time we simply must succeed.

As President Obama said earlier this year at our Joint Session, health care reform must not wait; it cannot wait, and it will not wait another year. As we debate the details and the intricacies of this draft, I want to be sure that we remember the people, the children and the families that are waiting with great hopefulness for us to act. Our country is suffering under this growing burden, and it is our responsibility to answer their call.

I am very pleased to see that this draft includes a public health insurance option. I have been unwavering in my support for this aspect of reform, and I believe that this plan will lead the way for reforming our delivery system, emphasizing prevention and paying for quality.

I have a few suggestions for improvement to the bill, but I look forward to working with my colleagues on moving this forward.

Thank you again, Mr. Chairman. I yield back the remainder of my time.

Mr. PALLONE. Thank you.

The gentlewoman from California, Ms. Matsui.

OPENING STATEMENT OF HON. DORIS O. MATSUI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. MATSUI. Thank you, Mr. Chairman. I want to thank you, Chairman Waxman, Chairman Emeritus Dingell, on the excellent work to get this crucial legislation to where it is today.

I am particularly pleased with Section 2231 and Section 2301 of the draft bill. These sections build off legislation I wrote to create a public health workforce corps and to centralize prevention spending in a wellness trust fund. Public health and prevention are critical aspects of a strong health care system. They must be part of our national strategy to control health care costs, create better health outcomes for people, and ensure that the health care system works for all Americans.

Without public health and prevention, we will never drive down health costs, nor will we move our society from one focused on treating sickness to one that promotes wellness and healthy living. I urge my colleagues to support these critical components of the draft bill before us today, and I yield back the balance of my time.

Mr. PALLONE. Thank you.

STATEMENTS OF RALPH G. NEAS, CHIEF EXECUTIVE OFFICER, NATIONAL COALITION ON HEALTH CARE; RICHARD KIRSCH, NATIONAL CAMPAIGN MANAGER, HEALTH CARE FOR AMERICA NOW; AND STEPHEN T. PARENTE, PH.D., DIRECTOR, MEDICAL INDUSTRY LEADERSHIP INSTITUTE

Mr. PALLONE. The committee will now receive testimony from the witnesses. And I will call up our first panel. Let me introduce each of them at this time if I could. Starting on my left is Ralph G. Neas, who is chief executive officer of the National Coalition on Health Care. Next to him is Richard Kirsch, who is national campaign manager for Health Care For America Now.

Good to see you.

And then we have Dr. Stephen T. Parente, who is director of the Medical Industry Leadership Institute.

And this panel is on health reform coalition views. I am going to ask each of you to give a 5-minute statement. Of course, your full statement becomes a part of the record. And then when you are done, we will start having questions for the panel.

And we will start with Mr. Neas. Thank you for being here.

STATEMENT OF RALPH G. NEAS

Mr. NEAS. Chairman Pallone and Ranking Member Burgess and members of the full committee and subcommittee, thank you so much for the opportunity to appear before you on this momentous occasion, day one of hearings to discuss the House Tri-Committee Health Care Reform Discussion Draft.

I am pleased and proud to be joined by the founder, the visionary founder, and president of the National Coalition on Health Care, Dr. Henry Simmons, who is sitting right behind me. Among many other things, Dr. Simmons was the deputy assistant secretary to President Richard Nixon for health in the early 1970s.

The National Coalition on Health Care is honored to be here and heartened by the progress made by the three committees. We hope that this draft bill can serve as the springboard for comprehensive and sustainable health care reform. Like you, we believe that the time for action is now, this year.

Reform of our health care system is a vital condition precedent for fixing the nation's faltering economy. The fiscal crisis facing us cannot be addressed successfully without the simultaneous over-

haul of our health care system. America is on a dangerous path to sharp increases in the cost of health care and the numbers of uninsured and underinsured Americans to unsustainable burdens on our economy and on Federal and State budgets, and to indefensible, avoidable harm to millions of patients and massive waste from substandard and uncoordinated health care.

The rigorously nonpartisan National Coalition on Health Care is the Nation's oldest, broadest and most diverse alliance of organizations working for comprehensive health care reform. The coalition's 78-member organization stands for more than 150 million Americans.

The Coalition's five basic principles for health care reform, coverage for all; cost containment; improved quality and safety; simplified administration; and equitable financing, are interdependent. We believe reform, to be effective, must address all of these issues in a systemic way that recognizes their interconnectedness.

After more than 18 months of deliberations, the Coalition developed a set of principles and specific recommendations. I would ask that they be included for the record, along with my written statement. As the Coalition operates on the basis of consensus, we have begun an expedited process of discussing the provisions of the draft bill with our members. Only as these internal consultations progress will we be able to provide more detailed views and consensus recommendations regarding optimal formulation of the final bill.

However, let there be no doubt that the Coalition strongly commends the cross-jurisdictional collaborative tri-committee effort to address the central challenges facing our Nation in health care, specifically how to slow the growth of health care costs; how to extend coverage to Americans without health insurance; and how to improve the quality of care and the efficiency with which it is delivered.

The draft is appropriately ambitious in its scope and its recommendations. We believe that reducing costs while expanding coverage not only can be done but must be done. Now is the time to be pragmatic and bold, to keep what is good and to fix what is broken in our Nation's health care system. We must come together to pass systematic reform that sets our Nation on a better path toward affordable, high quality care for all Americans and solid fiscal responsibility.

The Coalition members have long believed that securing coverage for all Americans should incorporate a range of mechanisms, including responsibilities for individuals and employers; the expansion of existing public programs, such as Medicare and Medicaid; information and framework to improve competition among private insurance plans; and the creation of an additional and carefully designed public option.

The Coalition would encourage consideration be given to adding detail to the definition of the service to be covered in an essential benefits package. Many of our members would want us to emphasize the importance of calibrating the revisions regarding the public option to make sure that it would function as the drafters clearly intend on a level playing field with other plans.

We applaud the inclusion of a wide range of measures to improve the efficiency of health care liberally while enhancing the quality and safety of care and also providing support for evidence-based prevention. Escalating health care costs puts health care coverage out of the financial reach of tens of millions of Americans and their employers. Thus we suggest consideration of the use of short-term regulatory constraints to slow the pace of increase in the cost of essential coverage.

The Coalition applauds the chairman for the leadership. The enormous added momentum your joint efforts have given to the reform process cannot be overstated. Indeed, this is truly an extraordinary moment in history. Too much is at stake for us to risk failure due to partisanship. It is only through a commitment to shared responsibility and shared sacrifice that we can rise to meet this once-in-a-generation opportunity to develop an achievable and uniquely American solution. To protect the generations to come, let us work together to enact health care reform that is at once moral and fiscally sound.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Neas follows:]

Statement of
Ralph G. Neas
Chief Executive Officer
National Coalition on Health Care
Before the
Committee on Energy and Commerce
Subcommittee on Health
United States House of Representatives
Washington, D.C.
June 23, 2009

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I.

Chairmen Waxman and Pallone, (Chairman Emeritus Dingell), Ranking Members Barton and Deal, and Members of the Subcommittee, thank you for the opportunity to appear before you on this momentous occasion -- Day One of hearings to discuss the House Tri-Committee Health Care Reform Discussion Draft. We are honored to be here today and heartened by the progress that this joint effort represents. We hope this unprecedented cooperative proposal for health care reform developed by the Energy and Commerce, Ways and Means, and Education and Labor Committees serves as the urgently needed springboard for finally achieving comprehensive and sustainable health care reform.

Like you, the President, and the Chairman of the Federal Reserve Board, we believe that the time for action is now — this year. Reform of America's health care system is a fundamental condition precedent for fixing our nation's faltering economy. The economic crisis facing us cannot be addressed successfully without the simultaneous adoption of a comprehensive, sustainable overhaul of America's health care system. America is on a dangerous path to sharp increases in the costs of health care and the numbers of uninsured Americans, to unsustainable burdens on our economy and on federal and state budgets, and to indefensible, avoidable harm to millions of patients and massive waste from sub-standard and uncoordinated health care.

II.

For over three decades, the Coalition's founder and President, Dr. Henry E. Simmons, has fought tirelessly for system-wide reforms to control health care costs and to ensure high-quality, affordable health care for all Americans. Dr. Simmons and the Coalition's Executive Vice President and chief policy advisor, Mark A. Goldberg, are here with us today.

The rigorously non-partisan National Coalition on Health Care -- co-chaired by former Governor Robert Ray, a Republican from Iowa, and former Rep. Bob Edgar, a Democrat from Pennsylvania -- was founded in 1990 and is the nation's oldest and broadest alliance of organizations working for comprehensive health care reform. The Coalition's 78 -- and counting -- member organizations include large companies and unions, pension funds, insurers, associations of health care providers, teaching hospitals, faith-based groups, disability and patient advocacy organizations, higher education councils and small business groups. Collectively, these member organizations stand for more than 150 million Americans.

The Coalition's five basic principles for health care reform – coverage for all, cost containment, improved quality and safety, simplified administration, and equitable financing – are interdependent. We believe reform must address all of these issues in a systematic way that recognizes their interconnectedness. After more than 18 months of deliberations by our members, the Coalition developed a set of recommendations – what we have termed specifications for reform -- that are appended to the Coalition's written statement. I would ask

that the full summary of the Coalition's principles and specifications be included for the record along with our complete written statement.

The Coalition's five principles for reform and specifications frame our discussion with you today. Also, it is important to note that the Coalition operates on the basis of consensus among its members. Yesterday, we began an expedited process of reviewing and discussing the provisions and particulars of the Tri-Committee Discussion Draft with our members. As these internal consultations progress, we will be able to provide more detailed views and consensus recommendations regarding optimal formulation of the bill.

However, at this critical juncture, let there be no doubt that the Coalition strongly commends the cross-jurisdictional, collaborative Tri-Committee effort to address the central challenges facing our nation in health care:

- How to slow the growth of health care costs,
- How to extend coverage to the growing number of Americans without health insurance, and
- How to improve the quality of care and the efficiency with which it is delivered.

The Discussion Draft is ambitious in its scope and its recommendations -- and, we think, very appropriately so. We believe that reducing costs while expanding coverage not only can be done, but must be done, and that doing so is essential both to providing health care to all and to revitalizing our Nation's economy. Now is the time to keep what is good and to fix what is broken in our nation's health care system. It is not a time for timid, half-way measures or self-

serving posturing. This is the time to come together to pass sustainable comprehensive reform that sets our nation on a better path: toward affordable, high-quality care for all Americans and fiscal responsibility.

Our members have long believed that the strategy for securing coverage for all Americans can and probably should incorporate a range of mechanisms, including responsibilities for individuals and employers; the expansion of existing public programs, such as Medicaid and Medicare; information and a framework to improve competition among private insurance plans; and the creation of an additional, and carefully designed, public option.

We are pleased that the Discussion Draft reflects an unswerving commitment to covering the uninsured and precisely this sort of pragmatism about how to go about it.

In addition, we would encourage you to consider adding more detail to the definition of the services to be covered in an essential benefits package. Many of our members would want us to note the importance of calibrating the provisions regarding the public option to make sure that it would function, as the drafters clearly intend, on a level playing field with other plans.

We applaud the drafters for including a wide range of measures to improve the efficiency of health care delivery while also enhancing the quality and safety of care and providing support for evidence-based prevention. Escalating health care costs put health coverage out of the financial reach of tens of millions of Americans and their employers. In addition, as the Chairman of the Federal Reserve Board and the President's Council of Economic Advisors have recently noted,

these surging costs inhibit economic growth, suppress wage increases and living standards, and undermine the competitiveness of American firms in global markets. We would urge the addition to your armamentarium of cost-containment strategies the use of short-term regulatory constraints to slow the pace of increase in the costs of essential coverage.

III.

The House Tri-Committee Discussion Draft is an excellent beginning and charts a course for enactment of the health care reform that our nation urgently needs. We applaud the Chairmen for their leadership and their deep appreciation for the fact that our present system is both inequitable and unsustainable.

This truly is an extraordinary moment in history. Too much is at stake -- the health and well-being of millions of American families and the future of our Nation's economic and fiscal health -- for us to risk failure due to partisanship. It is only through a commitment to shared responsibility and shared sacrifice that we can rise to meet this once-in-a-generation opportunity to formulate a pragmatic, achievable and uniquely American solution. In order to protect the generations to come, we must work ceaselessly now to enact reform that is at once moral and fiscally sound.

We appreciate this opportunity to offer our initial response to the Discussion Draft and look forward to helping formulate changes to strengthen the proposal before the bill is brought to the floor next month. Again, we and our members thank and commend the Committee and

Subcommittee and your colleagues on the House Ways and Means and Education and Labor Committees for the enormous added momentum your efforts have given to the reform process.

Building a Better Health Care System

SPECIFICATIONS FOR REFORM

National Coalition on Health Care

What Must Be Done

SPECIFICATIONS FOR REFORM

The Coalition's specifications for reform reflect a consensus among our member organizations. Before turning to the specifications themselves, we would make three points:

Health care reform must be a national priority.

Comprehensive health care reform is long overdue. Every year that reform is delayed, tens of millions of Americans live in peril, without health insurance; millions are harmed, and hundreds of thousands die needlessly, because of sub-standard care; and health care costs continue to spiral ever upwards.

The Coalition's specifications are meant not just to encourage and help to frame a national debate about health care reform, but to create momentum for the passage of legislation. These specifications are an expression of operational intent: Our member organizations are determined to work with other organizations and with policymakers in both parties to secure the reforms described here. Yes, we need a vigorous debate about health care policy — but what we really need is action, and soon.

Health care reform must be systemic.

The Coalition's specifications were developed not as a shopping list of potential stand-alone initiatives, but as a linked series of targets, criteria, and options — meant to be adopted concurrently and to work together.

The vast American health care sector is exquisitely and elaborately interconnected. Partial or piecemeal reforms, even those conceived and implemented with the best of intentions, can produce unanticipated adverse consequences far from the focus or locus of those targeted reforms.

For example, a dramatic expansion of access, implemented without accompanying measures to improve quality and manage costs, could produce an overloaded health care system that delivers worse care (albeit to more people) at higher costs. Similarly, constraints on costs (and reimbursements for care), pursued in isolation, could compromise both access and quality.

A system is a set of institutions and processes that function together to achieve defined objectives. The Coalition's specifications were designed to serve multiple goals simultaneously. We began our development of recommendations by agreeing on five core principles for reform (which appear below as section headings for our specifications). Then, as our deliberations proceeded, we continuously revisited and recalibrated our recommendations to make sure that the individual components fused together into a sensible systemic strategy.

We believe that a systemic approach can increase not only the substantive coherence of

reform, but also its political feasibility. Thus, if constraints on health care cost increases were proposed in isolation, providers might understandably anticipate that their revenues going forward would be diminished. By contrast, if those same constraints were conjoined in a systemic strategy with an assurance of coverage for all Americans and financing for their care, providers would receive payment for care that they now provide, with little or no compensation, to uninsured patients.

Health care reform must be system-wide.

The Coalition is calling for system-wide reforms, not for changes that would apply to only some payers, patients, or providers. Unless reform is system-wide, gains in some sectors or for some groups are likely to be offset by losses elsewhere.

There is, in addition to this practical consideration, another compelling argument for making certain that reform is system-wide. America is already a nation of health care haves and have-nots. Reform should aim to assure that all Americans receive excellent health care and are able to enjoy the quality of life and peace of mind for which such care is essential. Piecemeal reform that helps some categories of people to the detriment of others would not take us closer to an optimal health care system and could actually make it harder to attain.

We should move forward together. Let us begin by specifying where we want to go:

PRINCIPLE 1

Health Care Coverage for All

Every American* should have health care coverage, as defined below, and access to the services covered. Participation should be mandatory. The goal of health care coverage for all Americans should be achieved within two to three years after the passage of enabling legislation. We recognize that this is an ambitious timetable, but lives, and the quality of lives, are at stake.

Coverage should encompass medically necessary, comprehensive care, including emergency care, acute care, prescription drugs, early detection and screening, preventive care, care for chronic conditions, and end-of-life care. Pre-existing conditions should not be excluded from coverage. The details of the core benefit package, within each of the categories noted, should be consistent with best medical practices and should be adjusted over time, as science and technology advance and as the understanding of best practices evolves. Enrollees should be guaranteed the right to timely appeal of denials of coverage for particular services — first through internal review processes and then through independent external review processes.

Individuals or their employers should be able to purchase supplemental coverage — that is, coverage beyond the core benefit package.

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* We recognize that a more precise delineation of the application of this principle would require the consideration of issues — regarding immigration policy and its enforcement — beyond the ambit of our deliberations about health care reform. In light of the importance of health care and, therefore, health care coverage as predicates and safeguards for physical and financial well-being, we hope that policymakers will be more, rather than less, inclusive.

The Coalition has identified a range of viable options for insuring all Americans:

- employer mandates (supplemented with individual mandates as necessary).
- expansion (and perhaps consolidation) of existing public programs that cover subsets of the uninsured (such as the State Children's Health Insurance Program).
- creation of new programs targeted at subsets of the uninsured.
- establishment of a universal publicly financed program.
- Legislation incorporating any, or a combination, of these mechanisms
- should include adequate subsidies for those who are less affluent.
- should assure continuity of coverage for those who move from one form or context of coverage to another.
- should facilitate enrollment by all those eligible for coverage.
- should require individuals to establish — for example, by appending documentation to their annual tax returns — that they have coverage.

Group purchasing is more efficient and more equitable than disaggregated purchasing. Therefore, the Coalition recommends against relying on individual mandates and individuated purchasing as the sole or central mechanisms in a national strategy to achieve coverage for all Americans.

The Coalition also recommends against reliance on a sub-national strategy in which individual states would be responsible for devising and passing legislation to attain coverage for their own citizens. We recognize, however, that progress can and should be made in individual states pending the passage of national legislation to cover all Americans.

PRINCIPLE 2

Cost Management

Average annual percentage increases in the health care costs and insurance premiums associated with the core benefit package should be brought into approximate equivalence with annual percentage increases in per-capita gross domestic product. Cost management measures should be designed to achieve that goal within five years after the enactment of legislation. (The Coalition recognizes that unusual discontinuities, such as epidemics or the emergence of revolutionary new medical technologies with benefits that clearly outweigh costs, may warrant short-term cost or premium increases that exceed the rate of growth of per-capita gross domestic product.) In addition, cost management should serve the longer-term goal of increasing the value generated by health care expenditures — that is, the health benefits that accrue to patients from any given level of spending.

Cost management must be a multi-faceted undertaking. It must incorporate a mix of more and better information and incentives for patients, providers, and purchasers; a commitment to improving the quality and outcomes of care, as described below; an increased emphasis on prevention and early detection of disease; the accelerated development of an integrated national information technology infrastructure for health care; and steps to modernize and simplify the administration, and dramatically reduce the administrative costs, of the health care

system.

The urgent need for relief from rapidly rising costs also requires the establishment of constraints as soon as practicable after the passage of legislation. These constraints should take two forms: rates for reimbursing providers for episodes of care encompassed by the core benefit package and, only after those rates take effect, limitations on increases in insurance premiums for the coverage defined by that package.

An independent board, chartered and overseen by Congress, should be responsible for establishing and administering these measures and for calibrating rates and limitations that keep increases in costs and premiums in alignment with defined annual targets. (This board, which would also be responsible for coordinating efforts to improve the quality of care, is described in more detail below in the specifications regarding Principle 3.) The board could also develop capitated rates for particular categories of care (for example, care for patients with specified chronic diseases) to encourage coordinated, integrated, and efficient provision of care in those categories.

A national strategy for cost management should also incorporate the following elements: First, it should make health insurance premiums more readily comparable by requiring insurers to establish explicitly separate premiums for the core benefit package and for any supplemental coverage they offer. Second, it should include a rational mechanism for increasing the cost-effectiveness of capital spending. Third, it should incorporate cost-sharing and other tools to provide incentives for patients to make appropriate choices about health maintenance and health care and for reducing both overuse and underuse of care. To assure that the use of such tools does not block access to needed care, subsidies or exemptions should be provided for those who are less affluent.

PRINCIPLE 3

Improvement of Health Care Quality and Safety

A comprehensive and concerted national effort should be launched and sustained, with dramatically more public funding than has been previously available for this purpose, to improve the quality and safety of American health care.

Some progress has been made, in both the public and private sectors, on initiatives to help reduce medical errors and improve quality, but we need to do much more, much faster, across the entire health care system. A system-wide effort to improve quality should increase investment in the generation of information — about effectiveness and cost-effectiveness — to improve recommendations and choices among options for care. It should develop and make widely available measurements — of process and outcomes quality — to facilitate choices among plans and providers by payers and consumers. It should be designed to reduce variability, across regions and providers, in patterns of practice — and, more generally, to improve the consistency of such patterns with best

practices. It should seek to link payments for care to the measured quality of care.

In addition, a national quality-improvement effort should accelerate the development of an integrated national information technology infrastructure for the health care system. This infrastructure should include protocols for electronic patient records, prescription ordering, and billing; standards to protect privacy; a process for updating protocols and standards to reflect experience and technological advances; and mechanisms to incentivize and provide capital for the upfront investments necessary to build, and build out, the infrastructure.

These mechanisms to encourage investments in automated clinical information systems — and in further integration and coordination of the delivery of care — could include supplemental payments, changes in tax policy, programs to provide long-term low-interest loans to qualifying providers and provider organizations, and targeted grant programs.

This concerted national effort to improve the quality of health care in America should be coordinated by the new independent national board — with members drawn equally from the public and private sectors to reflect and reinforce a public-private partnership for improved quality. This board would be chartered and overseen by Congress.

The new board should be responsible for coordinating the development and refinement of national practice guidelines. The guidelines should be based on reviews, by panels of leading health care professionals, of research that has been conducted on the impacts of alternative technologies and procedures. These panels should collaborate with and leverage the work of professional societies, provider organizations, health plans, universities, companies and industry associations, patient groups, payers, and other organizations. For technologies and procedures about which additional data are needed for the development of guidelines, new studies and assessments should be funded by the board. The board should assure that guidelines are continually updated as new data — on current and new technologies and procedures — become available.

The board should also be responsible for disseminating national practice guidelines and measures of process and outcomes quality to those who deliver, pay for, or receive care. It is vital not only that more and better information be developed, but that it be encapsulated and communicated broadly so that it can be acted on.

The practice guidelines issued by the board could be adduced in malpractice cases as evidence of what is considered best medical practice. Conformance to these guidelines should help to protect medical professionals from frivolous or marginal lawsuits. Use of the guidelines, the development of an information technology infrastructure that includes computerized prescription ordering and electronic patient records, and the ready availability of measures throughout the system of process and outcomes quality should over time work to reduce the incidence of medical errors and malpractice and to protect the safety of patients.

As noted above, the core benefit package should not be static. The board should

periodically review the components of that package and adjust them as needed to reflect changes in national practice guidelines.

PRINCIPLE 4

Equitable Financing

Reform should seek to reduce or eliminate cost-shifting across categories of insurance programs and payers, both public and private, and to make the distribution of financial burdens more equitable.

The Coalition has identified a range of mechanisms or sources that could be used, individually or in combination, to fund the program costs of the initiatives described here, including the costs of assuring coverage for all Americans:

- general revenues.
- earmarked taxes and/or fees.
- contributions required from employers.
- contributions required from individuals and families (including co-payments, deductibles, and contributions toward premiums).

Financial obligations should be gradated, or subsidies provided, based on relative ability to pay for less affluent individuals, families, and employers.

PRINCIPLE 5

Simplified Administration

The United States spends more than any other nation — nearly $300 billion per year — to administer its health care system. And as the complexity of our system continues to increase, so too does the associated administrative outlay. According to the Centers for Medicare and Medicaid Services, just one category of administrative expenses — those incurred by private health insurers — rose 52 percent between 1999 and 2002, from $237 to $360 per person covered.

The complexity of the American health care system confuses and frustrates patients, payers, and providers. In addition, because it reduces the transparency of transactions and the comparability of performance and cost data, it also undermines accountability and the capacity of health care markets to function efficiently.

The mechanisms and initiatives recommended in these specifications would produce a streamlined, rationalized health care system — one that would be more efficient (and less costly), less cumbersome and perplexing, and safer. We can, and we should, reduce unproductive inconsistencies across the system. We can, and we should, more fully leverage in health care the capacities of available information and communications technologies — capacities that have improved productivity and performance in so many other sectors of the American economy.

For example, the assurance of coverage for all Americans and the establishment of a core benefit package would create a consistent set of ground rules and understandings for patients, payers, and providers — reducing the variations that now draw time and resources away from the protection and advancement of health. The creation, at long last, of an integrated national information technology infrastructure for health care — including electronic patient records, prescription ordering, and billing — would not only decrease administrative complexity and costs, but help to reduce medical errors, protect the safety of patients, and improve outcomes. (At present, only 10 percent of health care providers use computerized medical records and ordering — this in a health care system that is the most advanced in the world in its generation, adoption, and use of purely medical technologies.) Similarly, the development and application of national practice guidelines would simultaneously reduce complexity and variability and improve the quality of care for millions of patients.

The expensive administrative complications of our current health care system are not productive uses of our scarce resources. We would be better off saving some of the money we now spend just to administer our system — or investing that money in new technologies or organizational innovations that would improve the health of the American people.

Conclusion

The members of the National Coalition on Health Care are determined to work for comprehensive reform of the American health care system. We offer these specifications for reform as an agenda — an urgent agenda — for action. We close with two observations.

First, we would emphasize again our conviction that reform must be systemic and system-wide. The problems of our health care system — and the principles that guided our development of specifications for reform — are so closely interrelated that they must all be addressed at the same time. One-dimensional reform will not work.

Consider: Unless we improve the quality of care, we will not be able to manage costs or afford universal coverage. Unless we manage costs effectively, we will not be able to achieve equitable financing or cover all Americans. And unless we assure coverage for everybody, we will be unable to make the system less complex, establish a level playing field without cost-shifting, or create a truly competitive health care marketplace. (In fact, many of those who first advanced the market-based reform hypothesis called managed competition warned that a market for health care cannot function efficiently or effectively in the absence of mandatory universal coverage and government oversight.)

Second, the status quo — clearly, undeniably — is not working. It leaves tens of millions of Americans with no health insurance at all. It allows costs to skyrocket year after year, putting coverage out of reach for millions of Americans and compromising the vitality of

our economy and its capacity to create and sustain jobs. And it jeopardizes the safety of patients because of widespread sub-standard care.

The status quo is not acceptable. It is time — it is past time — to change it. The readers of this report can have a tremendous impact on the prospects for reform and the shape of reform. We hope that you will work with us in this important effort.

Mr. PALLONE. Thank you, Mr. Neas.

And as I mentioned, all of your written testimony, your documents that you gave me, will be included in the record. So you don't have to make a special request for that.

Mr. Kirsch.

STATEMENT OF RICHARD KIRSCH

Mr. KIRSCH. Good morning, Chairman Pallone, members of the committee. My name is Richard Kirsch. I am 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 a guarantee of quality, affordable health care for all according to specific principles.

Those principles have been endorsed in writing by the President of the United States and 196 Members of Congress, including 176 Members of this House from both parties.

And I am so glad to be with 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 system that is retooled to deliver better quality at lower costs. 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 too 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 were people with insurance.

And even if you have good insurance, you find your choices limited and your dreams deferred. You want to look for a new job, start that new business, retire at age 59; trapped because you won't be able to get affordable coverage if you can get coverage at all. And, of course, there are too many families that can't get coverage at all.

Neither can many small businesses, that other great 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 we can fix what is wrong with the system with a uniquely American solution. For those who say we can't do this, it is too complicated, it is too much to take on, it is 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 will increasingly ask, what does this mean to me? Here is how I would explain how this works to the average American 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 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 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.

If you don't get health coverage at work or you work several part-time jobs, you are self-employed, retire early or simply out of work, you will now be able to get good affordable coverage. You won't be turned down because of a pre-existing 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? 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 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 will have a choice of the new public health insurance plan, too. So you won't be limited to the same private insurance companies that have a record of denying or 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, a plan that doesn't pay the average CEO $12 million a year or sky-high administrative costs. The mission of the public health insurance plan will be to drive the kind of delivery systems changes we need to innovate, provide better value, and invest in our community's health. A plan that will inject competition into 94 percent of markets that—or into competitive under DOJ standards.

The second reason the President says we need a public option is to keep insurance companies honest. The 93 percent 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 the shareholders, is to make a buck. And when they pay for someone's costly care, their profits go down.

An additional reason for the public health insurance plan is to ensure they make real progress at 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 with strong support on bipartisan lines.

This legislation also answers the crying need for small business for affordable coverage by offering tax credits, and allowing small businesses to enter the exchange, and gives them the advantage of large pools and lower costs.

The 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 and access to health care.

I am almost done.

Are there ways of improving this draft? Although there are, there are not a great number. And I will detail that in my written testimony. Let me conclude by asking you to keep one question in mind

over the coming weeks: As you hear from a myriad of interest groups complaining about this and that, it is the question that 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 presented answers with a resounding yes. And if the answer remains yes next fall when you send the 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:]

HEALTH CARE FOR AMERICA NOW!

Testimony by
Richard Kirsch
National Campaign Manager
Health Care for America Now
Health Sub-Committee of the
House Energy and Commerce Committee
June 23, 2009

Good morning, Chairman Pallone 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.

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 the great majority of those are people who are insured. Even having good insurance limits

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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 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 bare-bones. 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 pre-existing condition or charged more because you've been sick or you're a woman of child bearing 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 market-place, 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 share holders – 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

plan 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 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. PALLONE. Thank you.
Dr. Parente.

STATEMENT OF STEPHEN T. PARENTE, PH.D.

Mr. PARENTE. Thank you, Chairman Pallone and members of this committee, for this opportunity.

We are in the midst of the seventh major attempt of national health reform, beginning with the Wilson administration. Since that first attempt, there has been President Roosevelt's second attempt in 1936; President Truman's third attempt in 1948; President Johnson's fourth attempt leading to a compromise that created Medicare and Medicaid; President Nixon's limited fifth attempt; President Clinton's sixth attempt.

With President Obama's call for reform, will seven be the lucky number?

My name is Steve Parente. I am a health economist from the University of Minnesota and a principal of a health care consultancy, HSI Network. My areas of expertise are health insurance, health information technology, and medical technology evaluation.

At the university, I am a director of an MBA specialization in the medical industry and a professor in the Finance Department with an adjunct appointment at Johns Hopkins School of Public Health.

Most recently, I and my colleague, Lisa Tomai from HSI, have scored health reform proposals as they have emerged in the last 4 weeks. We are using ARCOLA, a microsimulation methodology initially funded by the Department of Health and Human Services and published in the journal, Health Affairs.

There are two things people most want to know about these proposals. One, how many of the uninsured will be covered? Two, what will it cost the Nation in 1 year and in 10 years? HSI estimates, like CBO's recent results, find there is no free lunch to expand health insurance coverage.

Our early assessment of the Senate Finance Committee proposal shows a 74 percent reduction in the uninsured with a 10-year cost of $2.7 trillion using a public option plan modeled after the Massachusetts Connector.

We also modeled an FEHBP version of that plan and got a cost of over $1.3 trillion, but with a 30—only a 30 percent reduction in the uninsured because the plan is generally more expensive and not enough incentives are given.

CBO scored the Kennedy bill last week at approximately a 30 percent reduction for $1 trillion over 10 years. Using the ARCOLA model, we found nearly everyone will be covered if all elements of the Kennedy bill were enacted at a 10-year cost of $4 trillion. That $4 trillion estimate over 10 years assumes a public option plan with bronze, silver and gold levels and the proposed insurance exchange with a subsidy for premium support that is income-adjusted and calibrated at the silver level.

The silver level is what most Americans would like in health insurance today. It is the equivalent to a PPO plan with medium levels of generosity, something with a 15 percent co-insurance, manageable co-pays and good access to physicians and hospitals.

We accounted for the public plan being reimbursed at 10 percent above Medicare reimbursement, which is also 10 percent below commercial insurance plans.

In the individual market, we assume the public option plans would be community rated and the rest of the individual market would be as it is today. For those offered insurance, we assume the public plan would be—my teleprompter broke. Because the public plan can compete with the individual and group market offerings, we saw a crowd-out in the public plan of 79 million covered lives with the majority of people leaving employer-sponsored medium-sized PPOs and HMOs.

At this time, we are the only group yet to score the full Kennedy proposal. We released it last Sunday, June 14th, on our HSI network.com home page, 2 days before CBO's preliminary estimate. This work was completed as a public service without a funder from industry or a political sponsor.

Some proposals we have examined have specific pay-fors already scored by CBO that can substantially reduce their cost, such as the Coburn-Ryan bill, with a 72 percent reduction and a 10-year cost of $200 billion with the pay-fors accounted for or $1.7 trillion without.

One conclusion emerges every time we score a plan: None are revenue-neutral. Even with Medicare and Medicaid pay-fors, the savings in those programs need to deal with the cost pressures of those programs. In all likelihood, these proposals, if enacted, would escalate the rate of growth of our national debt, particularly the Kennedy plan.

As a Nation, we are on the verge of making a multimillion dollar gamble that more per-capita health care deficit spending will make us better off as a society. We are wagering with starting bids in trillions that have excessive spending in the health care system. Hoping that these billions and trillions will lead to a breakthrough medical technology that can eliminate whole diseases, such as diabetes and Alzheimer's. This is actually not a bad path. It happened before with tuberculosis, but not quite at this level.

It is not an unreasonable wager since Federal funding for heart disease and cancer either directly through research or indirectly through Medicare has yielded state-of-the-art medical care, but it is a wager nonetheless. And we find our reckoning is not only with the future debt of our children, but their security when the economic crisis has brought international scrutiny upon the U.S. from the principal purchasers of our treasuries.

Furthermore, saving businesses from paying health care costs or a State government with Federal intervention is simply an accounting cost shift that only saps our long-term economic growth.

President Obama spoke recently in Wisconsin of the need to expand health coverage to bend the cost curve down. I watched him say it 3 times in 5 minutes.

May I respectfully suggest that bending the cost curve down starts with active management of Medicare. For 5 months, we have been without a CMS administrator while there have been over 400 billion in——

Mr. PALLONE. Dr. Parente, I don't mean to interrupt, but you are a minute over, so If you could kind of wrap it up.

Mr. PARENTE. I will wrap up. Pardon me.

In summary, there is greater consensus today that health care reform must be undertaken. It will not be free. It will, as it always was, be a political decision that was more so political than economic. So much can be done now with great expansion, but it will come at great cost.

Thank you.

[The prepared statement of Mr. Parente follows:]

EXECUTIVE SUMMARY

U.S. Senate Finance Committee Health Reform 'Public Option' Score

June 7, 2009

Completed by:

HSI Network, LLC
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For more information contact:

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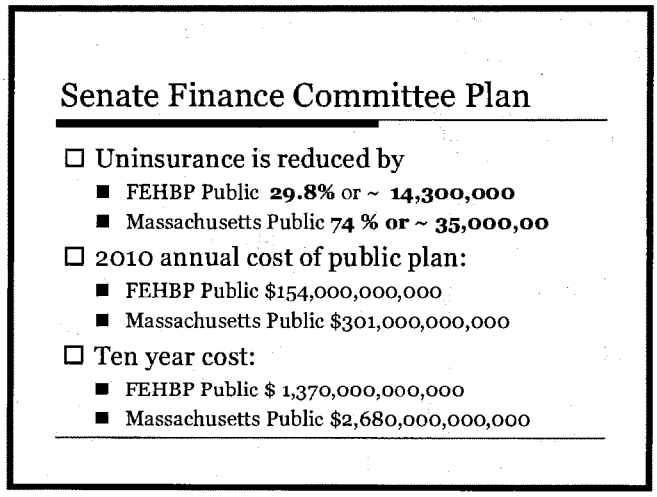
This work was completed independently for public dissemination. It was completed without funding or governance from any existing provider, payer or manufacturer. A more detailed and / or customized analysis is available upon request and circumstance.

U.S. Senate Finance Committee Health Reform 'Public Option' Score

Independent Assessment by HSI Network LLC
For Public Dissemination

Summary Snapshot

Staffers in the U.S. Senate Finance Committee have released a set of white papers and spoken of a possible Public Option healthcare plan. While there is not yet a specific proposal to score, there is sufficient information to suggest what the impact of the public option design would be, using the ARCOLA™ simulation model. The public option plan consists of a health plan design that would provide an additional health insurance choice to US citizens. One of the key assumptions of public plan simulation is the underlying benefit design package. In addition, the nature and extent of premium supports that will be included in order to increase coverage requires an explicit assumption. Below, we summarize the impact of the proposed plan in terms of the reduction on uninsured, the 2010 cost, as well as the ten year cost of the plan in 2010 dollars.



The underlying simulation model used is ARCOLA, a proprietary version of a health reform coverage and cost assessment analytic engine. A peer-reviewed presentation of the core model structure is summarized in the journal Health Affairs[1] and a longer version is available as a DHHS report at www.ehealthplan.org

[1] See Feldman, R., Parente, S.T. et al., "Health Savings Accounts: Early Evidence of National Take-up from the 2003 Medicare Modernization Act and Future Policy Proposals," Health Affairs, 24:6 (November/December, 2005), pp. 1582-1591.

Scoring Components

Major Policy Components Scored:

- Public Plan as Federal Health Employee Benefit Plan (BCBS-Style PPO): This assumption was made because of the frequent references to FEHBP as a potential plan model for health plan design. The ARCOLA model contains a reference point for medium to high option PPO that is used as favored benefit package for simulation under this scenario.

- Public Plan as a Commercial Low-option PPO: This assumption was made based on the high take-up of narrow network plan designs in Massachusetts as well as high cost sharing network plan designs with lower premiums.

- Regional insurance exchanges: It is assumed that either a national or regional exchange would be used to announce public plan availability as well as pricing, similar to the design of the Massachusetts Connector.

- Direct premium support for Public Plan: It is assumed that up to a 30% discount on the plan will be provided.

Summary

The plan achieves its principal aim of reducing the number of uninsured. The cheaper of the two options is the FEHBP style design – but there is far less uninsured reduction than with the Low-option PPO. This is because the price point of the low-option PPO increases overall take-up much more effectively and, thus, requires more federal dollar support.

ARCOLA Technical Documentation

The ARCOLA model is a national health policy impact micro-simulation model designed to estimate the impact of health policy proposals at federal and state levels. The model predicts individual adult responses to proposed policy changes and generalizes to the US population with respect to: 1) health insurance coverage and 2) financial impact of the proposed changes.

This model was first used for the Office of the Assistant Secretary (OASPE) of the Department of Health and Human Services (DHHS) to simulate the effect of the Medicare Modernization Act of 2003 (MMA) on take-up of high-deductible health plans in the individual health insurance market (Feldman, Parente, Abraham et al, 2005; Parente et al, Final Technical Report for DHHS Contract HHSP233200400573P, 2005). The model was later refined to incorporate the effect of prior health status on health plan choice – a necessary step if one wants to predict enrollment more accurately. The latest model also used insurance expenditures from actual claims data to refine premiums and then predict choices again with the new premiums. The model then iterates the choice model until premiums and choices converge, and then finds and equilibrium state. A subsequent change to the model permitted state-specific predictions of policy changes as well as total federal health policy impact.

Model Components & Data Sources

There are three major components to the ARCOLA model: 1) Model Estimation; 2) Choice Set Assignment and Prediction; and 3) Policy Simulation. Often, more than one database was required to complete the task. Integral to this analysis was the use of consumer directed health plan data from four large employers working with the study investigators.

The model estimation had several steps. As a first step, we pooled the data from the four employers offering CDHPs to estimate a conditional logistic plan choice model similar to our earlier work (Parente, Feldman and Christianson, 2004). In the second step we used the estimated choice-model coefficients to predict health plan choices for individuals in the MEPS-HC. In order to complete this step, it was necessary first to assign the number and types of health insurance choices that are available to each respondent in the MEPS-HC. For this purpose we turned to the smaller, but more-detailed MEPS Household Component-Insurance Component linked file, which contained the needed information. The third step was to populate the model with appropriate market-based premiums and benefit designs. The final step was to apply plan choice models coefficients to the MEPS data with premium information to get final estimates of take up and subsidy costs.

EXECUTIVE SUMMARY

The Impact of the 2009 The Patient's Choice Act

From Senators Tom Coburn (OK) and Richard Burr (NC), as well as Representatives. Paul Ryan (WI), and Devin Nunes (CA)

June 10, 2009

Completed by:

HSI Network, LLC
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This work was completed independently for public dissemination. It was completed without funding or governance from any existing provider, payer or manufacturer. A more detailed and / or customized analysis is available upon request and circumstance.

2009 The Patient's Choice Act Score

Independent Assessment by HSI Network LLC
For Public Dissemination

Summary Snapshot

Sens. Tom Coburn (Okla.) and Richard Burr (N.C.), as well as Reps. Paul Ryan (Wisc.), and Devin Nunes (Calif.) have proposed a health reform bill that seeks to reduce the number of uninsured and increase health system efficiency and quality. The proposal provided adequate information to suggest what the impact would be of the Patient Choice Act (PCA) using the ARCOLA™ simulation model. PCA would remove the tax exclusion associated with employer sponsored health insurance and use it to fund advanceable and refundable tax credits to all purchasers of a health insurance plan. This would permit a level playing field for the provision of health insurance. The plan also features an auto-enrollment component as well as an emphasis on prevention and wellness. Below, we summarize the impact of the proposed plan in terms of the reduction on uninsured, the 2010 cost, as well as the ten year cost of the plan in 2010 dollars.

Coburn/Burr/Ryan/Nunes Results

- Uninsurance is reduced by **72%** to cover approximately **34,000,000**
- Subsidy - Tax Recovery = Net cost:
  - 126,000,000,000 subsidy to the individual market
  - 259,000,000,000 subsidy to the ESI market with
  - Tax recovery of $194,000,000,000 billion
  - Net cost: $154,000,000,000 (annual)
  - Net cost: $1,400,000,000,000 (10 year)
  - Potential Final cost: $200,000,000,000 (10 year) after $1.2 Trillion of CBO scored 'pay-fors' removed

The underlying simulation model used is ARCOLA™, a proprietary version of a health reform coverage and cost assessment analytic engine. A peer-reviewed presentation of

the core model structure is summarized in the journal Health Affairs[1] and a longer version is available as a DHHS report at www.ehealthplan.org

Scoring Components

Major Policy Components Scored:

- Providing an advanceable and refundable tax credit of $2,300 per individual or $5,700 per family
- State Insurance Exchanges: Gives states the ability to band together in regional pooling arrangements, and allows the creation of robust high risk pools, reinsurance markets, or risk adjustment mechanisms to cover those deemed 'uninsurable'.
- Equalizes the Tax Treatment of Health Care: Consumers receiving their insurance through the work place would have the value of the benefit provided by the employer taxed.

Summary

The plan lowers the uninsured significantly, by nearly 75%, but not without a cost of over one trillion dollars over 10 years. The taxes recovered by removal of the employer sponsored health benefit tax exclusion are nearly $200 billion per year. While this is a substantial sum of money, it is not sufficient to cover the cost of the tax credits.

The net cost of the plan may be very close to revenue neutral if the following 'pay-fors' scored by the Congressional Budget Office (CBO) were added in (10 year estimates).

- $100B - Change Medicare Advantage to pay 106% above FFS[2]
- $28.3B - Mean-testing Part D[3]
- $556B - Converting Medicaid acute care from defined benefit to defined contribution[4]
- $600B+ - Block granting Medicaid long-term care[5]
- $5.6B Malpractice Liability Reform[6]

With these CBO pay-fors, the 10-year cost is approximately $200 Billion. If one adds in proposed Medicare and Medicaid fraud reductions (not scored by CBO though), the proposal would be cost saving.

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[1] See Feldman, R., Parente, S.T. et al., "Health Savings Accounts: Early Evidence of National Take-up from the 2003 Medicare Modernization Act and Future Policy Proposals," Health Affairs, 24:6 (November/December, 2005), pp. 1582-1591.
[2] http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf, p. 122
[3] http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf, p. 164-166
[4] http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf, p. 131
[5] http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf, assume bigger $$ than acute care
[6] http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf, p.21

ARCOLA™ Technical Documentation

The ARCOLA™ model is a national health policy impact micro-simulation model designed to estimate the impact of health policy proposals at federal and state levels. The model predicts individual adult responses to proposed policy changes and generalizes to the US population with respect to: 1) health insurance coverage and 2) financial impact of the proposed changes.

This model was first used for the Office of the Assistant Secretary (OASPE) of the Department of Health and Human Services (DHHS) to simulate the effect of the Medicare Modernization Act of 2003 (MMA) on take-up of high-deductible health plans in the individual health insurance market (Feldman, Parente, Abraham et al, 2005; Parente et al, Final Technical Report for DHHS Contract HHSP233200400573P, 2005). The model was later refined to incorporate the effect of prior health status on health plan choice – a necessary step if one wants to predict enrollment more accurately. The latest model also used insurance expenditures from actual claims data to refine premiums and then predict choices again with the new premiums. The model then iterates the choice model until premiums and choices converge, and then finds an equilibrium state. A subsequent change to the model permitted state-specific predictions of policy changes as well as total federal health policy impact.

Model Components & Data Sources

There are three major components to the ARCOLA™ model: 1) Model Estimation; 2) Choice Set Assignment and Prediction; and 3) Policy Simulation. Often, more than one database was required to complete the task. Integral to this analysis was the use of consumer directed health plan data from four large employers working with the study investigators.

The model estimation had several steps. As a first step, we pooled the data from the four employers offering CDHPs to estimate a conditional logistic plan choice model similar to our earlier work (Parente, Feldman and Christianson, 2004). In the second step we used the estimated choice-model coefficients to predict health plan choices for individuals in the MEPS-HC. In order to complete this step, it was necessary first to assign the number and types of health insurance choices that are available to each respondent in the MEPS-HC. For this purpose we turned to the smaller, but more-detailed MEPS Household Component-Insurance Component linked file, which contained the needed information. The third step was to populate the model with appropriate market-based premiums and benefit designs. The final step was to apply plan choice models coefficients to the MEPS data with premium information to get final estimates of take up and subsidy costs.

EXECUTIVE SUMMARY

The Impact of the 2009 Affordable Health Choices Act

From the Senate Committee on Health, Education, Labor and Pensions (HELP)

June 13, 2009

Completed by:

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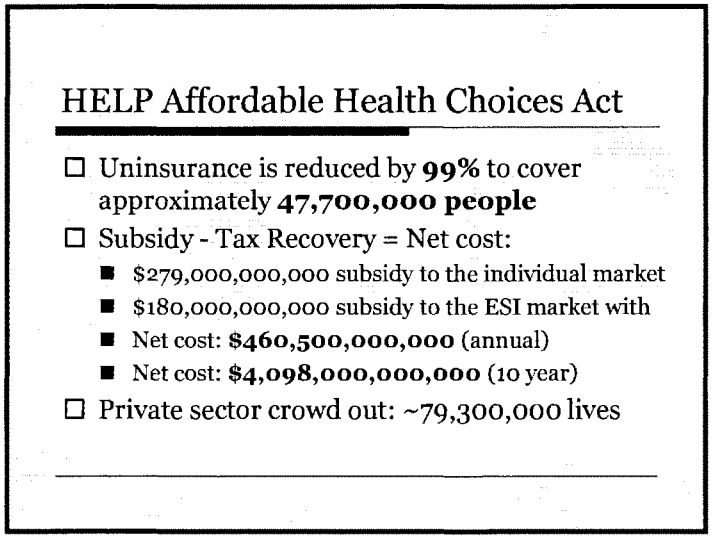
2009 Affordable Health Choices Act

Independent Assessment by HSI Network LLC
For Public Dissemination

Summary Snapshot

The Senate Committee on Health, Education, Labor and Pensions (HELP) have proposed a health reform bill called the Affordable Health Choice Act (AHC) that seeks to reduce the number of uninsured and increase health system efficiency and quality. The draft legislation was introduced on June 9th, 2009. The proposal provided adequate information to suggest what the impact would be of AHC using the ARCOLA™ simulation model. AHC would include an individual mandate as well as a pay or plan provision. In addition, it would include a means-tested subsidy with premium supports available for those up to 500% of the federal poverty level. Public plan options in three tiers: Gold, Silver and Bronze are proposed in a structure similar to that of the Massachusetts Connector, except that it is called The Gateway. These public plan options would contain costs by reimbursing providers up to 10% above current reimbursement rates. There is no mention of removing the tax exclusion associated with employer sponsored health insurance. There is also no mention of changes to Medicare and Medicaid, other than fraud prevention, that could provide cost-savings for the coverage expansion proposed. Below, we summarize the impact of the proposed plan in terms of the reduction on uninsured, the 2010 cost, as well as the ten year cost of the plan in 2010 dollars.



The underlying simulation model used is ARCOLA™, a proprietary version of a health reform coverage and cost assessment analytic engine. A peer-reviewed presentation of the core model structure is summarized in the journal Health Affairs[1] and a longer version is available as a DHHS report at www.ehealthplan.org

Scoring Components

Major policy components considering for scoring:

- Employers would have to offer health insurance or pay a tax not as yet specified
- Individuals would have to be covered by a qualified plan or pay a tax
- Medicaid for everyone up to 150% of poverty
- Sliding scale subsidy from 150% to 500% of poverty
- The government would define a qualified plan with 3 levels of coverage: gold, silver and bronze. We assume the subsidy would be priced at the silver level of benefit design
- All plans must use modified community rating: premiums can vary only by geographic region (to be defined), family structure, actuarial value of benefits, and age (maximum 2:1 range).
- Public plan that pays Medicare rates +10%
- Small-employer tax subsidy

Summary

The plan lowers the uninsured significantly, to less than 1% of the population, but not without a cost of over four trillion dollars over 10 years. There are no provisions in the legislation to offset this course. Even if the most generous estimate of the employer sponsored tax exclusion ($300 billion per year, including collecting FICA contributions from employers) where used and combined with fraud estimates and block granting all of Medicaid (acute and long term care[2]), this would be a challenging proposal to finance with budget neutrality. Finally, the public plans will be quite successful in recruiting large numbers of Americans. They will also likely crowd out at 79 million individual contracts with existing private insurers.

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[1] See Feldman, R., Parente, S.T. et al., "Health Savings Accounts: Early Evidence of National Take-up from the 2003 Medicare Modernization Act and Future Policy Proposals," Health Affairs, 24:6 (November/December, 2005), pp. 1582-1591.

[2] http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf, assume bigger $$ than acute care

Detailed Breakout of AHC Legislation Impact from ARCOLA™

		Affordable Health Choices Act Impact		
Individual Market	**Status Quo Population**	**Proposal Population**	**2010 Total Impact**	**Population Impact**
Insured	16,182,877	57,513,571	$279,903,791,139	11,572,054
Uninsured	41,843,646	501,918	0	-41,341,728
		Subtotal	$279,903,791,139	
Group Market				
Insured	162,665,411	168,980,727	$180,626,259,236	-70,763,315
Uninsured	6,773,521	443,524	$0	-6,329,997
		Subtotal	$180,626,259,236	
		Total	**$460,530,050,376**	
Total Market				
Insured	178,848,288	226,494,298	$460,530,050,376	
Uninsured	48,617,167	945,442	0	**-47,671,725**

2009 Affordable Health Choices Act
2010 Dollar Estimates by Plan Choices

Individual Market	**Status Quo Population**	**2010 Population**	**2010 Fiscal Impact**	**Delta**
HSA	6,764,409	8,837,503	$24,523,097,130	2,073,094
Public Gold	0	21,634	$38,352,668	
Public Silver	0	15,384,939	$85,340,451,551	
Public Bronze	0	14,352,067	$80,151,337,191	
PPO High	57,525	1,121,641	$7,691,906,410	1,064,116
PPO Low	9,009,693	6,569,646	$18,899,814,008	-2,440,047
PPO Medium	351,250	11,226,141	$63,258,832,181	10,874,891
Uninsured	41,843,646	501,918	$0	-41,341,728
			$279,903,791,139	
Group Market				
HMO	38,902,944	25,212,667	$18,220,965,760	-13,690,277
HRA	4,628,425	3,584,030	$2,636,475,136	-1,044,395
Employer-sponsored HSA	141,186	57,501	$43,016,344	-83,684
Opt-out HSA	277,905	2,261,246	$6,230,527,020	1,983,341
Public Gold	0	11,159,097	$4,940,047,142	
Public Silver	0	38,123,622	$47,241,576,558	
Public Bronze	0	27,795,913	$32,108,463,133	
Opt-out PPO Low	245,762	651,234	$398,087,278	405,472
PPO High	17,286,666	19,528,447	$26,951,344,787	2,241,781
PPO Low	2,023,263	996,385	$424,070,922	-1,026,878
PPO Medium	87,320,502	38,739,485	$41,431,685,157	-48,581,017
Turned Down - Other Private	11,838,759	871,099	$0	-10,967,659
Turned Down - No insurance	6,773,521	443,524	$0	-6,329,997
			$180,626,259,236	
		Total Subsidy:	$460,530,050,376	

ARCOLA™ Technical Documentation

The ARCOLA™ model is a national health policy impact micro-simulation model designed to estimate the impact of health policy proposals at federal and state levels. The model predicts individual adult responses to proposed policy changes and generalizes to the US population with respect to: 1) health insurance coverage and 2) financial impact of the proposed changes.

This model was first used for the Office of the Assistant Secretary (OASPE) of the Department of Health and Human Services (DHHS) to simulate the effect of the Medicare Modernization Act of 2003 (MMA) on take-up of high-deductible health plans in the individual health insurance market (Feldman, Parente, Abraham et al, 2005; Parente et al, Final Technical Report for DHHS Contract HHSP233200400573P, 2005). The model was later refined to incorporate the effect of prior health status on health plan choice – a necessary step if one wants to predict enrollment more accurately. The latest model also used insurance expenditures from actual claims data to refine premiums and then predict choices again with the new premiums. The model then iterates the choice model until premiums and choices converge, and then finds an equilibrium state. A subsequent change to the model permitted state-specific predictions of policy changes as well as total federal health policy impact.

Model Components & Data Sources

There are three major components to the ARCOLA™ model: 1) Model Estimation; 2) Choice Set Assignment and Prediction; and 3) Policy Simulation. Often, more than one database was required to complete the task. Integral to this analysis was the use of consumer directed health plan data from four large employers working with the study investigators.

The model estimation had several steps. As a first step, we pooled the data from the four employers offering CDHPs to estimate a conditional logistic plan choice model similar to our earlier work (Parente, Feldman and Christianson, 2004). In the second step we used the estimated choice-model coefficients to predict health plan choices for individuals in the MEPS-HC. In order to complete this step, it was necessary first to assign the number and types of health insurance choices that are available to each respondent in the MEPS-HC. For this purpose we turned to the smaller, but more-detailed MEPS Household Component-Insurance Component linked file, which contained the needed information. The third step was to populate the model with appropriate market-based premiums and benefit designs. The final step was to apply plan choice models coefficients to the MEPS data with premium information to get final estimates of take up and subsidy costs.

A Pharmaceutical Economic Stimulus Plan

Encourage health care spending as a way to stimulate the economy and care for the uninsured.

By Stephen T. Parente, Ph.D.

As a former campaign health policy advisor to Sen. John McCain, I have now reached the final stage of the Kübler-Ross process—acceptance. I accept the inevitability of our adopting a Keynesian macroeconomic policy to achieve health insurance expansion. Since this was not a thought experiment we considered during McCain's run for the White House, I would like to propose the following idea as thinking outside the box given the new Realpolitik.

Borrowing from the dual-use opportunities policy deployed by the Roosevelt Administration in 1941 to transform a consumer economy into a war-time economy, this proposal should be considered part of a domestic war-on-the-uninsured policy. It is guided by three principles: First, for any economic stimulus plan to work, money needs to be spent by consumers as quickly as possible. Second, inventing new programs or infrastructure for spending the money will not be as effective as using existing ones. Third, opportunities to achieve multiple public policy goals through a single program have great merit.

Health Care Debit Cards

As part of this proposal, every adult in the United States would get a debit card issued by the dozen or so national retail pharmacy chains to purchase needed pharmaceuticals and pay for primary care visits at the retail clinics associated with them. The cards would come preloaded by the federal government with $500. To receive a card, which would be available from cashiers at the stores, people would simply present their driver's license or other official identification. The cards could be loaded with as much as $3,000, depending on the financial need of the cardholder. Financial need would be determined by referencing the cardholder's income tax filing data. The cards could only be used at qualifying pharmacies and only for purchasing noncontrolled pharmaceuticals in order to prevent an oxycodone-fueled stimulus.

This proposal addresses the first principle by directly channeling money to consumers to help counter many of the ill-effects of the economic downturn, including loss of health insurance.

This proposal satisfies the second principle of using existing infrastructure to deliver the stimulus. If enacted, it would effectively turn Target, Walgreens, Wal-Mart, and other stores into analogues of the Ford Motor Company, which built bombers, and General Motors, which built tanks, during World War II. However, whereas it took nearly a year for Ford to retool its factories to make bombers, the retail pharmacies could likely gear up to accept the cards within months if not weeks.

Finally, the proposal satisfies the third principle of achieving multiple goals from one program. This dual-use policy would help uninsured or underinsured adults with chronic illnesses maintain or improve their health, and it would stimulate the economy. In addition, it would allow policymakers to learn who the uninsured really are in terms of their illness burdens based on the pharmaceuticals they purchase, and it would help them estimate the potential cost of insurance coverage expansion proposals.

Furthermore, the debit cards themselves might be a first step toward identifying a means for arranging future insurance contracts similar to the public-private hybrid approach used in the Netherlands and Switzerland. In the Netherlands, a private insurer receives an additional subsidy from the government for taking care of a sicker patient if it provides pharmaceutical consumption patterns as one of the key data elements. Switzerland uses clinical data similarly to determine payments to regional cantons providing coverage for high-risk individuals. Indeed, the Association of Health Insurance Plans recently stated it would support a national health insurance reform program under which insurance companies would provide coverage to all Americans as long as an individual mandate is in place. This proposal could jumpstart that process.

Pragmatic Proposal

How much would this cost? The potential market for the cards is roughly 210 million people, if you exclude those on Medicaid and Medicare. If you included people on Medicaid, we would be talking about a program serving roughly 255 million Americans. Based on results of previous health policy subsidy programs, only 20 percent of the U.S. population is likely to take advantage of this proposal. Historically, those who signed up for such programs have been the people most in need. With this level of participation, the implementation cost of this economic stimulus/health care reform proposal would likely run $25 billion at the most.

In playing the role of a Keynesian, I propose this policy with great trepidation, not because I think it will fail to stimulate the economy but because it will add to an

already high national debt. But if money is to be spent anyway, this strikes me as a comprehensive, efficient, and pragmatic proposal that would have measurable metrics for success. The policy prescription offered by the Obama administration of air dropping $30 billion for electronic medical records does not have nearly the direct consumer benefit or velocity of stimulus action required.

Many details would need to be worked out beyond what can be articulated in this short essay. But the logistical details Ford faced when gearing up to build bombers instead of sedans were no less daunting, and the outcome of this dual-use proposal would be a healthier economy and a healthier population. **MM**

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Health Information Technology and Financing's Next Frontier: The Potential of Medical Banking

STEPHEN T. PARENTE*

Calls to action for widespread adoption of electronic health records have come from a broad spectrum of the private and public sectors. The problem, to date, is not that information does not exist, as much as that the data have not been organized around the patient. An integrated Personal Health Record is a patient- or family-centered technology designed to capture not only the contacts with health care providers, but also personal information on insurance, diet, and personal preferences that a physician's health record will not capture. Medical banking, based on a new technology platform called the Integrated Health Card, is emerging as a solution to the problem of collecting and combining information from the electronic health record with personal health information. It may also be the only way for fledging health savings accounts to enable the price and quality transparency of the medical market that has been called for repeatedly in this decade. In analyzing the political and patient applications of widespread adoption of this new innovation, the positive contributions to social welfare are very likely to outweigh the negative.

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Robust information technology (IT) is considered an essential component of a high-performance health care system that will deliver the best treatment to improve, restore, or sustain health for a fair cost. Calls to action for widespread adoption of electronic health records have come from a broad spectrum of supporters, ranging from the Institute of Medicine to the U.S. President. [Institute of Medicine 1999, 2001; Department of Health and Human Services 2004, 2006]. The problem is that the majority of the medical industry has not embraced IT to improve performance, as have other industries where success has been greater. These include financial services, retail, transportation, and manufacturing [Brynjolfsson and Hitt 2000]. With expenditures over two trillion dollars per year and an ever-increasing share of the gross domestic product, health care is a full-blown industry in its own right.

One of the key frustrations with IT investment in health care is the lack of connectivity between medical providers, patients, and payers. Specifically, the problem is not that IT investments have not been made [Burke, Wang, Wan, and Diana 2002] and that the data do not exist, as much as that the data have not been organized around the patient. In 2004, the Bush Administration made a commitment to accelerate the use of health IT to improve quality of care and lower costs. David Brailer [2005] proposed a strategic plan as health IT czar that would promote health IT interoperability between all key stakeholders. In particular, medical providers would be called upon to exchange medical data using a common set of standards. However, since 2004, interoperability has slowed because making health IT systems open and transparent has not brought about a shared sense of Pareto improvement among medical providers. Specifically, transparency initiatives are suspected of rewarding low-cost, high-quality providers and leaving others that have less affluent patients and/

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or less profitability to suffer financially. Without a federal law that compels interoperability, the implementation of Dr. Brailer's vision has been lagging.

A new business model, "medical banking," has emerged that could change this situation for the better, from both a patient and provider perspective. Medical banking uses a new technology platform called the Integrated Health Card (IHC), which could provide a solution, scalable from existing technologies, to address the problem of collecting information from the electronic health record together with personal health information. It would also reduce transaction cost relating to the provision of health care. As it grows, medical banking will provide a powerful innovation to help deliver a high performance health care system.

In this paper, a vision for medical banking is stated. A patient vignette is used to illustrate how medical banking card technologies can be a viable platform for efficient utilization of personal health records (PHRs). And finally, a description of a set of factors is discussed to support the conclusion that some form of medical banking is highly likely but also quite disruptive to the status quo delivery system and to potential health reform initiatives.

1. Medical Banking Defined

The goal of medical banking is to enhance financial transactions associated with health care with information on the patient's condition, treatment outcome, and adherence to patients making their own human capital investments. If we consider Michael Grossman's [1972] landmark household production function specification, where medical care and other factors affect the production of health, medical banking explicitly makes it possible to collect the data necessary for a household production model to become a day-to-day reality aud a part of the current financial transaction system in health care markets.

As an illustration of the capability of medical banking, consider the development of the personal finance risk score. Consumer banking transactions, whether through checking accounts or credit cards, have produced an externality that constitutes an entire secondary market of data to be used for risk score information. Imagine that the same thing is possible for medical care at the individual patient level. Health risk scoring already happens today, though fairly crudely, for risk prediction by insurers of their current or prospective patients. Enhancement would provide metrics for personal health production akin to what Grossman described theoretically. These metrics could also be aggregated by associating physicians (without suggesting causality) with their aggregate medical productivity, pharmacies, group practices, or hospitals to the health outcomes of the patients who visited them.

How could simple financial transactions of medical providers that are no more than debits and credits yield sufficient data for measuring medical care production? The simplest answer is that the financial transaction system itself becomes a conduit for the transfer of not only bank account transfer instructions, but also clinical data from new and existing health IT platforms of the providers seeking payment. For example, if a laboratory testing company bills for blood work on a diabetes patient that produces numerical values describing the result of a specific test, a medical banking platform would require the attachment of the lab result as evidence of the service performed to receive the negotiated fee as reimbursement. The current practice is simply to pay for the test without additional information transmitted. This made sense in 1966, when all results were recorded on paper. But today, all results are digital and easy to transmit. This one innovation would provide a line of demarcation between the fee-for-service health insurance financial transactions of the last 60 or more years and the new medical banking platform described in this paper.

To understand the potential for medical banking, it is important to understand the status quo. Today, the overwhelming majority of health care financial transactions occur through third-party insurers that are private (such as Aetna or Cigna) or public (such as Medicare and Medicaid). The third-party insurance primary business model is the facilitation of a fee-for-service transaction system between employers, governments, and insurers who hold risk contracts and the providers of medical care—such as physicians, hospitals, and pharmacies—on behalf of the patient. Take for example, an insured person who breaks his leg and goes to the emergency room of a local hospital. The hospital will seek reimbursement from the insurer of this injured patient by submitting a claim for reimbursement with specific line items for use of the facility, physician time, medical equipment used to set the bone, pain medications prescribed, and x-rays taken. A consulting orthopedic surgeon,

retail pharmacy, anesthesiologist, and radiologist will all invoice separately. The insurer will receive these requests for payment and negotiate final payment over the course of 30 to 120 days following the emergency room event.

Where do banks enter the picture now? If this person works for a large firm where he has signed up for health insurance, the firm is likely to be self-insured through the Employee Retirement Income Security Act (ERISA); and this firm will instruct the insurer to pay the medical providers using the bank account of the employer following the negotiation of final payments to the providers. Thus, health insurance here is simply "negotiated" fee-for-service. If the injured patient worked for a small company that could not afford to be self-insured under ERISA, the payment would originate from the bank account used by the insurer associated with the patient. This would be the case if the injured bought their health insurance in the individual insurance market as well. If the patient had no insurance and was not in a public insurance program such as Medicare or Medicaid, they would be responsible to pay the charges of the hospital, which are likely to be at least twice the negotiated rate between insurers and the providers mentioned above.

2. The Business Model for Medical Banking

The status quo of health insurance provision in the United States is under assault. Today, employers buy health insurance for workers, providers submit claims to the insurance companies for covered services, and the insurance companies either pay or deny the claims. However, there are many flaws with this old and complex system, and it is possible that the lack of data to correctly price risk has led to nearly 50 million uninsured people at any given time during the year. In addition, health care costs at roughly twice the rate of inflation have made offering health insurance unaffordable for a growing number of companies.

One of the major foundations of medical banking is the growth in health savings accounts (HSAs) as part of a patient-driven health care system.[1] This growth is attributed to the lower premium cost of high-deductible health plan options. But more importantly to medical banking, HSAs are on track to have $10 billion in deposits held at banks. This puts banks at the center of a strategic crossroads in the health insurance market development.

So why would banks care to enter this market at all? The easiest answer is simply to see how banks have developed enhanced consumer service products, outside of health care, that enhance profitability. Any major bank today relies upon the Internet to be the front door to consumers. Given that health care may represent 20 percent of the U.S. GDP by 2015, if not sooner, and that banks already move the money of the existing system, why not develop additional consumer products? Consider the health risk analogy to a financial risk score. If patients were to find that the use of such a health risk score would decrease their premiums by 15 percent at a cost of $10 per year, a billion dollar market could be born. Clearly, a consumer's care and feeding of a financial risk score today can lead to better financial positions for consumer lending. In this example, the business of health insurance still remains intact and may grow if better risk profiles can be developed to price insurance at a more affordable level to patients. How can that alchemy be possible? If a health risk score based on prior health insurance transactions is seen as a valid metric of risk by insurers, underwriting costs could be substantially less, with less unnecessary laboratory costs and reduced transaction costs.

One barrier to making the medical banking system functional is that it requires the engagement of patients to use the Internet for their medical financing and care solutions. Another barrier is getting medical providers on board. Both of these critical barriers to medical banking have started to be addressed in the last two years as personal electronic health records have advanced beyond simply document management systems for patients to robust Internet applications with primary backing from Microsoft through its Health Vault platform [Microsoft, current] and from Google Health [Google, current]. Only recently have medical providers and insurers embraced these two platforms as possible open-source data feeds for insurance transaction data combined with patient-enhanced personal health information.

3. Nuts and Bolts of Medical Banking

To be successful, medical banking must engage patients and providers, deal with critical issues of

[1] A health savings account is a tax-advantaged medical savings account owned by patients. The funds contributed to the account are not subject to federal income tax at the time of deposit. Health savings account funds roll over and accumulate year after year if not spent.

data entry and storage, and establish the role of banks, as opposed to insurers. Briefly, a medical banking system involves all of these key agents. It begins by a patient setting an account on a secure website such as Google Health PHR that permits data transmission and receipt from providers, insurers, and financial intuitions. For example, a patient insured with Aetna can now use Google Health to view all of his or her claims records. The provider can also be given permission to see this data as well. If the patient has an HSA, the bank that holds their assets for medical care will have transmission, receipt, and viewing privileges as well. The patient could restrict some personal health data, but any financial transaction also defined as "personal health information" data are viewable to insurers, providers, and likely banks under the final rules resulting from 1996 Health Insurance Portability and Accountability Act (HIPAA). Information will be accessible to all parties, with permission to see the data through secure Internet portals. Data will be added at the point of care or service by providers, adjudicated by insurers, and transacted by banks.

Where is the "banking" in medical banking? There are two key answers. The first is that all health insurance transactions are really bank transactions, where insurers act as the agents of employers and patients to complete a bank transaction to reimburse medical care. The second is that medical banking provides a mechanism through the HSAs where the account holder would be allowed to invest its assets in a range of different financial products, including bonds and equities in addition to money market accounts. The difference from a regular commercial banking account would be that the dollars could only be used for medical services.

4. Vision and Significance

The vision of PHRs coupled with medical banking is that of a mobile resource that provides benefits to patients and their families for a lifetime. A PHR is a patient- or family-centered technology designed to capture not only the contacts with health care providers, but also personal information on insurance, diet, and personal preferences (for example, living wills, advance directives) that a physician's health record will not capture. PHR information is stored on a website and is password-protected. Specific transactions that involve PHRs coupled with medical banking might include:

- patient sets up a PHR, which is accessible from anywhere at any time by the patient, who authorizes a physician to access the website;
- services are billed to the PHR website, which are rolled on to the health insurance provider;
- cost-sharing is billed to the patient's checking or credit card account identified in the PHR;
- patient and physician receive notification that test results are available on the PHR;
- PHR serves as a basis for medical and financial information that can be used by insurers and others.

Patients using PHR technology would be equipped with a critical and immediate resource for health improvement, disease prevention, emergency care, and long-term medical care affordability. The PHR will give patients access to critical information and allow the record to be customized to clearly define their preferences for treatment. Likewise, patients who want their organs donated in the case of mortal injury could make their preferences known.

With respect to economics, the PHR will provide the data to reduce many of the medical industry information asymmetry problems between patients and health care providers, as discussed by Arrow [1963]. Physicians would have better knowledge of patient preferences, and patients could have better knowledge of physician treatment preferences based on PHR access to physician summary information. In addition, treatment plans for patients could be customized—based on the PHR information—to provide a menu of personal health choices instead of the current status quo of little or no readily available medical advice without clinical consultation.

The most important innovation is a PHR built upon the IHC technology platform—the integrated personal health record (iPHR). This platform, recently deployed by UnitedHealth Group, BlueCross, BlueShield, Kaiser Permanente, and several infrastructure vendors, will provide the information needed to promptly administer benefits and facilitate health care transactions and payments, thus simplifying the process for patients and providing health care professionals with an efficient administrative resource. The iPHR will also convey essential health records that support care interventions. From a patient perspective,

these services transcend benefit plan boundaries and traditional geographic limits, enabling people to have their information and financial resources follow them across products and providers anywhere in the country.

The IHC technology is built upon one of the most common forms of technology available today—the bank card. In 2003, as part of its health benefits modernization program, UnitedHealth Group began issuing "health benefit cards" with bank card technology, namely the magnetic strip on the back of the card. Three years after the introduction of this technology, nearly 20 million UnitedHealth Group members have unique magnetic-strip ID cards in their wallets. The member can verify eligibility and cost-sharing amounts with a simple swipe of the card.

The IHC is not vital for patient adoption of iPHRs. Consumers can simply use an iPHR portal with account names and passwords. However, the card provides one critical asset that David Brailer's vision of interoperability among provider electronic health records may not: financial incentives for widespread provider adoption of IT by facilitating transactions. The appeal of using a card technology is that the providers are being paid more quickly through the card technology in exchange for the patients exercising their right to own their data and then share it with other patients in order to measure the productivity of their physician.

The IHC also facilitates clinical data extraction from a patient record at the point of service. Point-of-service data extraction for tracking clinical care processes and outcomes is vital for the measurement of medical provider productivity. In effect, the card serves as a neutral medical information data collection and aggregation platform that enables examination of the health of the patient as well as the care rendered by the provider(s) treating the patient.

Moreover, the iPHR technology provides an extraordinary opportunity to measure medical care productivity. Brailer [2005] has remarked on the potential for better productivity measurement from a successful health IT interoperability initiative. To successfully measure productivity, one must be able to measure the inputs and outputs of medical care. At the most crude level, one can measure hospital mortality as an output and hospital labor and capital components as inputs. What the iPHR permits is measurement of productivity at the patient level, which can then be aggregated to performance information at the physician or hospital level. At the patient level, an outcome could still be a binary indicator of inpatient mortality. However, inputs would now include details on the patients underlying health status. For example, such details could include information on whether the patient who just got a cardiac bypass procedure was healthy otherwise, or was he or she obese, diabetic, and hypertensive, or suffered diminished lung capacity from smoking. The patient condition affects the marginal productivity of labor or capital. If a patient has substantial prior health issues as reported by an iPHR, and yet a surgeon has a good outcome, the surgeon should have the opportunity to show a higher productivity for his or her labor input. Today, it is very difficult, if not impossible, for that type of productivity measure to be recorded.

5. What's Innovative?

Applying the concept of a disruptive innovation introduced by Harvard professor Clayton Christiansen and colleagues (2000, 2006), the implementation of medical banking could be a powerful industry-changing technology. Specifically, an IHC will facilitate payment and benefit transactions. This is not an e-commerce innovation in concept only. Several large employers have various levels of the core components of this technology already deployed. In addition, the IHC will facilitate access to essential health records that support care interventions contained in iPHRs.

The IHC technology can be an advantage for patients by making available limited, but important, clinical data. For example, it would provide patient prescription history to any prescribing provider. Moreover, a swipe of the card will give a physician access to the iPHR to automatically compile a comprehensive summary of critical information, including:

- medical conditions and diagnoses,
- medication history,
- significant medical interventions and laboratory results.

The technology would also support an online summary of patients' medical histories built from the point of care. In addition, the iPHR can be augmented by patients who choose to provide details such as allergies, immunizations, and family history.

6. An Example of Medical Banking in Action

How might medical banking operate in the real world? To illustrate the potential of both the medical banking technology and the interconnecting components required to provide genuine improvement in health care, consider the case of Anna, a patient with diabetes.

Anna has just moved to a new city and starts work on the first of the year. On January 1, 2008, she begins health coverage in a new health plan with an iPHR that is supported by a medical banking technology platform. Prior to her start date, she receives an IHC with a magnetic strip from her employer. The iPHR website provides a list of endocrinologists accepting patients in her area, quality scores for the providers, and an indicator for those that are iPHR-enabled. She selects an endocrinologist from the list and schedules an appointment for an initial consultation.

Prior to her initial consultation, Anna logs onto a secure iPHR website from the health plan to verify her eligibility, and she adds limited personal health data, such as emergency contacts and a "do not resuscitate" order. She also requests her previous pharmacy history from a different health plan to be added to the iPHR. When Anna visits the endocrinologist, the physician's assistant swipes the IHC using a USB swipe card machine connected to the Internet. The swipe opens an iPHR page and requests Anna to authenticate her access with a password. She provides the required authentication, followed by approval for the physician to access the iPHR. The physician sees on the iPHR website that Anna has already authorized the provider to review her past history. The physician reviews all prior drug history and proceeds to conduct an initial evaluation with some sense of patient compliance regarding medications for a chronic illness, as well as prior dosing.

During the visit, the physician orders tests. Height, weight, and blood pressure are also recorded. At the end of the visit, the physician's assistant bills for an initial evaluation on the iPHR website. This site links to the health plan's transaction engine that requests standard claims processing information (for example, diagnosis and procedure codes) as well as Anna's height, weight, and blood pressure. Because this is a standard part of an initial evaluation (signaled by the initial evaluation procedure code that is submitted), the website knows how to make the request.

Because Anna's eligibility information is provided by the initial card swipe and the provider—who is iPHR-enabled—is known to the health plan, the allowed amount for the initial consultation is transferred directly to the physician's business account. Any cost-sharing is deducted from the checking account or credit card line that Anna has already entered in her iPHR preferences.

One day later, Anna receives an e-mail that the lab work has been completed, and she can log onto the iPHR to see and comment on the results. The physician also receives the e-mail and is invited to comment on the lab results.

Anna sees the endocrinologist four more times during the year. At the end of year, the health plan invites Anna to comment on quality of care. The technology can also track whether her lab test scores have improved. If they have improved, she will receive a reduction either in her co-insurance rate or a credit to her health savings/reimbursement account (if she is enrolled in a patient-directed health plan).

Credits in HSAs for healthy behavior have become an increasing part of the landscape in health insurance benefit design. However, as these incentives grow in appeal, the technology to support them is limited because of the time delay and the challenges of making data accessible to patients in such a way that it provides health incentives properly. What medical banking achieves is fusion between the health IT collection of relevance to the patient and the data critical for an insurer to provide patients with incentives for healthy behavior. Without medical banking, the insurer does not have a good mechanism to directly provide incentives for better health status. To date, tracking clinical data for the insured is only done for a handful of very large employers as part of disease management programs. For the majority of U.S. citizens, medical banking offers a technology platform that allows Anna from General Electric as well as Anna from Ye Olde Time Curiosity Shoppe to get the same monetary advantage from monitoring and managing her diabetes.

This last piece is a critical innovation for the chronically ill with moderate to lower incomes. One of the concerns about HSAs is that more than half of them have zero balances. This would provide an opportunity to reward a chronically ill person for taking steps to maintain their health.

Continuing with Anna, suppose that she decides to shop for a new health plan, using her

iPHR data with clinical information, preferences and comments, and lab values. She finds she can get a 15 percent discount from another plan because of her healthy habits and lifestyle as a diabetic patient. She decides to take the new plan and keeps her iPHR. The only changes are the designation of her health plan and eligibility criteria, as well as the plan's provider panel, which are pre-loaded into her iPHR website.

7. Are Financial Services and Health Information Technologies Compatible?

The idea of fusing together electronic medical records and financial transaction systems may seem a bit of a stretch, adding layers of unnecessary complexity. Nevertheless, health insurance data are quite similar to medical banking data in three critical areas. First, patient privacy is paramount in both settings. Second, the structures of the databases are quite similar in that they both use a debit and credit system to tabulate cash flows and services rendered. Third, both health and financial services data are warehoused for quick storage and retrieval for a variety of different purposes.

The IT architecture for the iPHR is health insurance claims data. This information systems architecture is as old as the banking technology, but not nearly as advanced. Banking IT was upgraded in the early 1980s to accommodate the rapid national adoption of consumer-friendly automatic teller machine (ATMs). The next step for an iPHR technology would be the ability to accommodate IHCs.

One of the first issues to address is whether claims data is the right architecture. Although not perfect, it is more like a "cousin" to the efficiently operating financial transaction services. In particular, the date/time stamp is the most important feature of a transaction-based system because it provides a data ordering construct for the iPHR. Likewise, the best medical records systems use time as the central marker for disease progression and health improvement. If a transaction-based system had more clinically relevant and health outcomes data, it could in fact be a substitute for a computerized physician order entry (CPOE) system, and become a full-fledged electronic medical record.

If health insurance/medical banking data were coupled with the capability for the patient to augment and add information to the record, perhaps even on a transaction-specific basis (for example, a lab test, prescription order, or physician visit), the result would be a very powerful iPHR technology. There would have to be some fields that a patient could review but would not be able to change without review of an insurance company or a medical provider. For example, a patient could comment about a diagnosis code, but would not have it removed unless she or he appealed to the insurer for modification and approval.

Could this really work in a practical sense? The biggest weakness of a health record built from insurance transaction data is that the data provided for billing and payment purposes are not complete from a diagnostic perspective. Insurance transactions provide little to no information on health outcomes and could be biased due to financial incentives inherent in payment rules from public and private insurers. However, these shortcomings are the fault of limited data, not the transaction-based data structure. For example, the Institute of Medicine's advocacy in 2001 of widespread adoption of CPOE systems indicates support for a more clinically relevant transaction (or order) based technology platform [Institute of Medicine 2001].

8. The Perfect Storm Brewing

There is a "perfect storm" brewing that could radically accelerate the use of medical banking and make it the common mechanism of health IT exchange and financing. This acceleration could happen concurrently in the private and public health insurance markets. In this case, the perfect storm consists of three powerful forces that appear to be on a collision course. First, there is the specter of health reform initiatives likely to appear between 2009 and 2012. The second factor is the desire of patients to have information on health providers and services customized to fit their needs. The third factor is that the health insurance "card" evolution may lead to financial institutions controlling the health benefit information flows through the use of existing patient transaction platforms, such as credit card data transfer.

Health reform initiatives

As a political topic, health reform is not new. National health insurance was first put forth as a congressional proposal early in the twentith century, but it is clearly on the contemporary

agenda. One potential "storm warning" is a growing number of state health reform initiatives, such as the initiative in Massachusetts, and several others under discussion in California, Maryland, and Minnesota. Although they could easily be trumped by a federal health reform initiative, states could prove useful as laboratory experiments if their experiences can be sufficiently extrapolated.

Judging from the rhetoric of the 2008 presidential campaign, health reform at the federal level is also real possibility. For many Americans, being uninsured has far greater consequences today than it did over 60 years ago, when the Truman Administration perhaps came closest to enacting a national health insurance program. The largest lobby blocking national health insurance in the 1940s, 1960s, and 1970s was the American Medical Association. If the physicians now see their incomes imperiled without national health insurance, perhaps the re-emergence of this issue will conclude with national health insurance for all. Generally, every cycle of renewed interest in health care reform has had some incremental improvement in coverage, with the largest being Medicare and Medicaid in 1966. Recently, the biggest difference experienced by patients since the last round of health reform in 1992 is Medicare insurance of prescription drugs to enhance quality of life, particularly for those patients with chronic diseases.

If health reform is possible in the next few years, the federal cost of the program will be weighed against the massive federal government infusion of resources to correct the macroeconomic weakness of 2008. Because wages have been largely flat since 2000, and health insurance premiums have increased well in excess of twice the rate of inflation, federal policymakers could use the IHC technology to issue direct financial stimulus to American patients as "debit cards for pharmaceuticals." This would, of course, be a short-term stimulus effect, but it would institutionalize the use of the card and perhaps provide a federal infrastructure that banks and insurers could use after the stimulus. In the long run, health reform is likely to cost at least an additional $100 billion per year to cover the uninsured. How it will be financed is not clear.

Medical banking could be the key to any of these health reform initiatives as an enabler of access to insurance coverage. For example, medical banking could be used to provide a data repository for health risk scores that could be used to immediately purchase an insurance policy. In addition, the application of tax credits, vouchers, employer-based coverage, or even Medicaid participation could all be accomplished as medical banking applications.

For example, assume that a state wants to enact an individual mandate for health insurance coverage. To do so, it works with one or several medical banking partners to issue IHCs through credit card services. Everyone in the state receives a card via his or her health plan, employer, Medicaid, Medicare, or social services. Eligibility for health insurance products would be coordinated by a contracted health benefits exchange service from a human resource service vendor. One of the key concerns of equity-minded state officials may be the charge per transaction, which varies by vendor.

The IHC would be used to authenticate and retrieve an actuarially validated risk score (referred to in this example as VitaRate) for an individual and/or their family members to price a proposed insurance contract. In the case of the uninsured patient, providers will authenticate the need for care and qualify the patient for a state uncompensated care pool. For example, something like the Web-based Quicken Health portal opens and provides a reported risk score as well as information on available, high-quality providers—both in hospital and in outpatient (clinic) settings—that are customized to a person's condition.

Next, the portal links to some site like ehealthinsurance.com to take VitaRate quotes and allows patients to shop for guaranteed plans with premiums reviewed by a certified actuary. Employers receive notification of their employee risks and identify whether they want to exit the self-insured marketplace if sufficient risk pooling for all employees can be identified in the wider market. They will use their benefits consulting vendor to project their optimal strategy going forward.

At year-end, the state health department gets health care quality and efficiency reports by different population segments and identifies funding strategies to cover the non-Medicaid uninsured who cannot afford a commercial insurance product. This would enable the state to deliver on its promise for price and quality transparency that has been advocated by the Bush Administration since 2004.

Desire for customized information

Like online retailing several years ago, early adopting patients are willing to trade some privacy for convenience as trust in health information networks grow. For example, Microsoft's Vault project as well as a prominent PHR initiative sponsored by AOL founder Steve Case known as Revolution Health may cause the cultural acceptance of medical records available on a web portal to be realized, as patients trade security concerns for treatment convenience [Revolution Health, current].

Control of health benefit information flows

Of course, medical banking would not be welcomed by all, even though it could lead to a net positive welfare improvement by removing the current information asymmetry hobbling the market between the provider, the insured, and the insurer. There are four substantial issues that would need to be overcome. The first is the "privacy sanctuary" claimed by the patient. The ultimate claim would be, "No one should have my information other than me, and I will not share it with anyone for any transaction." If taken to this extreme, the current system would seize up. Medical banking transactions would never be recorded because there would be no financial need for electronic financial transfer intermediation. This is likely to be an untenable position in the long run because of the existing data infrastructure in place to provide major public health insurance programs.

The key privacy question, however, is access to not only financial data but also to health data and how that access might be abused by insurers or others. If insurers and banks are to benefit from the new business model of medical banking, they must go to extraordinary lengths to certify the privacy practices of their firms. There are already safeguards today that were put in place seven years ago. For example, the consequences of leaking or abusing personal health information as outlined by HIPAA are quite severe and involve fines and jail time. The potential of abuse of medical banking information for underwriting is the same as for any personal health data. Medical banking will increase the velocity and detail of these data, but it would also have digital fingerprints that could make identification of inappropriate behavior easier to verify and prosecute.

The second issue is that medical risk rating as enabled by new and more current data from medical banking could place an unfair burden on the chronically ill. However, it should depend on how they became chronically ill. If behavior (smoking, over-eating, alcohol abuse, and so on) is the driver for illness, that person has become a moral hazard to the health insurance risk pool and should be priced appropriately. If, on the other hand, a major illness is the luck of the draw, then risk rating should create a new risk pool for unexpected circumstances—closer to the "pure" insurance models in other industries. This is precisely what happens in the Dutch health care system. Finally, premiums or out-of-pocket payments could be lowered for the chronically ill if they are taking steps to manage their own or their child's illness(es).

A third issue is that a provider may argue that HIPAA does not allow sharing information with another provider. Actually, this argument was recently weakened by the ruling that Medicare claims data for physician services would qualify under the Freedom of Information Act [Gerstein 2007]. Although this is likely to be appealed, it highlights the sensitivity of the issue. HIPAA allows patients to own their data and convey it to whomever they want.

The fourth issue is that HIPAA may not permit insurers to release any health information regarding patients. Currently, firms such as Medstat resell de-identified claims data for analysis and for postlaunch market surveillance programs of medical technology firms. If the data ultimately are owned by the patient, and a future court case or enacted legislation indicates that data cannot be commercially used without a patient's permission, there will be significant repercussions in the U.S. market. For example, the use of such data found the relationship between Vioxx and increased cardiac event risk. The recent ruling allowing access to Medicare data could easily be extended to other insurers as well, if they are providing insurance as part of a government-financed health insurance program tied to health reform initiatives.

9. Conclusion

Medical banking, if widespread, could break the control of health data by providers and insurers. In many major metropolitan communities and certainly all rural communities, there are less than

a handful of hospitals and insurers in competition with each other and they do not, with very rare exception, exchange data. The data necessary to gauge the performance of these institutions are not shared comprehensively and not at the patient level, as described above. In effect, this data monopoly provides genuine information asymmetry between providers and insurers and their patient clients. Owing to this organizational control, the lack of data-sharing arrangements for clinical data that is already in a digital format is an information bottleneck that can literally kill patients.

The significance of the new medical banking technology is that its development is based upon a currently accepted form of IT, insurance payment transaction processing. It provides a platform that links data across all sites of care without a command-and-control integrated delivery system, thus creating the information flow necessary for a high performance medical industry. But it will not be sufficient without widespread acceptance and wise use of the information by patients, providers, and financial intermediaries. Looking into the future, medical banking may be one of only a handful of disruptive innovations with the chance to seriously change the health care marketplace for a net societal welfare gain.

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REFERENCES

Arrow, K. 1963. "Uncertainty and the Welfare Economics of Medical Care." *American Economic Review*, 53: 941–73.

Brailer, D. 2005. "Economic Perspectives on Health Information Technology." *Business Economics*, 20(3): 7–15.

Brynjolfsson, E., and L.M. Hitt. 2000. "Beyond Computation: Information Technology, Organizational Transformation and Business Performance." *Journal of Economic Perspectives*, 14(4): 23–48.

Burke, D., B. Wang, T. Wan, and M.L. Diana. 2002. "Exploring Hospitals' Adoption of Information Technology." *Journal of Medical Systems*, 26(4): 349–55.

Department of Health and Human Services. 2004. "Towards Interoperability." Executive Summary.

———. 2006. "President's Initiative on Health Care Quality and Transparency." Briefing Paper.

Gerstein, Josh. 2007. "Medicare Claims Are Public, Judge Rules." *New York Sun*, (August 23).

Google. current. "Google Health." https://www.google.com/health.

Grossman, M., 1972. *The Demand for Health: A Theoretical and Empirical Investigation*. National Bureau of Economic Research, distributed by Columbia University Press.

Institute of Medicine. 1999. *To Err is Human*. National Academy of Science Press.

———. 2001. *Crossing the Quality Chasm*. National Academy of Science Press.

Microsoft. current. "Microsoft HealthVault." http://healthvault.com/.

Revolution Health, current. http://www.revolutionhealth.com.

Mr. PALLONE. Thank you.

We will now have questions from the members of the subcommittee.

I should mention that everyone, again, that members of the full committee are going to participate in the same way and have 5 minutes each. And if you were here and passed on the opening, you will get an extra minute. But if you weren't here, then you don't get an extra minute. Just to make the rules clear.

And I am going to start with myself. I am trying to get two questions in here, one about the need for comprehensive reform and one about the public option. So I will start with the comprehensive reform. But if we go too long, I may stop because I want to get to the public option, too.

Mr. Neas, the National Coalition on Health Care has always envisioned the need to address health reform in a comprehensive manner, as your testimony sets out this morning. And in our discussion draft, we address issues ranging from the workforce and prevention and wellness to coverage costs and quality improvement. Is it possible to address this in a piecemeal fashion, or do we need the comprehensive approach to tackle this issue?

Mr. NEAS. Mr. Chairman, it is absolutely essential that this be done in a comprehensive way, as we point out in our testimony and all of our published materials. It is essential that we have systemic, systemwide change in this country in our health care system. To do it piecemeal, we could end up with a system much worse. You could cover everybody, but you don't have cost containment or you don't have it paid for in the right way or you don't have quality. All of these principles are interdependent. They rely on one another. You have to do it all at once. You can't do it incrementally, and you can't do it piece by piece.

Mr. PALLONE. OK.

Let me go to Mr. Kirsch, then, about the public option. We have a public option in the discussion draft in a manner that assures, in my opinion, the levelest possible playing field with the multiple private insurers who will also be competing with the public option. So I have four questions, and I am just going to read them and ask you to try to get through them in the next few minutes here.

First, why do we need a public health insurance option? Won't the exchange function better with just the competing private insurers?

Second, what do you think of the alternatives to the public option set out in or draft? People have mentioned co-ops or State By State options or a public option triggered only if certain criteria are met.

And then, third, you know, outside the Beltway, as I guess we don't really care much about the Beltway anymore, is the public option a partisan issue?

And fourth, would a public option help or hurt small businesses?

If you could try to address those in 3 minutes or less.

Mr. KIRSCH. And try to talk not too fast. OK.

Why a public option? If we don't, we are just rearranging the deck chairs on the Titanic, and I guess the regulation is maybe giving those chairs a shiny coat of paint.

The fact is we have had a private insurance industry that has been running our health care system for quite a while now. We

have had premiums go up several times as much wages—in some states, multiple, multiple times as much as wages. At the same time people have poor quality care, and they are used to denial and delays all the time from health insurance companies.

We need a public option to do the two things the President says, to lower costs, to have an actor in the system that is mandated to have a kind of lower cost operations it can have, and also to keep insurance companies honest because their bottom line will always be hurt every time they pay for a significant claim.

Mr. PALLONE. What about the alternatives, the co-ops that trigger——

Mr. KIRSCH. The alternatives are basically ways to kill the public insurance option. The trigger is basically saying, we are not going to have it unless things get worse. There is an old expression: Fool me once, shame on you; fool me twice, shame on me. The insurance industry basically said in 1993, 1994, leave it to us to fix the system. We have seen what we have gotten. We can't wait any longer. We have waited a long time for the insurance system to fix this system, and they have failed.

The co-op, an interesting comment from an Oppenheimer & Company analyst says, the co-op proposal is a great gift to publicly-traded insurance companies. It is doomed to fail. It was basically a political invention to try to placate Republicans who didn't want a government role in providing an option, and it has no policy benefits. We have lots of nonprofit insurers in this country that haven't done the market-changing factors we need to provide the kind of care.

Mr. PALLONE. Third, would be outside the Beltway, is the public option a partisan issue?

Mr. KIRSCH. No. It is extraordinarily popular. The first polling question we asked was, public, would you prefer a public plan, just a choice of just public insurance, private insurance, or public and private insurance? Not only did 73 percent of Americans say they wanted a choice; that included 63 percent of Republicans.

In the case of the New York Times poll just released over the weekend, 72 percent of Americans say they wanted a choice of the language of a government-administered plan like Medicare to compete with private insurance. So using the government word, and still 73 percent of Americans wanted it, including 49 percent of Republicans, which means more than—and many fewer than that opposed it.

Mr. PALLONE. What about the impact on small businesses?

Mr. KIRSCH. And small businesses? Small businesses like everyone else need lower-priced coverage. And again, there are a lot of things in your legislation that make huge advantage of small business. We should talk about it. One of those is the public option because to the extent the public option is offering good quality at a lower cost, small businesses will benefit.

Mr. PALLONE. Thank you.

Mr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman.

Dr. Parente, first off, you were—the buzzer or someone interrupted you where you were about to make a point about not having a CMS director. Would you care to finish that point?

Mr. PARENTE. Simply to say that there should be a CMS administrator given that there is $400 billion that has already been spent by that program. If you want to bend the cost curve down, one of the places where the costs are going out the door right now is Medicare and Medicaid. That needs active management.

If even people were to put in modernization for some of the fraud, things that have been put on the table, some of it actually in the bill, that would be useful. But right now, because it is essentially a caretaker administration over at CMS, none of that can occur.

Mr. BURGESS. Let me ask you a question, and certainly, you know, hats off to your group for doing that exhaustive work on the Kennedy bill under such a short period of time. Are you going to do a similar scoring for the draft discussion that we have in front of us this morning?

Mr. PARENTE. Yes.

Mr. BURGESS. And when might we expect for that information to be publicly available?

Mr. PARENTE. I am hoping that it would be on the HSI Web site by tomorrow morning at 8:00 a.m.

Mr. BURGESS. Tremendous. Thank you for doing that as well.

Now, when you were here last fall, I think it was the day after Lehman Brothers failed, if I recall correctly, and the whole world changed. This $4 trillion figure that you talked about for the three tiers of the public option under an FEHBP-type structure, you also referenced a low end that would be essentially Medicaid for all that would be much less expensive. And if I recall correctly, that was about $60 billion a year or $600 billion over 10 years. Do I recall that correctly?

Mr. PARENTE. That is correct.

Mr. BURGESS. Now, assuming that the reality lies somewhere in between those two— well, let me just ask you this. Have you looked at—under the proposal before us today, Medicaid is offered—a full Federal component of Medicaid is offered for everyone at 133 percent of poverty and below, not just the existing populations, but for all populations. Do you have an idea what the cost for that is?

Mr. PARENTE. Not as specifically. Actually, the public option plans, with the subsidies that are proposed, at least in the Kennedy bill, addresses a fair bit of the population. A round guess on that cost would be probably somewhere in the vicinity of about—no more than about $30 billion or $40 billion per year.

Mr. BURGESS. Very well.

Let me ask you a question. And we hear the President all the time, in fact he said at the White House last March, that the only thing that was not acceptable was the status quo and, if you like what you have, you can keep it. Well, it is kind of tough to reconcile those two positions.

Do you think, under the bill that is under consideration today, the draft bill, the tri-caucus bill that is out there, do you think it is reasonable to assume that, if you like what you have, you can keep it, under the parameters of the bill that are before us today?

Mr. PARENTE. I think it is really determined by how the public plan is ultimately deployed. I mean, as you all know, it is a very

long road from whatever this legislation is to enactment, which could be 3 to 4 years from now.

The concern, really, is crowd-out. It is hard to say what the public plan model would look like, in terms of logistical, operational terms. It if it operates like TRICARE, that could be a crowd-out potential. If it operates like FEHBP, that would definitely be a crowd-out potential because it is more generous than the standard market today.

Mr. BURGESS. Mr. Kirsch, let me ask you a question. In yesterday's Politico you have an opinion piece, and you talk about the three things that are likely to make this legislation happen. And the third thing, the organization where it counts most outside the Beltway—now, I don't know how far outside the Beltway you have gotten. In north Texas, I will tell you that 65, 68 percent of the people in my district—and it is not a wealthy district, it is a working district, a rural district, an inner-city district, as well as a suburban district—but 65 to 68 percent of the people in my district are satisfied or very satisfied with the insurance coverage that they have today.

In spite of the fact that so many people are demanding change, that seems like a pretty high number that is accepting of where they are right now.

Mr. KIRSCH. Well, it always depends, on all these things, on how the questions are asked. Basically, if we look at the views nationally, according to the New York Times, 85 percent of people believe that the health insurance system needs fundamental change or it needs to be completely rebuilt; 86 percent believes it is a somewhat—61 percent believe it is a serious threat to the economy.

What people are dealing with is they may be happy with their insurance at the moment, but what they are totally terrified of is what happens if they lose their job. And so they want a system——

Mr. BURGESS. Correct. And let me just interrupt you there, because I think we can address those problems and correct those problems without turning the entire system on its head.

Now, the last New York Times-CBS poll that I guess is the one you are referring to, just a curious figure down toward the end of it: Of the people polled, 48 percent voted for President Obama, 25 percent voted for Senator McCain, and 19 percent didn't vote.

That is a curious sampling, and I wonder if that may not have skewed the results that were reported so widely on the Sunday shows yesterday.

Thank you, Mr. Chairman. You have been generous. I will yield back my time.

Mr. PALLONE. Thank you.

The gentlewoman from Colorado, Ms. DeGette.

Ms. DEGETTE. Thank you very much, Mr. Chairman.

Dr. Parente, I read your testimony, and I wanted to talk with you a little bit about some of your analysis around the public plan and cost savings and so on.

I certainly agree with you that we need to try to get cost savings in Medicare and in other programs. But what we have seen, for example, in Massachusetts, since they have put together their connector system without a public plan, the good news is they got almost everybody enrolled in health care. The bad news is they got

absolutely no cost savings, and their costs are going up as much as everybody's.

So I am just wondering if you can tell me—and I apologize, I didn't read your piece in Politico. But I wonder if you can tell me, do you think all potential public plans are a poor idea or just ones that would cause this crowd-out?

Mr. PARENTE. I don't think all public plans are a bad idea. I think, as I understand as an economist what you are trying to do——

Ms. DEGETTE. Or, at least, what you have done is you have analyzed the Senate bill.

Mr. PARENTE. Right.

Ms. DEGETTE. And I understand that was the bill that was out there. But we, as you know, are a little sensitive over here about having our own bill and having it be a work in progress. So you can give your opinion on the Senate bill, recognizing that is not our bill.

Mr. PARENTE. I understand. And there are similarities, so——

Ms. DEGETTE. Yes.

Mr. PARENTE. —a lot of the structure is very similar. Like I said, I applaud some of the things that are put in for Medicare that are related to cost savings and such.

A public plan is designed to inject competition into the system. What concerns me is that there already is quite a lot of competition in the private insurance market space. A few things——

Ms. DEGETTE. Well——

Mr. PARENTE. A few issues—just one clarifying comment. If you look at what Massachusetts did very well, it simplified the benefits so that most people can get a sense of what was available.

Ms. DEGETTE. Right.

Mr. PARENTE. But if you look at what actually did the deed to get everybody covered, it was mostly through high-deductible health insurance plans.

Ms. DEGETTE. Well, you know, I am sorry, I have a limited amount of time and we have two other witnesses. But there was a study that was just released by Health Care for America that found that 94 percent of the communities in the country do not have a competitive health insurance market. For example, in Pueblo, Colorado, they have one provider, WellPoint, that has 76 percent of the market share. And so, in fact, we don't have robust competition in 94 percent of the country.

So I am wondering, don't you think that a public plan might be able to help with competition in communities like that?

Mr. PARENTE. Not if it doesn't have active price competition. So my concern is what if the——

Ms. DEGETTE. Right. Well, let's say it does have active price competition, then your objection is that everybody leaves the private plans because it is cheaper. But isn't that a noble goal?

Mr. PARENTE. To have everybody leave the private plans?

Ms. DEGETTE. No, that people be able to buy cheaper health insurance.

Mr. PARENTE. Yes, that is a noble goal. But if you are going to regulate the public plan to basically go into price competition with the private insurance industry, you have to ask with your question,

how are you going to be able to price-fix those public plans to be able to do that?

Ms. DEGETTE. Oh, you know, just so you know, at least from the view of—at least from my view, I don't think that we should price-fix the public plan and give them an artificially low price. I think most of us on this committee would think, if we have a public plan, they should be able to compete with the private insurance companies.

Mr. Kirsch, I am wondering if you can comment on that study by Health Care for America and why that necessitates the need for a public plan.

Mr. KIRSCH. Right, yes, Congresswoman, as you said, 94 percent of the market—this is actually AMA data that we use in our study—are highly concentrated by Department of Justice standards, which means people don't really have choices in State after State, like in Pueblo, Colorado, and municipalities or areas around the country.

It is also the question of the right kind of competition. It is having competition; it is also having competition for an insurance company that cares about people's health care more than a healthy bottom line. So it is both factors we are looking at.

Ms. DEGETTE. Yes. And it would seem to me, for all the panelists, Mr. Neas and everybody, that one way that we could improve our health care system is to get the competition, but also to try to get cost savings through Medicare. And I don't think those things are mutually exclusive, do you, Mr. Neas?

Mr. NEAS. Absolutely not. And I think we can applaud the work of some of the States, like Massachusetts or Tennessee. However, they were not systemic, systemwide reform that addressed cost containment, that addressed simplified administration and other issues. You have to do it as a comprehensive package.

This could be done. And I think the committee has done a good job, a good start, on the public plan, trying to make sure that it would be on an equal playing field, not giving an advantage, be fair and competitive.

Ms. DEGETTE. And I won't vote for a public plan that has an unfair advantage over the private plans. But I do think we need to find some place for competition, to keep everybody trying to find their best price points.

Thank you very much, Mr. Chairman.

Mr. PALLONE. Thank you.

The gentleman from Georgia, Mr. Gingrey.

Mr. GINGREY. Mr. Chairman, thank you.

I want to address my first question to you, Mr. Kirsch. You made a statement in response to one of my colleagues, I think the question of why the public option plan. And you said, well, the insurance company—the health insurance companies are so egregious in what they have failed to do. I think you said, fool me once, shame on me; fool me twice—or just the opposite—fool me once, shame on you; fool me twice, shame on me.

Why do you feel that, based on that, that we should give the, as I think this will do, this bill, the death penalty, essentially, to the private market? Why not give them 30 years in prison rather than the death penalty? Why is it you want to come down so hard?

Why not let an exchange function, at least for a period of time, to see how that competition works to bring down prices, as it has indeed done by the prescription drug plans in Part D of Medicare?

Mr. KIRSCH. So, let me just say that single-payer would be the death sentence. This option is, in effect, saying, "You get a chance, but you don't get to have the field to yourself." I want to address——

Mr. GINGREY. But let me interrupt you just for a second. You understand I feel like that a public option is a step, a giant step, toward a single-payer.

Mr. KIRSCH. So I was just going to address, if I could—and this level playing field thing drives me crazy.

Private insurance companies have 158 million to 170 million customers. There are networks in place, they have years of brand loyalty, they have contracts with businesses, they have a well-established place in American society. They are going to continue, as they have done in Medicare, to try to do everything possible to cherry-pick and avoid people who have high health care risks even in a regulatory scheme.

In terms of a level playing field, the public health insurance option is going to start at an enormous disadvantage because it doesn't have all those things in place. And when the private insurance companies whine that can't compete with the government, I have to begin to wonder, do they really believe the polls that say that 93 percent of Americans don't trust them, and that is why they can't compete?

Mr. GINGREY. Well, let me ask you this question. You say on page 2 of your testimony, and I quote, "The good news is that we can fix what is wrong with the system with a uniquely American solution"—a uniquely American solution similar to what we did with AIG, uniquely American solution similar to what we did with General Motors?

What is uniquely American about interfering with the free-market system in this country?

Mr. KIRSCH. Well, first of all, we are not talking about bailing out the insurance industry like we bailed out General Motors and AIG. We are talking about giving the insurance industry some competition.

And what is uniquely American about this is saying, we are not going to have a system that is just private, we are not going to have a system that is just public; we are going to build on what works in America.

What works, in some ways is private insurance, has got problems, has worked for our parents and grandparents, is Medicare. We are going to use two systems you are familiar with and combine them, and that is the uniquely American part of the solution.

Mr. GINGREY. Let me switch to Mr. Parente.

Mr. Parente is an economist. I would like to get your opinion on what impact will the employer responsibility policies in this draft have on employers' ability to create jobs and put more people back to work? I want you to answer that.

And I also want to know if you have seen anything in this draft legislation in regard to the reserve funds that the public plan would have to come up with. And where would they get that money

to be on a level playing field with the private health insurance plans that also would be competing in the exchange?

Mr. PARENTE. The employer question, first of all, it really depends on the size of the employer. There is—I have to look at this more carefully, will before 8:00 a.m. Tomorrow morning. But there is the provision that there has to be some pay or play option that is in this. That will always impact employers in a way depending upon the size of those particular employers that are in place.

And your second question?

Mr. GINGREY. Well, let me switch it over to Mr. Neas on the second question.

Mr. Neas, do you see anything in this draft that calls for the public plan providing a reserve fund before they can do business, just like any other health insurance company doing business? Any State in this country would have to have a certain amount of money available before they could start offering a product so that they could cover these claims that occur. They would have to have that reserve.

Where would it come from in the Federal Government plan, and how much money are we taking about?

Mr. NEAS. Mr. Gingrey, I must confess not to knowing every single phrase or sentence in the bill. My recollection from going over the materials over the weekend was that the committees plan to have this public insurance option compete on an equal level, be competitive.

And, as I understand it, also that there would be an initial investment with respect to the reserve at the beginning, and then the public insurance option would be self-sufficient after the second or third year.

I defer to counsel and others up there, the members, but I think that is my recollection.

Mr. GINGREY. Mr. Neas, thank you.

And, Mr. Chairman, thank you for your indulgence.

I assume that money would come from the general fund and from John Q. Taxpayer.

Thank you, and I yield back.

Mr. PALLONE. Our vice chair, Mrs. Capps.

Mrs. CAPPS. Thank you, Mr. Chairman.

And thank you for your testimony, to each of you.

Mr. Kirsch, your organization, Health Care for America Now, has good representation in my district, so I will be addressing my conversation with you, because it comes right from some of the people who have been talking with me.

But I did want to mention in this discussion of competition, which I am happy we can get in to, agriculture is the basis of my congressional district in California, and large parts of it are rural, therefore. And, in those areas, there is only one private option. I don't call that competition. Maybe that is why there is such enthusiasm among many of my constituents for change, because they see a monopoly in health care delivery. If you make too much money so that you can't be on Medicaid, then you have to buy this plan that they keep raising and they do. Plus, we have a provider issue because it is a locality problem with our low reimbursement rate.

So that combination is really—in so much of America we didn't bring those points together. It is a part of our reform legislation, as well. So I am pleased that we have this opportunity to really get into what competition means.

And I want to get to that in a minute, but would you just expand for maybe a minute on so on why we cannot wait any longer?

There are a lot of people here in Washington, D.C., and some who are overwhelmed with our financial burdens, our economic situation, plus our debt, they are saying, "Why would you want to bring this up now?" to our President. And some of us, maybe, are wondering, too, because our agenda is really full.

Now, as I said in my opening, as a public health nurse, this is why I came to Congress, in large part because we have a system that isn't working, that is already so costly. I mean, we are talking about the huge costs of health care. We are already paying more than any other country in the world for health care.

So why must we seize on this very crowded moment in our agenda to do this?

Mr. KIRSCH. Well, I think you have answered the question yourself. I mean, you know, the fundamental point that to fix the economy in the long run we have to fix health care is just true. It is a point that the President has made, that Peter Orszag has made.

Our failure to do that, our failure to have a system which provides good coverage to everyone and systemic ways of controlling costs, is why we continue to have a system where health care inflation is larger than greater inflation, why we continue to outpace the rest of the world in how much we spend and yet get poor results.

What is true about the rest of the world is they understand that health care is not a private good, it is a public good. And there are two things you do with a public good: You regulate it or you provide it directly.

Mrs. CAPPS. Let me interrupt you. Do you think that feeling is shared in this country, that that is what it ought to be?

Mr. KIRSCH. Absolutely. And, again, the New York Times poll, great data from this about the public's feeling—I will pull it out—but that the government can do a better job of controlling health care costs than private insurance.

What the public actually understands is really interesting in this. They understand that nobody other than the government is strong enough to stand up to private insurance and the role they have in their life, the kind of thing your constituents see all the time. They want a strong, public government role for regulating the private insurance industry and providing a choice, so the only choice isn't private insurance.

And, you know, if you look at why so many larger employers now are saying they want reforms, it is because they understand the current system is unattainable, and small business—unsustainable.

Mrs. CAPPS. Let me ask you to use—and I wish I had time to ask all three of you. I think there is a huge lack of understanding. And I hope that these hearings and our President's press conference today and all the other things are going to really help explain to the American people what a public option is, that it is a level playing field, that the public option isn't a government-sub-

sidized program any more than any of the other options will be. If we have health reform, we are going to give an opportunity for everyone to be participating. And most people, so many people, up to 400 percent of poverty, are going to need help.

Mr. KIRSCH. Right. And I think what I am finding as I talk to constituents, and you may find the same thing, is there is a huge confusion between the exchange and the public insurance option. This is a new concept for people.

So people ask me questions like, I was on the phone yesterday and they said, "Well, will the public option cover the following things?" I said, "This is the wrong question."

Mrs. CAPPS. Yes.

Mr. KIRSCH. We are going to have a system—and what your bill does, which is great, is it says that every plan in the exchange will have to meet these benefits. And, actually, after 5 years, every employer will have to meet these benefits. So we are establishing a standard across the country.

And so much of what your legislation does, which is important in terms of a level playing field, is it says we are going to create a basic standard of health care in the employer system, which is one reason that we won't have the crowd-out, as well as in the exchange, and the public option will be one more option in that.

But that gives everybody the question of, again, will I be guaranteed good, affordable health coverage? Well, you know it will be good if it meets those standards.

Mrs. CAPPS. Uh-huh. And I think you are absolutely right that what the public is asking for is certainty. The great fear that people have with the health plan that they may even like is that there is no guarantee that next year the premiums will go up.

We did this Managed Care Modernization Act, and seniors welcomed the opportunity for a chance at lower costs, but then they found out that, at any moment, those companies—the insurance companies have had nobody overseeing the way they were able to manipulate the markets.

I will yield back for now, but thank you very much, all of you, for helping us have this conversation.

Mr. PALLONE. Thank you.

The gentlewoman from Tennessee, Ms. Blackburn.

Mrs. BLACKBURN. Thank you, Mr. Chairman.

And I want to thank all of you for being here. And I have a list of questions that I would love to go through with you all.

Mr. Neas, I think I will start with you. You know, you make a pretty bold statement on page 1 your testimony. "The economic crisis facing us cannot," which you underline, "be addressed successfully without the simultaneous adoption of a comprehensive, sustainable overhaul of America's health care."

Do you have specific research that you are citing in that, and would you like to submit that for the record?

Mr. NEAS. Yes, I do——

Mrs. BLACKBURN. Great. I would love to have——

Mr. NEAS. —Congresswoman. I would love to depend on the chairman of the Federal Reserve——

Mrs. BLACKBURN. OK. And let me ask you also——

Mr. NEAS. May I finish that question?

Mrs. BLACKBURN. Do you have any program that was a public-private option, competition, that you can point to that has been successful or successfully implemented?

Mr. NEAS. I think there are many examples of where there has been a public-private——

Mrs. BLACKBURN. Can you cite one for me for the record?

Mr. NEAS. I would certainly say that the Medicare and Medicaid and Veterans, all the so-called public programs have much interaction with the private——

Mrs. BLACKBURN. Can you look at the States and give us one? Because we know in Tennessee and Massachusetts they have both been shown as being examples that do not work.

And, you know, there was a question, in our question period, someone mentioned price-fixing with the public plan. What we found in Tennessee is that you cap what is going to be paid through that public plan and everything gets cost-shifted over to the private plans. And then you limit your access, and your private insurance becomes unaffordable. And rural areas like mine lose out.

So it just really—it doesn't have a great track record. So I appreciate your willingness.

Second question for you: Do you think this can only be addressed by the Federal Government? Can the States not help address this? Can the private sector not address this?

Mr. NEAS. The States have to be part of this. The private sector has to be part of this. But we also need a national plan that is systemic and systemwide——

Mrs. BLACKBURN. And you think everybody has to be in the plan?

Mr. NEAS. Absolutely.

Mrs. BLACKBURN. OK. Then do you agree with the premise over in the Senate where they are wanting to exempt the unions and the union workers would not have to pay? Let's see, those that are covered under collective bargaining agreements would not be subjected to the tax. The tax is on the health care benefits.

Mr. Kirsch, I see you weighing in on that. Do you want to speak on that one?

Mr. KIRSCH. Sure. I mean, first of all, you are talking about a question of whether or not we should be taxing people who have good health care benefits. And I think that is the wrong direction.

Mrs. BLACKBURN. So tax everybody but not the union.

Mr. KIRSCH. No, no, no. We don't think you should tax——

Mrs. BLACKBURN. OK.

Do you, Mr. Neas, think the unions ought to be exempted, or should union workers have to pay on this also?

Mr. NEAS. I don't think there is any provision in the Senate that is trying to treat union members differently than any member of society.

May I answer a couple of your questions just for 20 seconds or so?

I do want to go back to the private-public blending, the partnership. But, most importantly, you just can't, as in Tennessee or Massachusetts, address coverage for all or one these principles. You have to look at the cost, you have to look at the financing and the administration. $2.5 trillion a year in health care spending, ap-

proximately a trillion of that, according to dozens of studies, is waste and inefficiency. The money is there——

Mrs. BLACKBURN. OK. Let me interrupt you. Reclaiming my time, I appreciate that. And I would like—I am so limited on time, and I have so many things.

But Mr. Kirsch has just said that he is opposed to a single-payer system. And then your group sponsored a rally last year, and here is a comment that was made by a Member of Congress, said, "I know many people here today are single-payer advocates, and so am I. Those of us that are pushing for a public insurance option don't disagree with the goal. It is not a principled fight. This is a fight about strategy, about getting there, and I believe we will."

So, you know——

Mr. NEAS. Congresswoman——

Mrs. BLACKBURN. —we have to look at this. If we have those that say, "I am not in favor of a single-payer system; we really don't want to go there," and then others that say, "Well, this is a step along that way," as others members, in their questioning, have asked you today, I think that that causes us tremendous, tremendous concern.

And, Mr. Kirsch, I think it is fair to say that maybe you don't like the insurance companies, but, nevertheless, would you—your wanting to get to good, affordable coverage for all, that is a goal that I have. Going through what we have done, access to affordable health care for all of my constituents I think is an imperative. And everyone should be able to have access to that.

Now, are you completely opposed to a private-sector solution? Are you open to that? Or do you feel like it has to be done through government control?

Mr. KIRSCH. Well, let me just quickly—if you are saying we are going to continue to have this solved through the private market that got us into this mess, yes, I am opposed to that.

Mrs. BLACKBURN. OK.

Mr. NEAS. Fifteen seconds, Congresswoman? We did not have a rally last year. No one said anything like that at one our rallies. I think your facts are incorrect.

Mrs. BLACKBURN. OK, I appreciate the clarification.

Mr. Chairman, I will yield back. And I have some questions I didn't get to that I would love to submit for the record.

Mr. PALLONE. Every member can submit questions for the record. I will mention it at the end, but I can mention now, within 10 days we usually ask members to submit their written questions and then we ask you to get back.

The gentleman from Georgia, Mr. Barrow.

Mr. BARROW. I thank the Chair.

We have heard a lot about how beneficiaries are going to benefit under various proposals in the tri-committee draft. I want to hear a little bit about how providers are going to benefit.

Where I come from, people are mighty concerned about being able to keep their choice of doctor and their choice of hospital, but it would probably be more accurate, where I come from, to talk about getting that choice back, because a lot of folks don't have a choice in the current system as to where they can go to get the treatment.

And you talk to doctors, and they have this problem writ large. The consolidation of business in the health insurance sector has allowed fewer and fewer insurers to exert and abuse what is essentially a monopoly power to decide what folks are going to get reimbursed.

So when I hear folks talking about how participating in a public plan is going to get you at least what you get with Medicare plus 5, or something on that order, you are talking about a system that is already so bad it broke, where they were ignoring what is going on in the private sector, where the private insurers say, "If you are not in our network, you don't get to treat anybody, because we are the only insurer in town."

So what I want to know is, how are the rights of doctors and hospitals going to be strengthened here? I read a lot in the summaries about how the interests are going to be served pie-in-the-sky-wise, you know, down the road—we are going to grow the universe of providers, we are going to provide incentives to get more folks into the game.

Well, that stuff sounds good, but what about the rights? What can folks expect, as a matter of law, if this draft were to be enacted, in terms of what doctors get to participate in what plans, how insurers can discriminate against doctors of good standing in their community? How is this going to change in terms of how the world looks to doctors?

Who can go first on that? Mr. Kirsch, do you want to take a stab at that?

Mr. KIRSCH. Well, I think the first thing to note is that, while there are some access problems in Medicare, 97 percent of doctors accept Medicare. And, you know, seniors find that they get covered with a large variety of doctors in their community through Medicare, and you don't have the kind of network problems you have in private insurance, where you have restricted networks and, you know, you may change insurance plans and you lose your choice of doctor.

Mr. BARROW. The range of the benefits package is good, or at least it is standardized. Folks have a pretty good idea of what to expect in terms of what is covered. Doctors don't like, though, the way we have abused the system with the constant—you know, the sustainable growth rate issues have sort of abused that system so much that it is no longer the gold standard, in terms of what doctors look for and what they expect to get. They need to be reimbursed for the reasonable cost of what they are doing.

Mr. KIRSCH. Right. And I know that, you know, one of the things about the STR fix will hopefully mean that we are on a long-term path to make that more comfortable for physicians. At the same time, from a point of view of physicians participating, they participate in Medicare, and one of the things about a public option, having a stable—stability—and we would expect physicians participating the same way they do in Medicare, particularly in your legislation, paying 5 percent more than Medicare. You would then solve a lot of this problem of choice and stability for individuals, and then doctors would have a system that they can enter in at an enhanced rate for Medicare, particularly with that STR fix.

Mr. BARROW. So, basically, what you are saying is, if the doctors are being pushed around by the one or two dwindling providers—payers in the market, they have a place to go——

Mr. KIRSCH. Absolutely.

Mr. BARROW. —that they don't have right now? It is guaranteed to be open to them.

Mr. KIRSCH. Yep.

Mr. BARROW. OK. How about hospitals? How will hospitals come out of this, especially rural hospitals? How are their interests going to be strengthened or served by the draft?

Mr. KIRSCH. Well, you know, a huge burden for hospitals is uncompensated care. It is an enormous, enormous burden. And, you know, hospitals are always faced with, what do you do when someone comes to the emergency room who needs medical care and isn't covered? Let's provide coverage for those folks. And that is a revenue source for the hospitals, as opposed to having to collect—you know, not have the revenues, hurt their bottom lines, cost-shift to other payers.

So, you know, the estimates are that, actually, insurance policies—the average family insurance policy includes $1,100 for uncompensated care. Most of that is in hospital settings. And it is one way that, over time, as we get everybody in the system, we can reduce other premiums and also have a revenue source for hospitals that they don't have now.

Mr. BARROW. Mr. Neas, do you want to chime in?

Mr. NEAS. I just wanted to add, regarding the doctors, this is a very important point. I said in my testimony that we have 78 organizations that stand for 150 million Americans. One the best things is we have about 10 medical societies in the National Coalition on Health Care. That was not the case in 1993 and 1994.

And I know, sitting down with the doctors and nurses and others, with Henry Simmons and others on the staff, I said, "Why are you doing it this time?" And they said, "This time is different. We see an attempt to have comprehensive, systemwide, systemic reform. We don't mind making some sacrifice, as long as it is a shared sacrifice, a shared responsibility. We can give up something if everyone is going to be giving up something."

They want predictability. They want to make sure they are getting reimbursed. But they want a system that works, that is sustainable. And I think "sustainability" might be the most important word that I am going to state today before this committee. But I think that is why you are getting so much participation from all the stakeholders. This is such a different environment than 15 years ago, and I think that is the reason why.

Mr. BARROW. Well, we are addressing the interests and the rights of the existing universe of health care providers. Let's go back to the subject I passed over for a second, and that is the long-term problem of supply and demand, the fact that we don't have enough primary health care providers, for example.

Mr. NEAS. That is a big——

Mr. BARROW. Do you think the incentives and the proposals that are in this bill are adequate enough or robust enough or are muscular enough in order to be able to provide us the growth in the

sector of the health care community that is being underserved right now, not by area, but by area of practice?

Mr. NEAS. We have been meeting with the medical societies and one of our newest members, the American Association of Medical Colleges and Teaching Hospitals, and they have been pointing out to us this extraordinary workforce issue.

And, as you know all too well, primary doctors now only account for about a third of all the doctors in the country, sort of the reverse of what it was just 20, 25 years ago. We need more nurses, we need more doctors, we need more training, we need more money. We have to invest in our providers and our doctors and our nurses.

Mr. KIRSCH. And there are several measures in this legislation that do that. There are increases to the National Health Service Corps——

Mr. BARROW. My question was, though, are they adequate enough? Do you think they are strong enough to actually make a difference, to bend the curve in the areas that are being served by——

Mr. KIRSCH. Well, there are significant investments in doing this, which is really neat, in a whole variety of measures that the bill includes.

Mr. BARROW. All right.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you.

Ms. Christensen.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman.

Let me begin with Mr. Neas. And I thank all of you for being here this morning.

Mr. Neas, I agree with your statement in your testimony that this is not the time for halfway measures, but I also take the position that coverage alone doesn't reform the system. None of the principles in the national coalition address the huge gaps that exist in the health of people of color, in rural areas, or the poor.

Where and how does the elimination of these disparities that drain the system and our communities fit in your agenda, or is it included inherently in those five principles?

Mr. NEAS. You raise such an important issue. I was just meeting last week with many of the groups who are working on the disparity issues.

The question has been asked about how urgent this issue of enacting this bill is, and what is the crisis. It is an extraordinary crisis; we cannot afford to wait.

And I am addressing your issues. It is not just the Federal Government's fiscal crisis and economic crisis or the State and local governments', but it is the people who are being affected. 400,000 Americans die every year because of preventable medical errors, infections that they get in hospitals, just by mistakes. Millions more are harmed.

Those who are uninsured or those were are underinsured—many disproportionately are minority people without wealth—are the most affected by this. But it affects all of society. It affects our productivity. It affects the bottom line of businesses and the State and

local governments. This is a crisis of enormous proportions that cannot wait. The costs of inaction are unbelievable.

Mrs. CHRISTENSEN. Oh, I am not suggesting that we should wait. I am suggesting that all of it ought to be included.

Mr. NEAS. That is our position. That is why we say systemic, systemwide, which would address the issues that you are raising, which are very important. And without systemic, systemwide reform, you can't get to that.

And we have to make special efforts to make sure every American, including those who do not now have access or do not now have the affordability issue or the quality issues addressed, get those issues addressed.

Mrs. CHRISTENSEN. Thank you.

Mr. Kirsch, I know that eliminating disparities is one of your principles. But to be able to answer the question, as you say, at the end of the day, "Will I have a guarantee of good coverage I can afford?", if to be able to answer that affirmatively we have to fund this bill without a complete offset, should we cut back on being able to answer that question fully just to meet the $1 trillion limit? Or do you see us maybe budgeting for prevention, knowing that it will save money in the long run?

Mr. KIRSCH. Let me say that there are eight specific—by our count, there are eight specific measures to deal with inequities in health care for communities and people of color in your draft legislation. So that is really encouraging, and we are glad to see that.

But to this question of should an artificial, a trillion-dollar figure be used for this? Absolutely not.

You know, I understand that the Bush tax cut was $1.9 trillion over 10 years, and $1.3 trillion of that was for the 20 percent of people in the upper-income brackets. You all made the right decision, I think the right decision, to spend about $800 billion just for 2 years on the economic situation. We are going to be spending around $42 trillion on health care in the next 10 years. That is assuming a 5 percent inflation rate for health care, which is actually probably an optimistic rate.

So if we are talking about, at $42 trillion, adding $1 trillion or $2 trillion, it is really important to realize that if we believe what we do believe, which is that we have to create the kind of systemic reforms along with lower costs, we need to make the investment to realize those goals.

And these figures that sound so large, when we are talking about 10 years and the size of the health care system, are really not that large. So this should be driven on doing it right and coming with the resources to do it.

Mrs. CHRISTENSEN. Thank you.

Dr. Parente, much of the savings and reduction in health care costs, although they may be realized outside of the 10-year window, will come from community public health measures and broader policies implemented across all agencies, as well as for a more efficient system and the elimination of fraud and abuse.

Did you have any models that took into account community public health measures that would be implemented, or addressing the social determinants of health, and did that affect the costs?

Mr. PARENTE. The models just aren't precise enough to do that.

I mean, I personally recognize those are very good things. I actually brought along a book from 1932 that states that all of the same objectives that we want to achieve here today with this bill pretty much were there. This is a longstanding goal, what we are trying to do. This is from the Committee of the Cost of Medical Care from University of Chicago.

But they can't be accounted for. And, actually, a lot of things cannot be accounted for. Health IT savings cannot be accounted for easily. Prevention can't be accounted for quite easily, as well. And a 1 percentage point difference, in terms of the cost increases in health care, vastly change what these projections will look like, as well.

Mr. PALLONE. Thank you.

The gentlewoman from Illinois, Ms. Schakowsky.

Ms. SCHAKOWSKY. I want to talk about cost for a minute, because the cost numbers—and let me ask you, Mr. Neas. Dr. Parente's study looks at the funding for the Federal Government as if that is the only factor that we ought to consider. And I don't know, the $4 trillion or whatever, I have some disagreements over the—or at least my staff suggest that, having looked at that, some problems with the methodology. But that is not the central question.

When do we consider total costs spent by Americans—businesses, individuals, out-of-pocket, premiums, co-payments, all those things? When we talk about costs, don't we have to think about the aggregate and not just the Federal spending?

Can you answer that, Mr. Neas?

Mr. NEAS. Absolutely.

Some people were upset last week by CBO, by Congressional Budget Office. And I am not saying I agree with how they scored everything, but we are going to look back and thank the Congressional Budget Office, because they put on the table the cost issue. And I think, for this to be sustainable, we have to, as the President has said, make this budget-neutral.

But you asked the right question. It is not just an issue of payfors or the issue of the Federal Government; it is looking at the entire system. The best phrase that I heard so far in the last 6 months, again, out of the President, is shared responsibility, shared sacrifice.

Let's take the pharmaceuticals, let's take the insurance industry. They are obviously very happy about where this is going in terms of 10, 20, 30, 40 million new customers. They are going to the table, they are participating, and I applaud them. And I know they want predictability. I know they are scared, like we all are, by the economic conditions. But they have to come to the table and give up something too.

There is a lot of money that has to be saved by the pharmaceuticals, by the providers, by all of us, by the insurance companies. I said before about that, $2.5 trillion. The money is in the system; we just have to spend it well. We have to look at the cost containment——

Ms. SCHAKOWSKY. OK. Let me see if anyone else wants to comment.

Dr. Parente.

Mr. PARENTE. Well, the cost issue is, I think, the dominant concern that you really need to address here. Because of the situation we were in, actually the day that I testified last——

Ms. SCHAKOWSKY. See, I don't even agree with that. I mean, I don't even agree with that. I mean, I think that the polling showed, too, that the American people, a majority, said they would even be willing to pay somewhat more to have universal health care.

So your—but go ahead.

Mr. PARENTE. Let me put it back to you as a question.

Ms. SCHAKOWSKY. Yes, go ahead, sure.

Mr. PARENTE. Are the American people willing to take hyperinflation that could come if this thing basically capsizes treasuries? Because if that happens, it will come because of this bill.

Ms. SCHAKOWSKY. Mr. Kirsch?

Mr. KIRSCH. Well, you know, I would say what Mr. Orszag says, which is that the current biggest threat to the Federal Treasury right now is the current health care system. And if we don't get our hands on that, we are really in a huge economic problem in the long run.

Mr. PARENTE. And the only way you can bring those costs down is a statist solution that would control costs, which—let's be honest—that is what you are advocating, a statist solution.

I am sorry, I was out of order.

Mr. KIRSCH. We are actually advocating a system that has systemwide cost containment in a way that focuses on better delivery.

And, you know, there has been a lot of discussion of this trip from Dr. Gawande to McAllen, Texas, and looking at the perverse incentives there that lead to such high Medicare spending versus the, kind of, right systems that you have in a place like Mayo or others.

So we have to focus on good delivery, on prevention, all those things. And what I do think is important about your first question is that we have to look at this as a whole system. For instance, if we don't provide coverage for someone with a benefit package, it doesn't mean, like, their health need disappears.

Ms. SCHAKOWSKY. Right.

Mr. KIRSCH. If you don't, for instance—I mean, I think you generally have a good benefit package. I would criticize one thing: You have left out dental. Now, you get that as part of your basic package in Congress.

Ms. SCHAKOWSKY. Very poorly.

Mr. KIRSCH. Very poorly, but there is none in this. And it means that, you know, how many members of the committee may have been to a periodontist, and what would happen if you couldn't have it?

So, understand that leaving it out may save the Federal Government money, but it shifts tremendous cost onto that family, it makes their health more expensive, it makes them harder to be in the workforce. It is a whole system we have to look at.

Ms. SCHAKOWSKY. I wanted to just make a comment. I may have time for that.

This issue of competition, I think, is also bogus, because right now the insurance industry and Major League Baseball are the only businesses exempt from antitrust laws, from McCarran-Fer-

guson. And so, 94 percent of markets are noncompetitive right now. So this argument that somehow, you know, we ought to leave it to the private sector and competition is just absolutely false.

The insurance industry has tried all its time to avoid competition, and it seems to me that the injection of a private health insurance option—and, frankly, I cannot think of a public interest reason why that is not an advantageous thing to do. To have a choice would actually inject competition.

And I yield back.

Mr. PALLONE. Thank you.

The gentleman from Texas, Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman, for our first full hearing on the draft.

And I appreciate our first panel of witnesses for being here.

I have a district in Houston, Texas, and Texas has the highest percentage of uninsured in the country and also the highest number of uninsured. And I will give you an example of why we need, I think, a public plan to compete. If the private sector could have dealt with the 45 million estimated number of people, they would have already done it, because they would be making money on them.

I have huge refineries in my district, chemical facilities. About 3 years ago, the CEO of Shell Western Hemisphere sat in our office and said he was transferring some production jobs from their chemical facility in our district in Deer Park, Texas, to the Netherlands. Two reasons: The natural gas at that time from the North Sea was cheaper, and the cost for health care in the Netherlands was cheaper than the cost in Deer Park, Texas.

Now, it is a union-organized plant, but that was the business decision they made. And for a number of years, sitting on this committee, I have been wanting to hear from the business community, saying, "Look, this is a cost issue that we have. We can't compete in Deer Park, Texas, because of our high cost of health care in our Nation."

So I know there are a lot of businesses who are part of the coalitions, various coalitions, on this. And I wish if could just address that. And I know it came up in the last questioning.

You know, we have polls all over the board, but I think the one that I saw over the weekend and talked about, 70 percent of the American people want some type of government-run insurance. Now, a public plan is not government-run insurance, by any means. But a public plan that will give the insurer hopefully not last resort because otherwise it will be so costly, but an insurance product that people can go to have a medical home instead of showing up at emergency rooms.

And I will start with you, Dr. Parente.

Mr. PARENTE. Yes, I appreciate the concern about jobs. I mean, there has been research that shows that it is ambiguous just how much job loss is associated with essentially the provision of health insurance, or that cost that is associated there.

That said, let me tell you what I think could work. It starts with understanding, what is insurance? Insurance technically is a provision of a policy, therefore fairly high-cost with low-probability event. That is not health insurance, nor is it health care. We throw

those terms around quite a bit. If we were to offer insurance for all and call it really health insurance, that is a catastrophic plan, probably with a $5,000 or $6,000 or $7,000 deductible.

And to answer the previous question about what we can do better to do with $2.5 trillion a year, if you distributed that with an individual mandate to the entire country, you would have money left over. But that is not what we do. And because of that, we have, over a period of time, basically thrown in prevention, other services.

If you think about what the medical home originated from, it originated from the HMO Act of 1974, more or less saying let's move to a capitation model. It seems like it is back to the future. What was missing was health IT and actually some sort of cost accounting to make performance metrics come in. Maybe now with the stimulus bill that will happen, but that is still a long time coming.

The concern is that that design tried to emphasize prevention financially by having extremely low co-pays. The unintended consequences of that was that when pharmaceuticals went from basically nontrivial expenses to suddenly being covered by generous health insurance plans, those $5 or $10 co-pays got translated beyond just an office visit practice with a gatekeeper that was mandatory to everyone. That is what has driven up our costs. We are the enemy of ourselves here.

So the way to fix it, if you want to fix it and have it be budget-neutral, individual mandate, catastrophic plans, let the rest buy up by State preference, however you want to do it, that is budget-neutral. And it would actually preserve the most important thing that I think Americans want, and I think it is in your surveys——

Mr. GREEN. Well, let me respond to that, because I only have, actually, 25 seconds last.

Again, coming from the State of Texas where we have individual State options, we have 900,000 children in Texas right now who are qualified for SCHIP or Medicaid who are not on it because the State won't pass the match.

The one thing that I asked the Chair: to have a national plan. And don't come up with something that will say the States will make this option, because we know what will happen in certain States. And, again, I was a legislator for 20 years in Texas, and so I bring that as experience to you.

I know I am out of time, Mr. Chairman. Thank you.

Mr. PALLONE. Thank you.

The gentlewoman from Wisconsin, Ms. Baldwin.

Ms. BALDWIN. Thank you, Mr. Chairman.

I wanted to just comment. I am going to sound a little bit like a broken record on this, because my fellow committee members have heard me talk about the public option we have available in Wisconsin in our Medicare Part D program. And I don't know if any of the witnesses today have had a chance to study that, but, to me, it is ample evidence that a public option can be available and can compete favorably.

Let me just quickly comment on it. For perhaps a series of coincidences, we had a pharmacy waiver before the Medicare Part D program was implemented. We had a program available to seniors in

Wisconsin called SeniorCare. Our congressional delegation fought on a bipartisan basis to keep that program when Medicare Part D was implemented and make it a choice available to seniors and other eligible folks in Wisconsin.

And it has operated at about a third of the cost per enrollee compared with the private-sector options. But for those who think that having such a public option would drive away the private-sector competition, I can also tell you that Wisconsin has among the most vibrant array of private options for its citizens, I think I have heard more than any other State in the union.

So I just want to draw that to people's attention and perhaps, when grilled about is there an example that you can point to anywhere in the country of an exchange that has been set up with a public option competing with private options, you can study this, and I think it is a great example.

I want to move from that to a related issue of State innovation as we move forward with this.

Mr. Kirsch, you are committed to a strong and robust public health insurance option, and I am interested in your perspective on the role of States. Do you think that the ability of States to play a role in running these exchanges will enhance a national exchange? And do you think that this ability will empower them to build upon the reforms that we pass at the national level?

Mr. KIRSCH. Well, the legislation, as I read it, says States or groups of States can set up exchanges. And, you know, we think that that is an important option. It doesn't have to be just an individual State. I mean, you want these exchanges—every time you create an exchange, you have to set up another entity. And so, if groups of States can do it, it may be more efficient than having individual States do it.

And, you know, if you have a national public health insurance option, such as we have posed, then it is going to deal with each exchange. And so it becomes one more way of—less administrative hassle if it is dealing with fewer exchanges.

So it is fine to say States can do this, but we think groups of States doing it, looking at more efficient ways to set up exchanges, manage them, makes sense too. There is no reason, just because we have 50 States in the country, that we have to have 50 separate exchanges.

Ms. BALDWIN. I don't know if Dr. Parente or Mr. Neas have any comments on the State role in this.

Mr. PARENTE. I think States are a tremendous place for innovation. Actually, what I would welcome to see, how an exchange would go forward, is it actually would be something that would repeal McCarran-Ferguson and allow plans to compete across State lines. Because that would allow the innovations of those private players in Wisconsin that have demonstrated such innovation to actually compete in Santa Fe. I think that would be a nice solution.

Ms. BALDWIN. Mr. Neas?

Mr. NEAS. Congresswoman, I think this is an excellent question to ask, and it reminds me of a conversation I just had with my boss, Dr. Henry Simmons, a few days ago. We are talking, obviously, about having a comprehensive, systemwide, national health care plan.

However, this is only the first half of what we have to do. Once this is enacted this year, then we are going to have to implement it, oversee it, and enforce it. And I think the States are going to play an incredibly important role in that and be partnering with the Federal Government.

I think it does reinforce what this committee's role is going to be in overseeing whatever does get done at that level, as well as organizations like ourselves. The implementation and enforcement of this law, which will hopefully be done in conjunction with the States, is a question that should be addressed now and forevermore.

Ms. BALDWIN. Thank you.

Mr. PALLONE. Thank you.

The gentleman from Kentucky, Mr. Whitfield.

Mr. WHITFIELD. Thank you, Mr. Chairman.

Dr. Parente, you mentioned the staggering national debt. And we are on the verge of making a multi-trillion-dollar decision relating to health care.

In your mind, are there more cost-effective alternatives to expanding health insurance coverage than the Kennedy bill or the bill before us today?

Mr. PARENTE. As I said in the testimony, it is hard to, sort of, have a silver bullet for this at all. I think if you have a mandate on some very basic coverage, with some provisions for prevention, that will lower the price tag considerably, perhaps by half.

It still may not make it free; you are going to need to find some way to have this be paid for. But what it does is it actually, sort of, says to the American people, "You have a right so that if something happens and you face a catastrophic illness, you will be covered, and you will have choice of physician, and that is what we will guarantee."

But to actually go beyond that and to put it into "you have a right to a public option plan, which is based on sort of an FEHBP model of a BlueCross BlueShield plan that has been morphing for the last 60 years" adds a little too much extra cost, approximately probably 70 percent extra cost than you need to have, and probably reinforces the same behaviors you have in the inefficient system we have today.

Mr. WHITFIELD. Well, you know, of course, all of us are concerned about cost, and that is particularly important today with the economy being what it is and the amount of money that we are spending. But, in addition to that, of course, the American people want a quality health care system that they all have access to. They want health insurance that they can afford. And we want models that can be adopted, that we do not have the spiraling costs in health care.

And I have been reading recently, and I know he has testified over on the Senate side quite a bit, the CEO of Safeway. And I know that when the Medicare program started in 1965, CBO estimated that by 1990 the cost would be somewhere around $9 billion. As it turned out, in 1990 the cost was around $100 billion or so.

The thing that I like about this Safeway model, it appears from the evidence that the CEO is providing that they have actually been able to control health care, the cost, but, more important, they

have given their employees the right to make decisions on who they want to see. And they also have developed a system of transparency so that employees can shop around and determine the costs that various providers charge, and there is a real disparity in that.

So I would like to get your comments, those of you familiar with the Safeway program. And, Mr. Neas, I know you would like to make a comment on that, so go ahead.

Mr. NEAS. I do want to salute Steven Burd, I believe is the CEO of Safeway, and all those who make voluntary efforts with respect to well-being and prevention. I don't think there are any independent studies that corroborate what Mr. Burd has put before the committees of the House and the Senate.

And you are talking about cost, I do think that much of what is in the bill, whether it is the Kennedy bill or this bill or things that the President has brought up, there are good, long-range, cost-savings measures. I don't think anyone really has yet addressed the short term. And I think we are going to need some short-term regulatory constraints on the increase in the expenses systemwide.

As Congresswoman Schakowsky was saying, it is everyone's responsibility, but we need some short-term cost control in the bills that come out of the House and Senate, not just the long-term cost-saving measures. And I would hope that would be something that this committee and others would address.

Mr. WHITFIELD. Yes.

Mr. KIRSCH. I think what is good about what Steve Burd has done at Safeway and people have done at Pitney Bowes and a lot of other companies in the country is they have actually looked at ways to control costs. And, as you said, the key has been to not have financial barriers to preventive care, to get people in the system early.

One of the reasons we want a hybrid system is to encourage that kind of innovation and encourage it more in Medicare. If you look at Senator Baucus's options paper, it is all these things that Medicare has done to be innovative. So let's have the private sector innovate, let's have the public sector innovate, let's look for better delivery systems. That is what we have to do if we are going to move toward a solution that makes this affordable for everybody.

Mr. PARENTE. Just a quick comment. I studied consumer-driven health plans, and actually there is a report I have that was published by HHS last year that looks in design very similar to Safeway and found that it actually saved costs, at least bent down the curve, and prevention wasn't touched.

That is why I am advocating that as a model, because I think that could be a very cost-effective solution if the financial incentives are structured that way.

Mr. WHITFIELD. Thank you. I guess my time has expired.

Mr. PALLONE. Thanks.

The gentlewoman from Florida, Ms. Castor.

Ms. CASTOR. Thank you, Mr. Chairman.

And thank you all for your advocacy efforts.

Briefly, could you all, in 20 seconds, take a turn and characterize CEO profits of HMOs and CEO salaries, HMO CEO salaries and HMO profits over the past 10 years?

Mr. NEAS. I would have to give you my personal anecdotal response to that, that it seems excessively high over the last 10 years. There seem to have been numerous press stories that underscore the extravagance of some of those salaries and some of those profits.

Mr. KIRSCH. I think we are looking at average CEO salaries of $12 million for the top 10 insurance companies in 2007; average profits of about $12 billion, $13 billion.

Ms. CASTOR. Did you say billion?

Mr. KIRSCH. Billion for the profits. Top 10 CEO salaries of $12 million. And I believe there was a 400 percent increase in profitability from around 2000–2007. I am doing this from, sort of, my visual memory, but it gives you a scale of the kind of increase in profits we have seen in the industry over the last years.

And I want to conclude with a quote from Angela Braly, the CEO of WellPoint, We are talking a financial analyst, about what kind of decisions they are making. She says—this is a whole sentence—"We will not sacrifice membership for profitability." In other words, we are not insuring more people if we are going to lose money on them because they cost us too much.

Mr. PARENTE. They have been going up; we all know that. The question is whether or not they are returning value.

I spent 2 or 3 years working at a nonprofit BlueCross BlueShield plan. I liked the people, I liked the management. I was sort of disturbed by how inefficient everything could be. That is what drove me to become an academic, I suppose. And no comments there.

But what I found in terms of some of the good plans that are publicly traded is they introduced innovations that I was dying to see done in those nonprofit BlueCross BlueShields. And if there is anything that I think is of virtue to this public option plan, it is to put some competition into those plans for better business practices.

But keep in mind, those better business practices I see are coming mostly out of the for-profit plans that are being demonized. So I am of mixed mind when talking about what the return on investment of those salaries tend to be.

Ms. CASTOR. Well, let's just—I think we can all agree the American people are concerned, to put it mildly. I would say that they are angry.

In my home State of Florida, there is a recent example of the largest managed care provider, private HMO, whose offices were raided some time ago by the FBI, charged by the Justice Department, and just settled the case because Florida had embarked on a pilot project to privatize Medicaid.

So this private HMO came in and won the bid, and it turned out that they were paid money to provide health care services for children under Medicaid and under the State children's health insurance company. And rather than provide the medical services, they pocketed the money, and have just settled the case for $80 million that they are going to pay back to the State of Florida.

Meanwhile, the CEO was receiving multi-million-dollar salaries. They were posting the highest profit margins in the history of managed care in our State.

So when we talk about cost, isn't there enough cost—isn't there enough money in the health care system now? In fact, the CEO of a Florida HMO paid a visit last week, and that is exactly what he said to me: "There is enough money in the system. If you adopt a public option and a comprehensive health care reform bill, we can get this done."

In contrast to all that, what is happening to the average American family? Health care costs are driving Americans into financial ruin. A recent Harvard University study said that 62 percent of bankruptcy cases now are caused or influenced by medical bills—62 percent. In 2001 it was 50 percent, and in 1981 it was 8 percent.

And now with the rising numbers of uninsured, they are often completely hammered because they have to pay the entire bill, whereas if you actually have health insurance, you benefit from the negotiated lower prices.

Many people, in this day and age, really have nothing left because they took out a mortgage on their home; now their home is worth thousands and thousands of dollars less.

Isn't the real crowd-out issue the fact that Americans do not have access to affordable health care? Health care costs have skyrocketed, and their paychecks haven't kept up. Isn't that the real crowd-out issue we are going to tackle in this health care reform?

Mr. KIRSCH. Absolutely.

Mr. NEAS. Absolutely.

Mr. PARENTE. Just very—I know I only have a second here. The reason why costs go up is that we like medical care and it works really well. And, societally, that is a decision we are taking.

Individually, everyone has their hardship concerns, and I do not belittle at all what you are saying. But understand why this is occurring. Health care is a good, and we all want it. And we are not willing, necessarily, collectively, or have found the right mechanism to distribute that desire to meet our economic challenges.

Mr. KIRSCH. I would just say, if you look around the world, you see there is higher utilization in a lot of countries and they spend a lot less and get good quality. So I would disagree with Dr. Parente.

Mr. PARENTE. And let me make one personal comment back to that.

I worked for the British National Health Services, my first job, because I believed in single payer when I was 21 years old. When I worked for the British National Health Service, I was in southwest London in a teaching hospital.

Here is how they saved money, because they still do it the same way. Would you like to guess here, anyone, how many long-term beds, skilled nursing beds, they had available to a quarter-million people in that space? Anyone? How about 31. That is how you save money and how they did it.

That is why U.K. has the most advanced hospice program in the world, because, in order to save those resources, with a soft, velvet touch, you basically were able to say to someone who was 80, "You have CHF. I am sorry. This is the end of the road. Let's make you comfortable." Here, we don't do that as much.

Mr. NEAS. Congresswoman, you are really getting to the heart of the matter here as to why we have the kind of polling that we

have. People are starting to find out about these outrages. And we do have some of the finest, if not the finest, health care in the world, but, as Mrs. Christensen said, if you can afford it. But there are tremendous disparities.

And I said a little while ago, 400,000 preventable deaths per year in our system—400,000—costing $700 billion, $800 billion a year. These are all costs that could be addressed by systemic, system-wide care. This is a scandal that this is happening, absolutely a scandal. And you were talking about the cost for individuals and the bankruptcies, four times as much for health care costs as the increase in wages.

When people find out about this, as good as the polls are now, they are going to be even better. There is going to be a popular uprising on behalf of this kind of bill and for comprehensive health care reform this year. It is absolutely necessary.

Mr. PALLONE. I let them go because I didn't want them not to have the opportunity to answer your question, but we have to move on. Thank you.

The gentlewoman from Ohio, Ms. Sutton.

Ms. SUTTON. Thank you, Mr. Chairman.

Mr. Kirsch, I want to thank you for being here. I want to thank you all for being here. And, Mr. Neas, thank you for your leadership of your very diverse coalition. We appreciate it.

But, Mr. Kirsch, the coalition's five basic principles for health care reform: coverage for all, cost containment, improved quality and safety, simplified administration, and equitable financing.

That is how you—or is that Mr. Neas? I am sorry, Mr. Neas. I apologize.

Mr. NEAS. That is all right.

Ms. SUTTON. I bet you agree with those.

Mr. KIRSCH. Sure.

Ms. SUTTON. Mr. Neas, those are the broad principles that your coalition is fighting for in health care reform; is that correct?

Mr. NEAS. Those five principles, buttressed by many, many specifications that are part of our pamphlet. I bring this everywhere. Just like Senator Robert Byrd brings his copy of the Constitution, I bring this blueprint for reform, which has specifications that 80 organizations spent 18 months putting together to implement those five principles.

Ms. SUTTON. And I appreciate that and I appreciate that commitment, much the way I appreciate the commitment to the Constitution.

Dr. Parente, do you agree with those five basic principles for health care reform?

Mr. PARENTE. Yes.

Ms. SUTTON. OK.

And I just have a question, Dr. Parente, about—I apologize that I didn't get to hear your testimony, but I did get to read it. And so, based on that, you discuss at some length the parts of health care reform that can create costs without any regard for the many cost savers that will be included.

So, in particular, I am interested in your score of the public health plan option. You don't seem to consider that with a public health plan comes increased competition. You sort of almost scoff

at that in your testimony, that it will increase access and drive down premiums for beneficiaries.

Why do you choose to disregard that?

Mr. PARENTE. Because there is not a study to show that it would work.

Ms. SUTTON. OK. So, until somebody shows you a study—and I heard Ms. Baldwin talking about what is true in her State. Are you saying that there is no demonstrable evidence based on what is happening there to support this kind of conclusion?

Mr. PARENTE. Not on a national scale.

I am from the upper Midwest, as well. We in the upper Midwest, as was in the New Yorker article, just do things differently. We are more cooperative, maybe because it is cold. But to generalize this out to the Nation is not easy to do.

I mean, just take the examples from Florida. I guarantee you, Wisconsin and Iowa and Minnesota are really low on fraud. Florida, on the other hand, is the capital for the world.

To find a one-size-fits-all solution is going to be difficult. That is why I propose, if you are going to do something like an exchange, let insurance companies buy in each other's markets or compete in each other's markets and not be constricted to the same State-specific things that McCarran-Ferguson does today.

Ms. SUTTON. You know, a couple of things. You will concede then, though, that there is some, on a State-wide basis, evidence to support that a public plan can drive down costs and increase competition?

Mr. PARENTE. No, I—not at a national scale.

Ms. SUTTON. I know. I said at a State level.

Mr. PARENTE. There is evidence of State innovation that is successful.

Ms. SUTTON. OK.

Mr. Kirsch, would you like to comment?

Mr. KIRSCH. Well, Medicare has less than 5 percent annual inflation. Private insurance is about 7.5 percent inflation. Commonwealth Fund thinks the premiums—if we use Medicare rates, you guys are talking about Medicare plus 5 percent, would have 20, 30 percent savings.

So there are studies. Urban Institute says it will save money. Jacob Hacker at Cal-Berkeley thinks it will save money. So there are a bunch of studies that say it will actually save significant money. And we have seen that Medicare has lower inflation than private insurance. So I would beg to differ.

Ms. SUTTON. OK, thank you.

Dr. Parente, can you tell me, do you think that the majority of the millions of uninsured Americans, do you think that they are just simply waiting for the right plan to come along?

Mr. PARENTE. No, I—no. I think that there is a real problem. You know, most people would refer to this as a market failure, to have this level of folks be uninsured.

I think the question people have to ask is, when people hear that 45 million or probably now 50 million number by the time this year shakes out, you know, it is—the question I think people think about is, is that the number of people that started the year uninsured and ended the year uninsured and found nothing in be-

tween? Because that number is quite different. That number is a fraction of 50 million.

Ms. SUTTON. With all due respect, I think people, when they hear that number, think that is totally unacceptable in a country as great as this, that we would have millions of people uninsured with access to care when they need it.

But I am going to move on. I just have——

Mr. PARENTE. I just—I would agree. What I am saying is focus on the folks that start and finish the year uninsured. That is a priority.

Ms. SUTTON. Do you think that the American people who have insurance through the private insurance industry are very pleased with their care?

Mr. PARENTE. I have seen surveys that suggest that they are not. But it is heterogeneous mix, and they are upset for different reasons.

Ms. SUTTON. Do you think that it is appropriate that the pre-existing condition exclusions that exist in the private market should continue?

Mr. PARENTE. It all depends upon whether those pre-existing conditions actually really get premium to a point where insurance is unaffordable, which, actually, in several States it has done.

Ms. SUTTON. OK.

I know that my time is up. Thank you.

Mr. PALLONE. Thank you.

The gentlewoman from California, Ms. Matsui.

Ms. MATSUI. Thank you, Mr. Chairman.

I would like to focus in on one area. I would really like to ask a lot of questions, but this is one area I am really focusing in on, and this is prevention as an overall part of the health care reform.

And we can't forget it, because we understand that we need to prevent people from getting chronic diseases like heart disease, diabetes, and asthma. And unless we do, the costs of our health care system will just go up, no matter how well an insurance exchange is structured.

More than 75 percent of the health spending in this country today is attributable to chronic illness, but only about 3 percent of our health care spending is for preventive services and disease promotion.

Mr. Kirsch, your organization platform states that health care reform will emphasize quality care, including coverage for prevention and primary care, and good management of chronic conditions. And, as you know, our draft bill requires insurance companies to cover preventive services and waives our co-payments for these services.

Is your organization's vision for preventive care fulfilled in this legislative draft before us today?

Mr. KIRSCH. Well, yes, in terms of the benefit package, absolutely. Because what you have done is, as you have said, you have made prevention a standard part of the benefit package and, eventually, employer-based coverage, as well as the exchange, and you have done it without financial barriers to care. And you have also made a significant investment in the legislation into increasing the

number of primary care providers, because we are going to need that to be sure this preventive care is delivered.

Ms. MATSUI. But do you think the bill could be strengthened to place an even greater emphasis on preventive care?

Mr. KIRSCH. Well, the benefit package in terms of prevention is good. Now, some of the details of the benefit package are going to be left, under your bill, to a board to set that. The question is how much is put in law now versus not.

But the point is, you have said prevention, you have said financial barriers, and you have made the investment in a primary care infrastructure. So we think these are really, really good.

Ms. MATSUI. OK. Given that the draft bill requires a certain level of coverage for preventive care services already, do you see any role for the public option in driving private insurance toward a model that focuses more on services that will help people avoid getting sick in the first place?

Mr. KIRSCH. Well, we hope so.

You know, I had an interesting conversation years ago with the CEO of an insurance company who said, "It doesn't pay for us to invest in prevention, because we are only going to have these folks for a year or 2, so any savings won't accrue to our benefit." That is the kind of calculation you make if you run an insurance company. Or you just do your marketing to people who don't need a lot of health care in the first place.

A public option whose mandate is the public good, who is looking at the long term, will have a different set of incentives to look at: how do we promote the public health, how do we keep people in, how do we avoid them getting sick, having good chronic care management and innovate in that.

And it is very important that one of the goals you specifically laid out in this legislation for the public option is innovating delivery system options that do that. And so not being simply—you know, Medicare has done some of that, Medicare needs to do better. But the fact that you all made that a specific mandate for the public option is incredibly important.

Ms. MATSUI. So you think this is a real opportunity here on the public option aspect of it?

Mr. KIRSCH. The public option, actually, specifically is charged by the legislation with doing that kind of innovation delivery system to focus on better chronic care management, to do the kind of things you are asking about.

Ms. MATSUI. Mr. Neas.

Mr. NEAS. I just want to add to that.

There are some excellent provisions in the bill, and I think there is more and more discussion with respect to best practices and looking at Intermountain and Cleveland and Mayo and other places.

But I think it is very important to make sure that your deliberations and your eventual decisions and how it is implemented is evidence-based. And I think that is so essential for making this all work.

Ms. MATSUI. I believe that, too, and I think that there is evidence available. It is trying to get the evidence in the manner in which we can actually compare. And prevention and wellness, for many

people, seem to be more something that is a fluffier side. But, for me, I would rather not get sick. And I think if we don't get sick, we will probably lower the health care costs anyway.

But I was also considering, too, what—Mr. Neas, you did a lot of work on health care costs and how they hurt small businesses. And can we use the same model here that Safeway has used, as far as what they have done as far as prevention and wellness, as far as having small businesses do the same things too?

Mr. NEAS. I had an opportunity to respond to another member regarding Steven Burd and Safeway and saluted him for his innovations and his well-being and prevention efforts. I also did hasten to add that there hadn't been any independent study to corroborate some of the claims that have been made.

But, certainly, we want to welcome efforts by the private sector, by everyone, to try to keep people well, to prevent things from happening. That is an important part of the equation.

Ms. MATSUI. I think I have run out of time. Just quickly.

Mr. KIRSCH. Just quickly, though, I think the key and one of the reasons to have a strong public option is, how are we going to take—it is great that Safeway or Pitney Bowes or IBM can do it; how are we going to translate that into small businesses?

If we have a public option that drives those things and then small business, in exchange, can benefit for their employees, we can make it more than just the innovators in the private sector.

Ms. MATSUI. That is great. Thank you.

Mr. PALLONE. Thank you.

The gentleman from Utah, Mr. Matheson.

Mr. MATHESON. I waive.

Mr. PALLONE. The gentleman from Massachusetts, Mr. Markey.

Mr. MARKEY. Thank you, Mr. Chairman, very much.

This is an historic time, and we are very proud in Massachusetts that we adopted a new law that puts us in the same role, as revolutionaries, that our State has historically played in many other areas, except we are not any longer talking about Minutemen but MinuteClinics up in Massachusetts, and not Red Coats but the white coats of doctors, in terms of this revolution that we are trying to create.

What I would ask is, if we could, get your opinion as to this Massachusetts plan, and what lessons you draw from it, and what you would try to emulate or avoid in moving forward.

And we have moved now to 97.4 percent of our citizens with coverage, which is something that obviously we had as our goal. It has only been in place for a couple of years, but it obviously has been successful to that extent.

But, Mr. Neas, could we begin with you? And welcome back to this committee, for the many times you have been here. And whatever observations you have I would very much appreciate.

Mr. NEAS. Mr. Chairman, it is an honor and a pleasure to be back here. And, as you know, as a product of Massachusetts, as the former chief counsel of Republican Senator Edward W. Brooke, I am very proud of what Massachusetts has done—Senator Kennedy, yourself, the legislature, Mitt Romney, and others—especially with respect to, I believe, including about 95 percent so far of the population of Massachusetts.

Having said that, I know Massachusetts made a political decision several years ago that it was not going to address the cost management issues at that time. So we have my very good friend, Governor Deval Patrick, going to the legislature right now and going around the State to make sure there is additional legislation that would address the skyrocketing costs and increase in costs that affects Massachusetts and every other State in the Union and is such a national emergency.

So there are wonderful lessons to be learned from Massachusetts. There are also lessons that you expected, that it was not a sustainable plan unless the money was going to be raised and/or the cost-containment issues were going to be addressed. I think Massachusetts is starting to do that.

And I believe, with a national plan that addresses health care reform in a systemic, systemwide way and works in partnership with Massachusetts, the Paul Revere work that has been done will be completed over the next few years, the next number of years.

Mr. MARKEY. Thank you, Mr. Neas.

Mr. Kirsch.

Mr. KIRSCH. Sir, I have a daughter who is a nurse at Children's Hospital in Boston.

Mr. MARKEY. Beautiful.

Mr. KIRSCH. But, in terms of your question, more importantly, I have a daughter who just moved to Boston, Somerville, has taken not a very well-paying job between college and graduate school, but has good health insurance because of what you have done.

And when she was between jobs, we had to pay more than $300 for a medication she is on for a chronic condition. That was a lot of money for us to pay. What would have happened if she weren't able to have that—now be able to get that coverage through the plan?

The plan has been successful by expanding coverage to low-income and moderate-income people in Massachusetts. It is extraordinarily important.

Where are the things that we think can be improved?

One is, unfortunately—and this is a fiscal problem because the State is just doing it—the subsidies don't go more than 300 percent of poverty level, which means there are a set of people who have been exempt from the program because it is not affordable. What is good about your legislation is it goes up to 400 percent of poverty level. It also allows you to look at regional differences in costs, which is very important.

Second of all, it doesn't have a public option in Massachusetts. And by injecting that kind of role in controlling costs, that is an important factor.

Third, you don't really have employer responsibility because of the ERISA challenges and also because Governor Romney wasn't crazy about it. Employer responsibility is very important in terms of finding a lot more revenues. You are able to get away in Massachusetts because you are one of the highest employer-sponsored insurance penetrations in the country. You can't do that in other places.

So a lot of good things in the Massachusetts model were shown, but some things that we think can strengthen it. And, as Mr. Neas

said, you are all starting to deal with the cost-control issues, which are being built into the Federal reforms.

Mr. MARKEY. OK. Thank you, sir.

Dr. Parente.

Mr. PARENTE. I think you should be applauded for doing it. I think it is a landmark initiative.

Costs are the big issue, as are being discussed and have been previously mentioned. I think also there could be longer-term issues in terms of competition.

One thing that was learned that actually some of our work showed previously was that some of the higher-deductible plans or the low-option PPOs would be the magic price point to get many people to get the right incentives to come in. And we just have to be sure that if this happens, what we are discussing here, that those options are on the table as well.

One thing that—I will make this very brief comment—was that you really need to have as many private insurers to compete as you can. And I remember that that wasn't an initial concern, but that looks like it is being addressed.

Mr. MARKEY. Thank you, Dr. Parente.

But there are a lot of things in common, Mr. Chairman. You know, it includes expanding Medicaid, creating a connector to help patients select a plan, and helping to subsidize the low-income citizens so that they can have access to health care.

So I think the general principles are very similar. And we can learn, actually, from what went well and what needs to be reformed in the future.

And I thank you for your leadership.

Mr. PALLONE. Thank you.

And I think we are done—Mr. Dingell? Chairman Dingell.

Mr. DINGELL. Thank you, Mr. Chairman.

Your study of the costs was just limited to the Kennedy bill; is that correct?

Mr. PARENTE. It was also done, one on Coburn-Ryan and also one on the Senate Finance Committee, as well.

Mr. DINGELL. I see. You have not done one on the bill that is right now, the draft?

Mr. PARENTE. No. As I mentioned earlier, I hope to have estimates on that done by tomorrow morning at 8:00 a.m.

Mr. DINGELL. OK.

Now, I am curious, you have mentioned the English health system. Is there any significant similarity between the English health system, of which you appear to be critical, and the discussion draft that is before the committee?

Mr. PARENTE. Actually, I am not critical of the English system. I am just bringing it up as a comment. I think both systems grew out of, if you will, the socioeconomic history of each country.

Mr. DINGELL. But there is no similarity between the two, is there?

Mr. PARENTE. Well, there will be increasing similarities if we have to ration care.

Mr. DINGELL. Why do you make that statement?

Mr. PARENTE. Because the only way you can actually hold the cost curve down effectively with Medicare is effectively to limit patients.

Mr. DINGELL. This is your assumption; is that correct?

Mr. PARENTE. It is an assumption——

Mr. DINGELL. And, as in all other studies, the study is only as good as the assumption, isn't that right? Garbage in, garbage out.

Mr. PARENTE. Not necessarily. But if it is garbage in, garbage out, then all the Commonwealth stuff has to be thrown out, too, Congressman Dingell.

Mr. DINGELL. Now, this is not a single-payer system that we are talking about here, is it? The European system is a single-payer system to which you are referring; isn't that right?

Mr. PARENTE. The European system is made up of many countries——

Mr. DINGELL. Let's talk about the British.

Mr. PARENTE. They are not all single-payer systems.

Mr. DINGELL. The British system is a single-payer system, is it not?

Mr. PARENTE. It is a single-employer system, yes.

Mr. DINGELL. Now, your assumption that there will be rationing, there is rationing right now, isn't there?

Mr. PARENTE. Yes, there is.

Mr. DINGELL. We have 47 million Americans who don't have any health care. And, during the course of a year, we have as many as 86 million who have no health care. Obviously, those people without health care are being rationed, are they not?

Mr. PARENTE. Yes, they are.

Mr. DINGELL. OK.

I guess that is all the questions I wanted to ask. Thank you, Mr. Chairman.

Thank you, gentlemen.

Mr. PALLONE. Thank you, Chairman Dingell.

And I think we are done with questions, so I want to thank you all. It was very helpful. Appreciate it. And, you know, as we move along, we are going to certainly keep your ideas in mind. Thank you.

And I would ask the next panel to come forward.

And let me remind members that we are not taking a lunch break. And the reason for that is because I think, as the day goes on, we will get more members of the full committee, who, as I mentioned, can participate. So if you want to take lunch, maybe go while another member questions.

We are going to get right to it, so if the second panel would be seated, I would appreciate it. If you could take your seats.

Are we missing Dr. Shern? I think we will start, at least with the introductions. Is that Dr. Shern? OK, thank you.

Let me introduce the panel. Again, this is the panel on consumers' views. And from my left is Dr.—I shouldn't say "doctor." You may, in fact, be a doctor, but she is certainly well-known in any case—Marian Wright Edelman, who is president of the Children's Defense Fund.

Thank you for being here.

Next is Jennie Chin Hansen, who is president of AARP. And then we have Dr. David H. Shern, who is president and chief executive officer of Mental Health America; Dr. Eric Novack, who is an orthopedic surgeon with Patients United Now; and, finally, Shona Robertson-Holmes, who is a patient at the Mayo Clinic.

I assume in Rochester right?

Ms. ROBERTSON-HOLMES. Actually, no, Arizona.

Mr. PALLONE. Arizona, OK.

Again, you know we have 5-minute statements. Your full statement will be submitted for the record, and whatever else you would like to put forward. And then we will have questions after. And we will get written questions, you know, in the next few days to be submitted to you in writing.

And I will start with Ms. Wright Edelman. Thank you for being here. You have been here so many times.

STATEMENTS OF MARIAN WRIGHT EDELMAN, PRESIDENT, CHILDREN'S DEFENSE FUND; JENNIE CHIN HANSEN, PRESIDENT, AARP; DAVID L. SHERN, PH.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, MENTAL HEALTH AMERICA; ERIK NOVACK, MD, ORTHOPEDIC SURGEON, PATIENTS UNITED NOW; SHONA ROBERTSON-HOLMES, PATIENT AT MAYO CLINIC

STATEMENT OF MARIAN WRIGHT EDELMAN

Ms. EDELMAN. Well, thank you so much for the opportunity to testify on behalf of the 9 million uninsured children and the millions more underinsured children, which we have a chance to correct this year.

And we have said many good things about your proposals. They are in the written testimony. And I want to just limit myself to my hopes for true health reform for all children and pregnant mothers within any health insurance plan. So, whatever you adopt as a health insurance plan for all Americans, I want to just make sure that all children, all pregnant women are treated equitably and get affordable, comprehensive coverage.

And what a great opportunity this is. I am so pleased. And thank you for the CHIP bill that you enacted and the President signed, and that was a significant step, but we now have a chance to finish the job. That was not true health care reform for all children, and it is not the child health mandate that the President promised. But here we can do it now.

The need for health care reform that expands coverage for all children, cure benefit inequities between CHIP and Medicaid children, and establish a national floor of eligibility of 300 percent to end the lottery of geography across 50 States and to simplify enrollment and retention, particularly in Medicaid and CHIP, are the key things that I would hope that you will address in your final health proposal.

In these particularly devastating economic times, when the number of poor children could rise by 1.5 million to 2 million more, the need for a guaranteed, strong health care safety net to ensure their continuous access to coverage and every opportunity for a healthy start in life is absolutely urgent.

I want to just address these four points for a brief moment each.

One is I hope you will ensure health care coverage is affordable for all children and pregnant women and with a floor of 300 percent of the Federal poverty level, which is about $66,000 for a family of four.

Just as all children in the United States are entitled to a free public education, all children should be entitled to affordable health care. The high number of uninsured children exacts a high health, economic, and social toll on these children, the families, and our Nation. Uninsured children are at high risk of living sicker and dying earlier than their insured peers and are almost 10 times as likely as insured children to have an untreated medical need. These consequences of untreated medical needs can carry on into adulthood, and we must prevent them.

The consequences of being uninsured fall disproportionately on children of color, who represent almost two-thirds of all uninsured children. Children of color are at higher risk than white children of having unmet health and mental health and dental health needs. And they are at greater risk of being sucked—because of the absence of this preventive health and mental health coverage—of being sucked into something the Children's Defense Fund is very concerned about that we call the cradle-to-prison pipeline.

Many children without mental health services are having to be locked up in order to get mental health care in their community, at an enormous cost of $100,000 and $200,000 a year. Children should not have to go to jail in order to get mental health coverage. You can cure that this year.

The need for health care begins with maternity coverage. We have 800,000 pregnant women who are uninsured and having babies every year. They receive less prenatal care than their insured counterparts. They face greater risk for expensive and tragic outcomes, including complications, low birth weight, preventable illness, and even infant and maternal death.

We have about 350,000 low birth weight babies in the most recent data. The cost is 25 times greater than normal birth weight babies. We are the only industrialized country that does not provide prenatal care to all of its mothers. You can cure that. I hope your health reform act will do that.

All of our children need to be able to get what they need regardless of the State they live in. Today, each State sets its own income eligibility level for CHIP and Medicaid, which results in a profoundly inequitable patchwork of eligibility across the United States.

Imagine being a low-income parent or grandparent raising several children. One is eligible for Medicaid, the other is eligible for CHIP, with different income eligibility standards and benefit packages for each program. Why should a child in North Dakota be eligible for CHIP if their parents earn more than 150 percent of the Federal poverty level, while in 12 States and the District of Columbia families can earn twice that amount and children are still covered?

Children's ability to survive and thrive and learn must not depend on the lottery of geography of birth. A child is a child wher-

ever they live. They should have the comprehensive benefits. We must end this inequitable system.

Ten States have no children eligible for Medicaid above 133 percent, but half of our States offer Medicaid to children of all ages with families with incomes above 133 percent of the Federal poverty line. Almost half cover children at 200 percent. Thirty-nine States offer CHIP to children of families between 185 and 400 percent of the Federal poverty line.

We urge a national eligibility floor of 300 percent for all children and pregnant women wherever they live. And we should not force parents to have to choose between paying for child care, paying for health care, paying their rent. And so this is our chance to, sort of, give them the kind of national health safety net that I, as a grandma, have. I think I am important, but I think my grandchildren are even more important, and we should treat them fairly.

Secondly, we hope that all children will have the same comprehensive benefit packages, which include health and mental health coverage. We like the EPSDT program. It was designed and is appropriate for children. Children are not little adults. It has health and mental health coverage.

We believe and if you believe that every child's life is of equal value and that children don't come in pieces and they should get what they have to have their conditions diagnosed and treated early and prevent later costs, I hope you will make sure that every CHIP child and every child in the exchange will get the same benefits that the Medicaid children get.

Mr. PALLONE. I hate to slow you down, but you are a minute over.

Ms. EDELMAN. I am a minute over already? Good gracious.

Two last quick things, and I will just end, Mr. Chair.

Thirdly, all of our eligible children should have simplified ways of getting and keeping enrolled. The bureaucratic barriers that keep 6 million of the 9 million uninsured children now unenrolled need to be addressed. The package, as I see it, does not do that. We think that—and we lay out in our testimony, our written testimony, and we lay out in specific legislative language in the All Healthy Children's Act the steps that you can take to make Medicaid work.

I am glad you have moved to 133 percent of the Federal poverty level for adults, but children are already eligible for 133 percent but they are not getting it because of the bureaucratic barriers which you must address through the simplification measures we lay out.

And lastly, I just want to say, I know people are saying cost and we can't afford it. Well, you know, we can afford whatever we want to afford. We do not have a money problem in our Nation with a $14 trillion GDP. You found the money to bail out the banks, you found the money to bail out the insurance companies, you found the money to do the alternative minimum tax. We can find the money if we believe in it to make sure that we give our children a chance to survive and to thrive. That is cost-effectiveness.

And while CBO may not score prevention, we know that dollars invested in immunizations save States millions annually. And we know that if you give a child an office visit in a primary health

care setting, which is about $100 in Harris County, Texas, it is going to cost you $7,300 if they go to the emergency room and have to be hospitalized.

If you want to contain costs, children is where you do it. All of them should be covered. All should get the same benefits. It should be simple and easy. And you have a great opportunity to do it right this year.

Thank you.

[The prepared statement of Ms. Edelman follows:]

Statement
of
Marian Wright Edelman
President, Children's Defense Fund

Hearing on the Comprehensive Health Reform Discussion Draft

Before the
Subcommittee on Health
of the
Committee on Energy and Commeree
U.S. House of Representatives
June 23, 2009

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STATEMENT OF MARIAN WRIGHT EDELMAN
PRESIDENT, CHILDREN'S DEFENSE FUND

HEALTH REFORM FOR ALL:
A CRITICAL AND LONG OVERDUE OPPORTUNITY TO ENSURE ALL UNINSURED AND UNDERINSURED CHILDREN AND PREGNANT WOMEN COST EFFECTIVE, EQUITABLE AND EFFICIENT HEALTH COVERAGE

For Hearing on the Comprehensive Health Reform Discussion Draft

Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives

June 23, 2009

Good morning. I am Marian Wright Edelman, President of the Children's Defense Fund (CDF). The Children's Defense Fund has worked very hard for 36 years to ensure every child in America a Healthy Start, a Head Start, a Fair Start, a Safe Start and a Moral Start in life and successful passage to adulthood with the help of caring families and communities. CDF seeks to provide a strong, effective and independent voice for ***all*** the children of America who cannot vote, lobby or speak for themselves but we pay particular attention to the needs of poor and minority children and those with disabilities. CDF encourages preventive investment in children before they get sick, get pregnant, drop out of school, get into trouble, suffer family breakdown, or get sucked into the dangerous "Cradle to Prison Pipeline."

Thank you for the invitation to testify on behalf of children today. The Comprehensive Health Reform Discussion Draft takes strong steps towards quality health reform for millions of Americans – but I am concerned that under your proposal children don't get their fair share of needed reform, and rather than being better off than they are now, some are at risk of being worse off. You have the opportunity now to make this right.

Children are not little adults. They have unique health needs that will not be met in a health reform system designed for adults. While recently released health reform proposals and priorities – including the Comprehensive Health Reform Discussion Draft – address a number of critical health reform issues, it is important to have crystal-clear legislative language for key issues and solutions that are essential for children. Considering the substantial health and wealth disparities among children in communities of color, espousing child-specific solutions in health reform legislation is critical.

Nine million children in America are uninsured. Almost 90 percent of them live in working households and a majority live in two-parent families. Six million are currently eligible for but are not enrolled in Medicaid or the Children's Health Insurance Program (CHIP). Earlier this year, when President Obama and Congress reauthorized CHIP in the Children's Health Insurance Program Reauthorization Act (CHIPRA), they made an important initial investment to strengthen

the quality of children's health care and improve health outcomes but not enough. **CHIPRA was not the health care reform children must have this year or the child mandate President Obama promised during his campaign.** Like the overall health care system, this child health system is broken and now is our time to fix it.

The need for health care reforms that expand coverage to all children, cure benefit inequities between CHIP and Medicaid children, establish a national floor of eligibility to end the lottery of geography, and simplify enrollment and retention, particularly in Medicaid and CHIP, is imperative and crucial to child survival. Especially in these devastating economic times, when it is estimated the number of poor children could rise by 2.6-3.3 million, and the number of children in deep poverty could climb by 1.5-2.0 million, children must be guaranteed a strong health care safety net to ensure their continuous access to coverage and every opportunity for a healthy start in life.[1]

ESSENTIAL ASSURANCES FOR CHILDREN IN HEALTH REFORM

I urge the Committee not only to maintain existing protections for children and pregnant women, but also to strengthen these protections. ***All*** children and pregnant women in America must be covered. They must be ensured the medically necessary care they need. And they must be better—not worse—off than they were before health reform. Specifically, I strongly urge you to ensure that any final health reform proposal addresses the following three assurances for children.

1. Health Coverage Must Be Affordable.

All children and pregnant women must have affordable health coverage with a national eligibility floor of 300 percent of the Federal Poverty Level (FPL) ($66,150 for a family of four).

Just as all children in the United States are entitled to a free public education, ***all*** children should be entitled to affordable health care. The high number of uninsured children exacts a high health, economic and social toll on these children, their families and our nation. Uninsured children are at high risk of living sicker and dying earlier than their insured peers. Research shows that uninsured children are almost ten times as likely as insured children to have an unmet medical need, and the consequence of untreated conditions that go untreated are likely to continue into adulthood. An enormous concern is the fact that the distressing consequences of being uninsured fall disproportionately on children of color, who represent almost two-thirds of all uninsured children. Children of color are at higher risk than White children of having unmet health, mental health, and dental care needs.

The need for health care begins with maternity coverage. Each year in our rich nation 800,000 pregnant women go uninsured. They receive less prenatal care than their insured counterparts and face greater risks for expensive and tragic outcomes including complications, low birth weight, preventable illnesses, and even infant death. Lack of access to care can result in different

[1] Sharon Parrott, "Recession Could Cause Large Increases in Poverty and Push Millions into Deep Poverty." Center on Budget and Policy Priorities. November 24, 2008.

paths for our children from their earliest moments of life.

All children deserve a level playing field on which they can survive and thrive regardless of the state they live in or their family situation. Currently, each state sets its own income eligibility level for CHIP and Medicaid within broad federal guidelines and this has resulted in a profoundly inequitable patchwork of eligibility across the United States. Imagine being a low-income parent or grandparent raising several children and having one eligible for Medicaid and another eligible for CHIP, with different income eligibility standards and benefit packages for each program. Consider too that children in North Dakota will lose eligibility for CHIP if their parents earn more than 150 percent FPL while in twelve states and D.C., families can earn twice that amount and children are still covered. Children's ability to survive, thrive and learn must not depend on the lottery of geography or birth.

Ten states have no children eligible for Medicaid above 133 percent FPL. But half of the states already offer Medicaid to children of ***all*** ages in families with incomes above 133 percent FPL. Almost half already cover children at 200 percent FPL or higher. Thirty-nine states offer CHIP to children in families between 185 percent and 400 percent FPL. There must be a national floor of 300 percent FPL for all children and pregnant women. In establishing an eligibility floor, it is important that we consider the struggles families face daily to make ends meet. We should not require families to choose between paying for child care and other work-related expenses or health care. We should continue states' ability to allow families to disregard a portion of their earnings needed to cover work-related expenses, which are earnings not available to cover costs like the purchase of health care.

2. All Children Must Have Comprehensive Health and Mental Health Coverage

All children need a benefit package that reflects their unique health care needs and is designed to support their optimal development. This benefit standard should apply to all child health plans—Medicaid and CHIP, to those offered inside and outside the Exchange established in the Comprehensive Health Reform Discussion Draft, and to employers of all sizes. There are not two or three or more classes of children. Every child's life and health are of equal value. It is unjust to deny millions of children on CHIP the comprehensive benefits we extend to 28.7 million children each year on Medicaid or the national safety net we extend to seniors.

Children enrolled in Medicaid are entitled to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit package. It recognizes the importance for children of all ages to get regular and periodic screenings and assessments at various intervals throughout their lives, and is widely considered to be the best standard for age-appropriate child health coverage. Most importantly, it takes the next step to ensure that all eligible children are guaranteed the full range of comprehensive primary and preventive coverage they need and all medically necessary treatment to address health, mental health and developmental problems and chronic health conditions identified through these screens. Sara Rosenbaum, Chair of the Department of Health Policy at the George Washington University School of Public Health and Health Services, and a well-recognized expert on EPSDT, outlines clearly the ways EPSDT goes further than commercial insurance coverage to make care and treatment more accessible to the children and adolescents served by Medicaid:

- Ensures children all medically necessary treatment, with no exclusions related to certain physical and mental health conditions;
- Uses a preventive and ameliorative pediatric medical necessity standard;
- Makes care available to children without any limitations on scope or duration;
- Covers case management and personal attendant services and other supports to help ensure children benefit from the treatment they receive;
- Permits coverage of health care treatment in non-traditional as well as traditional health care settings, including settings where children are most likely to be such as child care programs, schools, or mobile vans that come to their neighborhoods; and
- Offers payment for transportation services and special nursing supports, as well as payments for community health centers and other safety net providers that can offer the children the special services and supports they need. [2]

As a parent and grandparent, I want all my children and grandchildren and all children to have access to this comprehensive range of care and support, and suspect that all of you do as well. We must now make comprehensive health and mental health care available to children in Medicaid the standard for ***all*** children, recognizing that it is based on children's assessed needs and that many children will only need basic supports. It is unconscionable to deny children the care they need. Covering children is the least expensive and most cost effective approach to help control skyrocketing health costs and to bend the long-term cost curve.

Estimates done for the Children's Defense Fund by the Lewin Group in 2007 indicated that providing EPSDT benefits to all children would cost about 12 percent more than providing the benchmark benefits more routinely provided by commercial insurance plans. I strongly urge the Committees to make this relatively inexpensive investment now.

3. All Eligible Children Should Get and Stay Enrolled in Health Coverage

The fact that two-thirds of uninsured children are already eligible for coverage under Medicaid or CHIP but are not enrolled clearly illustrates the numerous barriers that prevent children from getting health coverage. This is your chance to fix this big problem. The current health care system for children is neither simple nor seamless for families. They face formidable and unnecessary administrative barriers imposed by states that lead often to frequent, unnecessary, costly and harmful coverage gaps.

Just as the health insurance default for our nation's seniors is enrollment in Medicare, this should also be the case for our nation's children. We applaud the proposal in the discussion draft to enroll all children at birth. No infant should leave the hospital after delivery without health coverage. Other critical junctures provide easy opportunities for enrollment: child care, Women, Infant and Children's Program (WIC), the National School Lunch Program, food stamps, and school registration and health visits. More than 70 percent of low-income uninsured children are in families already receiving means-tested nutrition assistance. Using these programs as a basis for automatic enrollment, and adopting presumptive eligibility, could quickly enroll many low-

[2] Rosenbaum, Sara. "Creating Comprehensive and Stable Health Insurance Coverage for All Children: Resolving the 'Coverage Pathways' Challenge and Building High Performance." The George Washington University Medical Center, Washington, DC. http://www.firstfocus.net/Download/Rosenbaum_5.5.09.pdf

income children who are eligible but uninsured. The success of automatic enrollment in reaching a high percentage of the eligible population in other contexts – from retirement savings programs to drug discount cards – demonstrates the promise it holds to increase significantly children's enrollment. If we are serious about controlling costs, we need to get as many children into care to detect and treat their problems early. This is the most cost-effective approach, far preferable than denying coverage to save money in the short term (which costs far more in the long run) as too many states now do.

Building on CHIPRA's administrative improvements, we urge that a system of streamlined enrollment for children include: a simple, short joint Medicaid and CHIP application form translated into multiple languages; applicant self-attestation of eligibility subject to verification and random audits or both; the option to submit applications in-person, online, by mail, or as part of applications for other programs; express lane enrollment; 12-month continuous eligibility; presumptive eligibility during an interim period of coverage for individuals who appear to qualify for assistance under this title, on the basis of preliminary information; and a determination of continued eligibility at the end of the individual's eligibility period, based on all data available to the State. All waiting periods should also be eliminated.

Without requiring states to take such simple and inexpensive steps, many uninsured children could remain uninsured, even in the face of a parental mandate.

CHILDREN CANNOT WAIT FOR HEALTH COVERAGE

It is morally and practically indefensible in 2009 in the wealthiest nation in the world, with an annual GDP of more than $14 trillion, for our nation's leaders to be debating how many (or how few) children should have health coverage this year. Since the Medicaid program began in 1965, we have been laboriously trying to cover children—thousand by thousand, million by million, state by state. As we've debated incremental changes, generations and millions of our children have been sacrificed. And it's not about the money. It's about our values and our political will and commitment to basic justice. The real debate should be about why we have nine million uninsured children in America and how we are going to end this economically costly and morally intolerable reality right now.

As the Committee considers the Comprehensive Health Reform Discussion Draft and Congress continues to debate health reform proposals, I urge you to pass health reform legislation that ensures all nine million uninsured children and all 800,000 uninsured pregnant women in America access to affordable, comprehensive health and mental health coverage. In our great nation, no child should be born at low birthweight because of preventable causes or die in the first year of life because their mothers did not have adequate prenatal or postnatal care. The U.S. ranks 27th among 30 industrialized countries in infant mortality. Each year, more than 350,000 infants, one in every 12, are born at low birthweight and approximately 28,000 children die before their first birthday. Low birthweight babies are at risk for future health and learning difficulties. Undiagnosed, untreated, and poorly managed health and mental health problems increase a child's chances of falling behind in school or having disciplinary problems and decrease a child's chances of succeeding in and out of school. Our woefully inadequate mental health care system causes the inappropriate incarceration of thousands of children and youths in

costly juvenile detention facilities solely because community mental health services are unavailable. Children who go into the juvenile justice system are at much greater risk for entering the adult criminal justice system. Our children cannot wait any longer for the health coverage they need nor can our country.

Is there one elected official that has not professed that "children are our future"? Speaker of the House Nancy Pelosi recognized, "For too long, America's children have come in last in the competition for government investments. For too long, we have allowed outdated ways of thinking to determine our policies regarding our children. And for too long, there has been not enough political will to make children our number one priority in our work here in Congress." If we truly believe, as we must, that children are the foundation of family values and the future, that children have the right to be born healthy and be ready for and able to learn in school, then this Congress and this President can and must fully fund health reform and cover every child.

This is what the President himself called for when he signed CHIPRA into law earlier this year and eloquently testified to the urgent need to do more for children: "I refuse to accept that millions of our kids fail to reach their potential because we fail to meet their basic needs. In a decent society, there are certain obligations that are not subject to tradeoffs or negotiation—health care for our children is one of those obligations."

The test of the morality and common sense of a society is how it treats its children who are the human capital upon which our collective future depends. America is failing this basic test. No child should have to wait until age 65 for the health care guarantee we provide America's senior citizens. But what a moment of opportunity you have to move America and the world forward through our example and leadership.

INVESTING IN CHILDREN IS A SMART INVESTMENT

Making Health Coverage Affordable and Available Saves Lives and Money

Providing all children quality health coverage is not only the right thing to do, it's the smart and cost effective thing to do. Children without health coverage are at higher risk of living sicker and dying younger than those with coverage. A study by noted health economists Jonathan Gruber and Janet Currie suggests that expanding health coverage could prevent hundreds of deaths among children each year. Compared to their insured peers, uninsured children are almost ten times as likely to have no usual place of health care, ten times as likely to have an unmet medical need, more than eight times as likely to have delayed medical care due to cost, more than five times as likely to have an unmet dental need, more than four times as likely to have gone more than two years without seeing a doctor, and twice as likely to have gone more than two years without a dental visit.

Covering all children is one of the smartest, most cost-effective choices our country can make. A year's coverage for a single working adult costs about three times what it costs to cover a child for the same length of time. Investing early can prevent future problems. Poor health in childhood can cast long shadows later in life, so good childhood health is essential both for children themselves and the adults and workers they will become.

It makes *no* sense to wait until a child is born to invest. Hospitalization costs for a preterm or low birthweight baby are 25 times that of a healthy baby. Children born at low birthweight are twice as likely to have clinically significant behavior problems, such as hyperactivity, and 50 percent more likely to score below average on measures of reading and mathematics at age 17.

We know that investing in preventive services for children and addressing their health problems *now* is far more cost-effective than ignoring them. Research shows, for example, that every $1 spent on vaccinations for children saves $16 in medical and other costs.[3] These costs include direct medical costs related to the treatment of preventable diseases such as hospital costs, as well as the costs of caregivers who must miss work in the event of a child's illness.

Uninsured children also are more likely to rely on emergency care, which is not an effective solution. In Texas, taking a child for a doctor's office visit in the early stages of an asthma attack costs around $100. But if that same child fails to get early treatment and has to go to the emergency room with full-blown asthma symptoms, the child may face a three-day hospital stay that costs more than $7,300, according to the Harris County, Texas hospital. Relying on increasingly crowded emergency rooms to provide primary care for the uninsured is a penny-wise, pound-foolish solution.

Good oral health care is also an essential preventive service. Tooth decay is the most common chronic disease of childhood, costly to medical insurance if left untreated and consequential to eating, speaking and learning. Yet for every child lacking medical coverage, two lack dental coverage. About $8 million a year is spent on hospital care for the treatment of dental abscesses. In 2007, 12-year-old Deamonte Driver, who lived in nearby Prince Georges County, Maryland, died from an infection from a dental abscess that spread to his brain. A tooth extraction for $100 could have prevented the infection and the $250,000 in emergency care to try to save his life. He fell through the cracks of our broken child health system.

The Lack of Health Coverage Affects More Than Just a Child's Health

Poor health in childhood is linked not only with poor health as children grow into adulthood, but with lower income and wealth. One study found that having health insurance coverage during pregnancy substantially reduces the probability of low birthweight and prematurity, and that being born at low birth weight increases the probability of not working by more than seven percentage points among adults who did not have health coverage as children.[4]

A study by the National Bureau of Economic Research showed that controlling for parents' income, education, and social status, children who experience poor health have significantly lower educational attainment, significantly poorer health, lower earnings, and lower likelihood of

[3] Fangjun Zhou; Jeanne Santoli; Mark L. Messonnier; Hussain R. Yusuf; Abigail Shefer; Susan Y. Chu; Lance Rodewald; Rafael Harpaz. "Economic Evaluation of the 7-Vaccine Routine Childhood Immunization Schedule in the United States, 2001." *Archives of Pediatric and Adolescent Medicine*. 2005;159(12):1136-1144.

[4] Johnson RC and Schoeni RF. The influence of early-life events on human capital, health status, and labor market outcomes over the life course. National Poverty Center Working Paper Series #07-05, February, 2007.

working on average as adults.[5] Lack of health insurance also reduces the returns on major social investments such as education, and education levels are strongly associated with income. The median income for individuals 25-years-old and over with less than a high school diploma is $14,146; for those who completed a high school diploma the median is $22,184 – or about half of the median for those with bachelor degrees, which is $41,161.[6]

Covering All Children Makes Economic Sense

The average annual cost of group health coverage purchased through an employer is now more than $12,500. Since 2001, employer-sponsored health insurance premiums for families have increased 80%, rising more than three times as fast as wages (which rose 24% in the same time period) and almost four times the rate of inflation (21 percent). Rising costs are closely linked with loss of employer coverage.

Much has been made of the cost of universal coverage. But the costs of *not* insuring all children are much higher still. In addition to the costs to children's health and lives, our nation will continue to pay the hidden high costs of not insuring our nation's children. These include the costs of uncompensated care for the uninsured; treating non-emergencies in emergency rooms; and treating full-blown conditions and illnesses in children who could have received less expensive preventive care. Another example of "hidden costs" is the estimate that one quarter of the total costs of mental health treatment services among adolescents were incurred in the education and juvenile justice systems.[7] Despite the common belief that our nation does not have to pay for children without coverage, in fact, we subsidize some of these costs in higher premiums and higher tax dollars—paying a "hidden tax" to subsidize the uninsured.

Numerous health economists have discussed the economic benefits of universal coverage. A new 2009 study by researchers at Rice University's James Baker Institute for Public Policy concluded that the increased life expectancy and improved health status resulting from covering all children—in addition to productivity gains for future workers—will be cost-saving for society.

Jonathan Gruber and others have also documented the importance of "job lock," estimating that fear of losing health insurance reduces job mobility by as much as 25 percent among workers who receive insurance from their employers.[8] More efficient labor markets, along with improved productivity, could go a long way in restoring America's prosperity in this time of economic crisis.

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[5] Case, Anne, Angela Fertig, and Christina Paxson. (2003) From Cradle to the Grave? The Lasting Impact of Childhood Health and Circumstance. *National Bureau of Economic Research* Working Paper No. 9788.

[6] U.S. Census Bureau, Current Population Survey, 2006 Annual Social and Economic Supplement, Educational Attainment in the United States: 2006, Table 8, "Income in 2005 by Educational Attainment of the Population 18 Years and Over, by Age, Sex, Race Alone, And Hispanic Origin: 2006" Both sexes, at http://www.census.gov/population/www/socdemo/education/cps2006.html , accessed August 22, 2007.

[7] "Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities" Mary Ellen O'Connell, Thomas Boat, and Kenneth E. Warner, *Editors*. National Research Council and Institute of Medicine of the National Academics. The National Academies Press, Washington, D.C. 2009.

[8] Gruber, J and Madrian, B. Health insurance, labor supply and job mobility: a critical review of the literature. IN: McLaughlin CG, ed. Health policy and the uninsured. Washington, DC: Urban Institute Press, 2004: 97-178.

MAKE SURE HEALTH REFORM TRULY HELPS CHILDREN

I thank the Committees for the improvements that the Comprehensive Health Reform Discussion Draft would make to the current health care system, including many of the following that will assist both low income adults and children:

- Expanding the Medicaid eligibility floor to 133 percent FPL would theoretically expand health coverage to 36 percent of poor uninsured adults and 3.7 million uninsured children if all were able to enroll;
- Requiring numerous long-overdue insurance market reforms that will benefit both children and adults by prohibiting pre-existing condition exclusions, life time and annual limits on benefits, and limiting cost sharing;
- Specifying that maternity benefits, well baby and well child care, oral health, vision and hearing services, equipment and supplies for children under 21, and mental health and substance abuse disorder treatment must be covered for all individuals getting care through the new Exchange;
- Prohibiting cost sharing for preventive care, including well baby and well child care, and including a new grant program to provide a coordinated system of quality evidence-based home visiting to reach tens of thousands of low-income young children and their families;
- Ensuring that no newborn leaves a hospital in the United States uninsured by enrolling children in health coverage at birth;
- Facilitating access to health coverage by streamlining the application process for families;
- Recognizing that some families will need culturally and linguistically appropriate assistance in signing up for Exchange coverage;
- Including dependent coverage in the employer mandate;
- Establishing minimum loss ratio of 15 percent so insurers can spend more dollars investing in health;
- Including a strong public health insurance option that will force health insurance companies to compete, give consumers greater choice, and help control cost increases over time; and
- Taking steps to improve quality throughout the health care system.

The Children's Defense Fund strongly supports these long overdue policies and thanks you for your leadership in moving them ahead. However, there is much more to be done for health reform to achieve essential and transformational change for children. We agree with the President that this is truly a historic opportunity for transformative change and see a unique opportunity for you to correct the structural inequities that have been built into our health care system through incremental reforms over the past 42 years, when Medicaid first addressed the unique needs of young children.

I strongly recommend that you amend your draft bill to address the three critical areas for improvement that I stated earlier in my testimony: a national eligibility floor for children at 300 percent of the Federal Poverty Level; comprehensive health and mental health benefits for all children, building on what children now get in Medicaid; and a simplified system of enrollment

so that all children who are eligible will be enrolled. These are essential to ensuring that children truly benefit from health reform. Let me spend a minute on each of them.

Establish a uniform eligibility floor for children at or below 300 percent of the Federal Poverty Level, so children will no longer be subject to the lottery of geography.

More work must be done on affordability. Remember that in 29 states, Medicaid covers all children (of any age) at or above 133 percent FPL, and 12 cover children above 200 percent. In CHIP, of course, all states cover children at least up to 150 percent and some go as high as 400 percent FPL. We are very concerned that states will drop coverage for children above 133 percent FPL. We appreciate the fact that the draft includes a maintenance of effort provision, at least for Medicaid, but our policy experience over the years makes us skeptical that without additional incentives, the maintenance of effort will not offer these children the protection they need. It is also not clear what protections, if any, will apply to children enrolled in CHIP in states with Medicaid expansion programs, who are currently entitled to EPSDT benefits.

We also are deeply concerned that the draft bill leaves millions of children still subject to the lottery of geography. Earlier this year, there were still 33 states that had children of different ages eligible for different benefit levels. The legislation you write is an opportunity to eliminate the lottery of geography that currently leaves one third of our nation's children each year enrolled in 50 different state systems, each with different rules about eligibility, enrollment and recertification—in sharp contrast to the one national system we have created for our senior citizens.

A child is a child and each life is of equal value. Is a child in one state more worthy of comprehensive health coverage than a child in another state, or is a 5-year-old more deserving of care than a 7-year-old? Of course not—and yet this legislation as written would enshrine current vastly disparate and unjust eligibilities for children in perpetuity. In the strongest possible terms I urge the Committees to make all children and pregnant women to 300 percent FPL eligible for coverage under Medicaid and/or CHIP in all 50 states and the District of Columbia.

Another key aspect of affordability for health care is the need to help families pay premiums and the costs for care their children need. The Medicaid program requires states to cover children at higher income levels than adults to ensure they get the services they need in their critical formative childhood years, and sets strong limits on cost sharing. Additional evidence of the special place for children in our health system is the popularity of the CHIP program created with bipartisan support, to provide health coverage to help lower and middle income families pay for health care. In Medicaid, premiums are prohibited, and only nominal cost sharing is allowed for mandatory populations, and there is a total out of pocket cap at five percent of family income. Currently, state Medicaid programs cover children in families with incomes ranging from 100 to 300 percent FPL, depending on their age and where they live. Similarly, in CHIP, costs cannot exceed five percent of family income and there is no cost sharing for well-baby and well-child care, including immunizations. I was pleased to see the prohibition against cost sharing for these services in your bill.

Clarify that all children in Medicaid, in CHIP and in the Exchange will be eligible for the comprehensive health and mental health benefits that children in Medicaid are already guaranteed.

All children need a comprehensive package of health and mental health benefits that responds to their unique health needs. The draft bill does not assure them of this support. There is little clarity in the draft as to what benefits different groups of children will be eligible for and what enforcement mechanisms will be in place to ensure they actually get these services. It is not clear, for example, that children in CHIP will even receive in the Exchange all they are currently receiving in the CHIP Program. I urge you to make clear that children in the Exchange will be eligible for comprehensive benefits comparable to what children in Medicaid receive. While you have included a strong list of "essential" services to be covered in the Exchange, these terms are not yet defined and it is not clear that the other features of comprehensive coverage will also be included. We would like to work with the Committees to develop language to ensure that the Health Benefits Advisory Committee has clarity through the statute about the standard of care that must be provided to children in the Exchange. There must also be more attention to who must participate on the Committee to ensure that the needs of children and adolescents are adequately addressed.

Our concerns about children getting the comprehensive benefits they need are significantly heightened when we read they can be moved from Medicaid or CHIP to the Exchange. The Exchange is an unknown quantity and we strongly recommend that no children be transferred from Medicaid or CHIP to the Exchange until it is clear that it is a robust program. We must not gamble with children's lives and health. We must be able to ensure that the Exchange structure can provide the most vulnerable children the benefits and protections equal to or superior to what they have today. No children should be worse off.

We see language in the Comprehensive Health Reform discussion draft that refers to wrap around services being guaranteed to children in Medicaid who are transferred to the Exchange. However, we are well aware of the challenges parents and advocates have faced in trying to obtain these wrap-around services in states with managed care plans. Similarly, other efforts have also tried to require that states ensure children a Medicaid wrap on top of other benefits and that too has been problematic.

Simplify enrollment procedures so that children who are eligible but not enrolled will be able to get coverage without jumping through unnecessary hoops.

In order to ensure that our recommendations above will truly benefit children, any health reform bill must include critically important steps to simplify enrollment and to end the bureaucratic barriers that now result in two-thirds of uninsured children being eligible for but not enrolled in health coverage. The new eligibility floor in your draft bill will potentially provide health coverage to 3.7 million uninsured children, but please remember that all of these children are already eligible for Medicaid or CHIP, but are <u>not</u> currently covered due to restrictive state-imposed administrative requirements. Without requiring states to drastically simplify enrollment and institute automatic enrollment at various points, as you do at birth, it is likely that many of the children you add will remain uninsured, even if the individual mandate were adopted.

I urge the Committees to build upon the simplifications and improvements that were included in CHIPRA and to require all states to implement a simplified enrollment and re-enrollment process that include all the steps I mentioned above. All waiting periods should be eliminated. All of these simplifications will make it easier for parents and children to actually get health care.

I also urge the Committees to extend opportunities for automatic enrollment beyond birth to other critical junctures for children, including child care, and school registration and health visits. Children should also be able to enroll when they apply for other means-tested programs, such as WIC, the National School Lunch Program, and food stamps.

Let me close with a final brief point on affordability. All of the above improvements I urge you to take now are affordable – especially when you consider the enormous costs down the road if children's needs are not addressed, and the very small proportion of the overall health reform budget that is or will be spent on children. You have already included important steps in your draft – and we are just asking you to finish the job for children.

Congress can and must find the money to ensure all children comprehensive health and mental health coverage up to 300 percent FPL. Health care financing is an important part of the health reform debate, but we must do what's right for children's health and finance it accordingly, not make small changes to fit a number and call it transformative health policy reform. Our first reforms in Medicaid for children were made in 1967. How many children have fallen through the cracks over the past 42 years? Children can wait no longer. The time is now.

Congress found the money to bail out banks, insurance companies, and auto companies. Congress didn't struggle to pay for a "patch" to the Alternative Minimum Tax which has cost tens of billions of dollars. Congress cannot waive PAYGO rules for banks and corporations and insist that we don't have the money to offer health coverage to all uninsured children. It is unconscionable to extend portions of the 2001 and 2003 Bush Administration tax cuts without offsets while children's critical health needs are ignored. Right now, hedge fund managers are paying lower effective tax rates than their secretaries; millionaires are receiving annual tax breaks averaging more than $100,000; and there are proposals to gut the estate tax, which will affect the estates of three in 1000 people who die this year, who already are receiving an inexcusable level of support (when in full effect, they would cost taxpayers about $440 billion over ten years.) We can't afford not to cover children now.

Funding a strong health reform package for children and all in America will require shared sacrifice across multiple sectors; the Children's Defense Fund believes that all options must be on the table. There is no more important priority than our children's health. We do not have a money problem. We are the world's richest nation. But we have a profound values and priorities problem that places tax cuts for millionaires ahead of life giving care for mothers and investments in bombs and missiles that kill above our children's health. All children in America should have access to comprehensive health coverage so that they can grow up to be healthy, educated, productive adults and can build a strong American nation that can lead and compete in the globalizing world. Now is the time to show that democratic capitalism can work for *all* our children and all our people.

Thank you all for your hard work. We look forward to working closely with you as you continue to forge a transformational health reform proposal this year for all in America.

Appendix 1[9] to the Testimony of Marian Wright Edelman, Hearing on the Comprehensive Health Reform Discussion Draft on June 23, 2009.

Is our country living its creed and preparing for the future?

How America Ranks Among Industrialized Countries in Investing In and Protecting Children

1st in gross domestic product
1st in number of billionaires in the world
1st in health expenditures
1st in military technology
1st in defense expenditures
1st in military weapons exports
16th in maternal mortality rates
21st in 15-year-olds' science scores
22nd in low birthweight rates
23rd in neonatal mortality rates
25th in 15-year-olds' math scores
27th in infant mortality rates
Last in relative child poverty
Last in the gap between the rich and the poor
Last in adolescent (age 15 to 19) birth rates
Last in protecting our children against gun violence
Worst in the number of persons incarcerated

The United States and Somalia (which has no legally constituted government) are the only two United Nations members that have failed to ratify the U.N. Convention on the Rights of the Child.

The United States is the only major industrialized country that does not guarantee prenatal care to pregnant women.

If we compare just Black child wellbeing to children in other nations:

62 nations have lower infant mortality rates, including Barbados, Malaysia, and Thailand.

Over 100 nations have lower percentages of low birthweight births, including Algeria, Botswana, and Panama.

Black women in the United States are more likely to die from complications of pregnancy and childbirth than mothers in Azerbaijan, Turkmenistan, and Uzbekistan.

[9] Compiled by the Children's Defense Fund from official United States government sources and peer reviewed journals. For further information, contact Janet M. Simons, Principal Researcher, at jsimons@childrensdefense.org

Appendix 2[10] to the Testimony of Marian Wright Edelman, Hearing on the Comprehensive Health Reform Discussion Draft on June 23, 2009.

Racial Disparities in Children's Health and Health Coverage

Minority children experience significant health disparities in childhood that follow them throughout their lives. Of the 9 million uninsured children in America, minority children are uninsured and underinsured at far greater rates than White children. One in 13 White children is uninsured compared to: 1 in 5 Latino children, 1 in 5 American Indian children, 1 in 8 Black children, and 1 in 9 Asian/Pacific Islander children. **Health coverage for *all* children is a necessary step toward eliminating health disparities and ensuring access to care.**

Lack of access to health coverage helps explain some of the considerable racial and income disparities that can result in different life paths for our children from their earliest years. While only a small percentage of all children in America are in fair or poor health, Latino and black children are more than 4 times as likely as white children to be in only fair or poor health. Developmental delays caused by poor health make children less ready to learn in school, disproportionately affecting children of color's ability to reach their full potential and robbing America of the opportunity to have the healthiest and most productive workforce possible. In the emerging global economy, it is absolutely vital to the future of our nation's economic standing in the world that we expend every effort to ensure our children get the best education they can. Keeping them healthy and in the classroom is the most basic way to ensure that.

Health disparities begin before birth, putting children of color at a disadvantage that can continue throughout childhood and into adulthood. Black infants are more than twice as likely as white infants to die before their first birthday and have higher infant mortality rates than children in 62 nations including Barbados, Malaysia, and Thailand. One in every seven babies born to Black mothers is born at low birth-weight and compared to the rate of Black infants born at low birth-weight, Latino children are almost three times as likely as white children to be uninsured and have a lower rate of private health coverage than black or white children, and make up almost 40% of the entire population of uninsured children in the United States. Between 1989 and 2006, the proportion of Latino babies born at low birth-weight increased by 13 percent, and the proportion of pre-term Latino births increased by 10 percent. More than 100 nations have lower low birth weight rates than the United States, including Algeria, Botswana, and Panama.

Black and Latino children also face significant challenges in accessing regular health care and have incidences of childhood illnesses higher than those of white children. Black children are 56% more likely than White children to have gone more than two years without seeing a doctor and almost three times as likely as White children to use the emergency room as their usual place of health care while Latino children are twice as likely. Latino children are two and a half times as likely as white children to have gone more than two years without seeing a doctor, they are more than twice as likely as white children to have an unmet medical need, and are more than twice as likely as white children to have no regular place for health care. One out of eight black

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children has asthma – one of the most common illnesses in children – compared to one in twelve white children. One out of every four black two-year-olds, and one out of every five Latino two-year-olds is not fully immunized; yet we know that every dollar spent vaccinating children against measles, mumps and rubella saves $16 in future costs. More than 30 percent of black children and about 40 percent of Latino children report not receiving dental care. For dental-related illness alone, children missed more than 51 million hours of school in one year, resulting in more than $8 million in costs to their local communities.

Even though minority children are more likely to be living in poverty, racial disparities are not just about socio-economic status. More than three-quarters of uninsured black children have a working parent, and more than half have a parent who works full-time throughout the year. While only a small percentage of all children in American are in fair or poor health, black children are more than four times as likely as white children to be in only fair or poor health. But it does not have to be this way -- three-quarters of all uninsured Latino children are eligible for CHIP or Medicaid according to their family income qualifications, yet are not insured. **Without comprehensive, affordable coverage for all children, minority children will continue to be uninsured and underinsured at greater rates than higher income and white children. Considering the substantial health and wealth disparities among children in communities of color, espousing child-specific solutions where necessary in health reform legislation is critical. Every child and pregnant woman must be guaranteed timely access to all medically necessary services and products to maximize health and development.**

Coverage must be affordable – we must eliminate the "lottery of geography", and establish a national eligibility floor of 300 percent of the federal poverty level for all children and pregnant women, with an affordable sliding scale buy-in above that level. The system must be simple, seamless and equitable to ensure children get enrolled and stay enrolled.

Appendix 3[11] to the Testimony of Marian Wright Edelman, Hearing on the Comprehensive Health Reform Discussion Draft on June 23, 2009.

Covering All Children Makes Economic Sense

Providing all children quality health coverage is not only the right thing to do, it's the smart and cost effective thing to do. The costs of *not* insuring all children are simply too high to ignore.

Public Investments

Lack of health insurance misuses valuable community resources and significantly reduces the returns on major social investments. An uninsured child costs the local community $2,100 more than a child with Medicaid or CHIP.[12] Education is an investment that yields high returns for the public. In the United States, the internal rate of return to the public of an individual obtaining a high school diploma (or its equivalent) is between 9.7 and 12.5 percent in additional taxes received; for an individual obtaining a college-level degree, the rate is between 13.0 and 14.1 percent in additional taxes received.[13] However, the public's investment in education is increasingly diminished every year due to children's lack of health coverage. The developmental delays caused by poor health make children less ready to learn in school and prolonged illnesses contribute to children missing school days.

Developmental delays and absenteeism prevent many children from reaching their full potential, and rob America from having the healthiest and most productive workforce possible. Children miss more than 51 million hours of school each year because of dental-related illnesses.[14] In 2003, children missed almost 13 million school days due to asthma. These numbers are especially significant considering that children who miss 10 percent of the school year (approximately 18 days) in kindergarten show lower levels of achievement in math, reading and general knowledge during first grade.[15] Chronic absenteeism exacts a high price from children, who have difficulty making up the work they missed and keeping up with their peers, and also from their parents, who must take time off from work during these absences. Parental loss of work contributes to nearly $1 billion in indirect costs to the nation in lost productivity. Further evidence of the loss of productivity is found in one analysis of national data that concluded a sibling who reported excellent or very good health in childhood earned 24% more than a sibling

[11] Compiled by the Children's Defense Fund from official United States government sources and peer reviewed journals. For further information, contact Janet M. Simons, Principal Researcher, at jsimons@childrensdefense.org
[12] Rimsza M, Butler R, Johnson W. Impact of Medicaid Disenrollment on Health Care Use and Cost. *Pediatrics* 2007; 119; e1026-e1032
[13] Organization for Economic Co-operation and Development, 2007, Education at a Glance 2007 - OECD Indicators, Table A9.7 "Public internal rates of return for an individual obtaining an upper secondary or post-secondary non-tertiary education, ISCED 3/4 (2003)," and Table A9.8 "Public internal rates of return for an individual obtaining a university-level degree, ISCED 5/6 (2003)," at http://www.oecd.org/dataoecd/4/55/39313286.pdf . Accessed June 29, 2009
[14] Oral Health in America: A Report of the Surgeon General, National Institute of Dental and Craniofacial Research, National Institutes of Health, U.S. Dept. of Health and Human Services, 2000.
[15] Chang H, Romero M "Present, Engaged, and Accounted For: The Critical Importance of Addressing Chronic Absence in the Early Grades" National Center for Children in Poverty, September 2008.

who was not in good health[16]. With that said, children enrolled in the Children's Health Insurance Program missed fewer classes and showed better school performance than when they were uninsured.[17] Our children and our society cannot afford to continue without healthcare for every American child.

The solution to reducing many of these health care costs is through preventive health care; prevention costs far less than illness. Specifically, investments in prenatal and maternal care, primary and dental care, and childhood immunization will yield significant savings over spending on emergency care.

Prenatal and Maternal Care

Investments in prenatal and maternal care are particularly cost effective. For every $1 spent on prenatal care, $3.33 can be saved in costs associated with postnatal care and another $4.63 in long-term costs.[18] The most common medical complication in a pregnancy is gestational diabetes, with approximately 180,000 reported cases in 2006.[19] However, every $1 spent on preconception care programs for women with diabetes yields a $5.19 reduction in health costs for the mother and baby.[20]

Smoking cessation programs for pregnant women are also an especially sound investment.[21] Smoking cessation for pregnant women has a cost-benefit ratio of 3:1, that is, for every $1 spent on smoking cessation among pregnant women $3 are saved in later health-related costs.[22] One out of every eight babies born each year is born to a mother who smoked during pregnancy. Babies exposed to tobacco during pregnancies experience numerous health risks, including low birth weight. Increasing women's access to health care will be essential to preventing preterm births and the financial and health consequences of low birthweight babies.
In 2006, about 350,000 babies were born at low birthweight. The cost of hospitalization for a preterm or low birthweight baby is 25 times the cost of hospitalization when a healthy baby is born; according to the Institute of Medicine, preterm birth in 2005 cost the United States at least

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[16] Smith, J.P. "The impact of childhood health on adult labor market outcomes." WR-310. 2005. RAND Labor and Population Working Paper.
[17] Children's Health Assessment Project. *Health status assessment project: First year results.* San Diego, CA: CHAP, Data Insights Report No. 10, November 2002. Available online at http://www.mrmib.ca.gov/MRMIB/HFP/PedsQLYr2CHHS.pdf
[18] MC Lu, YG Lin, NM Prietto, & TJ Garite, Elimination of public funding of prenatal care for undocumented immigrants in California: a cost-benefit analysis, American Journal of Obstetrics & Gynecology, Vol. 182, No. 1 (January 2000), 233-239.
[19] Martin, Joyce A., Hamilton, Brady E., Sutton, Paul D., Ventura, Stephanie J., Menacker, Fay, Kirmeyer, Sharon, Mathews, T.J. *Births: Final Data 2006*, National Vital Statistics Reports. National Vital Statistics System, Vol. 57, No. 7 (January 7, 2009).
[20] Centers for Disease Control and Prevention. Chronic Disease Overview: Costs of Chronic Disease. http://www.cdc.gov/nccdphp/overview.htm., accessed June 29, 2009.
[21] Guyer B et al. "Early Childhood Health Promotion and Its Life Consequences" *Academic Pediatrics* 2009; 9: 142-9
[22] Ruger, JP; Emmons, KM. Economic evaluations of smoking cessation and relapse prevention programs for pregnant women: a systematic review, Value in Health, Vol. 11, No. 2 (March/April 2008), 180-190.

$26.2 billion or $51,600 for every preterm infant born.[23] Children born at low birthweight are twice as likely to have clinically significant behavior problems, such as hyperactivity, and are 50 percent more likely to score below average on measures of reading and mathematics at age 17.[24] In addition to other benefits, postpartum care helps women appropriately space pregnancies, thus reducing the risk of preterm birth. Further, having health insurance coverage during pregnancy substantially reduces the probability of low birthweight and prematurity.[25]

Primary and Dental Care Visits

Primary care doctor visits cost less than emergency rooms. The cost for a child to visit a doctor in the early stages of an asthma attack is about $100, but going to the emergency room to treat full-blown asthma symptoms could lead to a three-day hospital stay costing more than $7,300.[26] Good oral health care is also an essential preventive service. Children's average dental related costs almost double when a child's first preventative visit occurs at age 4 or 5 (about $546), compared to when that visit occurs before the child is age 1 (about $262).[27] Further, approximately $8 million a year is spent on hospital care for the treatment of dental abscesses. In 2007, 12-year-old Deamonte Driver in Maryland died from an infection from the dental abscess that spread to his brain. A tooth extraction for $100 could have prevented the infection and the $250,000 spent in an unsuccessful effort to save his life with emergency care

Home visitation programs are also incredibly cost effective. Each $1 invested in home visitation programs for at-risk mothers and children results in almost $3 in benefits.[28] These benefits came in the form of decreased crime rates, higher earnings for participants, less child abuse, and fewer welfare payments by taxpayers. Home visitation programs such as nurse-family partnership programs are excellent ways to promote good prenatal care and the healthy development of infants and toddlers.

Immunizations

Immunizations are another extremely cost effective preventative measure; every $1 spent on vaccinations for children saves $16 in medical and other costs.[29] Analysis of the routine childhood vaccinations finds that for every $1 spent on the measles/mumps/rubella vaccine, more than $13 are saved; every $1 spent on the diphtheria/tetanus/pertussis vaccine yields more

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[23] Institute of Medicine, Report Brief: Preterm Birth: Causes, Consequences, and Prevention. Washington DC: National Academies Press; 2006. http://www.iom.edu/Object.File/Master/35/975/pretermbirth.pdf, accessed June 29, 2009.

[24] Breslau N, Paneth NS, Lucia VC "The lingering academic deficits of low birthweight children" Pediatrics 2004; 114(4):1035-1040

[25] Institute of Medicine, Committee on the Consequences of Uninsurance. Report: Health Insurance is a Family Matter. Washington DC: National Academy Press; 2002

[26] Children's Defense Fund Texas, "In Harm's Way: True Stories of Uninsured Texas Children" Houston TX: March 2007. The estimate comes from the Harris County Hospital District.

[27] Savage Matthew, Lee Jessica, Kotch Jonathan, and Vann Jr. William. "Early Preventive Dental Visits: Effects on Subsequent Utilization and Costs". *Pediatrics* 2004; 114 pp.418-423.

[28] Isaacs, Julia. *Cost-Effective Investments in Children.* The Brookings Institution. January 2007.

[29] Economic Evaluation of the 7-Vaccine Routine Childhood Immunization Schedule of the United States, 2001. Zhou, Santoli, et al.

than $27 in savings. And, every $1 spent on the varicella vaccine, saves more than $5.[30] These seven routine childhood vaccines prevent 33,000 deaths and almost 14 million incidents of disease over the lifetime of children born in any given year; this is an annual $9.9 billion in savings in direct medical costs and a further $43.3 billion in savings in indirect costs.[31]
In addition to the seven routine immunizations, investment in additional vaccines for children is critical. The most common reason a pre-school aged child visits a physician's office is for acute otitis media (a middle ear infection). A 2008 study conducted by researchers at the Centers for Disease Control and Prevention found that vaccinating against the pneumococcal disease results in an estimated $460 million annually in direct savings of acute otitis media-related medical costs. Investment in these preventative measures will not only improve and save the lives of our children, but also decrease the debilitating financial burden of health care costs.

Conclusion

Poor health in childhood can cast long shadows later in life; consequently, good health at birth and throughout childhood is essential both for children themselves and the adults and workers they will become. Further, the cost effectiveness of providing health care to all children makes universal coverage a sound financial investment. All children must have access to affordable, quality health care.

[30] U.S. Department of Health and Human Services. HHS Fact Sheet: The Childhood Immunization Initiative. July 6, 2000. http://www.hhs.gov/news/press/2000pres/20000706a.html, accessed June 29, 2009.
[31] The Department of Health and Human Services. FY 2006 Performance and Accountability Report. http://www.hhs.gov/of/reports/account/acct06/pdf/section2/goal1.pdf, accessed June 29, 2009.

Mr. PALLONE. Thank you.
Ms. Jennie Chin Hansen?

STATEMENT OF JENNIE CHIN HANSEN

Ms. HANSEN. Thank you.

Chairman Pallone, Ranking Member Deal, and distinguished other subcommittee members, I am Jennie Chin Hansen, president of AARP. Thank you very much for inviting me to be here today and for your leadership on leading comprehensive health care reform.

Enacting legislation to give all Americans quality, affordable health coverage options is AARP's top priority this year. The draft tri-committee legislation marked substantial progress toward this goal.

Today, I am really proud to represent nearly 40 million members of AARP, half over the age of 65 and half below 65. Both age groups face serious problems in today's health care system, especially the 7 million people aged 50 to 64 who are uninsured.

The draft includes critical reform priorities for AARP members for all ages. For our younger members, it would curtail discriminatory insurance market practices that use age and health status to block access to affordable coverage. Reforms must include strict limits of no more than 2:1 on how much more insurers can charge to people who are in this age bracket of 50 to 64.

Reform must also provide sliding-scale subsidies for those who need help to make coverage affordable, as well as provide some strict limits on cost-sharing. The draft legislation achieves our goals on these vital points in health care reform.

For our older members, the draft closes Medicare's prescription drug donut hole so that they will be able to afford the medications that they need. This drop in coverage has been a major reason why one in five people who get drug coverage through Medicare delayed or didn't even fill the prescription because of that cost. Under current law, the hole keeps getting larger every year. The draft begins to close the donut hole and includes other steps to lower drug costs.

And for people with limited incomes, the draft closes the gap right away by strengthening the Part D low-income subsidy and eliminating its asset test that penalizes people who really did the right thing in saving for a small nest egg in retirement.

The draft also fixes Medicare's broken system for paying doctors and puts Medicare on a path to fiscal stability by revising payment systems to reward quality instead of quantity of care. It includes incentives to reduce costly and preventable re-hospitalizations. It strengthens our health care workforce that we know is actually, at this point, short already, let alone what will happen in the future. And it takes important steps to address racial and ethnic disparities in care.

Many challenges remain on the road to really full, comprehensive health reform. But AARP and many other stakeholders share a broad and growing consensus that any differences that we may have cannot stop us from finding common ground and enacting comprehensive health care reform this year. We know—and it has been said time and time again—the status quo is just unsustainable, and we cannot afford to fail.

Thank you all for your leadership, and we continue to looking forward to work with all of you in Congress to enact this comprehensive reform this year.

Thank you.

[The prepared statement of Ms. Hansen follows:]

STATEMENT FOR THE RECORD

SUBMITTED TO THE

Energy and Commerce Health Subcommittee

on

E&C Health Reform

June 23, 2009

AARP
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WITNESS: **JENNIE CHIN HANSEN**
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Chairman Pallone, Ranking Member Deal, and other distinguished members of the Subcommittee, 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 be 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), 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) 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) 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 age 50-64 who are not yet eligible for Medicare and those with pre-existing chronic conditions, cannot secure health coverage, at any price. Industry data show that insurers reject between 17% and 28% of applicants age 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 age 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.

[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 age 50-64 experience worse outcomes and use more services when they enter the Medicare program, and their uncompensated health care costs in the years before Medicare 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.

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.

Requiring everyone to participate is necessary because it increases the risk pool, greatly reduces insurers' interest in underwriting based on age or health status and ensures that healthier individuals are included in the risk pool. AARP can support only these requirements because the Draft proposal also includes the assurance of adequate subsides. If people or businesses are required to purchase coverage is must be affordable, therefore, subsidies must also be adequate, available, secure and administratively feasible. The Draft appears to achieve the appropriate balance.

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 an 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 higher than current Medicare rates. It is important to our members who are not yet eligible for Medicare and are seeking access to affordable coverage that a viable Exchange be up and running quickly. Therefore, we support the temporary nature of this requirement. At the same time, 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 leadership for recognizing the importance of eliminating the Medicare doughnut hole. The Draft proposes to reduce and, over time, eliminate the donut hole in Part D. Combined with the June 22nd White House announcement about drug manufacturers' 50% price discount for brand-name drugs purchased by enrollees when they fall into the coverage gap, this will be an important change for beneficiaries as eliminating the donut hole will save Medicare beneficiaries 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 lowering drugs costs. 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; and
- Safe Importation of Drugs

Making Medicare More Affordable: In addition to lowering all beneficiaries' out-of-pocket costs, it is essential that health reform improve the patchwork of 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.

[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.

- 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.

Fortunately, many proposals to improve the quality of the care in Medicare will save money for both beneficiaries and taxpayers in the long run. 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;
- Gradually eliminating excess payments to Medicare Advantage plans;
- 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 Sustainable Growth Rate (SGR) formula.

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 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.

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[7] Congressional Budget Office, *The Long-Term Outlook for Health Care Spending*, November 2007.

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.

AARP is pleased that the Draft is attempting to address unnecessary hospital readmissions through payment policy changes and we note that the House bill does provide some funds to certain hospitals to pay for transitional care services. We agree that is it critical to address this issue. However, we urge a more meaningful and robust approach to ensure that high-risk Medicare beneficiaries receive transitional care services to help keep them out of the hospital and improve their quality of care. We strongly urge that the AARP-endorsed Medicare Transitional Care Act (H.R. 2773/S. 1295) be included in the final Tri-Committee health reform bill. H.R. 2773 would target transitional care services to Medicare 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.

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]

[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.

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 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.

However, we are disappointed that the Draft does not include any significant provisions to expand access to HCBS. These 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 reform, such as the following from the Empowered at Home Act (H.R. 2688) and the Retooling the Health Care Workforce for an Aging America Act (H.R. 468):

- Improvements to the Medicaid HCBS state plan option, such as raising the income limit and broadening the scope of covered services;
- An enhanced Federal Medicaid Assistance Percentage (FMAP) for states that take up the Medicaid HCBS state plan option;
- Mandatory spousal impoverishment protections for HCBS;
- Modifications to asset/resource limits for individuals applying for Medicaid HCBS to allow them to keep some funds to maintain their home;
- Training opportunities for family caregivers and an assessment of their needs to connect them to services and supports, such as respite care, information, counseling, and training; and
- Training for health professionals in long-term care, chronic care management, and geriatrics and improved training for direct care workers.

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.

Mr. PALLONE. Thank you.
Dr. Shern.

STATEMENT OF DAVID L. SHERN

Mr. SHERN. Mr. Chairman, members of the committee, Mental Health America is honored to participate in today's hearing on ways to reform our health care system.

I want to start by expressing our appreciation for the many important proposals included in the tri-committee bill released last week that recognize how integral mental health is to overall health.

You know, this is our centennial year; our organization is 100 years old this year. And for the last 100 years, we have advocated for people with mental health. And from the beginnings of our organization, we had kind of a dual vision. On the one hand, we were concerned with people who had severe and disabling illnesses, who would have traditionally been treated in State hospitals. But, on the other hand, from our very beginning we have had a commitment to a public health perspective and to prevention as the only real way to drive down the prevalence of illness.

So we are very heartened by this bill, because we see it as including many of the issues that need to be addressed in order to become the healthiest nation. We think that it addresses historical patterns of discrimination by including parity for mental health and substance use services. And, importantly, it addresses the prevention and management of chronic diseases as the real strategy to control costs and improve overall health care status. We think these are very important.

You know, mental health and substance use conditions are really paradigm cases for what goes wrong when we discriminate against a class of illnesses and fail to prevent and appropriately treat them. And this resonates very much to what Ms. Wright Edelman was talking about, in terms of not addressing issues of mental health services in children.

Increasingly, our science is telling us that mental health and substance use conditions—we used to think they were diseases of early adulthood. We now know that they are diseases of adolescence. They are developmental disorders that occur early in life. For all people who are going to develop a mental health diagnosis during the course of their life, 50 percent of those people will have that diagnosis by the time they are 14 years old. However, they will not receive services until, on average, they are 24 years old.

So, during that 10-year period, substantial disability begins to develop. Academic achievement starts to drop off; these are very strong predictors of academic achievement. Ultimately, occupational achievement is compromised. We need to do a much better job at early identification and addressing issues of mental health and substance use disorders if we are going to develop the healthiest nation.

The reason that WHO estimates that mental health and substance use conditions are, in fact, the most burdensome of all health conditions, causing twice as much burden of disease as cardiac illnesses, is in part because they are diseases of early adolescence that we do not effectively address.

So, clearly, this bill, from our perspective, includes all the key components that are necessary to start to address this problem, at least structurally.

First of all, it clearly addresses the importance of preventative services. You know, I think in some contradiction to some of the things that were said earlier, we have a brand-new report from the Institute of Medicine that was released in March that is a comprehensive summary of what we know about the effectiveness of preventative services for emotional and behavioral disorders in children and young adults.

And we know a lot. Our science base is strong. We know that community-based interventions work, and we applaud the committee for emphasizing the importance of community-based interventions. We know that early identification when coupled with treatment works, as the Preventive Services Task Force has indicated. And we applaud the committee for including those services, as well.

It is also clear, if you look at what is required to manage chronic disease, it is very clear that in order to do that you need to address the entire person, not the person in segments or subspecialties. The notion of the medical home that is included in the bill I think is extraordinarily important, and the inclusion of behavioral health services in that medical home is absolutely critical.

Not only are mental health and substance use conditions the most chronic illnesses, they are the most common co-occurring illnesses with other chronic disorders. And when they co-occur, they drive costs way up, drive outcomes way down. So the medical home and comprehensive integrated care is clearly an important part of what we need to accomplish here.

You know, we have a tragedy in this country in that people with chronic mental illnesses who are served in our public system die 25 years early—25 years early. They are dying on average in their 50s. And they are dying from a broad range of the same disorders that will kill all of us in our 70s or 80s or 90s.

So it is a critical imperative that we address comprehensively the needs of that population as well as persons with other chronic conditions who are likely to have mental health and substance use conditions.

Finally, I would just like to say that closing the donut hole is very important for people who rely on psychiatric medications, which can be very expensive.

The committee's attention to workforce provisions is critically important. As several people have noted, we have a very predictable workforce crisis coming up on us quickly.

And then, finally, a word about comparative effectiveness research. You know, I left academia 3 years ago at the University of South Florida, where I used to work for Ms. Castor's mother, to join an advocacy organization because of my frustration with our inability to get our incredible science base to people who need those services.

Comparative effectiveness research provides a framework for us to better codify and understand what works and to translate it into information that can be supportive of individuals and their clinicians, their caregivers, in making better decisions.

So I applaud the committee for all the components of the bill, which seem to nicely round out both improving the quality of care, emphasizing preventative services, and bringing better science to bear in terms of our decision-making processes.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Shern follows:]

Statement of

David L. Shern, Ph D
President and CEO, Mental Health America

before the

Energy and Commerce Committee
Health Subcommittee

Hearing on Health Care Reform

June 23, 2009

Mr. Chairman and members of the Committee, Mental Health America is honored to participate in today's hearing on ways to reform our health care system to cover the uninsured and improve the quality of care while reducing cost. While this is an ambitious goal, we believe the draft bill issued by the Chairmen of the Ways and Means, Energy and Commerce, and Education and Labor Committees last week would start us on the right path toward achieving quality, affordable health care for all Americans.

For over one hundred years, Mental Health America, previously known as the National Mental Health Association, has advocated for the interests of mental health consumers. Along with over three hundred affiliates across the United States, we raise the concerns of those who are often excluded or discounted, even in health care discussions. And we applaud your decision to highlight the importance of addressing the needs of people with mental health and substance use conditions by inviting us here today. We also appreciate the many important provisions in the Tri-Committee bill that recognize how integral behavioral health (which encompasses mental health and substance use) is to overall health and the critical need to fully incorporate the goal of improved availability and quality of preventive, treatment, and rehabilitative services for these conditions into our broader health care reform efforts.

People with mental health and substance use conditions have traditionally not been well served by our current health care system. The President's New Freedom Commission on Mental Health proclaimed in 2002 that mental health care in this country is in shambles.[1] We could not agree more, although there are isolated examples of excellent care. And, scientific advances over the last half century have led to reliable diagnosis and a range of treatments for these conditions with effectiveness rates comparable to or exceeding those of treatments for many other health conditions.

[1] President's New Freedom Commission on Mental Health, Interim Report, October 2002, Washington, D.C. [available at www.mentalhealthcommission.gov]

Tragically, despite such significant advances in our understanding of how to effectively treat behavioral health conditions, people with serious mental illnesses who are treated in our public systems die on average 25 years earlier than the general population due primarily to other co-occurring health disorders including diabetes, heart disease, cancer, and asthma.[2] Behavioral health consumers have some of the greatest unmet needs for improved care coordination and prevention services.

Mental health and addiction treatment have historically been subject to blatantly discriminatory limits on coverage through private insurance plans that block access to effective and critically needed therapies. And more insidious but no less devastating has been the more aggressive management of care for these conditions than for other health conditions through utilization management and other treatment limitation techniques. A recent report found that about two-thirds of primary care physicians could not get outpatient mental health services for their patients – a rate that was at least twice as high as that for other services – due in part to health plan barriers and inadequate coverage.[3]

Last year, we made tremendous progress working together on this front with enactment of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (Pub L. 110-343) to prohibit unequal treatment limits and financial requirements for mental health and substance use benefits compared to medical and surgical benefits. Groundbreaking as well were improvements to Medicare coverage of mental health treatment through the Medicare Improvements for Patients and Providers Act (MIPPA) (Pub. L. 110-275) -- especially the provision phasing out the higher 50 percent coinsurance rate for outpatient mental health services.

We are very pleased to see that the principle of non-discrimination and parity for behavioral health services would be maintained in the new Health Insurance Exchange and health care coverage provisions proposed in the Tri-Committee bill. In light of the long history of discrimination against individuals with behavioral health conditions, we also strongly support the insurance market reforms in the bill that would establish a guaranteed issue requirement and prohibit pre-existing condition exclusions and premium rating based on health status as well as annual and lifetime limits on benefits. In addition, we appreciate the provision to repeal the discriminatory 190-day lifetime limit on psychiatric hospital inpatient care under Medicare.

As we have seen, particularly in the Medicaid program, when funding is tight and benefits are reduced, behavioral health services are often the first place cuts in coverage are made. However, providing access to behavioral health services will be essential in light of recent research showing that a large proportion of low-income, uninsured individuals have poor mental health.[4]

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[2] Parks, J., Svendsen, D., Singer, P., Foti, M., Mauer, B., Morbidity and Mortality in People with Serious Mental Illness, National Association of State Mental Health Program Directors, 2006.
[3] Cunningham, P.J., Beyond Parity: Primary Care Physicians' Perspectives on Access to Mental Health Care, Health Affairs, April 2009.
[4] Kaiser Commission on Medicaid and the Uninsured, Policy Brief entitled "Low-Income Adults Under Age 65 – Many are Poor, Sick, and Uninsured", June 2009.

Thus, the provision in the Tri-Committee bill to ensure that mental health and substance use services are available to all individuals covered through the new Health Insurance Exchange is absolutely critical.

In light of the high degree of mental health needs among the uninsured population, we commend the efforts of so many in Congress and the Administration to expand health care coverage to all. And, we strongly support the provision requiring outreach to vulnerable populations to inform them about the Exchange, including individuals with mental health conditions. As we have learned through implementation of the Medicare Part D program, additional efforts will be needed to ensure that those with serious mental health conditions are aware of the program and can successfully enroll. Mental health providers and other organizations that regularly interact with individuals with behavioral health conditions can provide valuable assistance in educating these individuals about the new coverage program and helping them navigate it.

Prescription medication is often a key component of effective behavioral health care and we have been actively working to ensure that the Medicare Part D program provides comprehensive coverage of medications to treat these conditions. The gap in coverage commonly referred to as the "doughnut hole" has proven very burdensome for many mental health consumers and we frequently hear from consumers unable to access critical medications because of this gap in coverage. Thus we strongly support the provision to phase out the doughnut hole.

We would also encourage the Committee to include language in the bill to strengthen the protection established administratively by the Centers for Medicare and Medicaid Services (CMS) to ensure full coverage of six classes of clinically sensitive medications. CMS put this requirement in place out of concern that the diseases associated with these six classes have among the highest predicted drug and medical costs and the risk that individuals with these conditions may be discouraged from enrolling or denied needed medications due to discriminatory tactics. These concerns were well-founded and Medicare beneficiaries with these conditions, including behavioral health conditions, continue to need assurance that Part D will provide access to substantially all medications in these classes.

As more individuals with mental health conditions receive health care coverage, it will be important to ensure the availability of behavioral health service providers. We thus strongly support the grant program proposed in the Tri-Committee bill increasing the public health workforce that identifies mental health as a severe shortage discipline and the expansion of the National Health Service Corps which includes behavioral health professionals. We also appreciate the provision in the bill to allow Medicare coverage for mental health counselors and marriage and family therapists and to maintain Medicare reimbursement levels for outpatient mental health services which hopefully will help to increase access to behavioral health through Medicare and the broader health care system.

Many of the uninsured have disabling mental health conditions but have for one reason or another not been designated as disabled under federal programs and thus eligible for Medicaid and/or Medicare. However, it will be important to ensure that these individuals receive care, at

least initially, through the traditional Medicaid program which provides community-based support services which may not be offered through private plans in the Exchange. The two-year waiting period for individuals with disabilities to receive Medicare coverage should also be addressed since some 40 percent of people with disabilities, including many with behavioral health conditions, are without health care coverage at some point during their wait for Medicare. We recognize that some of these individuals would be covered in the Exchange and encourage the Committee to keep the high needs of this population in mind as health care reform legislation develops.

We also strongly support the provision in the bill to ensure that plans in the Exchange provide rehabilitative and habilitative services, which hopefully would encompass some of the same types of community-based services covered by Medicaid. This provision is critical to overcoming the high degree of unemployment among those with serious mental health conditions. Despite the fact that many are willing to work and would benefit from the socialization and positive reinforcement that engagement in employment can offer, a powerful disincentive to getting a job is currently created by the risk of losing Medicaid coverage and thus access to critically needed community-based services.

Moreover, resources could not be more efficiently spent than on improving care for behavioral health conditions because they are among the most chronic and disabling conditions affecting the U.S. population. In fact, the World Health Organization has pronounced mental health disorders to be the leading cause of disability in the United States based on burden of disease.[5] And severe mental illnesses cost the U.S. $193 billion in lost wages in 2002[6] which exceeds the gross revenue of 499 of the Fortune 500 Companies.

Mental illnesses often accompany and greatly increase the cost of treating other chronic conditions. Prevalence studies have found depression to be commonly associated with diabetes, asthma, heart disease, and obesity. Research has also shown that individuals with these health conditions who also have a mental health disorder, such as depression, are likely to experience worse functional disability, a poorer quality of life, and, in some instances, higher mortality, than individuals whose chronic / health conditions are not co-morbid with mental disorders.[7] One study has even indicates that depression contributes to the risk of heart disease as much as diabetes, high cholesterol, or obesity.[8] The most tragic outcome of this high degree of co-morbidity, as mentioned earlier, is the finding that individuals with serious mental health conditions die 25 years earlier than the general population due to inadequate care for co-morbid health conditions.

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[5] The World Health Organization, The World Health Report 2004: Changing History, Annex Table 3: Burden of disease in DALYs by cause, sex, and mortality stratum in WHO regions, estimates for 2002.

[6] Kessler, R.C., Heeringa, M.D., Lakoma, M.P., Rupp, A.E., Schoenbaum, M., Wang, P.S., and Zaslavsky, A.M., Individual and Societal Effects of Mental Disorders on Earnings in the United States: Results from the National Comorbidity Survey Replication, Am J Psychiatry, May 7, 2008.

[7] Von Korff, M., Scott, K., Gureje, O, eds., Global Perspectives on Mental Disorders and Physical Illness in the WHO World Mental Health Surveys, (New York: Cambridge University Press, forthcoming).

[8] Sherrer, J.F., et al, "Depression Is a Risk Factor for Incident Hear Disease in a Genetically Informative Twin Design" (paper presented at the annual meeting of the American Psychosomatic Society, Chicago, Illinois, 4-7 March 2009).

Thus we strongly support provisions in the Tri-Committee bill to improve chronic care management through medical homes and other models. We encourage the Committee to ensure that the medical home programs that would be funded through Medicare and Medicaid under the bill would include behavioral health specialists on the treatment teams established and also that mental health or addiction treatment facilities would be allowed to serve as medical homes. In addition, we also strongly support the provisions to increase reimbursement for primary care and community health centers but encourage the Committee to also include community mental health centers in these initiatives because these facilities generally provide a full range of services including the case management so crucial to improving care coordination and access to primary care for individuals with behavioral health conditions. We also applaud the program to enhance primary care training that targets vulnerable populations including individuals with mental health conditions.

Half of all people with a mental health diagnosis first experience it by age 14, but will not receive treatment until age 24.[9] Because of this early age of onset and ten year delay in treatment, these conditions often interfere with a young person's ability to succeed in school and gain employment and increase the likelihood of developing a costly disability. Moreover, research indicates that childhood adverse experiences and early onset mood and anxiety disorders may significantly increase the risk of a wide array of chronic physical diseases later in life.[10] Thus, Mental Health America has placed a high priority on improving access to preventive services and mental health promotion as a key component of health care reform.

In March, the Institute of Medicine (IOM) issued a report on "Preventing Mental, Emotional, and Behavioral Disorders among Young People" illustrating the dramatic impact these conditions have on our population but also the tremendous opportunity we have to prevent them.[11] In recent decades there has been an explosion in research on the prevention of mental health and substance use conditions. Many interventions can result in long term reductions in behavioral health disorders as well as other positive outcomes such as improved academic achievement. The report asserts that the greatest prevention opportunity is among young people and highlights the finding that there is a window of opportunity from the time a symptom first appears to development of a diagnosable disorder, usually two to four years. A number of successful interventions focus on improving parenting skills and mitigating disruptive family influences such as divorce and maternal depression, as well as engaging schools in prevention initiatives.

Thus we are heartened by the many provisions in the Tri-Committee bill to improve access to preventive services including the requirement that plans in the Exchange cover screening services without cost-

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[9] Kessler R.C., Berglund P., Demler O., et al., Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication, Arch Gen Psychiatry, 2005; 62:593-602.

[10] Von Korff, M., Scott, K., Gureje, O, eds., Global Perspectives on Mental Disorders and Physical Illness in the WHO World Mental Health Surveys, (New York: Cambridge University Press, forthcoming).

[11] National Research Council and Institute of Medicine, "Preventing Mental, Emotional, and Behavioral Disorders among Young People," Mary Ellen O'Connell, Thomas Boat, and Kenneth E. Warner, Eds., Washington, D.C., The National Academies Press, March 2009 [http://www.bocyf.org/prevention_policymakers_brief.pdf]

sharing as well as well-child checkups (although it would be helpful to also stress the importance of mental health screenings and education as part of these check-ups). Also important are the provisions requiring Medicare and Medicaid to cover preventive services without cost-sharing requirements. We also strongly support the proposal that would include a behavioral health specialist on the new "Task Force on Clinical Preventive Services" and the proposal to establish stakeholder advisory boards that would give consumers input into the workings of the clinical and community preventive services task forces.

In light of the IOM report which discussed the strong evidence showing the effectiveness of nurse home visitation programs, we strongly support the proposal to allow states to cover these services through their Medicaid programs. We also encourage the Committee to specify that evidence-based variations on the nurse home visitation program could also be covered. The provision requiring Medicaid coverage of services provided by school-based health clinics if covered in a physician's office is also important because the best way to ensure children receive vital health care services is to make those services available where the children are most of the time.

Many of the most effective behavioral health prevention programs are community-based including working with schools to engage them in practices that strengthen social and emotional development while fostering a positive learning environment and mental health literacy. Thus we strongly support proposals in the bill to strengthen the Task Force on Community Preventive Services and establish community-based prevention and wellness research grants and services grants that would cover services recommended by this task force or another comparable review body.

We also appreciate the provisions in the Tri-Committee bill to improve the quality of care, including through enhanced support for comparative effectiveness research (CER). Consumers/patients should be fully represented in all phases of research priority-setting, development, and interpretation. Consumers/patients bring valuable perspectives and expertise to discussions regarding research priorities and how clinical research should be conducted. As the individuals most personally and forcefully affected by the outcomes of this research, consumers/patients should be considered the primary audience and ultimate end users of this information, but their voices are rarely heard in discussions which determine the direction clinical research and comparative effectiveness research (CER) should take. It is vitally important that consumers/patients be well-represented at all levels of oversight and on any entity charged with setting national priorities and distributing federal funding for comparative effectiveness research.

Thus, we support the proposal to establish a clinical perspective advisory panel for each research priority which would consult with patients and advise the Center for CER on research questions and methods to ensure the information produced is clinically relevant to decisions made by clinicians and patients at the point of care. We encourage the Committee to ensure that each advisory panel include several consumer/patients that would be most affected by the research and provide educational and other support to enable them to effectively participate. We also

appreciate the proposal in the bill to establish a patient ombudsman to serve as a point of contact for any patients interested in CER studies and to ensure any comments from patients on proposed studies are heard. In addition, we support the provision requiring that the research take into account the potential for differences in the effectiveness of health care items and services used with various subpopulation such as racial and ethnic minorities, women, different age groups, and individuals with different co-morbidities.

Finally, we support the provision requiring Agency for Healthcare Research and Quality to establish quality measures for the delivery of health services and would suggest that behavioral health services be included in this effort since these conditions are some of the most chronic and costly conditions. Quality measures would help provide incentives to providers to use best practices and help identify consumers who are not receiving care that complies with treatment guidelines.

Again, thank you for the opportunity to testify, and I look forward to answering any questions the Committee members may have.

Mr. PALLONE. Thank you, Dr. Shern.
Dr. Novack.

STATEMENT OF ERIK NOVACK

Dr. NOVACK. Good afternoon. I want to thank Chairman Pallone and the rest of the committee for having me here today. My name is Eric Novack, and I am a medical doctor who has actually spent the last 23 years training and working in health care.

Make no mistake: The variability for everyone in this room and your families to seek out the kind of health care you believe is best is under direct assault. And the risk you will lose control over your health and health care has never been greater. Unbelievably, nowhere in the U.S. Constitution or in the Constitution of any of the 50 States do any of us have any right to be in control of our own health.

In November 2008, Arizona's Proposition 101 sought to place two basic rights into the State Constitution: first, to preserve the right of Arizonans to always be able to spend their own money for lawful health care services; and second, to prevent the government from forcing us to join a government-sanctioned health care system.

Because once we are forced into a plan, our health care options will be restricted by the rules of the plan, whether it be public or private. It was a true grassroots campaign, and an idea went from concept to well over a million votes in less than 18 months and failed by less than one-half of 1 percent.

Fortunately, the Arizona legislature has courageously recognized the critical issues raised by the initiatives and, just yesterday, referred the Arizona Health Care Freedom Act to the ballot in 2010.

Unfortunately, the reforms that have recently passed Congress and the bulk of those that are being considered do not appear to have much respect for the basic freedoms that the Arizona initiative seek to protect.

The stimulus bill was used as a tool to vastly expand the Federal health care bureaucracy. By the end of 2014, every American will be forced to have an accessible electronic health record that can be viewed by government officials without consent, permission, or notification.

The stimulus bill created the Federal Coordinating Council for Comparative Effectiveness Research, whose ultimate function will be to become a Federal health care rationing board for all Americans, starting with seniors. As Health and Human Services Secretary Kathleen Sebelius said during her confirmation testimony, quote, "Congress did not impose any limits on it," referring to the council.

And now MedPAC may be empowered to make the full slate of recommendations for every condition and treatment. Congress will only be able to make an up-or-down vote on the entire package.

The President recently spoke to the American Medical Association, touting the importance of using evidence-based medicine to figure out what works and what does not. When it comes to the best treatments for our ailing health care system, we have some compelling evidence.

Leaders in Congress regularly cite Massachusetts as the model for reform. But what really is going on in Massachusetts, and do we want to repeat it on a grand scale?

Costs are even more out of control than in the country as a whole. Use of the emergency room for care has not diminished despite the higher percentage of people with insurance. And there is exactly zero evidence—there is exactly zero evidence—that forcing people to have insurance has made any difference on slowing health care spending.

Medicare has tried several disease management and prevention projects. The idea that spending money upfront to prevent Medicare patients from needing expensive hospitalizations and disease complications will save money in the long run.

Unfortunately, the results do not bear that out. Among the conclusions in the June 2007 report to Congress on the trials, quote, "Fees paid to date far exceed any savings produced." In other words, the cost of administering the plan made the prevention plan more expensive.

Real research also suggests that obesity and smoking prevention, while admirable, do nothing to reduce health care spending.

Supporters of the President have also reviewed the literature on the impact of electronic health records on spending and concluded, quote, "We need the President to apply real scientific rigor to fix our health care system rather than rely on elegant exercises in wishful thinking."

And research has been done demonstrating geographical variations in health care spending, but there is no evidence that having Washington forcibly taking money being spent in Massachusetts, New York, or California and sending it to lower-spending States will improve anyone's health.

We cannot afford to make mistakes that will mean our grandchildren will, in the words of the President, suffer from, quote, "spiraling costs that we did not stem or sickness that we did not cure."

Congress should fix Medicare first before radically changing the health care of every American. Congress should demonstrate that the government can prevent the disturbing failures even more exposed this week of the VA system before radically changing the health care for all Americans. And Congress should work very hard to increase the options and availability for the 3 percent of Americans who are truly, quote, "chronically uninsurable" before radically changing the health care for the other 97 percent.

Health care reforms are critically needed. Our path is unsustainable. But jamming through a piece of legislation that few will have read and the American public will not have had time to fully review makes no sense.

The cynics who shout that we cannot have health care reform without sacrificing our personal freedoms are false prophets offering a false choice. I urge the members of this committee to consider health care legislation that protects individual liberty, preserves privacy, limits government power, and has reforms that have actually been shown to work—in other words, reforms that protect patients first.

Thank you very much for the opportunity to present my views today.

[The prepared statement of Dr. Novack follows:]

Written Testimony

Eric Novack, MD

to the

United States Congress

House of Representatives

Committee on Energy and Commerce

Subcommittee on Health

23 June 2009

Good morning. I want to thank Chairman Pallone and the rest of the committee.

My name is Eric Novack and I am a medical doctor who has spent the last 13 years training and in the practice of orthopedic surgery. In those years, I have had the incomparable honor of taking care of literally thousands of patients and families whose lives have been disrupted by injury and infirmity. I have spent most of the past six years taking upwards of 14 days of emergency room call each month.

I have taken care of the young and the old, the healthy and the sick, the wealthy and those in need. And I make it my philosophy to try to treat everyone with the same level of dignity and respect.

My health care career spans over 23 years: I have worked as an emergency medical technician answering 911 calls in impoverished and dangerous inner cities, as well as in college towns and rural areas of New England. I have worked as a mental health worker assisting in the care of the acutely and chronically mentally ill in Rhode Island. I have volunteered in homeless clinics in San Francisco during the AIDS epidemic. I worked as a resident taking care of countless trauma patients at one of the nation's premier trauma centers in Seattle. I took care of our nation's true heroes, our veterans, at VA hospitals in San Francisco and Seattle. And I have spent the last 8 years in the practice of orthopedic surgery in Arizona.

Make no mistake—the very ability for everyone in this room and your families to seek out the kind of health care you believe is best is under direct assault. And the risk that you will lose control over your health and health care has never been greater.

My testimony will discuss the fundamental importance of protecting patient's rights first when considering health care reform as well as some areas of reform that have already passed and others that are being considered. Health care reform must be built on a foundation consisting of the protection of the right of individuals to be in control of their own health and health care, not special interests or government bureaucrats. If those rights are not made the top priority, they will be lost.

The first and second amendments of the US Constitution, and the rest of the Bill of Rights, have become the bedrock of our free society. Fundamentally, our Bill of Rights is written in a way that restricts government power and promotes individual liberty. They are the rights that were designed to create the framework where a free people could wake up each day and seek the best for themselves, their families, and future generations.

Unbelievably, nowhere in the US Constitution, or in the constitution of any of the 50 states, do any of us have any right to be in control of our own health. And until our last election, nor has there been any modern attempt to protect or preserve those rights in any Constitution. Arizona's Proposition 101 sought to place two basic rights in our state Constitution. First, preserving the right to always be able to spend your own money for lawful health care services. Second, to prevent the government from coercing you

to join a government-sanctioned health system—because once you are forced into a plan, your health care options will be restricted by the rules of the plan, public or private. This was a true grassroots campaign. It was an uphill battle, but a remarkable one—and an idea went from concept to over 1 million votes in 18 months, and came up less than 0.5% short of winning.

Fortunately, the Arizona legislature has courageously recognized the critical issues raised by the initiative, and is on the verge of referring the Arizona Health Care Freedom Act to the ballot in 2010. The basic rights of Proposition 101 are preserved, but the language is more clearly defined and those who run Arizona's safety net health care system believe that their ability to provide care will be protected.

Obviously, health care reforms are now an enormous issue here in Washington. Unfortunately, the reforms that have recently passed and the bulk of those that are being considered do not appear to have much respect for the basic freedoms that the Arizona initiatives seek to protect.

The stimulus bill passed by this body in February effectively gives the federal government nearly unfettered access to every American's most private information: their personal health records. The stimulus bill forces every American to have an accessible electronic health record by 2014. Government bureaucrats can access that information without either permission or notification of patients as long as it is considered 'research'. Perhaps even more amazingly, the government may share or sell our health information to private entities that are doing research without our permission either.

This is so critical that it bears repeating: my personal health records, and those of my family and my patients, must be in an accessible database, presumably over the internet and can be viewed without consent. It is one thing to have your social security number stolen—while inconvenient and sometimes worse, the damage caused by identity theft is fixable.

Once someone hacks into a database with private health information and puts it out there with the intent to harm, however, will be a different matter entirely. That genie cannot be put back into the bottle.

Think that cannot happen? The state of Virginia is currently trying to negotiate a situation where a hacker is holding the personal health information of 8 million people hostage. The data was stolen from government computers. The perpetrators are demanding $10 million, or they will release the information to the public at large.

Now imagine a single repository--- even if technically not 'centralized' on one set of servers--- where 300 million people have our most personal information. The potential for damage and harm is endless.

At least in the private world, each company only can hold so many records—and they understand that losing data, which is rarely as complete as the planned database will contain, could result in such severe penalties and lawsuits as to put them out of business. No one really thinks the government health IT department would be closed down if such a breach

occurred. To paraphrase Milton Friedman, the result would rather be an *increased* budget for the agency.

Nowhere in the health care reforms discussed since the passage of the stimulus do I find any mention of restoring real privacy to medical records. Given that the majority of committee members are attorneys, I would ask if the members would be comfortable if the federal government were to be a place where all private attorney-client communications were stored, and could be used for research purposes without consent.

The stimulus bill contained more than simply a codification of the end of patient privacy. It created the Federal Coordinating Council for Comparative Effectiveness Research. The FCCCER sounds benign. Even more than that, it sounds like something that makes no sense to most anyone who hears it.

The stated goal of supporters is to expand the amount of research being conducted to determine which treatment works better for a given condition. But that is not how it was created. Health and Human Services Secretary Kathleen Sebelius said during her confirmation testimony "When authorizing comparative effectiveness research in both the Medicare Modernization Act and the American Recovery and Reinvestment Act, Congress did not impose any limits on it."

The reality, and the fear of those of us who have grave concerns about a group of unelected bureaucrats with unlimited power over our health, is that a primary goal will be to determine which treatments and which conditions

the coordinating council members *think* are cost effective. Those cost effectiveness recommendations will then find their way—one way or another—to become a government-controlled health care rationing body.

This would mimic the National Institutes for Clinical Effectiveness (NICE) in England, the same people who delayed and denied herceptin to breast cancer patients because it was too expensive, and who believe that individuals should be viewed as statistics with arbitrarily determined quality life years remaining. It would also, incidentally, mirror the recommendations of former Senator Tom Daschle, who has been very influential in shaping the health care policies of the current administration.

Senator Kyl has made attempts to protect patients' rights by blocking comparative effectiveness research from becoming the basis of a government health care body dedicated to delaying and denying care. He proposed an amendment to the budget bill that would have added those protections. During the debate over the amendment to the budget bill, Senator Baucus stated, "I'm not going to get into all the details and all the various provisions that we must enact to get meaningful health care reform. By meaningful health care reform, I mean controlling costs." The amendment was defeated with only 3 Democrat votes and all Republicans voting in favor.

Using cost control as the driving force behind health reform will turn every American from being a patient into an expense. Without question, those without political power or access, or who perhaps have a rare disease without good lobbyists, will find themselves "cut" from the budget.

In the New England Journal of Medicine (NEJM) in March 2001, Health Technology Czar David Blumenthal, MD, "[g]overnment controls are a proven strategy for controlling health care expenditures".

This picture should put fear into every senior. Because when FCCCER board member Ezekiel Emanuel, MD, brother of President Obama's chief of staff, writes that medical student training should move away from the Hippocratic Oath and toward "toward more socially sustainable, cost-effective care", senior citizen health care is likely to be the first to be sacrificed for the 'public good'.

The current reform legislation being considered goes even further. It would remove even further the ability for patients to protect themselves from arbitrary bureaucratic power that would determine who gets health care. White House Chief of Staff said of health care reform, "[t]he only nonnegotiable principle is success. Everything else is negotiable." Apparently, even our right to petition our elected officials is negotiable.

MedPAC, the Medicare Payment Advisory Commission, has for years been in an advisory role to CMS on coverage and payment decisions. Citizens can give input to the Commission and contact their legislators to emphasize the importance of a particular issue of concern. Final determinations are currently made by the Center for Medicare and Medicaid Services after weighing all of these factors.

What is being considered will strip the democratic process out completely. MedPAC will be empowered to make the full slate of recommendations for *every condition and treatment.* Congress will only be able to make an up or down vote on the entire package. So, if the treatment you need to function does not make the cut, you are out of luck.

As a physician, as a patient, and as a family member with loved ones who have health problems, I am very interested in what treatments work, and, just as important, what treatments simply do not work. Health care reforms that put patients first must withstand the same scrutiny.

President Obama recently spoke to the American Medical Association touting the importance of using 'evidence based medicine' to figure out what works and what does not.

When it comes to the best treatment for our ailing health care situation, we should do exactly that: "figure out what works," and what does not. And we have some compelling evidence.

Some of the proposed reforms have been tried already, and in most cases the results have been very disappointing.

Leaders in Congress regularly cite Massachusetts as the model for reform. But what really is going on in Massachusetts, and do we want to repeat it on a grand scale?

10

Since enacting "universal health insurance" in 2006, Massachusetts' health care spending has increased at a much higher rate than the country as a whole. And average health insurance for a family of four is now 33% higher than the national average.

Costs are so out of control that legislators and the president's good friend and supporter, Governor Deval Patrick, are considering a massive increase in the penalties businesses must pay if they do not contribute their "fair share". The burden on business will be much higher than what the business community and legislators agreed to just three years ago.

To achieve cost controls, the Massachusetts state government is considering forcing people into stringent HMO-style plans, bringing us back to the days of "capitation" of the 1990s, where patients rebelled at the notion that doctors and hospitals were significantly incentivized to *not* give care. Under a capitated system, providers and hospitals get a lump sum based upon the number of people they treat, and only make money if it is not 'used up' actually providing care.

A study of the Massachusetts reforms just published in May 2009 in the journal Health Affairs noted that 1 in 5 adults was told in the last year that a desired physician was not taking new patients. Despite the state's "reform," the number of emergency department visits had not declined.

At a time when the president is focusing so much attention on "what works and what doesn't," why would this data be ignored?

In Chicago, President Obama began his remarks with the statement that "one essential step on our journey [to prosperity] is to control the spiraling cost of health care in America." A piece of that, he claims, is "is to invest more in preventive care so that we can avoid illness and disease in the first place." That sounds good, so let's examine the evidence.

Medicare has tried several disease management projects. The idea is that spending money up front to prevent Medicare patients from needing expensive hospitalizations and disease complications will save the government money in the long run. Among the conclusions in the June 2007 report to Congress on the trials: "fees paid to date far exceed any savings produced." In other words, the costs of administering the plan made the prevention plan *more expensive*—and did not save any money.

The president also touted the impact on health care costs of reducing smoking and obesity. Surprisingly, the evidence shows that reducing our vices – and even improving our fitness – doesn't reduce overall health care costs. That's because healthier people live longer, continuing to use the health care system, and still develop end-of-life health problems.

Health researcher Pieter H. M. van Baal and his colleagues from the Netherlands concluded that, "[o]besity prevention, just like smoking prevention, will not stem the tide of increasing health-care expenditures. The underlying mechanism is that there is a substitution of inexpensive, lethal diseases toward less lethal, and therefore more costly, diseases."

Also critical to the president's prevention plan is the expansion of electronic medical records for every American, which could be accessed anytime, anywhere. This would, according to President Obama, "mean less paper-pushing and lower administrative costs, saving taxpayers billions of dollars."

Once again, real-life data do not bear this out. In analyzing various reports and studies on the effectiveness of electronic medical records, Drs. Jerome Groopman and Pamela Hartzband, Harvard researchers and self-professed Obama supporters, concluded, "[w]e need the president to apply real scientific rigor to fix our health-care system rather than rely on elegant exercises in wishful thinking."

President Obama made clear in his speech, "one thing we need to do is to figure out what works." In medicine, that takes time, patience and intellectual rigor. Policymaking is no different in that respect. Since the health of 300 million Americans is on the line, health care reform should not be rushed for political expediency. We cannot afford to make mistakes that will mean our grandchildren will, in the words of the president, suffer "from spiraling costs that we did not stem, or sicknesses that we did not cure."

Dr. Benjamin Rush, signer of the Declaration of Independence and namesake of Rush Medical College and Rush University Medical Center in Chicago, is purported to have made the case for putting health care liberties alongside our cherished freedoms of speech and the press. If we do not do so, he warned, "the time will come when medicine will organize into an undercover dictatorship and force people who wish doctors and treatment of their own choice to submit to only what the dictating outfit offers."

I have grave concerns about the ability of any federal dictating outfit to keep the best interests of individual patients as the priority.

Recently, I had the honor—and it is most humbling to be a part of taking care of people in need—of taking care of a 94 year old woman who fell and broke her hip. She fit the picture above, and then some. Looking at her and talking with her family, it was hard to believe she functioned as well before her fall as they claimed.

On paper and in person, her chances of dying around surgery or in the few weeks after were great. The anesthesiologist explained to the family that he was very afraid she would not survive the surgery. But the family felt strongly that the benefits outweighed the risks and we proceeded.

This was right around Thanksgiving.

I received a call after Easter thanking me, because their Grandma came in using her walker to Easter dinner and the whole family was there.

I have no doubt that this woman would have failed to 'make the cut' in a system where bureaucrats far removed from the bedside and family are put in control of who can and cannot get care.

Orthopedists are often accused of not using straightforward language—broken bones are not sore and they do not sting, they HURT. No matter what name the bureaucrats and politicians want to use, the plan being put

forth by this committee will mean Washington bureaucrats will have the power to DENY YOU CARE.

Health care reforms are critically needed. Our path is unsustainable.

But instead of jamming through a piece of legislation that few will have read and the American public will not have had time to fully review, we should be following the example of the Arizona legislature with the Health Care Freedom Act.

If we are truly in favor of, as the President has said, not being beholden to the "same entrenched interests", then protecting those rights first should be the number one priority.

Congress should first pass language mirroring the Health Care Freedom Act—and then embark on further health reforms, knowing with confidence that individual liberty will not be sacrificed on the altar of health care reform.

The cynics who shout that we cannot have health care reform without government intruding into our most personal decisions are false prophets offering a false choice.

I urge the members of this committee to consider health care reform legislation that protects individual liberty, preserves privacy, prevents government bureaucrats from having limitless power over our health, is

based upon genuine evidence that proposed reforms could work: in other words, reforms that protect patients first.

Thank you very much for the opportunity to present my views to you today.

Mr. PALLONE. Thank you, Dr. Novack. Ms. Robertson-Holmes, thank you for being here.

STATEMENT OF SHONA ROBERTSON-HOLMES

Ms. ROBERTSON-HOLMES. Thank you. Thank you, Chairman and members of the committee. Four years ago sitting in my doctor's office, never did I believe I would be here in Washington talking about this situation. But I am here because I was fortunate enough to be able to in amongst my nightmare come to this country and get treatment.

I actually am the face of public insurance. We have—I am from Canada and we do have public insurance, a mandatory monopoly on our insurance. And I am here to say when it doesn't work, it doesn't work. Unfortunately, in Canada we have 33 million people, which is approximately the size of the State of California, and we currently have 5 million people without family doctors.

What started many years ago as a seemingly compassionate move in our government to treat all equally and fairly by providing the same medical coverage has in fact turned into a nightmare of everyone suffering equally. Now we have limited resources and funds that offer timely treatment to our citizens.

A system like this starts to crack under pressure and special treatment is ultimately given to those who have contacts and resources to jump the line for treatment, and for someone like myself, the average Canadian citizen, forced to go to another country for care.

I will never get the time, money or life back that I have dedicated to the fight to basic treatment that I was promised by my government; but not only promised, it was ordered. I will never forget the experience of the treatment in a facility suffering so bad from government funding and shortages of staff and resources.

I know that the American health care system is not perfect, but I do credit the system for saving my life. It is because of the choices available here in this country that I was able to receive immediate care. We as Canadians have one insurance company, the government. We have no options. We can't choose another country, we can't supplement with after-tax dollars to purchase extra care.

We can purchase health insurance for our pets, but not our children. I have very few rights as a patient. Patients there have to fight for every basic service and care, much less any kind of specialized care.

Another thing that I would really like to point out is that our health care is not free. In fact, I would argue that the cost is much greater than the tax we pay each and every citizen towards this care. The costs are loss of quality of life while living with pain, discomfort, or just the fear of the unknown and also for waiting long term for diagnostic testing, the cost of employers and self-employed people waiting for employees to be treated and be well enough to return to work.

Medications are also something that Canadians are struggling like Americans to pay for. We are not covered for our medications under our health care plans. We pay the cost of local ERs closing, losing a wealth of talented doctors that leave the country because they just don't have the resources to do their job properly at home.

We have rationed services and treatments and a fear of living without a safety net.

The one thing that I wanted to sort of point out when I was making my testimony today was if I have gotten any criticism from anybody that I have done for what I have done is that I must have had the resources in order to be here today. I am here to say that I didn't. I am so average, and in order to get what I had to do, my husband took a second job, he put a second mortgage on our house. We owe every single person we know money. And I will never forget all of that that has happened, but I also want to wake up grateful for what happened to me in America. And I want to have those same options in Canada.

And I just felt from the very beginning of my experience that it was my job to point out to both Canadians and Americans what we can do together and what we need to learn from each other's situation.

Thank you.

[The prepared statement of Ms. Robertson-Holmes follows:]

Good Morning Chairman Waxman and Members of the Energy and Commerce Committee. Thank you for inviting me to testify on health care, a vital issue of utmost importance to all Americans, especially as you, the nation's leaders, consider reforming the health care system in this country.

My name is Shona Holmes and I am a Canadian citizen but I am eternally grateful to Americans for their health care system. I feel honored to be a voice of experience, as I have experienced treatment from both sides of our borders. If I had relied on my own government-run health care system in Canada, I would not be sitting here before you today. At the very best, I would be blind and the very worst I would be dead.

In 2005 I started to have crushing headaches and insomnia. I always felt on edge and my adrenaline levels were through the roof. My eyesight was also severely worsening. Although 5 million unfortunate people in Canada are without a family doctor, thankfully I had one and was able to make an appointment to see my primary care physician, who referred me to two different specialists. The Canadian government, which runs a dangerous monopoly of the health care system in our country, ultimately offered me the only option of a four-month wait time to see a neurologist and a six-month wait time to see an endocrinologist. As my health worsened, I knew there was no possible way I could wait that long. I have a husband, a family and I am self-employed. How could I wait that long for the care I so desperately needed? How could I allow my government to gamble with my health?

I tried to expedite the specialist appointment, but due to the shortages of specialists, the capping of our doctors' wages and restrictions on doctors' work hours, and the incredibly long wait lists that are already in place, I had no options.

Our health care system is a single-payer system, which means there are no options for alternative avenues of care. In fact, to exercise the right to see a doctor outside of my government-run insurance in my own country is in fact illegal. I had to leave the country in order to use any resources that I could scrape together in order to get diagnosed. What started many years ago as a seemingly compassionate move in government to treat all equally and fairly by providing the same medical coverage for everyone has in fact turned into a nightmare of everyone suffering equally. Now we have limited resources and funds to offer timely treatment to our citizens. A system like this starts to crack under pressure, and special treatment is ultimately given to those who have the contacts and resources to jump the line for treatment, or for someone like myself, an average Canadian citizen, forced to go to another country for care.

My family and I decided to contact the Mayo Clinic in Arizona. We got an appointment immediately and I flew alone to Phoenix, 2,000 miles from my home outside of Toronto. Within a week, the doctors at the Mayo Clinic diagnosed me with a brain tumor, pressing on my optic chiasm causing the rapid vision loss. I had to have it removed within six weeks or my vision would continue to deteriorate and I would lose my sight. This was the tip of the iceberg of treatment that I would need to seek; however, it was the most crucial.

I flew back to Canada, diagnosis in hand, and attempted to have the surgery under my government-run health care plan. The government refused to do the surgery within the six-week time frame. I was devastated. My government had failed to take care of its own citizen. The country that had been known for being kind and compassionate was showing its true colors. I was quickly educated through a series of hard knocks about how much trouble single-payer health care could cause.

Three weeks after my diagnosis and unable to expedite the surgery in Canada, my husband bumped up hours in a second job, took out a second mortgage on our home, borrowed from family and friends, and rallied all of our financial resources so we could cover the $100,000 worth of expenses for my surgery and we flew back to Arizona so the doctors at the Mayo Clinic could remove my tumor. Ironically at that time a second surgery was strongly recommended by the Mayo clinic. I required a second surgery to remove my adrenal glad. I returned to Canada and got back in line. I am here to report that surgery was done in Canada, but three years later. I will never know the amount of irreversible tissue damage that such wait times have caused. I will never get back the time, money, and life I dedicated to the fight to get the basic treatment that I was not only promised by my government, but was ordered by my government. I will never forget the experience of treatment in a facility suffering so badly from government funding shortages in staff and resources that even a pillow case on my bed was not to be found.

I know that the American health care system is not perfect, but again, I credit the system for saving my life. It is because of the choices available here in this country that I was able to receive the immediate care I needed. We as Canadians have one insurance company – the

government. No option. Can't choose another company, can't supplement with after-tax dollars to purchase extra care. We can purchase health insurance for our pets, but not our children.

In Canada, I have very few rights as a patient. Patients there have to fight for the very basic services and care, much less any kind of specialized care. I am here today not only to tell you my own story but also to ask you, as leaders of this great country, not to destroy American health care but to keep in place the options that all Americans have for acquiring health care. Where would we Canadians go if the American health care system becomes like Canada's? I could spend hours with stories from others from both minor to tragic, but my message is the same: I am not alone in my huge disappointment with government-controlled health care.

The neighborly thing I felt I could do was to open the communication between both your citizens and ours to the myths that many of us believe about each other's health care situation. Our health care is not free. In fact I would argue that the cost is greater than the tax we pay, each and every citizen, toward this care. The costs are loss of quality of life while living with pain, discomfort or just fear of the unknown, and waiting on lists for diagnostic testing. The costs to employers or self-employed people: waiting for employees to be treated and be well enough to work. Medications are something Canadians struggle to pay for as well – these are NOT covered under our government-run health care plan. We pay the costs of local ERs closing, losing a wealth of talented doctors to other countries because they don't have the resources to do the job they were trained to do. We have rationing of services and treatments and the fear of living without a safety net.

I am so grateful to the doctors at the Mayo Clinic and to the American health care system. It is for this reason that I am here today, sitting before you to tell my story. I am expecting my first grandchild this fall, and I am certain that if my fate was left in the hands of the Canadian government, I would not be here to share that joy.

Thank you.

Mr. PALLONE. Thank you. And now we have questions, 5 minutes from the panel. And I am going to start with myself. And let me just say I am not looking for a response. But I really appreciate, Ms. Robertson-Holmes, that you came today. I am not being critical in any way because I know you took your time. But I really have to stress that this draft is not meant in any way to put together a single payor system or emulate Canada. Canada is a nice place, but I am not really looking to create a Canadian system or even praise the Canadian system because I really believe that the draft implements a uniquely American system that in no way replicates Canada. But I appreciate your being here. I am not trying to denigrate it in any way.

Ms. ROBERTSON-HOLMES. The problem is it is a very slippery slope. Once you start on that sort of road—and unfortunately a lot of the Americans that I am talking to have said to me, well, we are going to get free health care too, we are going to get Canadian style health care.

Mr. PALLONE. Well, I think you are right, that there are some people who think that somehow this is single-payer, but I just want to stress I don't think it is and I don't see how it becomes a single-payer. But whatever, I appreciate your being here. And I don't want to take away in any way the fact that you came here and how difficult I am sure it was to be here.

Let me ask the question of Ms. Wright Edelman about Medicaid. I am very proud of the fact that in this discussion draft we really discuss Medicaid in a major way in the sense that we are trying to cover and fill in the gaps with 100 percent Federal dollars for those who are not covered by the States now up to 130 percent, that we are increasing the reimbursement rates so that it is more like Medicare. A big part of this is Medicaid, And I think in many ways it hasn't really gotten attention, unfortunately.

But what I wanted to ask you is, there have been those who say that once we—if we set up what is in the discussion draft, that Medicaid would no longer be needed and that those people who are in Medicaid should be put into the Exchange, be able to get their insurance with the Exchange. The draft doesn't do that and—because we are concerned that that might be harmful, at least initially to Medicaid.

So I just wanted you to discuss the types of benefit and cost sharing protections available in Medicaid that are generally not found in private health insurance products. And if you could talk about the need to keep and improve the Medicare safety net undisturbed for years to come in response to those critics. We are not putting Medicaid in the health Exchange.

Ms. EDELMAN. I hope you will not. Do not put Medicaid into the Exchange. Nobody should end up worse off than they are currently. Medicaid is a crucial safety net. I applaud in my written testimony your extension of 133 percent for all. And the adults that need that help, I applaud you for it. I am glad that you are reaffirming it for children, but all children are currently covered at that level. So it will not result in an increase.

But what we do hope you will do in protecting Medicaid—in fact, I would like it if you want to take it up to 300 percent. That would be wonderful, too. I don't care how you do it, as long as you can

kind of try to get all those folk who are uncovered, but I think that Medicaid is essential, it is comprehensive benefits. As I go for children, it is essential. The fact that it is an entitlement is absolutely crucial, and I think it is one of the strongest pieces of what you have done.

On the children's front, I hope that you will make sure that Medicaid's benefit protections are extended to CHIP children and children in the Exchange because we think it is the most appropriate benefit package. So we hope you will do that. But it also raises another important point because many of the children now at 133 percent of poverty under Medicaid are eligible but are not getting it because the bureaucratic systems are impeding that. So one of the things that is essential if the children under 133 percent of Federal poverty level are going to get their Medicaid coverage, we are going to have to simplify. And we have laid out a number of simplification steps.

One of the good things you have in your provisions is automatic enrollment of any child that is uninsured at birth. I think that is fantastic. We would like to see automatic enrollment for any child that is in any means-tested program. We would like to have 12 months continuous eligibility. We have laid out a number of steps that can be taken to ensure that those children currently eligible for Medicaid will in fact get it. But you are going to have to do the systems reform to make it effective.

Mr. PALLONE. I appreciate it. And I am sorry to stop you, but I want to ask another question of Ms. Hansen. Yesterday the PhRMA and the President announced some kind of a deal to cut costs for seniors with incomes up to $85,000 in the doughnut hole by 50 percent; in other words, to fill in the doughnut hole in part, the people whose incomes are up to $85,000, that they would only pay 50 percent for brand name drugs once they fall in the doughnut hole.

Now, I am not taking away from that. I appreciate the fact that the pharmaceuticals are doing that. But in the discussion draft, we fill about $500 of this cost for the doughnut hole immediately and then phase out the doughnut hole for all Medicare beneficiaries over time. And we also reinstate the ability of the Federal Government to get the best price for prescription drugs for the most vulnerable low income Medicare beneficiaries. Those are rebates again to fill the doughnut hole.

How do you see this provision in the draft, the discussion draft as working together with the commitment by the pharmaceutical manufacturers yesterday? I don't see them as mutually exclusive. I think they are both positive. But I just wanted you to comment on that.

Ms. EDELMAN. Well, I have actually——

Mr. PALLONE. Well, I was going to ask Ms. Hansen originally. Go ahead. I am sorry. We are just out of time. Go ahead.

Ms. HANSEN. Thank you. Mr. Chairman, we agree with you. This does not preclude the continuance of it because it is actually only 50 percent of the doughnut hole and for people who are at that income level. It doesn't cover every Medicare beneficiary. But it is—part of what it does do for the people who are on drug coverage,

as I stated briefly, that people who are falling in that hole are not oftentimes continuing with their medications.

So part of our job as an organization is to really get the most relief in the quickest time on behalf of people who are already in that conundrum. I mean, that even relates to people who are becoming bankrupt as well. So that cost element is real important.

I think what the draft does is importantly to continue to build on that so that we have a more whole, seamless coverage on behalf of people. So I do think that they can work—and we are continuing to work with you on making sure that coverage continues.

Mr. PALLONE. And I appreciate that. I know you were part of this deal. I don't know if that is the right word, or agreement yesterday. But I also appreciate your working with us to try to completely fill the doughnut hole.

Ms. HANSEN. I just wanted it to be really clear, I think it was Senator Baucus that really took the leadership role with PhRMA. And I know that the President supported it. And we again appreciated it because it makes such a big real difference in people's pocketbooks.

Mr. PALLONE. We try not to talk about the Senate here, but there are occasions we have to acknowledge their existence.

The gentleman from Georgia, Mr. Gingrey.

Mr. GINGREY. Mr. Chairman, thank you. I want to ask Ms. Shona Holmes. First of all, thank you for your testimony. We really appreciate that. And I as a medical doctor, I mean, I understand, I think, what you were describing to us. I guess a benign pituitary tumor, the pituitary gland is about the size of your little thumbnail in the normal circumstance. But when it is growing so rapidly as in your case, it is right in front of the optic nerve where it crosses over and as it compresses on that optic nerve, as it gets larger, that is what would lead to the blindness and I am assuming the doctors at the Mayo Clinic in Arizona informed you of that and said that you really need to get this surgery done within about 6 weeks.

Now you went back to Canada and I understand from your testimony they said that there was no way they could do it in the 6 weeks. Did they say why? Did they have a reason for that?

Ms. ROBERTSON-HOLMES. The biggest problem in Canada is that the wait times even just to get in to specialists in order to get diagnostic testing done. So when I returned to—in fact, I had this false sense of security when I was in Arizona because 2 of my doctors were, in fact, Canadian. I have never questioned the talent that comes out of the medical system in Canada. They just don't have the resources. And so when I saw these doctors, they said go home, you can get this done at home and you have insurance, this is what you should do. Here is your——

Mr. GINGREY. And you said it would probably have cost you $100,000 to have it done in the United States.

Ms. ROBERTSON-HOLMES. In total, with all my expenses and everything being away, and I had to return—I took 3 solid runs at this particular situation. So this is not just that I fell through a crack. And I had to go—I had to go originally for diagnostic testing. I had to go back for surgery and I had to return for follow-up because I couldn't get any of those things done in Canada.

Mr. GINGREY. So there was a real problem with the rationing basically, a long queue, and getting——

Ms. ROBERTSON-HOLMES. And at the time I was also diagnosed with a potential tumor in my adrenal and it was recommended at the Mayo Clinic at that time that I have that surgery and, you know——

Mr. GINGREY. That additional surgery. And also that was going to be delayed in Canada as well?

Ms. ROBERTSON-HOLMES. Three years to the date.

Mr. GINGREY. Time is running out. I want to ask you one other thing. In your testimony you credit the United States health care system for saving your life. You just said that. You also mention your lack of rights as a patient in Canada. Tell me, as someone who has seen health care from both sides of the Canadian border, what advice can you give to American patients who may be following this debate in Congress?

Now, keeping in mind what our chairman and I know in all sincerity he mentioned that this is in his opinion not nor is it designed to lead to a single-payer, U.K. or Canadian type system. That is what Chairman Pallone said. You have some concerns about that. I have some concerns about that with this public option.

What would you say to the American people in regard to this?

Ms. ROBERTSON-HOLMES. It is my understanding from—actually all my family is in Great Britain and it actually is a 2-tiered system. They actually have public and private, and they are almost in worse condition than we are. What I am saying is I am insured. I have insurance. But the money isn't there. It is expensive. Health care is expensive anywhere. And I was promised that I had insurance. But when it came to using the services that I was supposed to be covered for, they weren't there.

Mr. GINGREY. Yes. So having an insurance, a plastic card doesn't guarantee you access, affordability, availability if there are no physicians there to provide that care.

Great point. Thank you very much for your testimony and for your response. I want to go now to Dr. Novack, Dr. Novack, thank you. I know you practiced orthopedic surgery—is it in Arizona, I think you mentioned to us. And you reference in your testimony the study published I think May of 2009, the Journal of Health Affairs, one in five Massachusetts adults were told in this last year that a desired physician was not taking new patients. Here again, they had insurance, they had coverage, they just couldn't find a doctor. Do you know if the type of insurance a person carried influenced their ability to see their desired physician, whether it was the public plan option or a private plan option? There was a delta in regard to who can get——

Dr. NOVACK. I don't have an answer for you on that. What it is illustrative of is the regular attempts to conflate health insurance with health care. So here the 47 million number, which is a bit inaccurate in and of itself, that don't have health care, those are people who don't have health insurance. And since 20 million of these people change every year because of job changes, et cetera, about 10 million are in the country illegally, about 10 million are between 18 and 30 and don't think they will ever get sick. You are left with about, as I mentioned, about 3 percent of the country that is chron-

ically uninsured. So just giving people health insurance, what we see in the Massachusetts example, is no guarantee that you have access to health care.

Mr. GINGREY. Mr. Chairman, if I might ask Dr. Novack to submit a written answer to my question in regard to the different discrepancies between or among the plans where there were no doctor available, I would appreciate that. My time has expired and I yield back.

Mrs. CAPPS [presiding]. Yes.

It is a pleasure now to yield 5 minutes to our chairman of the full committee, former chairman, John Dingell.

Mr. DINGELL. Thank you, Madam Chairman. I would like to begin by welcoming our old friend and my very dear personal friend, Marian Wright Edelman, to the committee. I am delighted to see you here, Marian.

Ms. EDELMAN. Nice to see you.

Mr. DINGELL. I want to get right down to the business at hand here and to say to you, Ms. Holmes, welcome. Your comments I found to be most interesting. Tell me, you are referring to a single-payer system you have in Canada; is that right?

Ms. ROBERTSON-HOLMES. I am, yes.

Mr. DINGELL. You are aware that the draft that is before us is not a single-payer bill?

Ms. ROBERTSON-HOLMES. All I am aware of is I needed to tell what my story was.

Mr. DINGELL. So then help me. How would your concerns with a single-payer system apply to the draft of the legislation we are working on today?

Ms. ROBERTSON-HOLMES. My concerns are basically in order to open up the communications so that people know the questions to ask when a bill is passed so that they know what is safe to get into——

Mr. DINGELL. In other words, your comment is a warning rather than a criticism?

Ms. ROBERTSON-HOLMES. Just my experience.

Mr. DINGELL. Well, I think it is a very good criticism, and I thank you for it, or rather a very good warning as opposed to a criticism.

Now, Dr. Novack, I found your—you made a very frightening comment here that I would like to address with you because if your fears are correct, this is a very bad situation. And in this—and I can tell you that I am going to stay up night and day to get it out if there is anything like that in here. You made this statement. You said no matter what name the bureaucrats and politicians want to use, the plan being put forth by the committee will mean Washington bureaucrats will have the power to deny you care.

That is a very frightening statement, and I would appreciate it if you can tell me where in this draft that there is language that would authorize that so that I can get this out? I will work with you to get it out. Tell me where it is.

Dr. NOVACK. I think the issue here is when you—what has been very vague of course is exactly how the cost control is going to happen.

Mr. DINGELL. No, no, no, no. Where is the language? You made a bold, flat statement, and frankly I am scared to death. Now, I want you to tell me where it is in there so I can get it out.

Dr. NOVACK. I don't have the exact line for you, sir. But I can——

Mr. DINGELL. But where is it, Doctor? I would probably be unfair to you because you are a doctor and I am a lawyer, and I would never presume to tell somebody how to take out an appendix or to replace a knee, but I do know a little bit about drafting law. I have been doing it for about 50 years and you made a statement that scares the bejabers out of me, and I want you to tell me where it is.

Dr. NOVACK. Again, I don't have the exact line numbers for you, but I will get it for you.

Mr. DINGELL. So you made the bold statement, though, which you are not able at this time to tell us where the language is in the bill that has caused you to make this statement, and I will repeat it again because quite frankly it is a very serious charge: No matter what name the bureaucrats or politicians want to use, the plan being put forth by the committee will mean Washington bureaucrats will have the power to deny you care. And you capitalized "deny you care."

Dr. NOVACK. Again, the answer here is that we know that care is going to be denied because you have to come up with a package—the plan is to come up with a standard benefit package and then to give some authority the ability to determine which benefits are going to be accessible to—it will start with seniors, I imagine, if we start applying this to patients in Medicare first. If those benefits are different than the benefits that people currently enjoy today, that will potentially be care that will be either delayed or denied for what they are getting right now.

Mr. DINGELL. That is the basis for your statement, is it?

Dr. NOVACK. Yes.

Mr. DINGELL. I find that to be interesting. It is kind of like building a house of cards here or maybe setting up a straw man. And that is a good thing to do because then you can knock them down fairly easy. But I still want to hear you tell me what is the precise thing.

Let us go to something. You have got Blue Cross and Blue Shield. You have got Aetna. You have got all kinds of insurance companies in this country. Do you remember when we had the big fight over patient's bill of rights? Do you remember that?

Dr. NOVACK. Not entirely.

Mr. DINGELL. The AMA was very, very interested in it, and they were very helpful to me in my efforts to try to get that legislation through. That was to stop a bunch of health insurance bureaucrats, green eyeshade actuaries from telling you as a doctor what you could do and telling me as a patient what treatment I could get. And I find your same apprehensions were joined in by my friends at AMA when we tried to correct this iniquitous situation which we have now. And I am trying to find out where the abuses that we complained about are to be found in the legislation.

Dr. NOVACK. Sir, I think——

Mr. DINGELL. And how this situation, even if it is as you say, is true, would be worse than that which we have now where we have 47 million Americans who haven't gotten any health care and who haven't got anybody to tell them what they can have or not have. The only thing they can say is you can't have treatment because you can't pay your bill.

Dr. NOVACK. Well, I think the question is what kind of tradeoff are we looking to make. It is true and I can tell you both as a provider and as a patient and as a patient advocate that there is often times no love loss between me and the bulk of the private health insurance industry. The tradeoff that the legislation appears to be making is to be moving away from green eyeshade private health insurers towards green eyeshade Washington bureaucrats. And I think at the end of the day when we look at examples where there have been abuses in the private health insurance industry, there is resource. When Blue Cross did recisions in California and other companies did recisions in California, there has been significant—but my concern is, for example, in the VA system—there is no resource to the 10,000 people that are exposed to HIV——

Mr. DINGELL. My time has expired. Thank you.

Mrs. CAPPS. Thank you, Mr. Dingell. And I yield now 5 minutes for questions to Mr. Whitfield.

Mr. WHITFIELD. Thank you, Madam Chairwoman. Let me ask you, have any of you read this bill? Ms. Edelman, have you read this legislation?

Ms. EDELMAN. I have read or my staff has read it multiple times and we have struggled to make sure that I read the key portions of this bill that relate to children.

Mr. WHITFIELD. When did you all receive it?

Ms. EDELMAN. We got it on Friday and it is over 800 pages long, but we have done the best we could.

Mr. WHITFIELD. Well, I don't think any of you have read it. Certainly I have not read it. Not many members up here have read it. And one of the things we are concerned about, when you have this sort of dramatic change in health care—and evidently this bill, they are going to try to bring it to full committee the first week of July or the second week of July. We don't really have a lot of time here.

But let me just talk philosophically about a couple of things and then I will get into some specific questions. I would ask all of you, does the American taxpayer have the responsibility to pay for nonemergency health care for illegal immigrants? Ms. Edelman, what do you think?

Ms. EDELMAN. I think all children should be covered because as a public issue if there are any children that are in our country or in our schools—all children go to schools.

Mr. WHITFIELD. What about adults?

Ms. EDELMAN. I am here to talk about children. Our bill is about all children being covered.

Mr. WHITFIELD. What about you, Ms. Hansen?

Ms. HANSEN. We don't have a policy on immigration because that is not part of our public policy covering our——

Mr. WHITFIELD. So you don't have a position? OK. Dr. Shern, what about it.

Mr. SHERN. Similarly we don't have a position on——

Mr. WHITFIELD. Dr. Novack.

Dr. NOVACK. I would just say currently as a provider—and I take about 14 days of emergency room call every month, I take care in the Phoenix area of a whole lot of people who are not in the country legally and they get the same care, whether——

Mr. WHITFIELD. But I said nonemergency room care.

Dr. NOVACK. I think that given the tens of trillions of dollars of unfunded liabilities, that we ought to be directing the resources to people in the country legally first.

Mr. WHITFIELD. There has been a lot of discussion here about there is not going to be any government payor plan or government plan. And yet in section 203 of the bill, which very few of us have read, it says the Commissioner that will be established under this legislation shall specify the benefits to be made available under Exchange, participating health benefit plans during each plan year. And I have been told that that applies not only under the government option but also the private plans.

So do you think it is right that some government officer will be dictating what benefits will be available under private as well as the public option plan? Dr. Shern.

Mr. SHERN. Well, I think that the intention, as I understand it of that provision, is to provide a floor of services that will be available for everyone upon which you can build. And I also think that if——

Mr. WHITFIELD. That is your understanding. Do you know that to be a fact?

Mr. SHERN. No, I don't know that to be a fact.

Mr. WHITFIELD. What about you, Ms. Hansen?

Ms. HANSEN. I can't answer it.

Mr. WHITFIELD. Have you read the bill?

Ms. HANSEN. Not since Friday.

Mr. WHITFIELD. But you all have helped work on this legislation. You have been a part of drafting this legislation; is that correct, Ms. Hansen?

Ms. HANSEN. We don't draft the legislation.

Mr. WHITFIELD. Did you have input into it?

Ms. HANSEN. There have been conversations between our staff.

Mr. WHITFIELD. Now, the CBO says that they estimate 15 million people will lose their present insurance, health insurance coverage as a result of this legislation. So, Ms. Hansen, what would you say to your members who will lose their employer health coverage because of this bill?

Ms. HANSEN. Well, we take the position that people—the principle of choice—and we also support that people who have insurance now can and want to keep that. And that is something that we actually believe in the maintenance of a public and a private——

Mr. WHITFIELD. Does this legislation give each individual the right to keep their current insurance?

Ms. HANSEN. Those are the principles that we are supporting.

Mr. WHITFIELD. But do you know for a fact that it does it? Do you know for a fact that it does it?

Ms. HANSEN. I don't know for a fact personally, but the principles I can ascribe to——

Mr. WHITFIELD. My understanding is that this legislation also includes an employer mandate which will force businesses to either provide health insurance to their employees, which is fine, or pay a tax of 8 percent of wages paid. Now, that is going to particularly hit hard small businesses. And there have been estimates that there may be 4.7 million Americans that would lose their jobs because of the additional tax that small business men and women will have to pay.

Does that concern you all? Does that concern you at all, Dr. Shern?

Mr. SHERN. If those estimates are correct, that would be a concern.

Mr. WHITFIELD. Ms. Hansen.

Ms. HANSEN. Right. We feel that the ability to cover should also be supplemented by understanding affordability and cost for both employer, as well as the employee.

Mr. WHITFIELD. OK.

Ms. EDELMAN. But it is also my understanding that small businesses can buy into a public plan, but everybody should be contributing something.

Mr. WHITFIELD. Everyone.

Ms. EDELMAN. This should be a shared sacrifice.

Mr. WHITFIELD. Let me ask you a question. What do you think if we just took the money that this plan is going to cost and just put everyone under Medicaid? I mean, I know you are a supporter of Medicaid. It is a good system. What do you think about that?

Ms. EDELMAN. Well, I think that the committee can deliberate. I don't care how we do it. We should thoughtfully determine that we are going to get health coverage for everyone. What they are trying to do here is to give people——

Mr. WHITFIELD. Would you be opposed to everyone being under Medicaid?

Ms. EDELMAN. I would be not be opposed to all children being under Medicaid. That is what I know about.

Mr. WHITFIELD. What about adults?

Ms. EDELMAN. But I think that the issue here is how we are going to give everybody coverage and choice about a public or a private——

Mr. WHITFIELD. And my question is would you object to everyone being under Medicaid?

Ms. EDELMAN. I am here to talk about children today and to say whatever plan we do, that we should absolutely make sure that all children and pregnant women are covered, and I would love it if Medicaid took them all up to 300 percent, all of the children got the Medicaid benefits and the Medicaid entitlement.

Mr. WHITFIELD. I think my time has expired.

Mrs. CAPPS. Thank you, Mr. Whitfield.

May I just make a correction to a statement that was made? It is my impression or my understanding that CBO has not taken a position on this bill and that actually a private-public benefit advisory committee determines what the benefit is that should be on

the floor—or what is offered in coverage in the new marketplace or sold in the new marketplace, and that is just for the record.

And I now call upon or recognize our colleague from Colorado, Ms. DeGette, for 5 minutes.

Ms. DEGETTE. Thank you, Madam Chair. And I want to add my thank to Ms. Robertson-Holmes for coming today. It is always important to hear the patient perspective. When you were testifying about the great care that you got at the Mayo Clinic, I was thinking about my next door neighbor when I was a little girl, Randy West. I knew him since I was 6 years old. And about 2 years ago, Randy was diagnosed with prostate cancer and he was treated and the doctor said they thought he was cured. And then the next spring when his private insurance plan came up for renewal, his insurance company said they would renew his insurance but that they would not insure him for any future complications he might have gotten from the prostate cancer. So he said, well, why should I get insurance then because that is the thing that is the most likely to affect me. So he didn't get the insurance renewal, and you know the rest of the story. Last summer, his symptoms returned, he went back to his old doctors, his old doctors would not now treat him because he didn't have health insurance anymore and he spent about 2 or 3 months trying to get on to Medicaid so he could afford to go see the doctor and get treatment for his now advanced prostate cancer. Last week, on Wednesday, was Randy's 57th birthday, and he died suddenly of a heart attack because of the advanced prostate cancer that had riddled his body.

So there are problems with the single-payer system in Canada, but there are real problems for 47 million Americans like my friend Randy West who died because he didn't get the insurance. And I don't even need a response to that. I just want to say what we are trying to do is make it so insurance companies don't deny people for those pre-existing conditions and so that people who have diseases in this country can go to the doctor.

And I just want to point out to you, Ms. Hansen, I want to thank you for mentioning the Empowered at Home Act in your written testimony because Chairman Pallone and I worked on this bill a lot together, and what that does is it incentivizes States to provide home and community-based services which allows disabled individuals to stay in their homes. It is not only about better health outcome, it is also more cost effective. And so I want to thank you for that, and I think, Madam Chair, that is an important component to keep in the bill as we move along.

And finally, I have to thank my dear friend, Ms. Edelman, all of our dear friends and a real icon for children in this country for coming over today, and I want to ask you a couple of questions about kids. As you know, I have worked for many years on kids' health.

The first one is, do you think that as we design a program to try to enroll all kids in this country in health insurance or some kind of health coverage that we should look at their unique needs and not just assume that the adult programs will cover them?

Ms. EDELMAN. Yes, which is why we feel so strongly about the Medicaid benefit package which has been thought through as being the most child appropriate because it is targeted at children and

it is targeted at early diagnosis and early treatment. So I don't think we need to reinvent anything, and I hope you will not come up with a benefit package, whatever it is, that takes away what children now have that works, and we want you to extend that package to all children because that is what we think they need.

Ms. DEGETTE. And that includes mental health and——

Ms. EDELMAN. Mental health. It is the comprehensive, all medically necessary services. And we think that that should be Medicaid children, CHIP children and any children regardless of whether they are in an Exchange or not.

Ms. DEGETTE. And we talked earlier. I think you mentioned in your testimony the early and periodic screening diagnosis and treatment benefit. That is very expensive, though. And I am wondering if you can opine as to whether you think that additional cost is worthwhile and might even save money in the long run for kids and, if so, why.

Ms. EDELMAN. I think it would save money and when we had Lewin & Associates do cost estimates for extending coverage to all children and giving them the Medicaid benefit packets, they said that you could extend the EPST benefit packets to all 9 million uninsured children—this was a 2-year ago study—and for about 12 percent added cost.

So I think that the cost effectiveness of this in the long run is going to pay itself back. So we think it is not a big huge add-on.

Ms. DEGETTE. Part of the draft legislation, and part which I am sure you have read because it applies to children, is the part that if children come in at birth and their parents don't have insurance would automatically enroll them in Medicaid for the first year.

Do you think that is a good step in the legislation?

Ms. EDELMAN. I think that is terrific. And we would like to have automatic enrollment when they go to preschool or if they are in any WIC program or early Head Start program. You want to get children in because they are prevention. You want to prevent them——

Ms. DEGETTE. And preventive care for children actually saves——

Ms. EDELMAN. Many, many dollars on the other end. And we can give you added testimony that shows you the cost of doing that.

Ms. DEGETTE. I would appreciate it if you would supplement your testimony in that direction. Thank you very much, Madam Chair.

Mrs. CAPPS. Thank you, Ms. DeGette. And now I am pleased to recognize for 5 minutes Dr. Burgess from Texas.

Mr. BURGESS. Thank you, Madam Chair. Ms. Wright Edelman, let me just ask you a question. Last fall, in the interest of full disclosure, I was a surrogate for the opposite side. I got to know President Obama's proposals last fall pretty well because I always had to prepare to argue against them. And one of the overarching themes that was always put out there first was that there was going to be a mandate to cover children under President Obama.

Have you talked to him lately about what happened to that?

Ms. EDELMAN. No. But he certainly knows that I am expecting him to keep his promise. And I know that he has expressed his great interest in seeing that we take care of all of our children, and

I think that this is the time to do it and the individual mandate——

Mr. BURGESS. I don't mean to interrupt, but I always had difficulty getting his surrogates to identify the definition of a child. Sometimes it was age 19, sometimes it was age 25, sometimes it was age 27. Do you have an opinion as to where that limit should be set?

Ms. EDELMAN. Well, I certainly—we would take the definition of a child that is under Medicaid or CHIP now, but I think that we are talking about everybody getting coverage. And we know that there are a lot of younger people in college——

Mr. BURGESS. But in the interest of time, I have got to interrupt you. What is the difficulty with a child on Medicaid today? What is the difficulty with getting them in to see a dentist if they have dental coverage under Medicaid?

Ms. EDELMAN. Well, the first part—Texas, since you have the highest number of unenrolled children and we——

Mr. BURGESS. Let us just focus on those enrolled.

Ms. EDELMAN. Well, may I provide reimbursement rates? We all heard—and because children do still face bureaucracies. But let us just take the child out in Prince George's County, Deamonte Driver, who—Deamonte Driver died last year—tried to get—25, 26 dentists his mother went to, couldn't get them to take him because of the low Medicaid, low reimbursement rates, and I know you are trying to do something about that in your proposal. And the upshot was his tooth abscessed and infected his brain and then he died. 250,000 emergency rooms have huge bureaucratic barriers first to even enrolled children and not enough providers, and in rural areas it is worse.

Mr. BURGESS. But fundamentally the problem has been reimbursement rates.

Now, Dr. Novack, you talk about 14 days out of every month you cover the emergency room, and we have put a mandate on providers. We may not have a mandate for kids, we may not have a mandate on employers or a mandate on individuals, but you have a mandate called EMTALA, which requires that within 30 minutes of somebody showing up at the door you have to see them. Is that not correct?

Dr. NOVACK. That is correct. And the consequence, of course, is that a very large majority of my colleagues just no longer have any privileges at the hospital. So for sometimes some complex things, where it might be nice to have a particular person available and when someone comes into the emergency room, you are no longer even able to get that person's assistance on a difficult case because of the regulations. People abandon their privileges completely.

Mr. BURGESS. And this is an extremely—and both of these issues are really getting to the same problem. And I recall back in—I practiced obstetrics back in Texas for 25 years, and we made an agreement amongst ourselves that our individual practices would each take a certain number of Medicaid patients every month into our obstetrics practice so no one would be unduly burdened by a larger number of patients who reimbursed at a lower rate. And that worked great until you had somebody who had a complicating medical condition and they had to be referred to a specialist. And

it was virtually impossible to find anyone because of just exactly what you described, those very low reimbursement rates.

As we sit up here and plan a national program that may very well be based on Medicaid, I just think we are obligated to make the program that is already there work first and demonstrate that it can work before we go extending it to increasingly larger segments of the population.

Dr. Novack, do you have an opinion about that.

Dr. NOVACK. My sense is that it is no different than when I do something in orthopedics, which is you are not going to introduce a new procedure until there is some data in a small group that it works. And what is being proposed here is to push through massive legislation in an incredibly short order where there has not been full time for people across the country to look at it and examine the problems and try to get it passed before people realize what has happened. And then all of us as patients will live with the unintended consequences of those actions.

Mr. BURGESS. So we should have evidence-based policy as well as evidence-based medicine?

Dr. NOVACK. I suspect the—as Shona has demonstrated, look, there are good people in health care, whether they are physicians, nurses, all through the system, top to bottom in lots of places, not just the United States. But the system within which you are allowed to provide care is as important to the delivery as the people providing it. So if we are not willing to put the same level of attention and same level of attention to detail on the level of intellectual rigor into designing the system, it is doomed to fail.

Mr. BURGESS. Doomed to fail. Shona, let me just—I know I have no time left, but I just wanted to let you know that my grandfather was an academic OB at the Royal Victoria Hospital in McGill and my dad also did his training at McGill Medical School. He did a fellowship at Mayo Clinic back in the 1950s, when there was only the one in Rochester, and never went back to Canada. And I am so grateful you are here today, and thank you for sharing your story with us.

Ms. ROBERTSON-HOLMES. I don't want to pull down any doctors or anything from either side of the border. It is just what they are able to do.

Mr. BURGESS. The doctors and nurses are all good people. The systems they are having to work under are where we are encountering the stress. Again, thank you for sharing your story with us today.

Mrs. CAPPS. Thank you, Dr. Burgess. And now I would recognize myself for 5 minutes.

I want to just point out that this legislation is not coming out of nothing, that there are—I will just mention three examples of best practices or good care, medical home, if you want to call them that. Cleveland Clinic is one, Mayo Clinic is another. John Hopkins. All have been very participatory. And many of our hearings have been focused on areas where practices have worked and where we see examples in small communities.

I want to start with you, Dr. Shern. Mental health and substance abuse are some of the most chronic and disabling of conditions. Treatment often does not begin until as long as 10 years after diag-

nosis. And diagnosis, we all know, oftentimes happens much after the symptoms begin. This increases the risk of developing a very costly disability. Mental health and substance abuse conditions often also go hand in hand with other costly chronic conditions like diabetes and heart disease.

Can you comment—and I want to turn to children as well as a former school nurse. We must address that. But I want you to comment briefly on how we might be able to improve the provisions of the draft bill to better guarantee earlier access to mental health treatment. We tried to take as many steps as we could, but this is a single—with all the stigmas and stuff still around, please address this for us.

Mr. SHERN. First of all, I would say that we are lucky to have the Institute of Medicine report on prevention in general, and there are many things we can do universally to drive down the rates of mental illness over a long period of time.

So one thing we should think about—and I think that the community task force that is anticipated in the bill is, in fact, moving in the direction of the evidence about what is effective in terms of prevention. I also think that the inclusion of mental health screenings in adolescents, as recommended by the Preventive Services Task Force and as included in the bill, is a very important step forward.

It is ironic that we test eyes, we test hearing, we look to see whether or not there is a scoliosis in the spine, but we don't test kids for the things that they are most at risk for routinely, and those are social and emotional problems. We have data that indicates that when we do that with an appropriate model, as the Preventive Services Task Force has recommended, we can effectively identify and treat those conditions and that will be beneficial in the long run. Anything we can do to strengthen those provisions I think would be very helpful.

Mrs. CAPPS. And I am going to have to ask you to submit this to the written record. If you have ideas about how we could better integrate—support better integration of behavioral health and medical care, as well as in a way of maybe branching out. Hopefully this will be a beginning start and then we can expand upon it.

You mentioned children naturally. Because when you talk about health care and mental health, really, as you know, Dr. Edelman, Marion Wright Edelman, that is when we should start looking at screenings. I want you to focus on a different topic. When you mentioned children, I always think of the mother and I want to elaborate on the importance. I would like to hear you elaborate on the importance of ensuring that women receive adequate maternal care coverage and the effect of a mother's health on the health of her children. It is so clear to those who have studied it that if you have adequate prenatal care, your chances of having a healthy baby are that much more important.

Ms. EDELMAN. Well, a depressed mother is not going to be the best mother for her child. So what is good for the mother is always good for the child. So it is in all of our self-interest to make sure that mothers do get prenatal care, that any problems that they have are—substance abuse problems, domestic problems, other things that may lead to them being less able to do all they need

to do for their children, those can be detected early and treated early because the impact on their children in the short and long term will be enormous, and we also just know the cost effectiveness of prenatal care, if they are having babies that are at low birth weight, are not adequately nourished, and don't know how to take care of themselves and their children. So you can't separate the two. So I think going forward we should make sure that the mother is in good shape and the children are in good shape.

And I am happy to submit additional evidence of the effectiveness of prenatal care and the effectiveness of maternal care and hope that there will be a full fledged capacity to make sure that all children have mothers who get full maternity care in this bill.

Mrs. CAPPS. Thank you very much. We have done a bit of work in Congress recently to recognize the situation around maternal mortality. But also the fact that—I don't think many Americans realize that this country, the United States, has one of the highest rates of infant mortality, 27th out of 30 industrialized countries. That is a red flag for starters.

And I want to thank each of you again for your testimony. And now I will recognize Mrs. Christensen for 5 minutes for her questions.

Mrs. CHRISTENSEN. Thank you, Madam Chair, And I thank all of you for your testimony. Ms. Chin Hansen, AARP has taken a position back a few years ago in support of lifting the Medicaid cap for the Territories. This bill does not go that far.

Is it still the position of AARP that all of the Federal programs should be equally accessible to all Americans regardless of where they live?

Ms. HANSEN. As you have in my written testimony, that it does speak to really supporting that elevation. So it is something that we continue to support.

Mrs. CHRISTENSEN. Thank you. Dr. Shern, you talk about providing mental health care and the savings that we would realize from that and the reduction in the productivity losses that we experience, and you give some pretty good figures to back that up. But I wonder if just for the record you would speak to the impact of treating mental health, mental illness, and chronic disease and how that would also produce savings in terms of chronic disease treatment.

Mr. SHERN. Mrs. Christensen, as I said in my verbal testimony today, mental health conditions are the most likely co-occurring conditions with other chronic illnesses. And when they occur, there is lots and lots of data that indicates that the course of treatment is much rockier, costs are much higher and outcomes are much poorer. We have a study of older adults with diabetes, called the Prospect Study, who also had depression, half of whom were randomly assigned to effective depression treatment, the other half were assigned sort of a watchful wait and counseling but to balance off the amount of time that was spent. What we found was over a 2-year period, those people who didn't have their depression effectively treated died at twice the rate of the individuals who had their depression effectively treated.

And in this study we found that in the first year there was an overall cost increase for care, but in year two the overall cost of care for those people declined and their clinical status improved.

So we have lots of examples of what is called collaborative care models in which the entire person's needs are addressed. In this case we are talking about diabetes and depression.

Additionally and quickly, if you look at workplace presenteeism and productivity, there is also ample data—and this gets to your earlier point about thinking about costs more broadly than simply the costs within health care sectors—there is ample data that shows that these are very cost effective programs that have effective return on investment.

Mrs. CHRISTENSEN. Thank you. And, Ms. Edelman, I think most of the questions that I wanted to ask you have already been asked. But you know that I have always shared your passion and your commitment to making sure that every child and pregnant female has been covered.

We are expecting a PAYGO bill to come to the Congress shortly. I think it is still coming and, cost being the major barrier to achieving what we all know we need to achieve on behalf of children and really all Americans, do you agree that it is important enough to take this issue out of PAYGO if that is where it needs to be?

Ms. EDELMAN. Well, I don't think we have a money problem in the richest nation on Earth. I think we have a values and priorities problems and that if we can find the money for all the more powerful special interests, if we can continue without having had a PAYGO for the tax cuts, many of which came through the Bush administration, if we could find the money so quickly for bailing out the banks and the others, if we can continue to have these disparate things, I don't for a moment believe we can't afford to take care of our children. It is really about values. And if we are serious about cost containment and if we are serious about prevention and if we are serious about creating a level playing field for everybody and if we believe, as we profess to believe and which is America's promise, that every child's life is of equal value, then we will find the money to do what is right and cost effective. So I hope we will do it.

Mrs. CHRISTENSEN. Dr. Novack, do you agree—I don't agree with a lot—some parts of your testimony, but I agree with your position on MedPAC, if I understand it correctly, and where you say that using cost control as a driving force behind health reform will turn every American from being a patient to an expense.

Do you also agree that this ought to be done regardless of cost because we cannot, as the President said, afford not to do it?

Dr. NOVACK. No. I disagree. I think that if we look at overall government spending, government should work the same as families. And that at some point we have—look, we actually have a health care bubble. It is like we had a housing bubble. Our overall unfunded liabilities are massive in health care, and that bill will come due some day no matter where people want to stick it on the ledger. So given all the bailouts—and I share the concerns with the other members of the panel about some of the bailouts that have gone on since they seem to go with whoever has the biggest mega-

phone. But that is not an excuse to not use basic fiscal responsibility when we are trying to reform health care.

Mrs. CHRISTENSEN. But families do it in emergencies, borrow to meet those emergencies and make sure that they are taken care of.

Mrs. CAPPS. Now I recognize Mr. Green for 5 minutes.

Mr. GREEN. Thank you, Madam Chairman.

Dr. Shern, I am a cosponsor of H.R. 1708, the Ending Medicare Disability Waiting Period Act, and it would actually phase out the 24-month disability waiting period for disabled individuals. And I want to thank you for being a member of the coalition in the 2-year waiting period which has more than 120 members.

Can you speak on the importance of that elimination, that 24-month waiting period for individuals with mental disabilities and illnesses, even with the creation of this Exchange that is in the bill?

Mr. SHERN. I think it is very important that we eliminate that waiting period. It is such a counterintuitive thing. And you know how difficult it is for someone to qualify for SSDI, to make it through the disability process. And people with mental health and substance use conditions have a particularly difficult time making it through. And then once one finally gets through to say, well, in 2 years—it was now agreed that you have a chronic illness that needs to be treated and say, well, the good news is you made it through the SSDI. The bad news is we are not going to be able to provide you healthcare coverage for 2 years. It makes no sense.

So I think that that repeal is really important. Anything we could also do to expedite the elimination of the discriminatory 50 percent copay in Medicare. We took care of eliminating it over a 5-year period. We have good data to show that that, in fact, drives cost on the inpatient side by denying people or making it more expensive for them to get ambulatory care.

So we are very enthusiastic about reducing that 2-year waiting period, and anything we can do to drive down that copay I think would also be very cost effective and beneficial.

Mr. GREEN. Dr. Edelman, in Texas we have the largest uninsured in the United States and approximately 900,000 children uninsured. Approximately 600,000 of those children are Medicaid eligible but unenrolled and the remainder are SCHIP eligible but unenrolled. This can be attributed to times in the past when Texas was facing budget issues and required parents to reenroll their children in SCHIP every 6 months and the same with 6-month reenrollment for Medicaid. There are two pieces of legislation. In fact, my colleague, Ms. Castor from Florida, and I both are cosponsors of it.

In your testimony you mentioned 12-month continuous eligibility for Medicaid as part of the solution to the problem with the number of uninsured children in the U.S. Can you explain why that is important also, the 12 months for the SCHIP program?

Ms. EDELMAN. Well, I think that if you want to keep children enrolled, and you should make the enrollment and re-enrollment procedures as easy as you can possibly make it, rather than as difficult as many States, including Texas, has made it. And we lost a child last year to Bonnie Johnson whose mother tried to do everything right but couldn't get her paperwork sorted out in Texas, and

this 14-year-old child died from kidney cancer, which could have been allayed had he not been dropped from coverage for 4 months.

And I have been so pleased that the business community in Texas has come now and really understood the importance of investing preventively and that Texas is losing millions of dollars, in fact almost a billion dollars, by turning down a Federal match and the local taxpayers are paying for it in emergency care.

And so I just hope that we can—and we have submitted as a part of our longer testimony all of the simplification things, including the 12-month eligibility, presumptive eligibility, express lane, and a number of things that can make it easy to get children in for preventive care. And I would love, Mr. Green—and thank you for your comments this morning—to submit for the record the new study done by the Baker Institute that talks about the cost effectiveness of investing in coverage for all children in Texas and nationally, and lastly, some of the studies the business community have done in Texas in support of their reforms for 300 percent eligibility in Texas, as well as for the 12-month continuous eligibility.

Mr. GREEN. And we know that the numbers—you can actually decide if you want to keep children off of CHIP or even Medicaid, you know, if you make those parents go down and stand in line every 6 months as compared to the year. Now, during that year they can still be investigated. If somebody finds out that family may not be qualified for Medicaid or even SCHIP, they can go get that. I appreciate it.

Also, Congressman Doggett is working with the Ways and Means Committee on the same issue for both SCHIP and Medicaid. Hopefully we can at least get SCHIP. It is much smaller, but we need to do that, look at the total goal for Medicaid also.

Dr. Novack, let me just ask questions about your statements. Health care reform must be built on a foundation consisting of the protection of the right of individuals to control their own health and health care, not special interests of government bureaucrats. I would submit right now I don't know if it is controlled by government, but it is controlled by somebody on special interests. If you are lucky enough to have insurance and you get preapproval, I can tell you that it is already going to be controlled by someone that is—whether it is insurance companies or Medicaid officials or someone else. So I agree with you. I want health care to be controlled by individuals, but we all have to answer to someone. And I can't just go to the doctor and get everything I want. They tell me that is not part of the policy or you not treated for that.

Let me go next to your statement on the first preserving the right to be able to spend their own money, and let me understand. In Arizona, there is a constitutional amendment that the goal is to preserve the right to always be able to spend your own money for lawful health care services?

Dr. NOVACK. That will be on the ballot in 2010.

Mr. GREEN. Is there something in Arizona law that prohibits people from spending their own money for their health care?

Dr. NOVACK. No, but it is in Federal law, from the 1997 Balanced Budget Act, that effectively prevents Medicare beneficiaries from spending their own money. If you are a patient on Medicare and you come to me as a Medicare provider—and let me give you—if

you bear with me, because it only takes a moment to do an example. If you have had your hip replaced, for example, two or three times and you need it done for the fourth time, which happens, you want to go to somebody who really knows what they are doing. Well, the physician you want to go to who does a lot of replacements, what we are seeing more and more frequently is that those people are no longer doing what we call redo or revision operations. And the reason is why for a primary or first-time uncomplicated hip replacement, Medicare pays $1,400. But for a redo——

Mr. GREEN. I understand where you are coming from. Let me give you another example, though.

Mr. PALLONE [presiding]. Excuse me. You are over almost a minute and a half. So I would like to end this if I could.

Mr. GREEN. Let me ask you just to compare to that. If someone comes into you——

Mr. PALLONE. Mr. Green, you can't ask an additional question.

Mr. GREEN. We don't have time?

Mr. PALLONE. If he wants to respond, fine.

Mr. GREEN. I just wanted to make the comparison, Mr. Chairman.

Dr. NOVACK. The difference is a $250 difference for what would be three times the work. So if you say I want Dr. Jones to do the operation, I will pay you the difference out of pocket because it is extra time, the only recourse a physician has is to resign from Medicare and not see any Medicare patients for 2 full years.

Mr. PALLONE. If you want to respond to that, you can. But I have got to move on.

Dr. NOVACK. It is technically an effective prohibition on spending your own money on health care.

Mr. PALLONE. If you want to respond to that.

Mr. GREEN. There are a number of members here who voted for that Balanced Budget Act in 1997. There is a lot of things that have happened since then that I disagree with. But I also know one of the concerns is that in an area that I have that is not a wealthy area, if we didn't have that, if we didn't have the current provision in the 1997 act, we would not have people being able to find a doctor to be treated under Medicare—because they couldn't afford that extra money plus what they are already spending on Medicare.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. The gentlewoman from Tennessee, Mrs. Blackburn.

Mrs. BLACKBURN. Thank you, Mr. Chairman, and thank you all for taking your time to be here.

Ms. Holmes, I wanted to talk with you for a few minutes. It sounds like you had an incredible journey.

Ms. ROBERTSON-HOLMES. I did.

Mrs. BLACKBURN. And you were happy to be able—and grateful and fortunate to be able to find health care. You were here during the first panel and you have heard what I have had to say about TennCare in the State of Tennessee and our concerns there, because what you outline in your testimony is what I see happening many times in our State. You had to fly 2,000 miles to access health care. In rural west Tennessee, because of all the cost shifting that has taken place, because people are not able to access

health care and many providers are no longer taking TennCare, then they find that that health care is available a long way away from them. And sometimes 30 miles might as well be 3,000 miles if no one has the ability to take you there. And I am just assuming, from what I read in your testimony and listening to you, that your outcome had you had to depend on a single-payer system that allows you no recourse, that allows you no alternatives, which says take a number, get in the queue and wait your turn, that your outcome would have been very, very different.

Ms. ROBERTSON-HOLMES. Very, very different. And this is the whole reason why I am here because I feel very—to stick my nose in American business, but I was fortunate to be able to come here. But not only did I have to just travel away from my home, I had to travel outside my country. And when it gets like that—because it is actually illegal for me to try and do what I did in Canada. And that is what we have to be able to—to open the doors of communication about and realize that you get rationed care. It is one thing to not have insurance, and it is another thing to have insurance and not have doctors.

Mrs. BLACKBURN. So basically your government provided insurance. When you needed it, your government provided insurance was worthless to you?

Ms. ROBERTSON-HOLMES. Exactly.

Mrs. BLACKBURN. So you mortgaged your home, put a second mortgage on your home. Your husband picked up a second job.

Ms. ROBERTSON-HOLMES. That is right.

Mrs. BLACKBURN. And you got the money that was necessary, the $100,000 to pay for that.

Ms. ROBERTSON-HOLMES. Yes.

Mrs. BLACKBURN. Now when you had flown back to Mayo and then you went back to Canada with your test results, and you said all right, here it is, I am going to be blind in 6 weeks, did a bureaucrat make the decision or a physician make the decision?

Ms. ROBERTSON-HOLMES. They wouldn't even look at my medical reports. It was get back in line and wait.

Mrs. BLACKBURN. So the bureaucrat turned to a citizen and said, you are out of luck, get in line?

Ms. ROBERTSON-HOLMES. Get in line.

Mrs. BLACKBURN. That is real compassion, isn't it.

Ms. ROBERTSON-HOLMES. No, absolutely zero compassion from a country that is known to be compassionate. The same country that will cover illegal immigrants the second they arrive in our country.

Mrs. BLACKBURN. Thank you, ma'am.

Ms. Hansen, a quick question for you, and thank you for being here and I know you all work hard for our Nation's seniors. I have lots of seniors in my district and I had the opportunity this weekend to visit with some of them. You know, they are really very concerned about what they have been hearing from the Obama plan, because they feel like they have had money taken out of their paycheck every week and now they get to near retirement or they get to retirement and they are being told basically that that is worthless to them, that if there is a nationalized plan that they are going to be treated more like—they are feeling they are going to be treated more like Medicaid than Medicare and they are very, very con-

cerned about losing Medicare Advantage, they are very concerned about losing options, and concerned with losing their Part D coverage.

What would you suggest that I tell these seniors that say I have been putting money in, it is my money and came out of my paycheck, I have been letting the government have first right of refusal on that money all of these years, and now it is basically people—everybody is going to have the same thing? How do you respond to that? What should I tell the senior?

Ms. HANSEN. Well, I think that what I think I have heard that the President said if you have current insurance and it works for you, you can keep it. So I don't know if in this discussion whether it is that everything comes back into the pot, and I don't think that the Medicare program is meant to be structurally dismantled. So I think that my sense is that their assurance of whether it is the Medicaid program that Dr. Edelman has spoken about and Medicare. I mean, we have these right now codified in law with each of these different parts. So there is that.

I think one of the things that we want to do is to make sure they get best value for their hard earned money, for what they have spent. So in other words, we want to make sure they get safe care, we want to get timely care. We want to make sure when they need medications, and most older people have medications, of the fact that it is affordable for them.

So these are the things that I know AARP really strongly supports, and so I think the ability to really square as to what is discussed about President Obama's plan and the principles of maintaining choice, coverage, and private options.

Mrs. BLACKBURN. Thank you, I yield back.

Mr. PALLONE. Thank you.

Gentlewoman from Ohio, Ms. Sutton.

Ms. SUTTON. Thank you very much, Mr. Chairman. Five minutes isn't going to do it, but I am just going to request that Ms. Wright Edelman and Ms. Chin Hansen and Dr. Shern, if I can follow up with you outside the committee to talk about some ideas of how we might strengthen some things and make this work for our children and our seniors and those who have needs, Dr. Shern, you have so eloquently identified.

I want to thank you very much, Ms. Robertson-Holmes, for coming and testifying. Dr. Novack. And I want to address the issue that I think you raise. And I think it is very important as we have this discussion to talk about the reality that this isn't just about getting people health care insurance. This is about improving the delivery of health care to people when they need it the most in a way that makes sense both for health outcomes and economically. And so your point is well taken when you talk about you paid for your insurance, right?

Ms. ROBERTSON-HOLMES. Oh, sure.

Ms. SUTTON. And when you needed it, it wasn't there.

Ms. ROBERTSON-HOLMES. Right.

Ms. SUTTON. I listen to you because I was so struck because I was in the State legislature in Ohio and did a lot of work related to the private insurance industry, and that very same problem, people who paid for care and then when they needed it and their

doctor said they needed it, the insurer wouldn't pay for the coverage that they had been paying for all this time. And there is a person by the name of Linda Kerns, it is K–E-R–N-S, Doctor. And Linda was a witness who came in to testify. And Linda was a very special person and most people are, but she was special because she was actually an HR person for an insurance company. And Linda had a history in her family of breast cancer, that was a very aggressive form of breast cancer. And so her doctor when she went in for treatment, that she was vulnerable for this potential for breast cancer, the doctor wanted to treat her aggressively, and the insurance company bureaucrats overruled the doctor and said no, I am sorry, you have been paying for coverage but that care is not going to be provided, we don't think you need it. So she didn't get it. She didn't get that coverage.

Now what she did was what you did. She eventually over time, with great delay, raised the money and went into debt to get that surgery, but there was a delay. So we really never know the value of that delay or the health outcome.

Ms. ROBERTSON-HOLMES. Irreversible tissue damage, no question.

Ms. SUTTON. And in this country, unfortunately, there was no recourse for her even if there was a proven health consequence to the unreasonable delay or denial of that coverage, even though if a doctor had done it—if a doctor had said we are not giving that to you and then he was found to have unreasonably delayed or denied then, there would have been a malpractice case against them. There was no accountability for that private insurer to be held accountable for the health outcome other than the cost of the procedure, not the loss of life or health.

Ms. ROBERTSON-HOLMES. That is the exact same situation as we have, and there is no accountability from the government.

Ms. SUTTON. See, this is my point though, because you experienced that under your system. We see people experience that here under our system as well and people going into bankruptcy because the costs are spiraling or they don't have access to the care they need when they need it. The problem is that I guess maybe what I would ask is that if you had—and you talked about the need to have some competition for your government-run plan, and that is exactly what we are offering here. We are assuring that people have access to coverage in this country, and right now the private insurers are the only game in town. If they unreasonably delay or deny, no accountability. If we have a public option that also allows people to have the chance to purchase it, that that cannot only drive down costs but I would argue can drive up the quality of the delivery of care.

And so I just point that out, because I can't help but think of Linda.

Ms. ROBERTSON-HOLMES. And I understand and the major difference between the two of us is——

Mr. PALLONE. Ms. Robertson, you have to turn that mike on, because otherwise you won't be transcribed.

Ms. ROBERTSON-HOLMES. The major difference between her and I is that what I did by coming to this country, mortgaging my house, et cetera, et cetera, was illegal for me to do at home. It is

not an avenue for me to do at home. I cannot step out of that. I am mandated to use that, and that is it.

Ms. SUTTON. And you would have preferred to have the option of buying private insurance and then you would be resolved?

Ms. ROBERTSON-HOLMES. Or if worse came to worse, the same situation that happened to me here, I could have at least stayed in my house, had my children with me, had my father, you know months before he passed away still with me at my hospital bed. Instead I was in Arizona 2,000 miles away alone.

Ms. SUTTON. I understand, and I thank you very much for your testimony.

I know I am out of time. So bureaucrats there, bureaucrats here. Of course this bill I know you had the question, Dr. Novack, from our chairman emeritus about the exact language that you used in your testimony to describe the bureaucrats that will in your opinion be performing the functions under this bill, but it really does provide, the bill, if you find the language, it provides for health care professionals to do the analysis and of course what we must tell the American people is that right now insurance companies are doing it.

So with all due respect, thank you.

Dr. NOVACK. My answer is——

Mr. PALLONE. Listen, I am sorry. I don't think she was addressing a question to you.

The next person is the gentlewoman from Florida, Ms. Castor. I apologize that I passed over you by mistake.

Ms. CASTOR. Thank you, Mr. Chairman, and thank you to all of the witnesses who are here.

To Dr. Shern, you were an outstanding director of the Florida Mental Health Institute in Tampa at the University of South Florida. They miss you there, we miss you. USF is doing great things, as you know, in medical, in health care policy and research.

Back in Tampa before I was elected to Congress, I served as county commissioner and the county government there had the responsibility for all health and social services, including very fairly robust children's services, compared to many other places across the country. But I was always floored by the total lack of mental health care services. There is nothing, there is nothing for these families that struggle day to day with what is going on in their homes.

Now of course the county government also had responsibility for law enforcement and the county jail, and the greatest advocate for mental health care services was always the sheriff and the folks that were running the county jail because they understood the population in jail, and that is the most expensive way to address mental health care in America.

So I am pleased that the discussion draft here in the House takes the first few steps in providing that comprehensive early integrated care, and there is no better place to start of course than with children.

As a mother, what would I do if I didn't have the same pediatrician that I have had for my daughter's 12 years of life to be able to just make that phone call, to call a nurse in the office. It is very cost effective rather than trying to chase down and go to a clinic

or go into an emergency room. We are all paying for that very expensive model out there. If you have health insurance and you think you are not paying for other people's care right now, you are wrong, you are. That is one of the reasons your health insurance bills and copays have been increasing over time to such a great extent because of the uninsured showing up in the ER.

But to promote this early integrated comprehensive care reform that we have taken a stab at here early in our discussion draft, I would like you to focus on a couple of things. Workforce. We know we don't have those primary care medical professionals, and I am not sure we have the mental health professionals that we need. Are we doing enough in our discussion draft to tackle that problem? I would also like you to address the terrible bureaucratic red tape. Ms. Edelman has emphasized that time and time again. You have some good recommendations in here, but I don't think the discussion draft goes far enough. In the State of Florida we have 800,000 children that do not have that easy access to the doctor's office. The State of Florida even one time quit printing the application form for SCHIP.

So what else can we be doing to knock down these crazy bureaucratic barriers that make it difficult for a parent just to walk into the doctor's office and make sure that their son or daughter gets a checkup? So the workforce issue and this terrible bureaucracy.

Mr. SHERN. Workforce is a critically important component, and I am heartened it is addressed in the bill, and of course we would always like to be able to do more, because we have a real pipeline problem in terms of people who were being trained to deliver the services that we need across the spectrum.

You talked about primary care physicians. I think we continue to rely more and more and more on primary care physicians in the medical home. As we know, the current incentive system isn't producing enough primary care physicians and we are not reinforcing them or rewarding them to the degree to which we can or should.

Additionally, I think we need to think about what we can do to continue to improve practice of people who are in practice now. We don't have very good models for doing that. We have what has been characterized as the Nike model. We sort of train them and say go out and just do it. We give them CME but we know that the CME doesn't do what it needs to in terms of improving skills.

And there are other models, some with the hope of HIT is better support, and comparative effectiveness research is better support for people to make better decisions.

And I think I will defer to my colleague, Ms. Wright Edelman, to talk about bureaucracy.

Ms. EDELMAN. Well, I just think a single eligibility standard for everybody, for all children, that is why we suggest 300 percent will make it easier rather than have all these different eligibility standards. A single set of benefits that are child appropriate, it will make it a whole lot easier.

And secondly and third, we talk about all the simplifications and we have it in legislative language, they are all included in the All Healthy Children Act, would be another terrific start. But getting rid of all the State lottery and all the disparate things and the two child health bureaucracies, whether the children are in Exchange

or in EPS or Medicaid or in CHIP, they should all get what they need with a single eligibility standard, comprehensive benefits, and the simple sort of measures that we all know how to do.

And I just hope that you will look at the specific legislative language. We will be happy to submit it as part of our testimony. And these are the true child health reforms we need in order to make sure that all of our children get what they need.

Mr. PALLONE. Mr. Sarbanes.

Mr. SARBANES. Thank you, Mr. Chairman. I want to thank the panel. Mr. Chairman, I want to thank you and Chairman Waxman and everyone who has been working on this issue for so long, because this is it, this is not a dress rehearsal. These panels that we are having probably are kicking themselves that they are here to speak on an actual discussion draft that includes these critical proposed changes to our health care system. I just hope that Americans watching this realize that this is exactly what they were pushing for in the last couple elections where they were expressing their frustration with the current health care system.

This is our chance to get this right. It doesn't have to be perfect, but we have to get a new framework in place, one that we can build on and one that answers the frustrations and the feeling of helplessness that millions of Americans feel out there.

I think the source of that is many fold, but I will point to a couple things, that sense of helplessness that I am describing. One is that you deal with an insurance industry that appears to be primarily engaged in the exercise of denying payment for the kinds of services that people need. And there is a paper chase. You get these things in the mail that say we will not pay, this is not a bill, this is your third notice, this is your fourth notice. Many Americans just give up after a certain point because they can't fight it.

So that is one source of the frustration. That is why I think we need a public plan option to compete, and I am not going to revisit that discussion. But as a train leaves the station on health care, if public plan is not on the train, it is a train to nowhere. It has got to be there.

The second source of frustration on the part of many people is they know that there are certain kinds of things that if that was reimbursed in the system it would be better for their health, it would save the system money over the long term. They can see it, it is right there, but the system doesn't cover it.

Elderly patients know that if they can spend another 20 minutes with their physician or half an hour, God forbid, that in that time the physician could better understand their situation and probably prescribe a regimen that would make a lot more sense to that patient and save the system over the long term. But physicians who do that are penalized by a system that doesn't recognize that kind of primary and preventive care.

So that is another thing that needs to be on the train as it leaves the station, primary and preventive care. The other one is investing in the workforce. Because if we have the coverage, that is all very well, you show up with your insurance card, but there is no providers to deliver the care.

So these are all things that are a part of this draft, this is why people need to be incredibly excited that we are talking about this right now. This is it, this is it. This is the moment.

Now with that preface, let me go to health care delivery. I wanted to ask you, Ms. Wright Edelman, because you talked a lot about SCHIP and getting these services to children, but continue to be frustrated on kind of the delivery system. Congresswoman Capps and I have pushed to try to create more school-based health centers and also allow for reimbursement of services provided there if they would otherwise be reimbursed if delivered in a physician's office setting.

Could you just speak briefly to this idea of capturing people where they are, this concept of place-based health care, go to where the children are, make it easier to access services at that point on the front end? Ninety-eight percent of our kids ages 5 to 16 are in one place 5 to 6 days a week.

Ms. EDELMAN. In school.

Mr. SARBANES. For 6 or 7 hours. We ought to take advantage of that. So if you could speak to that as part of this overall perspective.

Ms. EDELMAN. I want to say amen. You go to where they are, you make it as easy as you can. We need to expand the community health centers, we need to expand school-based health centers. And if the mother is in WIC and that is where kids are coming in, you get them enrolled and you make sure that you are making it available. And one of these days I look, as we talk about health and school reform, is that we can really make the new schools that we construct real community centers and collocate services so that is easy rather than hard for people to get their care.

So whatever we can to go where children and families are and to make sure that it is accessible would be terrific. I think none of this is rocket science. I think we know how to do it.

And I just want to reemphasize what you have just said. This is it. You have got all the skeletons for what you need to get done in your plan. We just need to kind of finish it and make sure that you have got the instructional forms there.

And I would like to say one little thing, because this is not a dress rehearsal. This is a window of opportunity. If we miss this opportunity, we are going to lose more generations of children and see escalating costs.

I just was looking for a thing that is in the written testimony about the President's statement. And I guess I think it states what you have stated in strong terms. He says I refuse to accept—when he was signing the CHIP bill—that millions of our kids fail to meet their potential because we failed to meet their basic needs.

In a decent society there are certain obligations that are not subject to tradeoffs or negotiations. Health care for our children is one of those obligations. This is the moment to fulfill that obligation, for you to fulfill it you know how to do it, you have got lots to build on. We have been working and many of the leaders here on Medicaid for 42 years. We know from the incremental problems how to make it simple, but we can address the health infrastructure. You made such a good start. I just hope you can just finish it and make

sure that it is transformational and true health reform for all of us.

Mr. SARBANES. Thank you very much. I yield back.

Mr. PALLONE. Thank you, and I think we are done with the questions, but I want to thank all of you again. Obviously what we are doing is crucial and we do plan to move ahead and meet the President's deadline. Thank you very much. Again, you will get written questions within the next 10 days and we would ask you to respond to those.

Could I ask the next panel to come forward, please?

Could I ask those who were standing or talking to leave the room so we can get on with our third panel?

Let me introduce our three witnesses here. Again starting with my left is Dr. Jeffrey Levi, Executive Director for the Trust for America's Health. Next is Dr. Brian Smedley, Vice President and Director of the Health Policy Institute, Joint Center for Political and Economic Studies. And then we have Dr. Mark Kestner, Chief Medical Officer for—is it Alegent Health?

Dr. KESTNER. Alegent.

Mr. PALLONE. Alegent Health. And this panel is on prevention and public health, certainly one of the more important parts of what we are discussing in the discussion draft. You heard me say before that we ask you to talk for about 5 minutes and your written testimony, your complete written testimony will become part of the record. And we will have questions after for 5 minutes from the members, and we may send you written questions afterwards which we would like you to respond to as well.

I see we are joined by our ranking member, Mr. Deal. And we will start with Dr. Levi. It is Levi?

Mr. LEVI. Yes, it is.

STATEMENT OF JEFFREY LEVI, PH.D., EXECUTIVE DIRECTOR, TRUST FOR AMERICA'S HEALTH; BRIAN D. SMEDLEY, PH.D., VICE PRESIDENT AND DIRECTOR, HEALTH POLICY INSTITUTE, JOINT CENTER FOR POLITICAL AND ECONOMIC STUDIES; AND MARK KESTNER, M.D., CHIEF MEDICAL OFFICER, ALEGENT HEALTH

STATEMENT OF JEFFREY LEVI, PH.D.

Mr. LEVI. Thank you, Mr. Chairman, and thank you for the opportunity to testify on the House discussion draft of health reform legislation.

Trust for America's Health and our colleagues throughout the public health community are delighted that this legislation recognizes that prevention, wellness, and a strong public health system are central to health reform. We also support the premise that without strong prevention programs and a strengthened public health capacity surrounding and supporting the clinical care system, health reform cannot succeed.

While my testimony will focus on the public health provisions of the discussion draft, I must first say that universal quality coverage and access to care are central to health reform. We believe this bill can achieve this goal. Inclusion of evidence-based clinical

preventive services as part of the core benefits package with no copayments also assures cost effective health outcomes.

Trust for America's Health has worked with over 200 organizations to articulate the importance of prevention and wellness to health reform. Our joint statement is attached to my written testimony and I will briefly review its key components.

First, we have urged that as part of a renewed focus on public health Congress should mandate the creation of a National Prevention Strategy. The discussion draft meets the central criterion by requiring the Secretary to develop a National Prevention and Wellness Strategy that clearly defines prevention objectives and offers a plan for addressing those priorities.

Second, the groups urged establishment of a trust fund that would be financed through a mandatory appropriation to support expansion of public health functions and services that surround, support, and strengthen the health care delivery system. We envision the trust fund supporting core governmental public health functions, population level non-clinical prevention and wellness programs, workforce training and development, and public health research that improves the science base of our prevention efforts.

We applaud the inclusion of the Public Health Investment Fund, which will support through mandatory appropriations the core elements of the public health title, including the prevention and wellness trust. By including mandatory funding for community health centers, the discussion draft also assures a much closer link between the prevention and wellness activities that happen in the doctor's office and those that happen in the community.

Let me now review some of the key activities associated with the investment fund and our rationale for supporting them. On workforce, the focus on frontline prevention providers and public health workforce places appropriate emphasis on where the need is greatest in our health care system. Assuring the development of a robust public health workforce through creation of the public health workforce core, which will offer loan and scholarship assistance, finally places public health recruitment, training, and retention on par with the medical profession.

Community prevention and wellness programs are also critical. The expanded investment in these programs will be important to the success of health reform. There are evidence-based proven approaches that work in the community setting to help Americans make healthier choices, by changing norms and removing social policy and structural barriers to promoting healthier choices. We know that targeted uses of these interventions can reduce health care costs. We are particularly pleased to see that this draft recommends establishing health empowerment zones where multiple strategies can be used at one time.

In terms of support for core public health functions, we appreciate the recognition in this draft that the strength of our Nation's State and local health departments will significantly affect the success of health reform. Without the capacity to monitor population health, respond to emergencies, and implement key prevention initiatives, the health care delivery system will always need to backfill for a diminished public health capacity at a higher price in dollars and human suffering.

Improving the research base and revealing the evidence is also an important component of this legislation, and it makes a crucial investment in both public health and prevention research. While we have a strong base of prevention interventions today, much more needs to be learned about non-clinical preventive interventions, including how to best translate science into practice and how to best structure public health systems to achieve better health outcomes.

Dr. Smedley will address in more detail the issue of inequities, but I want to note that we are pleased that this draft focuses on disparities in access and health outcomes. From better training to targeting resources in communities where disparities are greatest, we harness what we already know will work to reduce inequities. We must recognize that the goal of health reform is not just creating equality of coverage and uniform access. We need to assure equity in health outcomes, too.

Mr. Chairman, there are few times that we have the privilege of watching history being made. This may well be one of them. If the public health provisions of this draft become law, in the years ahead we will witness the transformation of our health care system from a sick care system to one that emphasizes prevention and wellness. This is what our Nation needs and what the American people want.

Recently, Trust for America's Health released the results of a national bipartisan opinion survey. Perhaps the most impressive finding in that survey was that given a list of current proposals considered as parts of health reform, investing in prevention rated highest, even when compared to concepts like prohibiting denial of coverage based on pre-existing condition.

In short, by placing this emphasis on prevention and wellness in the discussion draft, this committee is responding to a compelling call from the American people.

On behalf of our partners in the public health community, Trust for America's Health thanks you for your leadership and looks forward to working with you to see these enacted into law.

[The prepared statement of Mr. Levi follows:]

Written Testimony of
Jeffrey Levi, PhD
Executive Director
Trust for America's Health

Before the House Energy and Commerce Committee
Subcommittee on Health

June 23, 2009

Mr. Chairman, thank you for the opportunity to testify today on the House tri-committee discussion draft of health reform legislation. Trust for America's Health (TFAH) and, I believe all our colleagues throughout the public health community, are delighted that this legislation recognizes that prevention, wellness, and a strong public health system are central to health reform. We also support the premise that without strong prevention programs and a strengthened public health capacity surrounding and supporting the clinical care system, health reform cannot succeed. We endorse this approach to health reform, which endeavors to keep people out of the doctor's office and makes what happens in the doctor's office more effective.

While my testimony today will focus on the public health provisions of the discussion draft, I must first say that universal, quality coverage and access to care are central to health reform, which in turn, provides all Americans with the opportunity to be as healthy as they can be. We believe this bill can achieve this goal -- by not just assuring coverage, but also providing access to care and a medical home. Inclusion of evidence-based clinical preventive services as part of the core benefits package with no copayments also assures cost-effective health outcomes.

TFAH has worked with 227 organizations ranging from the American Public Health Association to the YMCA to articulate the critical elements of a prevention and wellness approach to health reform. The joint statement of this group is attached to this testimony. In structuring my comments on the discussion draft, I will review the key elements in our joint statement.

First, we have urged that as part of a renewed focus on public health, Congress mandate the creation of a **National Prevention Strategy** that sets specific goals and objectives for improving the nation's health through federally-supported prevention programs. The signatories suggest that the National Prevention Strategy be consistent with the Healthy People 2020 goals and identify priorities for public health expenditures. It should also help promote public health across all federal agencies and foster inter-agency and inter-departmental cooperation regarding health issues. The discussion draft meets this central criterion by requiring the Secretary to develop a National Prevention and Wellness

Strategy that identifies clearly defined prevention objectives and a plan for addressing those priorities.

Second, the groups urged establishment of a **Trust Fund** that would be financed through a mandatory appropriation to support expansion of public health functions and services that surround, support, and strengthen the health care delivery system.

The 227 groups envisioned the Trust Fund supporting core governmental public health functions, population level non-clinical prevention and wellness programs, workforce training and development, and public health research that improves the science base of our prevention efforts. The groups also hoped that through these efforts, federal prevention and public health policy would address health inequities and disparities and improve our ability to track critical health indicators and monitor and evaluate disease trends.

We are delighted to see inclusion in the discussion draft of the Public Health Investment Fund, which will support, through mandatory appropriations, the core elements of the public health title of the discussion draft, including the Prevention and Wellness Trust. By including mandatory funding for community health centers, the discussion draft also assures a much closer link between the prevention and wellness activities that happen in the doctor's office and in the community. The discussion draft makes an historic commitment to guaranteeing for the very first time that essential public health services will be reliably and adequately funded.

Let me briefly review some of the key activities associated with the Public Health Investment Fund and our rationale for supporting them.

- **Workforce:** The focus on frontline health providers and the public health workforce places appropriate emphasis on where the need is greatest. Without an adequate primary care workforce, the impact of universal coverage will be limited. We are especially pleased to see the recognition that significant investment is needed to expand the public health workforce by incentivizing public health students to enter the public sector and to address the predicted shortfall in the workforce due to expected retirements over the next decade. According to a survey by the Association of State and Territorial Health Officials, (ASTHO), by 2012, over 50 percent of some state health agency workforces will be eligible to retire. A profile by the National Association of County and City Health Officials estimates that approximately 20 percent of local health department employees will be eligible for retirement by 2010. Assuring the development of a robust public health workforce, through creation of the Public Health Workforce Corps, which allows for loan and scholarship assistance for public health professionals in the Corps, as well as strengthening health workforce data collection, finally places public health recruitment, training, and retention on a par with the medical professions. We are particularly pleased to see the options for retraining the current public health workforce -- since a reformed health care system will place very different demands on the public health community -- and

the emphasis on preventive medicine training. Public health needs partners in the clinical setting; we need physicians better trained in preventive medicine for that partnership to succeed.

- **Community prevention and wellness programs:** The expanded investment in community prevention and wellness will be critical to the success of health reform. We now have evidence-based, proven approaches that work in the community setting to help Americans make healthier choices -- by changing norms and removing social, policy, and structural barriers to exercising those healthier choices. And we know that targeted use of these interventions can reduce health care costs. Last summer, TFAH, working with colleagues at the New York Academy of Medicine, Prevention Institute, and the Urban Institute, published a report that showed that an investment of $10 per person in proven community prevention activities focused on smoking cessation, physical activity and nutrition could save $5.60 in health care costs for every dollar invested. We are particularly pleased to see that the discussion draft recommends targeting these grants in Health Empowerment Zones, where multiple strategies can be used at one time. The evidence shows that use of multiple strategies targeted at particular needs in a community can be more effective, especially since the empowerment zones have higher prevalence of the targeted conditions, which increases the potential return on investment in terms of improved health outcomes and lowered health care costs.

- **Support for core public health functions:** Of special note is the recognition in the discussion draft that the strength of our nation's state and local health departments will significantly affect the success of the health reform effort. Without the capacity to monitor our health, respond to emergencies, and implement key prevention initiatives at the population level, the health care delivery system will always need to backfill for a diminished public health capacity -- at a higher price in both dollars and human suffering. Providing this core support should, however, come with expectations of a minimum standard of performance that all health departments should be able to meet. We currently have a varied set of capacities in state and local health agencies; Americans should be equally protected by public health regardless of where we live. Therefore, we are pleased to see support in this section of the discussion draft for the nascent process for accrediting public health agencies and the expectation that in awarding these funds, the Secretary would assure that core capacities of grantees is improved.

- **Improving the research base and reviewing the evidence:** The discussion draft makes a crucial investment in public health and prevention research. While we have a strong base for prevention interventions today, much more needs to be learned about the multiple approaches to non-clinical prevention, including how we can best translate science into practice and how we might best structure public health systems to achieve better health outcomes. The expansion of the roles of the task forces on community and clinical prevention will assure more rapid

translation of science into practice -- and also assure taxpayers that programs funded under this title meet a high standard of evidence.

- **Addressing inequities:** We are pleased to see that the discussion draft places a particular focus on addressing disparities in access and outcomes. From better training with regard to cultural competencies, to a targeting of resources in community prevention on those communities where disparities are greatest, we can harness what we already know will work to reduce these inequities. We must recognize that the goal of health reform is not just creating equality of coverage and uniform access; we need to assure equity in health outcomes as well.

- **Better use of information and data.** As we enter a reformed health care system, harnessing the power of health information technology for public health purposes as well as health care is going to be essential. Assuring that the American people have a true sense of our progress in achieving the goals outlined in the National Prevention and Wellness Strategy will require a commitment to collecting, analyzing, and releasing in an accessible manner, a full range of data about our nation's health. Creation of the position of assistant secretary for health information appropriately elevates the importance of accessible data in assuring a more accountable health and public health system in the United States.

Mr. Chairman, there are few times that we can be sure that we are witnessing history being made. This may well be one of them. If the public health provisions of this discussion draft become law, in the years ahead, we will witness the transformation of our health system from a sick care system to one that truly emphasizes prevention and wellness. This is what our nation needs and what the American people want. Earlier this month TFAH released the results of a national opinion survey conducted by Greenberg Quinlan Rosner and Public Opinion Strategies. A summary of the poll is attached. In that poll, we found that 76 percent of American voters believe that the level of funding for prevention should be increased; 77 percent believed that prevention will save us money and 72 percent believed that we should invest more in prevention even if it doesn't save money. Perhaps most impressive of all, when given a list of current proposals being considered as part of health reform, investing in prevention rated highest, even when compared to concepts like prohibiting denial of coverage based on pre-existing conditions.

In short, by placing this emphasis on prevention and wellness in the discussion draft, this committee is responding to a compelling call from the American people.

On behalf of our partners in the public health community, TFAH thanks you for your leadership and looks forward to working with you to see these provisions enacted into law in the months ahead.

May 13, 2009

The Honorable Henry Waxman
Chairman
Committee on Energy & Commerce
2125 Rayburn HOB
Washington, DC 20515

The Honorable Frank Pallone
Chairman
Subcommittee on Health
2125 Rayburn HOB
Washington, DC 20515

The Honorable Joe Barton
Ranking Member
Committee on Energy & Commerce
2322A Rayburn HOB
Washington, DC 20515

The Honorable Nathan Deal
Ranking Member
Subcommittee on Health
2322A Rayburn HOB
Washington, DC 20515

Dear Chairmen Waxman & Pallone and Ranking Members Barton & Deal:

As your committees craft and consider a health reform package, the 227 undersigned organizations urge you to ensure that public health and prevention are essential elements of such legislation. We hope that health reform can serve as an opportunity to strengthen our public health infrastructure and reorient our health system towards prevention and preparedness. In particular, we request that your proposals accomplish the following goals:

Create a renewed focus on public health by establishing a **National Prevention Strategy** that sets specific goals and objectives for improving the nation's health through federally-supported prevention programs. The National Prevention Strategy would be consistent with the Healthy People 2020 goals and would identify priorities for expenditures. It could also help promote public health across all federal agencies and foster inter-agency and inter-departmental cooperation regarding health issues.

Establish a **Public Health and Wellness Trust Fund** which could be funded through a mandatory appropriation or set-aside of a portion of new revenues generated through the financing of health reform. Resources from the Trust Fund would be allocated to specific public health programs or activities as directed by the appropriations committees funding for Function 550 public health programs. The Trust Fund would support expansion of public health functions and services that surround, support, and strengthen the health care delivery system. It would finance:

- The core governmental public health functions of assessment, assurance, and policy development at the federal, state, and local levels.
- Population-level non-clinical prevention and wellness programs, which can be delivered through governmental agencies and non-governmental agencies, including

those programs that integrate community-based population prevention with systems of medical care. Programs would be evidence-based community prevention programs that target priority health outcomes as identified in the National Prevention Strategy.
- Clinical preventive services (such as screenings and immunizations) delivered in community settings or by health departments that are not covered by third party payers.
- Workforce training and development, as well as public health research.

In addition, health reform legislation should:

- Strengthen scientific research and ensure the dissemination of best practices as the foundation of evidence-based public health;
- Ensure that federal prevention and public health policy addresses health inequities and disparities;
- Improve health surveillance to enable tracking of critical health indicators and monitoring and evaluation of disease trends; and
- Ensure that investments in Health IT take into account the needs of public health; and incorporating public health emergency response

As you know, the U.S. currently spends more than any other nation in the world on health care, but we lag behind on key health indicators, such as life expectancy. We need to make a serious course correction and reorient our health system towards prevention. As you develop and debate health reform proposals, we urge you to prioritize prevention and public health.

Sincerely,

1. 100 Black Men of Charleston, Inc. (SC)
2. 317 Coalition
3. Access Community Health Network
4. Access Institute
5. Advocates for EMS
6. AIDS Action Baltimore
7. AIDS Action Council
8. AIDS Foundation of Chicago
9. AIDS Project Los Angeles
10. ALERT Health
11. Alliance for Healthy Homes
12. All Saints Home Care and Referral Services
13. Alzheimer's Family Organization (Florida)
14. Alzheimer's Foundation of America
15. Alzheimer's Foundation of Staten Island, Inc. (NY)
16. Alzheimer's Services of the Capital Area (Baton Rouge, LA)
17. American Academy of HIV Medicine
18. American Academy of Nursing
19. American Academy of Pediatrics
20. American Academy of Physician Assistants
21. American Alliance for Health, Physical Education, Recreation, and Dance
22. American Association for Health Education
23. American Association of Colleges of Pharmacy
24. American Association of Occupational Health Nurses
25. American Association on Health and Disability
26. American Association on Intellectual and Developmental Disabilities
27. American College of Clinical Pharmacy
28. American College of Occupational and Environmental Medicine
29. American College of Preventive Medicine
30. American College of Sports Medicine

31. American Heart Association
32. American Lung Association
33. American Nurses Association
34. American Osteopathic Association
35. American Pediatric Society
36. American Pharmacists Association
37. American Psychiatric Association
38. American Public Health Association
39. American School Health Association
40. American Social Health Association
41. American Society of Bariatric Physicians
42. American Thoracic society
43. amfAR, The Foundation for AIDS Research
44. Arthritis Foundation
45. Assembly on School-Based Health Care
46. Association for Prevention Teaching and Research
47. Association for Professionals in Infection Control and Epidemiology, Inc.
48. Association of Child and Maternal Health Programs
49. Association of Immunization Managers
50. Association of Medical School Pediatric Department Chairs
51. Association of Public Health Laboratories
52. Association of Schools of Public Health
53. Association of State and Territorial Dental Directors
54. Association of State and Territorial Directors of Nursing
55. Association of State and Territorial Health Officials
56. Autism Society of America
57. Bazelon Center for Mental Health Law
58. Black Women's Health Imperative
59. Brain Injury Association of America
60. Breathe California
61. Bridgeway Pointe Assisted Living in Cincinnati, Ohio
62. California Center for Public Health Advocacy
63. California Conference of Local Health Officers
64. California Food Policy Advocates
65. Campaign for Public Health
66. CANN - Community Access National Network
67. CardioVision 2020 (Minnesota)
68. Caring Days Adult Day Care, A Program of Caring Congregations (Alabama)
69. Center for Behavioral Research, School of Public Health, San Diego State University
70. Center for Biosecurity, University of Pittsburgh Medical Center
71. Center for Cognitive Fitness & Innovative Therapies
72. Center for Communications, Health & the Environment
73. Center for Infectious Disease Research and Policy, University of MN
74. Center for Science in the Public Interest
75. Chenango Health Network (NY)
76. Cherokee Nation
77. Children's Dental Health Project
78. Children's Health Fund
79. CityMatCH
80. Cleveland Department of Public Health
81. Coastal Health District, Georgia
82. Commonweal (WA)
83. Community Health Councils
84. Community Health Partnership: Oregon's Public Institute
85. Community HIV/AIDS Mobilization Project (NY and RI)
86. Continuum Senior Care Management, Inc.
87. County Health Executives Association of California
88. Defeat Diabetes Foundation
89. Dementia Care Services, LLC (Texas)
90. Directors of Health Promotion and Education
91. Emergency Nurses Association
92. Environmental Health Watch
93. Epilepsy Foundation
94. Every Child By Two
95. Fall Prevention Center of Excellence
96. FamilyCook Productions
97. Family Voices
98. Fay W. Boozman College of Public Health - University of Arkansas for Medical Sciences
99. First Focus

100. Fitness Forward
101. Flint Odyssey House, Inc Health Awareness Center (MI)
102. Georgetown County Diabetes CORE Group (SC)
103. Georgia District 2 Public Health
104. Georgia Public Health Association
105. Golden Gate Designs
106. Healthcare Consortium, Inc
107. Health District 3-1 (Georgia)
108. Health Education Network of Delaware
109. Health Promotion Research Center, University of Washington
110. Hepatitis B Foundation
111. Hepatitis Foundation International
112. Hidalgo Medical Services (NM)
113. HIV Medicine Association
114. Home Safety Council
115. Housing Works
116. Howard University Center for Wellness and Weightloss Surgery
117. Human Rights Campaign
118. Immunization Action Coalition
119. Infectious Diseases Society of America
120. Institute for Agriculture and Trade Policy
121. Institute for Health and Productivity Studies, Rollins School of Public Health, Emory University
122. Institute of Public Health, Georgia State University
123. InterAmerican Heart Foundation
124. International Health, Racquet & Sports Club Association
125. Khmer Health Advocates, Inc
126. Lifelong AIDS Alliance (WA)
127. Louisiana Public Health Institute
128. Lutheran Family & Children's Services
129. March of Dimes Foundation
130. Massachusetts Public Health Association
131. Mental Health America
132. Michigan Department of Community Health, Healthy Homes University Program
133. Nacogdoches Treatment Center – Alzheimer's Day Activity Program (Texas)
134. National Alliance of State and Territorial AIDS Directors
135. National Association for Public Health Statistics and Information Systems
136. National Association of Chronic Disease Directors
137. National Association of Community Health Centers
138. National Association of Counties
139. National Association of County and City Health Officials
140. National Association of Local Boards of Health
141. National Association of People with AIDS
142. National Association of RSVP Directors
143. National Association of School Nurses
144. National Association for Sport & Physical Education
145. National Athletic Trainers' Association
146. National Birth Defects Prevention Network
147. National Coalition for Promoting Physical Activity
148. National Coalition of STD Directors
149. National Environmental Health Association
150. National Forum for Heart Disease and Stroke Prevention
151. National Health Council
152. National Health Foundation
153. National Health Science Honor Society (Eta Sigma Gamma)
154. National Hispanic Health Foundation
155. National Hispanic Medical Association
156. National Initiative for Children's Healthcare Quality
157. National League for Nursing
158. National Medical Association
159. National Network of Public Health Institutes
160. National Nursing Centers Consortium
161. National Nursing Network Organization
162. National Parent Teacher Association
163. National Recreation and Park Association
164. National Research Center for Women & Families
165. National Student Nurses' Association
166. National TB Controllers Association

167. National WIC Association
168. Nemours
169. Nevada Cancer Institute
170. New York Academy of Medicine
171. New York State Nutrition Council
172. Novo Nordisk
173. Pacific Center of Excellence in the Elimination of Disparities
174. Partners for a Healthy Nevada
175. Partnership for Prevention
176. Physicians Committee for Responsible Medicine
177. Physicians for Social Responsibility
178. Pop Warner Little Scholars
179. Prevention Institute
180. Preventive Cardiovascular Nurses Association
181. Project Lifesaver International (Virginia)
182. Public Health Foundation
183. Public Health Institute
184. Public Health-Seattle & King County
185. REACH US Lawndale Health Promotion Project, Chicago Dept. of Public Health
186. Rebuilding Together
187. Research!America
188. Researchers against Inactivity-related Disorders
189. RI Lead Techs, Inc.
190. RWJF Center for Health Policy
191. SAGE Eldercare (New Jersey)
192. San Ysidro School District
193. Save the Children
194. Shaping America's Health
195. Society for Pediatric Research
196. Society for Public Health Education
197. South Beach AIDS Project, Inc.
198. Sporting Goods Manufacturers Association
199. State and Territorial Injury Prevention Directors Association
200. Sudden Cardiac Arrest Association
201. TAKE CHARGE!!! Lifestyle Management, Inc.
202. The Access Project
203. The AIDS Institute
204. The ARK, Adult Respite Kare and Alzheimer's Family Support Services
205. The Midwest Latino Health Research, Training and Policy Center at the University of Illinois at Chicago
206. The National Alliance to Advance Adolescent Health
207. The National Coalition for LGBT Health
208. The National Nursing Network Organization
209. The New England Coalition for Health Promotion and Disease Prevention
210. The Praxis Project
211. The Society for Healthcare Epidemiology of America
212. Treatment Access Expansion Project
213. Treatment Action Group (IL)
214. Trust for America's Health
215. United American Nurses, AFL-CIO
216. United Fresh Produce Association
217. United States Water Fitness Association
218. United Way of America
219. U.S. PIRG
220. Visiting Nurse Associations of America
221. Washington Coalition for Promoting Physical Activity
222. Washington Health Foundation-Healthiest State in the Nation Campaign
223. WomenHeart: The National Coalition for Women with Heart Disease.
224. Women's Sports Foundation
225. YMCA of Greater Cleveland
226. YMCA of the USA
227. YOUR Center (MI)

GREENBERG QUINLAN ROSNER RESEARCH

PUBLIC OPINION STRATEGIES

May 18, 2009

Americans Overwhelmingly Support Investment in Prevention

Disease Prevention Plays a Lead Role in Health Care Reform

To: Interested Parties
From: Greenberg Quinlan Rosner Research
Public Opinion Strategies

The following analysis is based on a national research project funded by the Robert Wood Johnson Foundation and the Trust for America's Health, and conducted jointly by Greenberg Quinlan Rosner Research and Public Opinion Strategies. The national survey of 1,014 registered voters was conducted May 7th – 12th, 2009. The margin of error is +/- 3.1 percentage points at the 95 percent confidence level.

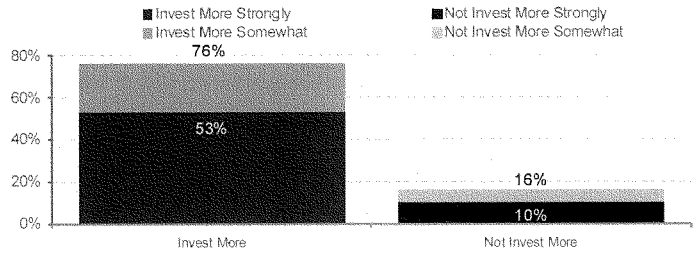
With 72 percent of American voters believing that the country is getting less healthy and 60 percent saying that the American health care system needs a complete overhaul or major reform, the national electorate is voicing a call for change to our health care system. And prevention is playing a lead role.

More than three-quarters of American voters support increasing funding for prevention, and the data shows that they clearly point to prevention's effect on reducing disease, keeping people healthy, and improving quality of life as the most compelling reason why. While a vast majority believes that prevention will in fact save us money, more than 7 in 10 support an investment in prevention regardless of whether it will save money or not.

Voters Show Strong Support For Increased Investment in Prevention

More than three-quarters (76 percent) of American voters believe the level of funding for prevention[1] should be increased, and they believe this with a high level of intensity—a 53-percent majority feel *strongly* that we should invest more in prevention.

[1] Respondents were given a description of "prevention." Please see question language on following page.



"Just so everyone has the same information, when we talk about prevention we mean providing people with information and resources and creating policies that help people make healthier decisions. Thinking about the level of funding for prevention in the United States, do you think we should invest more in prevention, or do you think we should not invest more in prevention?"

Support for an increased investment in prevention is as broad as it is deep. This support is not bound by political partisanship—86 percent of Democrats, 71 percent of Republicans, and 70 percent of Independents believe we should invest more in prevention—nor by geography (79 percent in the Northeast, 78 percent in the South, 76 percent in the West, and 72 percent in the Midwest support more prevention funding). At least 65 percent of every demographic subgroup supports increasing our investment in prevention, including conservatives and the least healthy segment of the population.[2]

A Sizable Shift Toward Prevention

When it comes to approaches to health and sickness, voters believe that we should be giving more emphasis to prevention rather than more emphasis to treatment by a nearly four to one ratio (59 – 15 percent). As shown in the table below, this represents a significant shift toward prevention on this measure, albeit occurring over the last two decades. In 1987, only 45 percent said we should be giving more emphasis to prevention, while 43 percent thought we should be giving more emphasis to treatment or that the balance was right.[3]

	May 2009	1987	Change
More emphasis to prevention	59	45	+14
More emphasis to treatment	15	11	+4
Right balance	22	32	-10

There are two approaches to health and sickness. One approach – treatment – which seeks to cure sickness, and another approach – prevention – which seeks to prevent sickness. At the moment, do you think that health care services in your area have got the right balance between treatment and prevention -- or should we be giving more emphasis to treatment, or more emphasis to prevention?

[2] Least healthy is defined as scoring between 0 and 5 on the health scale, and falling into at least 2 of the 3 following categories: currently a smoker, had 5 or more drinks in the past week and/or exercise a few times a month or less.
[3] 1987 data from a survey by Prevention Magazine, conducted by Louis Harris & Associates and based on telephone interviews with national adult samples of 1,250. 2009 data reflects opinions of national registered voters.

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Prevention Ranks As The Top Health Care Reform Priority

When given a list of current proposals being considered to reform health care, investing in prevention trumps them all, including the popular notions of providing tax credits to small businesses and prohibiting health insurers from denying coverage based on health status.

As demonstrated by the following table, when asked how important a priority each proposal is on a scale from zero to ten (where zero means not at all important and ten means very important), seventy percent rank investing in more prevention between 8 and 10, a very strong score. Nearly half the population (46 percent) rates it a 10 on this scale, and prevention receives the highest mean score rating, indicating an extremely high level of intensity.

	Mean	% 8 – 10 score
Invest in more prevention to help people stay healthy and reduce diseases such as diabetes, cancer and heart disease.	8.0	70
Provide tax credits to small businesses to help small businesses provide affordable health insurance to their employees.	7.9	66
Prohibit insurance companies from denying coverage because of age, medical history, or pre-existing condition.	7.7	66
Require all Americans to have health insurance while providing financial assistance to those who cannot afford it.	6.7	52
Require all businesses to provide health care for their employees or contribute to a fund to help pay for their coverage.	6.7	50
Give all Americans a choice of keeping their current insurance or joining a national insurance pool with a choice of private and public plans administered by the government.	6.1	43

Now, I am going to read you a list of proposals related to health care. For each, please tell me, on a scale of 0 to 10, how big a priority that proposal is for you in reforming health care in our country. Zero means it is not at all an important priority.

Voters Overwhelmingly Think Prevention Will Save Money, And They Strongly Support Prevention Even If It Doesn't

By a wide margin, American voters believe that prevention will save us money, rather than cost us money. In a forced-choice exercise where voters were asked to choose the statement they agree with more, 77 percent say "prevention will save us money" against just 16 percent who say "prevention will cost us money" (see figure on following page). An outright majority (56 percent) agree with the "save us money" statement *much* more, a high level of intensity.

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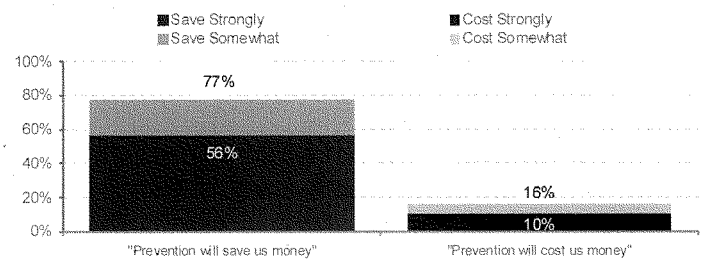
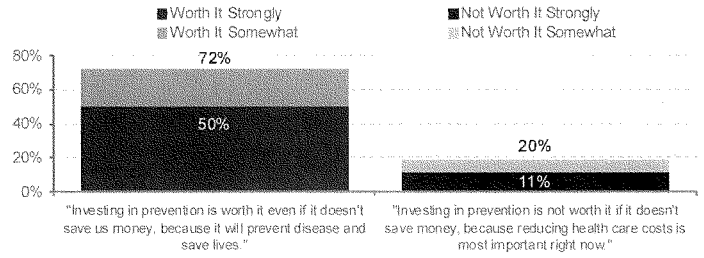


"Please tell me which statement you agree with more."

In a similar forced-choice exercise, an overwhelming 72 percent majority reports that "investing in prevention is worth it even if it doesn't save money, because it will prevent disease and save lives," including 50 percent who agree with this statement strongly. Only 20 percent agree more with the sentiment that investing in prevention is not worth it if it doesn't save money.



"Please tell me which statement you agree with more."

This commitment to investing in prevention regardless of cost implications is largely the result of a belief among voters that human health is a better reason to invest in prevention than saving money. In a third forced-choice, 57 percent say "we should invest in prevention to keep people healthier and improve quality of life," against 21 percent who believe that "we should invest in prevention to lower health care costs."

The Bottom Line

American voters, from coast to coast and across the political spectrum, make it clear that not only do they view prevention as an important part of health care reform, but they are overwhelmingly in favor of increasing our investment in prevention programs. On this issue, people believe it's less about cost and more about keeping people healthy and improving quality of life, as voters strongly support investing in prevention even if it does not save us money.

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Mr. PALLONE. Thank you.
Dr. Smedley.

STATEMENT OF BRIAN D. SMEDLEY, PH.D.

Mr. SMEDLEY. Thank you, Mr. Chairman, for the opportunity to provide testimony on the potential to address racial and ethnic inequities in health and health care in the context of the tri-committee health reform legislation.

For nearly 40 years the Joint Center for Political and Economic Studies has served as one of the Nation's premier think tanks on a broad range of public policy issues of concern to African Americans and our communities of color. We therefore welcome the opportunity to comment on this important legislation.

Many racial and ethic minorities, particularly African Americans, American Indians, and Alaskan Natives, native Hawaiians and Pacific Islanders, experience poorer health relative to national averages from birth to death. These inequities take the form of higher infant mortality, higher rates of disease, and disability and shortened life expectancy.

Health inequities carry a significant human and economic toll, and therefore have important consequences for all Americans. They impair the ability of minority Americans to participate fully in the workforce, thereby hampering the Nation's efforts to recover from the economic downturn and compete internationally. They limit our ability to contain health care costs and improve overall health care quality. And given that half of all Americans will be people of color by the year 2042, health inequities increasingly define the Nation's health. It is therefore important that Congress view the goal of achieving equity and health and health care not as a special interest, but rather as an important central objective of any health reform legislation.

To that end, the draft tri-committee legislation contains a number of important provisions that will strengthen the Federal effort to eliminate health and health care inequities. Importantly, the legislation offers the kind of comprehensive strategy of targeted investments that are likely to help prevent illness in the first place, manage costs when illness strikes, and improve health.

Over the long haul these provisions will result in a healthier Nation with fewer health inequities, greater workforce participation and productivity, and long-term cost savings. These provisions do several things.

They emphasize and support disease prevention and health promotion. For example, the legislation would require the CDC Clinical Preventative Task Force and Community Preventative Task Force to prioritize the elimination of health inequities.

In addition, the legislation would authorize health empowerment zones, as Dr. Levi has emphasized, locally focused initiatives that stimulate and seed coordinated, comprehensive health promotion and community capacity building.

Provisions in this draft legislation would also improve the diversity and distribution of the health professional workforce; for example, by increasing funding for the successful programs such as the National Health Service Corps and Health Careers Opportunity Program, expanding scholarships and loans for individuals in need-

ed health professions in shortage areas, particularly nursing, and encouraging the training of primary care physicians. It will also strengthen Medicaid by expanding eligibility and by increasing reimbursement rates for primary care providers. And it will improve access to language services; for example, by requiring a Medicare study and demonstration on language access.

While the tri-committee draft bill addresses a number of important needs to achieve health and health care equity, there are several areas where the legislation could be strengthened with evidence-based strategies that will improve the Federal investment in health equity. These include encouraging the adaptation of the Federal cultural and linguistic appropriate services standards which would help improve access and quality of care for diverse populations, expanding successful community-based health programs such as the Centers for Disease Control and Prevention's Racial and Ethic Approaches to Community Health Program, addressing health and all policies by funding and conducting health impact assessments to understand how Federal policies and projects in a range of sectors influence health.

Strengthening the Federal health research effort by elevating the National Center on Minority Health and Health Disparities to institute status. The national center has led an impressive effort to improve research on health inequities at NIH and needs the resources and influence associated with institute status to continue this work.

Strengthening Federal data collection by establishing standards for the collection of race, ethnicity, and primary language data across all public and private health insurance plans and health care settings, and insuring that immigrants lawfully present in the United States face the same eligibility rules as citizens for public programs, including Medicaid, Medicare and CHIP.

Mr. Chairman, in conclusion, addressing health inequities requires comprehensive strategies that span community-based primary prevention to clinical services, a long-term commitment and investment of resources and a focus on addressing equity in all Federal programs in all elements of health reform legislation. The failure to do so ignores the reality of important demographic changes that are happening in the United States and fails to appreciate the necessity of attending to equity as an important step in our effort to achieve the goals of expanding insurance coverage, improving the quality of health care, and containing costs.

Encouragingly, the tri-committee draft bill recognizes the importance of achieving equity in health and health care and proposes a number of policy strategies to achieve this goal.

Thank you, Mr. Chairman, and we look forward to working with you on this important legislation.

[The prepared statement of Mr. Smedley follows:]

SUMMARY

Many racial and ethnic minorities – particularly African Americans, American Indians and Alaska Natives, Native Hawaiians and Pacific Islanders – experience poorer health relative to national averages from birth to death, in the form of higher infant mortality, higher rates of disease and disability, and shortened life expectancy. Health inequities carry a significant human and economic toll and therefore have important consequences for all Americans. Health inequities impair the ability of minority Americans to participate fully in the workforce, thereby hampering the nation's efforts to recover from the current economic downturn and compete internationally. Because many people of color are disproportionately burdened with unmet health care needs, these inequities also limit our ability to contain health care costs and improve overall health care quality. And by the year 2042, about half of all Americans will be people of color, which means that their health status increasingly defines the nation's health. It is therefore important that Congress view the goal of achieving equity in health and health care not as a "special interest," but rather as an important central objective of any health reform legislation.

To that end, the draft Tri-Committee legislation contains a number of important provisions that will strengthen the federal effort to eliminate health and health care inequities. They:

- **Emphasize and support disease prevention and health promotion;**
- **Improve access to primary care and medical homes;**
- **Improve the diversity and distribution of the health professional workforce;**
- **Strengthen Medicaid by expanding eligibility and increasing reimbursement rates;**
- **Improve access to language services;**
- **Improve the accessibility of Health Information Technology (HIT) in underserved communities;**

While the Tri-Committee draft bill addresses a number of important needs to achieve health and health care equity, there are several areas where the legislation could be strengthened with evidence-based strategies that will improve the federal investment in health equity. These include strategies such as:

- **Expanding successful community-based health programs;**
- **Assessing the health impact of non-health policies through the use of Health Impact Assessment;**
- **Strengthening the federal health research effort by elevating the NIH National Center on Minority Health and Health Disparities to an NIH Institute;**
- **Strengthening federal data collection;**

Addressing health inequities requires comprehensive strategies that span community-based primary prevention to clinical services, a long-term commitment and investment of resources, and a focus on addressing equity in all federal programs and in all elements of health reform legislation. To fail to do so ignores the reality of important demographic changes that are happening in the United States, and fails to appreciate the necessity of attending to equity as a necessary step to help achieve the goals of expanding insurance coverage, improving the quality of health care, and containing costs. Encouragingly, the Tri-Committee draft bill recognizes the importance of achieving equity in health and health care and proposes a number of policy strategies to reach this goal.

Addressing Racial and Ethnic Health Inequities:
The Tri-Committee Discussion Draft

Brian D. Smedley, Ph.D.
Director, Joint Center for Political and Economic Studies Health Policy Institute

Thank you, Mr. Chairman, for the opportunity to provide testimony on the potential to address racial and ethnic inequities in health and health care in the context of the Tri-Committee Health Reform legislation. For nearly forty years, the Joint Center for Political and Economic Studies has served as one of the nation's premier think tanks on a broad range of public policy issues of concern to African Americans and other communities of color. We therefore welcome the opportunity to comment on this important legislation.

Many racial and ethnic minorities – particularly African Americans, American Indians and Alaska Natives, Native Hawaiians and Pacific Islanders – experience poorer health relative to national averages from birth to death, in the form of higher infant mortality, higher rates of disease and disability, and shortened life expectancy. Health inequities carry a significant human and economic toll and therefore have important consequences for all Americans. Health inequities impair the ability of minority Americans to participate fully in the workforce, thereby hampering the nation's efforts to recover from the current economic downturn and compete internationally. Because many people of color are disproportionately burdened with unmet health care needs, these inequities also limit our ability to contain health care costs and improve overall health care quality. And by the year 2042, about half of all Americans will be people of color, which means that their health status increasingly defines the nation's health. It is therefore important that Congress view the goal of achieving equity in health and health care not as a "special interest," but rather as an important central objective of any health reform legislation.

This testimony will briefly review the extent and causes of health and health care inequities, comment on the provisions of the Tri-Committee draft legislation to address inequities, and offer recommendations to strengthen the impressive and comprehensive strategies outlined in the bill.

The Extent of Health and Health Care Inequities

While the nation has made progress in lengthening and improving the quality of life, racial and ethnic health inequities are stubbornly persistent, and in some cases are increasing. These inequities begin early in the life span and exact a toll throughout the life-course. For example:

- While the life expectancy gap between the African Americans and whites has narrowed slightly in the last two decades,[1] African Americans still can expect to live 6-10 fewer years than whites, and face higher rates of illness and mortality.[2]
- The prevalence of diabetes among American Indians and Alaska Natives is more than twice that for all adults in the United States;[3]

- Among African Americans, the age-adjusted death rate for cancer is approximately 25 percent higher than for white Americans;[4]
- Although infant mortality decreased among all races during the 1980-2000 time period, the black-white gap in infant mortality widened;[5] and

In terms of lives, this gap is staggering: A recent analysis of 1991 to 2000 mortality data concluded that had mortality rates of African Americans been equivalent to that of whites during this time period, over 880,000 deaths would have been averted.[6]

Communities of color also experience significant disparities relative to whites in both access to care and in the quality and outcomes of care received. The National Healthcare Disparities Report (NHDR), prepared and released annually by the U.S. Agency for Healthcare Research and Quality, is an authoritative source for the documentation of access and quality gaps. Summarizing a range of measures of health care access, the report found that access for some groups, such as African Americans and American Indians, was worse than for whites in the preponderance of the study's measures. Latinos experienced the greatest access problems of all ethnic groups; they received equivalent care as whites in only 17 percent of the measures, while the remaining access measures were overwhelmingly poorer for Latinos (83 percent).[7] With regard to health care quality, minority groups again faired poorly relative to whites: African Americans and Latinos receive poorer quality care than whites on 73 percent and 77 percent of measures, respectively, and Asian Americans and American Indians received poorer care on 32 percent and 41percent of measures, respectively. These growing access and quality gaps are not trivial. For example, from 1999 to 2004 the proportion of adults age 65 and over who received a pneumonia vaccine increased for whites (from 52 percent to 59 percent) but decreased for Asians (from 41 percent to 35 percent), and from 2000 to 2003 colorectal cancer screening rates increased for whites while falling off sharply for American Indians and Alaska Natives.[8] These growing gaps are not unexpected given that the increase in the numbers of the uninsured has been more dramatic in communities of color than in non-minority communities.

The NHDR provides a window to the health care experiences of a diverse patient population, but it does not disentangle the influences of race, income and insurance on health care. A substantial body of evidence demonstrates that racial and ethnic minorities receive a lower quality and intensity of health care than white patients, even when they are insured at the same levels, have similar incomes and present with the same types of health problems.[9] Below are a few examples from the research literature:

- Insured African-American patients are less likely than insured whites to receive many potentially life-saving or life-extending procedures, particularly high-tech care, such as cardiac catheterization, bypass graft surgery[10] or kidney transplantation.[11]
- Black cancer patients fail to get the same combinations of surgical and chemotherapy treatments that white patients with the same disease presentation receive.[12]
- African-American heart patients are less likely than white patients to receive diagnostic procedures, revascularization procedures and thrombolytic therapy,

even when they have similar incomes, insurance and other patient characteristics.[13]

- Even routine care suffers. Black and Latino patients are less likely than whites to receive aspirin upon discharge following a heart attack, to receive appropriate care for pneumonia and to have pain – such as the kind resulting from broken bones – appropriately treated.[14]
- Minorities are more likely to receive undesirable treatment than whites, such as limb amputation for diabetes.[15]

Of these health care disparities, inequities in long-term care services are among the most troubling. Population trends show that people of color are the fastest-growing segments of the U.S. population. Racial and ethnic minorities are also burdened with a higher prevalence of chronic diseases. These realities require long-term care policies and funding streams that address the needs of minority patients, their families and their communities.[16] Yet people of color requiring long-term care are less likely to be treated in such a system. Despite the increasing supply of nursing home beds and the emergence of assisted living facilities, African Americans are less likely than similarly-situated whites to be placed in a nursing home.[17] Studies also show that nursing home care remains largely separate and unequal. Most African American nursing home residents tended to be concentrated in a few predominantly African American facilities, whereas the vast majority of white nursing home residents live in predominantly white facilities. Facilities housing African Americans are more likely to admit residents with cognitive and/or physical impairment, and have lower ratings of cleanliness/maintenance and lighting.[18] The nearly 15 percent of U.S. nursing homes that serve predominantly African American residents have fewer nurses, lower occupancy rates and more health-related deficiencies. They are more likely to be terminated from the Medicaid/Medicare program, are disproportionately located in the poorest counties and are more likely to serve Medicaid patients than are other facilities.[19] Other studies document a strong relationship between nursing home or long-term care facility racial concentration and quality. For example, controlling for individual, facility and market characteristics, blacks were admitted to nursing homes with 32 percent higher rates of deficiency (defined as evaluations of poor quality made by state surveyors under the federal nursing home certification regulation).[20]

Oral health disparities are also alarming. Many racial and ethnic minority groups experience poorer oral health than national averages, and these disparities contribute significantly to health inequity. The landmark 2000 Surgeon General's Report, *Oral Health in America*, found that African Americans, Hispanics, and American Indians and Alaska Natives generally have poorer oral health than other racial and ethnic groups in the United States.[21] These problems begin early in the lifecycle, and persist or widen with age. Hispanic and African-American preschoolers experience tooth decay at rates 2.5 and 1.5 times higher, respectively, than white children. This inequity is even more profound among American Indian and Alaska Native children, who are nearly six times more likely to experience tooth decay than white children. Destructive periodontal disease occurs in nearly 60 percent of American Indians and Alaska Natives, 33 percent

of African Americans, 25 percent of Mexican Americans, and 20 percent of whites. And a disproportionate percentage of minority retirees have lost teeth due to gum disease.[22]

Access to dental services and dental insurance explains some of these disparities, but community-level factors—such as the availability of dental services, high-sugar products in schools and stores, and fluoridation in drinking water—also contribute to racial and ethnic disparities in oral health.[23] Many racial and ethnic minority groups are less likely than whites to receive dental services. While nearly half of whites report receiving dental services in the past year, just 27 percent of African Americans and Hispanics, 36 percent of Asian and Pacific Islander Americans, and 41 percent of Native Americans and Alaska Natives reported receiving services in the same time period. Among children, white preschoolers are 1.5 times more likely to have a dental visit than minority children and are 2.4 times more likely to receive preventive services. Differences in preventive care persist after adjusting for income; among poor children, only 13 percent of Blacks and 16 percent of Hispanics received a preventive dental visit in the past year, relative to 25 percent of white children. Disparities in dental insurance coverage also explain many of these gaps; a disproportionate number of the 108 million American who lack dental coverage are minorities. White children, for example, are 70 percent more likely than non-white children to have private dental insurance. Workers without dental coverage are only about half as likely as those with coverage to have a dental visit in a year.[24]

What Are the Factors that Contribute to Health and Health Care Inequities?

Many factors contribute to health inequities, but some of the most important underlying causes are socioeconomic inequality and differences in living conditions. A large and growing body of public health research demonstrates that to address health inequities, we must improve the social and economic contexts that shape health. As the World Health Organization's report on social determinants of health states, "[I]nequities in health [and] avoidable health inequalities arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces."[25] It is therefore important to address factors outside of health care by improving socioeconomic opportunity and community conditions for health, as will be discussed below.

Many of the same problems associated with racial and ethnic inequality in education, employment, housing and criminal justice are implicated in health care inequities. One of the most pressing fundamental causes of these inequities is residential segregation. Racial and ethnic minorities are more likely to live in segregated, high-poverty communities, communities that have historically suffered from a lack of health care investment.[26] The result too often is that the geographic distribution of health care resources within and across communities results in racially disparate health care: institutions that serve communities of color are more likely to experience quality problems and have fewer resources for patient care than institutions serving non-minority communities.

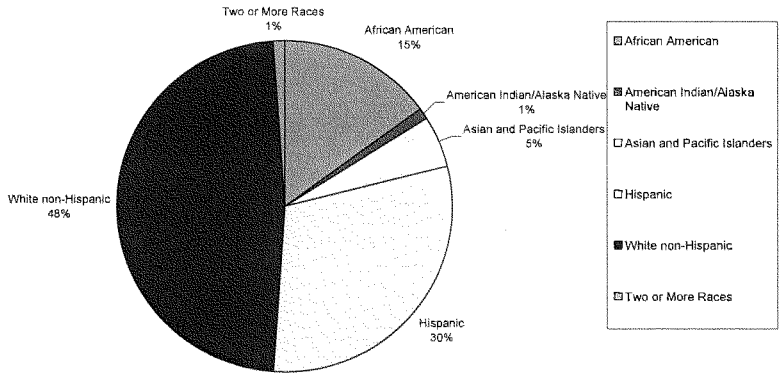
Racial and ethnic segregation and inequality therefore "sets the stage" for inequitable health care in the United States.[27] But many other causal factors – such as policies and practices of health care systems, the legal and regulatory context in which they operate and the behavior of people who work in them – are also involved.[28] Some of these causal factors include 1) differences in insurance coverage and sources of coverage, 2) the inequitable distribution of health care resources and 3) aspects of the clinical encounter, including cultural and linguistic barriers in health care systems and the interaction of patients and providers. These examples are explored in greater detail below.

Sources of Insurance Coverage

In its landmark series on the causes and consequences of uninsurance, the Institute of Medicine concluded that the availability and quality of health care in the United States suffers when large segments of the population lack health insurance.[29] Racial and ethnic minority and immigrant communities are disproportionately uninsured (see Figure 1), making them especially vulnerable to health crises.[30] For example:

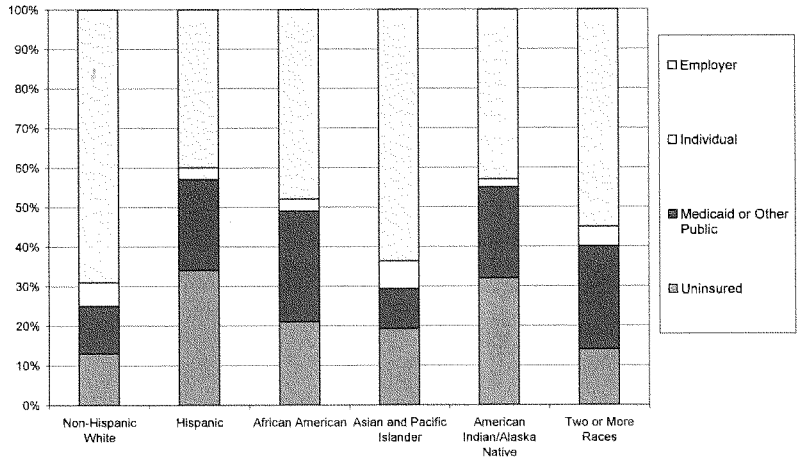
- While about 21 percent of white Americans were uninsured at any point in 2002, communities of color were more likely to be uninsured at any point (including 28 percent of African Americans, 44 percent of Hispanic Americans, 24 percent of Asian Americans and Pacific Islanders and 33 percent of American Indians and Alaska Natives), and are more likely to be dependent upon public sources of health insurance.[31]
- While Hispanic children constitute less than one-fifth of children in the United States, they represent over one-third of uninsured children.[32] And among children in fair or poor health who lack insurance (nearly 570,000 children in 2002), over two-thirds are Hispanic.[33]
- More than 11 million immigrants were uninsured in 2003, contributing to one-quarter of the U.S. uninsured.[34] Between 1998 and 2003, immigrants accounted for 86 percent of the growth in the uninsured population.[35]
- Foreign-born people are 2.5 times more likely than the native-born to lack health insurance, a gap that remains unchanged since 1993.[36]

Figure 1: Nonelderly Uninsured by Race/Ethnicity, 2005
Source: Kaiser Family Foundation, 2007



The crisis of health insurance disproportionately hurts low-income families and communities of color in no small part because health insurance in the United States remains linked to employment. Higher-paying jobs tend to offer more comprehensive health benefit packages, while lower-paying jobs – jobs disproportionately occupied by people of color – tend to offer only limited health benefits, if offered at all, that are often accompanied by high cost-sharing arrangements with employees. Moreover, as noted above, racial and ethnic minorities are disproportionately dependent on public insurance sources, such as Medicaid (see Figure 2). While Medicaid has been vital for expanding access to health insurance, its limited benefit package and low reimbursement rates have a dampening effect on health care access and quality among its beneficiaries.

Figure 2: Health Insurance Coverage of the Nonelderly by Race/Ethnicity, 2005
Source: Kaiser Family Foundation, 2007



The Distribution of Health Care Resources

These economic pressures can sustain a form of "medical apartheid"—that is, separate and unequal care for low-income and minority patients.[37] For example, physicians who serve predominantly racial and ethnic minority patients are less likely to possess board certification, and have greater difficulties accessing high-quality specialists, diagnostic imaging and non-emergency admission of their patients to the hospital than physicians who serve predominantly non-minority patients.[38] A recent study of African-American and white Medicare patients found the risk of admission to high-mortality hospitals was 35 percent higher for blacks than for whites in communities with high levels of residential segregation.[39] Another recent study of over 300,000 patients treated at 123 hospitals across the country found that minorities disproportionately receive care in lower-quality hospitals, a problem that explained the largest share of disparities.[40] The geographic mal-distribution of services likely contributes to the problem. For example, a study of the availability of pain medication revealed that only one in four pharmacies located in predominantly non-white neighborhoods carried adequate supplies, compared to 72 percent of pharmacies in predominantly white neighborhoods.[41] Nearly one in five Latinas (18 percent) and one in ten African-American women reported not seeking needed health care in the last year due to transportation problems, compared to five percent of white women.[42] These problems are the by-product of residential segregation and economic pressures that reward the concentration of services in outer suburbs and wealthier communities, and create disincentives for practice in urban centers.[43]

Regular Source of Health Care

Having a regular source of health care – a local physician, clinic or health center that patients can consider their "medical home" – is important, particularly for individuals

who face or are at risk for chronic illness. When patients are able see a health care provider consistently, they are better able to build trusting relationships, ask questions and give and receive information. Patients who lack a regular source of health care often report miscommunication, misdiagnoses, and greater frustration about their ability to receive needed care.[44] The uninsured and underinsured, many racial and ethnic minorities, people who are not proficient in English, those who live in rural communities and those who have low incomes are more likely to report not having a regular source of health care.[45] Yet the regular-source-of-health-care gap among racial/ethnic and income groups is growing:

- African Americans, Hispanics and the poor and near poor (of all racial and ethnic groups) are more likely than white non-poor groups to face barriers to having a regular source of health care. These gaps have increased since 2000. Over 42 percent of Hispanic poor and 37 percent of Hispanic non-poor people lacked a regular source of health care in 2001 and 2002, an increase of more than 30 percent and 18 percent, respectively, since 1995 and 1996.[46]
- During this same period, the percentage of poor and near-poor African Americans and whites without a regular source of health care went largely unchanged. But these groups were up to 75 percent more likely than non-poor African Americans and whites to lack a regular source of health care in 2001 and 2002.[47]
- The percentage of Hispanics from all income groups who lacked a regular source of health care increased between 1993 and 2002, despite a 15 percent decline over the same period in the ranks of white poor individuals who lacked a regular source of health care.[48]
- African American and Hispanic patients are nearly twice as likely as whites to report having a "non-mainstream" usual source of care (e.g., a hospital-based provider, rather than a private physician.[49]

Language Barriers

More than 46 million people in the United States speak a language other than English. Of those, more than 35 million speak English "well" or "very well," but over 10 million speak the language "not well" or "not at all."[50] Individuals with limited English proficiency are less likely than those with strong English language skills to have a regular source of primary care or to receive preventive care. Moreover, they tend to be less satisfied with the care they receive, are more likely to report overall problems with care and may be at increased risk of experiencing medical errors.[51] The quality of their health care therefore depends on the ability of medical professionals to effectively communicate. But many health care organizations do not provide adequate interpretation services:

- Nearly half of Latinos who are primary speakers of Spanish report having difficulty communicating with doctors or other health care providers because of language barriers.[52]
- Over one in five non-English speaking patients avoid seeking medical help altogether because of language barriers.[53]

The Clinical Encounter

Aspects of the clinical encounter – the interaction between patients, their providers and the health systems in which care is delivered – can play a powerful role in contributing to health care inequality. Patients and providers bring a range of expectations, preferences and biases to the clinical encounter that can be expressed both directly and indirectly. For example, at least part of the disparity results from biases and stereotypes that health care providers may carry about racial and ethnic minorities. Experimental studies confirm that physicians can hold a host of negative beliefs about minority patients. They are presumed to be more likely to abuse drugs or alcohol and to be less educated. They aren't expected to comply with physicians' instructions, to want an active lifestyle or to participate in rehabilitation if prescribed. Doctors are likely to consider white patients more "pleasant" and "rational" than black patients, and to prefer white patients as "the kind of person I could see myself being friends with." These kinds of stereotypes and biases are often unconscious, the IOM reported, but nonetheless can influence physicians' decisions regarding when and what treatments to offer.[54]

More recent research confirms that implicit biases (that is, unconscious biases that may reflect racial socialization) influence medical professionals' decision-making. For example, Green and colleagues assessed the relationship between implicit biases (as measured by a widely-accepted computer-based test of the speed with which individuals make associations between people and concepts) and physicians' decisions regarding the use of thrombolysis (i.e., clot-bursting medications) among hypothetical patients in the midst of a heart attack. While physicians reported no explicit preference for white versus black patients or differences in perceived cooperativeness, scores on implicit association tests revealed a preference favoring white Americans and implicit stereotypes of black Americans as less cooperative with medical procedures, and less cooperative generally. More importantly, physicians' level of pro-white implicit bias significantly predicted their likelihood of treating white patients and not treating black patients with thrombolysis. That is, physicians who harbored the highest level of implicit racial bias were less likely to treat black heart attack patients with a potentially life-saving treatment.[55]

Eliminating Health and Health Care Inequality

Health and health care inequities are complex problems rooted in systemic racial and ethnic inequality that is embedded in multiple institutions. Their elimination will require a long-term commitment and investment to address multiple problems, involving many public and private stakeholders.

Several evidence-based strategies can improve access and equalize the quality of health care for all, with particular attention to the needs of communities of color. These include strategies to:

1. **Expand Access to Health Insurance**. The most important step toward eliminating racial and ethnic health care disparities is to achieve universal health insurance coverage. Benefits should be comprehensive, and should include services that many communities of color need to access appropriate care, such as interpretation services.

2. **Improve the Diversity and Distribution of Health Care Providers**. Even if the United States achieved universal health insurance coverage, because of residential segregation and the dearth of health care providers and resources in communities of color, special efforts must be made to ensure that health care resources are better aligned with these communities' needs.
3. **Promote Equal High Health Care Access and Quality**. As the studies noted above demonstrate, health insurance coverage by itself is insufficient to ensure that communities of color have access to and receive high quality health care. Several policies offer mechanisms to elevate and promote equitable care for all.
4. **Empower Patients and Communities**. To ensure that health care meets their needs, patients should be empowered to participate in treatment decisions, and in the same vein, communities should be empowered to inform policies regarding the distribution of health care resources at the community level.
5. **Address Social and Community-Level Influences on Health.** As noted above, health inequities are largely the by-product of socioeconomic inequality and community-level conditions that shape health. Several policy approaches can improve these social determinants of health in ways that provide broad returns to society.

Each of these is discussed below.

Expand Access to Health Insurance

High rates of uninsurance and underinsurance among for people of color are the foremost problems to solve to eliminate health care inequality. The United States is the last modern, industrialized nation to adopt a universal health care program. Health insurance coverage is primarily provided by employers, but as benefit costs rise employers are declining to offer coverage or are purchasing plans that require greater employer cost sharing. These economic pressures contribute to growing inequality in insurance coverage. Health insurance coverage is increasingly unequal, disproportionately hurting those who need health care the most—particularly racial and ethnic minorities, children and lower-income women and their families. For example, less than half of low-wage workers have employer-provided health insurance from their own employer or a family member's employer, and female low-wage workers are half as likely as male low-wage workers to receive health insurance from their employer.[56]

Strive for Universal Insurance Coverage. Health care access inequality must be tackled by state and federal efforts to develop a universally accessible, comprehensive and equitable health care system. The most cost-effective way to achieve this goal is by pooling risk as broadly as possible in a common, comprehensive health insurance system. Such an approach allows patients to choose their health care provider and insures that the delivery of care remains in public and private systems while allocating health care resources more fairly. For example, by allowing employers and individuals to buy into a public health insurance plan, policymakers can expand insurance options and take significant steps toward improving health care efficiency and lowering costs.
Promote Fair Sharing of Costs. Many health care expansion proposals weigh new cost-sharing arrangements that are intended to make costs more transparent and promote cost-

conscious consumer behavior. But several studies demonstrate that low-income communities are less likely to access health care as out-of-pocket costs rise.[57] Equitable cost-sharing takes into account and attempts to minimize the disproportionate impact that cost-sharing arrangements can have on health care access and utilization among currently underserved groups. These include public subsidies for those with low incomes to purchase health insurance, sliding fee scales for premiums, co-payments and out-of-pocket costs, and efforts to study and respond to potential unintended effects of cost-sharing on utilization.

Promote Comprehensive Benefits. As noted above, many in communities of color require services such professional interpretation and translation. In addition, because these communities are less likely to access other needed services, such as dental and mental health services, comprehensive benefit packages should cover these services. Equalizing access to the same kinds of health care products and services regardless of insurance source will also help to reduce "fragmentation" of the health insurance market. A potentially significant source of racial and ethnic health care disparities among insured populations lies in the fact that minorities are likely to be disproportionately enrolled in "lower-tier" health insurance plans. Such plans tend to limit services, offer fewer covered benefits and have relatively small provider networks. These limits can harm access to quality care.[58] Given that several states are examining strategies to expand health insurance coverage, it is important that these coverage expansion proposals improve access to the same health care products and services, regardless of coverage source.

Target and Evaluate Outreach Efforts to the Underserved. Racial and ethnic minorities and immigrants are underrepresented, relative to eligibility rates, in public health insurance programs. States that have achieved greater success in increasing minority participation in public programs have developed and sustained aggressive outreach programs and have taken steps to improve and streamline enrollment, with particular attention to the needs of cultural and language-minority groups. Moreover, because state health insurance expansions may not reach communities of color equally, states should consistently evaluating outreach to and enrollment of underserved groups in public health insurance programs. Measurement of public insurance take-up rates in low-income communities and communities of color is an important step to ensure that health care expansion efforts reach underserved groups. States that regularly conduct such evaluations can be expected to see improved coverage rates among eligible populations.

Improve Access to Health Care Providers and Services

Universal health insurance coverage is an important step toward improving the geographic distribution of health care providers and resources, but federal, state and local governments must take steps to improve underserved patients' access to providers. Several jurisdictions have adopted strategies that improve community-level access to providers and services with particular attention to the needs of communities of color.

Improve Provider Diversity. State and federal governments must also take steps to strengthen the health professions' ability to serve the nation's increasingly diverse

population. By the middle of this century, nearly half of all who live in the United States will be members of racial or ethnic minority groups, and four states – California, Hawaii, New Mexico and Texas – are already "majority minority." Racial and ethnic minority patients are more likely than majority-group patients to experience cultural and linguistic barriers when attempting to get the health care they need, and often express greater satisfaction when they receive care from a provider of the same background.[59] In addition, several studies demonstrate that racial and ethnic minority health care providers are more likely to express interest in and work in medically underserved communities.[60] To help health care systems to address the needs of an increasingly diverse patient population, state and federal governments should take steps to increase the racial and ethnic diversity of health care providers by reducing or eliminating financial barriers to health professions education for low-income students, strengthening magnet science programs in urban high schools, and, consistent with the U.S. Supreme Court's ruling in the 2004 *Gutter v. Bollinger* decision, supporting the consideration of applicants' race or ethnicity as one of many relevant factors in higher education admissions decisions.

Support Safety Net Institutions. People of color and low-income individuals are more likely to access health care in safety net institutions, such as public hospitals and community health centers. In many cases, these institutions face financial vulnerability because of low Medicaid reimbursement rates and/or the costs of providing uncompensated care to uninsured individuals. These institutions may fare better in states where near-universal health insurance coverage proposals are enacted and where health insurance expansions are realized, but they will likely to continue to face financial vulnerability until truly universal coverage is achieved. States vary widely, however, in their support for safety net institutions. California, for example, has assumed much of the cost of hospital indigent care; Maryland and Massachusetts have established statewide uncompensated care funds, but many other states fail to assist institutions that serve low-income and uninsured populations.

Provide Incentives to Providers for the Underserved. Creating and/or enhancing incentives – such as education loan repayment or debt forgiveness – to encourage health care professionals to establish practices in underserved communities can be an important strategy to balance the distribution of health care providers, particularly primary care providers. Low-income and minority communities often have the most pressing need for health care services, but they are served by a dwindling number of providers and institutions that lack resources to expand and improve services. State and federal governments have attempted to address this imbalance by providing incentives, such as funds for graduate medical education programs that focus on underserved populations, tuition reimbursement and loan forgiveness programs that require service in health professional shortage areas.[61]

Address Geographic Imbalance of Health Care Resources. State and local governments are increasingly returning to Certificate of Need (CoN) assessments as a tool to reduce geographic disparities and reduce the "fragmentation" of the health insurance market. Historically, the purpose of the CoN process has been to control health care costs and ensure that capital and technology investments in the health care industry reflect

community needs. In most states that employ CoN, the process has required hospitals or other health care institutions that seek to establish or expand services to submit proposals so that state boards can evaluate projects to eliminate unnecessary duplication of services and ensure that investments strategically address health care needs. But the process has met significant resistance and criticism for its failure as a cost-containment measure. The CoN process, however, has great potential to encourage a better distribution of health care resources and to reflect community and statewide need. States should re-evaluate, and in some cases reinvigorate CoN through new policies that ensure accountability for the use of public funds.[62]

Promote Equal High Health Care Access and Quality

As the studies cited above demonstrate, universal health insurance coverage by itself is insufficient to ensure that communities of color have access to and receive high quality health care. Federal, state and local governments are increasingly examining mechanisms to promote "equality of health care quality." These strategies have the potential to improve the accountability of health care systems to patients and employers, and reduce health care costs and improve quality for all patients by encouraging greater use of evidence-based guidelines and by rewarding the provision of cost-effective primary care.

Collect and Monitor Data on Disparities. State and federal contracts and policies are increasingly requiring all public and private health systems to collect data on patients' race, ethnicity, gender, primary language and educational level, and to monitor for inequality in access to needed services and in the quality of care received. Currently, federal and state data collection efforts with regard to health care disparities are inconsistent. Some states require recipients of state funding (e.g., Medicaid managed care organizations) to collect and report health care access and quality data by patient demographic factors, but many others fail to utilize their leverage as regulators, payers and plan purchasers to encourage all health systems to collect and report data using consistent standards. And given that federal and some states non-discrimination laws apply to health care settings and require diligence to enforce, federal and state requirements to collect and report standardized data are an important benchmark for efforts to reduce health care inequality.

Publicly Report Data. Publicly reporting health care access and quality disparities at the institutional (e.g., hospital or health clinic) level is important to ensure that the public and policymakers are aware of when and where health care inequality occurs. Once state and federal governments have obtained health care access and quality data by patient demographic data, this information should be publicly reported at the smallest possible level (e.g., hospitals and health centers), to promote greater public accountability, to allow consumers to make more informed decisions about where to seek care and to assist efforts to monitor disparities and take appropriate action to investigate potential violations of law.

Adopt Cultural and Linguistic Standards. To ensure truly accessible health care, health care systems must also be responsive to patients' cultural and linguistic needs. State and

federal policies can expand access for disparity populations by promoting cultural and linguistic competence in health care settings, and diversity among health care professionals. The federal Cultural and Linguistic Access Standards (CLAS) identify over a dozen benchmarks that have been widely accepted and increasingly adopted by health systems and providers. And despite the fact that federally-funded health care organizations are mandated to meet four of the standards, few states have taken steps to encourage more widespread adoption of the guidelines and recommended standards. Such programs improve the cultural competence of health systems and increase the likelihood that patients of color will have access to satisfactory health care. In addition, some jurisdictions are requiring cultural competency training for all health care professionals as a condition of licensure. As of 2005, for example, New Jersey required that all physicians practicing in the state must attain minimal cultural competency training as a condition of licensure.

Encourage Attention to Disparities in Quality Improvement. State and local jurisdictions are also increasingly extending financial incentives to health systems that adhere to evidence-based clinical guidelines as a means of promoting the highest standards of health care for all patients. Health care quality improvement efforts, such as pay-for-performance or performance measurement, are gaining increasing attention. But they can unintentionally deepen health care access and quality gaps. Because underserved communities are typically sicker and face greater barriers to treatment compliance, performance measurement can inadvertently dampen provider enthusiasm for treating low-income communities or communities of color. Quality improvement efforts should take into account the challenges and needs of underserved communities and reward efforts that reduce disparities and improve patient outcomes relative to baseline measures. Some quality improvement measures adjust for patient case mix or emphasize disparities reduction efforts, to avoid unfairly penalizing providers while holding them and health systems accountable for improvements in health outcomes.

Empower Patients and Communities

Too often in American health care, patients are expected to make sound health care decisions and advocate for their needs absent the knowledge and power necessary to do so. Such an approach can be particularly problematic for communities of color, who face lower levels of health literacy and who often – because of historical and cultural reasons – feel less empowered to aggressively advocate for their health care needs than more socially and educationally advantaged groups. Moreover, governments have the power to lessen the impact of a market-driven health care industry that has tended to overlook the needs of low-income communities and communities of color in favor of wealthier communities that promise lower financial risks and greater financial reward. State and federal governments should give all communities the power to make recommendations and weigh in on decisions regarding health care policies that affect them.

Promote Patient Education and Health Literacy. Several jurisdictions are developing and assessing the efficacy of patient education programs, such as health literacy and navigation programs, and are replicating effective strategies. Patient education programs commonly seek to help patients understand how to best access health care services and

participate fully in treatment plans. Successful programs are well-researched and are tailored to the need of underserved communities. Such efforts to empower patients can help reduce health care disparities by providing patients with skills to effectively navigate health care systems and ensure that their needs and preferences are met. Patient education programs are most effective when designed in partnership with target populations and when language, culture and other concerns faced by communities of color are fully addressed.

Promote the Use of Lay Health Navigators. Health departments can support the training of and reimbursement for community health workers, sometimes also known as "lay health navigators" or *promotores*, who can serve as a liaison between health care institutions and their patients. Community health workers are trained members of medically underserved communities who work to improve community health outcomes. Several community health workers models train individuals to teach disease prevention, conduct simple assessments of health problems and help their neighbors access appropriate health and human resources. In health care contexts, they serve as a liaison between patients and health systems. Community health worker models are rapidly spreading, as research and practice indicates that such services can improve patients' ability to access care and understand how to manage illness. State and federal governments can stimulate these programs by providing grants, seed funding or other resources to help stimulate their promulgation.

Promote Community-Based Health Care Planning. States can promote and/or (in most cases) reinvigorate community health planning, in which members of the community identify their needs and assist policymakers in planning, implementing, and evaluating the effectiveness of public health care systems. Community health planning has a long history, but its promise as a tool to reduce health care disparities has yet to be fully realized. Community health planning seeks to strengthen communities to play a greater role in their own health, actively involving residents in the planning, evaluation and implementation of health activities in their communities. The 1974 National Health Planning Law sought to create and support a network of community Health Services Agencies (HSAs), but a lack of funding and effective mechanisms for community input to shape health policy has led to a decline of HSA power and influence. Some states, such as New York, are examining strategies to reinvigorate HSAs and to include disparities reduction efforts as part of the mission of these planning agencies.

Strengthen Community Benefits Obligations. Non-profit and tax-exempt health care institutions attain their special status as a result of contributions they make to the broader public good. By far, most tax-exempt institutions allocate their charitable resources to the costs of care (particularly emergency room services) for the uninsured. But policymakers are increasingly seeking a more in-depth understanding of the potential charitable contributions of non-profit hospitals and health systems. These can include comprehensive approaches such as strategies to encourage healthy behaviors and improve social and physical conditions in communities. If successful, these efforts meet both the community's and the hospital's goals of improving health status and reducing the demand for high cost emergency room and inpatient care. Such strategies centralize the

importance of improving community health, empower community members to voice concerns, and increase non-profits' public accountability for their tax-exempt status.[63]

Social and Community-Level Influences on Health Disparities

The policy strategies outlined above aim to improve the ability of our health care systems to respond to the needs of communities of color. As discussed above, however, improving the health status of many racial and ethnic minority groups will require policy strategies focused outside of the health care arena. These include efforts to improve housing and community living conditions, improve food resources and nutrition options, improve conditions for exercise and recreation, and ultimately, to reduce economic and educational gaps. These social and community-level strategies – along with examples of state and local efforts to implement them – are discussed in Text Box 2. At the federal level, these strategies should include a mandate to execute, administer, and enforce provisions to address environmental justice in minority and low-income populations. The federal government should also establish health empowerment zones—which create incentives for health investments—in communities that disproportionately experience disparities in health status and health care.

Text Box 2 - Addressing Social and Community-Level Determinants of Health

Social and economic inequality among racial and ethnic groups and other marginalized populations is the most significant underlying factor behind most health status inequality. Racial and ethnic discrimination and segregation perpetuate and deepen these gaps. Health care, therefore, cannot eliminate health status gaps between population groups. Federal efforts should look to a broad range of social and economic policy when crafting strategies to improve and equalize health status for all, and state health agencies should play a leadership role in coordinating these efforts. And states can play a large role in providing incentives for effort to improve health conditions in a community and more effectively punish acts that weaken community health conditions. These include efforts to:

- Improve the coordination of relevant state and federal agencies that should address determinants of health inequality (e.g., in education, housing, employment, criminal justice). Governments that seek to reduce racial and ethnic social and economic gaps are inherently engaging in health equity work. Almost all aspects of federal, state and local policy in education, transportation, housing, commerce and criminal justice influence the health of residents, and can have a disproportionate impact on marginalized communities. Governments that have taken steps to coordinate the work of agencies that impact health disparities are likely to reduce duplication of effort, increase efficiency and more effectively address health outcome disparities.
- Create incentives for better food resources and options in underserved communities (e.g., grocery chains, "farmers' markets"). Several local jurisdictions have established public-private partnerships to bring supermarkets to underserved areas. For example, the city of Rochester, New York, which experienced an 80 percent decline in grocery stores in the 1970s and 1980s, used public resources (the Federal Enterprise Community Zone program, the Community Development Block Grant program and other sources) to attract a major supermarket chain to open stores in the city.[1] More recently, Pennsylvania awarded a $500,000 grant to help establish a supermarket in the Yorktown section of Philadelphia, part of a broader initiative to support the development of supermarkets and other food retailers in urban and rural communities that lack adequate access to supermarkets.[1] State and federal governments can make similar investments.
- Develop community-level interventions for health behavior promotion (e.g., smoking cessation, exercise). Federal and state programs to promote healthy behaviors are increasingly recognizing the need to target community-level risk factors and strengths that affect individual health behavior. Such programs are often vital for low-income communities and communities of color, which have fewer community resources for exercise (e.g., safe public parks and recreation centers), effective nutrition and reduction of individual health risks (e.g., low-income urban communities have more public advertisement of tobacco products and greater availability of alcohol). State and federal agencies can exert legal and regulatory authority to reduce community-level health risk and promote healthy behavior.
- Address environmental injustice (e.g., by aggressive monitoring and enforcement of environmental degradation laws). Racial and ethnic minority communities are disproportionately hurt by the presence of toxic waste dumps, and industrial and occupational hazards. Through legal and regulatory strategies, state and federal agencies can reduce environmental health risks and monitor whether and how communities are affected by governmental or commercial activity.

Promising Strategies to Address Health and Health Care Inequities in the Tri-Committee Draft Legislation

The draft Tri-Committee legislation contains a number of important provisions that will strengthen the federal effort to eliminate health and health care inequities. Importantly, the legislation offers the kind of comprehensive strategy of targeted investments that are likely to help prevent illness in the first place, manage costs when illness strikes, and improve health. Over the long haul, these provisions will result in a healthier nation with fewer health inequities, greater workforce participation and productivity, and long-term cost-savings. These provisions:

Emphasize and support disease prevention and health promotion. Community-based primary prevention would be strengthened through this legislation. The draft legislation targets at least half of new grant funds for the delivery of preventive health services at the community level, establishes a Public Health Investment Fund, and would prioritize funds to community health centers and others to create community-based interventions and expand data collection to understand what works to promote health and reduce health inequities. The legislation would also require the CDC Clinical Preventative Task Force to prioritize the elimination of disparities as they draft clinical guidelines, and similarly would authorize the Community Preventative Task Force to prioritize the elimination of health inequities. The bill also would require that 50% of Community Intervention funds must be allotted toward addressing health inequities. In addition, the legislation would authorize Health Empowerment Zones, locally-focused initiatives that stimulate and seed coordinated, comprehensive health promotion and community capacity-building.

Improve the diversity and distribution of the health professional workforce. The draft bill contains several important provisions that will improve the diversity and distribution of the health professional workforce. The bill would increase funding for the National Health Service Corps, expand scholarships and loans for individuals in needed professions and shortage areas, encourage the training of primary care physicians by increasing training opportunities outside of hospitals, and reauthorize the Centers of Excellence program for underrepresented minorities. The proposal also reauthorizes the scholarship program for individuals from disadvantaged backgrounds and reauthorizes the faculty loan program for individuals from disadvantaged backgrounds. The draft bill also increases the maximum annual amount of awards and reauthorizes the Health Careers Opportunity Program (HCOP) for disadvantaged backgrounds. With regard to Title VIII programs, the bill would reauthorize the workforce diversity grants to increase nursing education opportunities for individuals from disadvantaged backgrounds and authorizes $90 million dollars in mandatory funding above baseline appropriations for these activities. The legislation also authorizes training grants for the purpose of addressing health disparities by promoting cultural and linguistic competency. The bill would also require the Secretary of HHS to coordinate diversity activities and cultural and linguistic competency programs to foster collaboration.

Create incentives to reduce health care inequities. In the context of the proposed public plan option, the draft legislation creates innovative payment mechanisms to determine payments for services, including patient-centered medical home and other care management payments that reduce health disparities and address geographic variation in the provisions of health services. In addition, the bill would include the reduction of health inequities among the National Priorities for Quality Improvement.

Strengthen Medicaid. The draft bill includes provisions to expand Medicaid with federally-financed dollars and will improve provider participation in the program by increasing reimbursement rates for primary care providers to ultimately match those of the Medicare program.

Improve access to language services. The legislation would require a Medicare study and demonstration on language services, similar to be provisions included in CHIPRA for CHIP enrollees and Medicaid-eligible children. The legislation would also expand this demonstration program as a state option for adults in Medicaid.

Improve the accessibility of Health Information Technology (HIT) in underserved communities. The draft legislation would expand grants and training programs to ensure that health care providers working in underserved communities have access to HIT tools and appropriate training to effectively incorporate HIT in clinical practice.

Improve the application of Comparative Effectiveness Research to address health inequities. The legislation would require that research take into account various subpopulations (including racial and ethnic minorities, women, and people of different age groups) and seek to include these populations in the research where appropriate. In addition, the bill would require the dissemination of appropriate findings among health care providers, patients, vendors of HIT focused on clinical decision support, professional associations, and federal and private health plans.

Suggestions for Additional Provisions to Address Health Inequities

While the Tri-Committee draft bill addresses a number of important needs to achieve health and health care equity, there are several areas where the legislation could be strengthened with evidence-based strategies that will improve the federal investment in health equity. These include:

Codifying the federal Cultural and Linguistic Appropriate Services (CLAS) standards. The federal government currently requires providers receiving federal funds to meet only four of the 14 CLAS standards.[64] Expanding the requirement to all 14 standards and to all providers would help improve access and quality of care for diverse populations. The standards call for health care organizations to take a number of steps including providing culturally competent care, offering language assistance and ensuring a diverse workforce that undergoes ongoing CLAS training. In addition, the federal government should provide explicit funding for language assistance services in all public programs.

Expanding successful community-based health programs. Several community-based health disparities elimination programs, such as the Centers for Disease Control and Prevention's Racial and Ethnic Approaches to Community Health (REACH) program, are demonstrating positive results. The CDC REACH program provides grants to assist communities in mobilizing and organizing resources in support of effective and sustainable programs that will reduce or eliminate inequities in health and healthcare experienced by racial and ethnic minority individuals. Supporting such programs will ensure that an array of public and private community-based organizations, public health departments, university and research organizations, American Indian tribal organizations, and others can continue to receive grants to assist in designing, implementing, and evaluating culturally and linguistically appropriate, science-based and community-driven sustainable strategies to eliminate racial and ethnic health and healthcare disparities.

Addressing health in all policies. As noted above, health inequities are driven largely by social and economic inequality and unhealthful living conditions. Developing strategies to address these conditions requires an understanding of how policies, practices, and programs regarding transportation, housing, education, employment, the environment and other sectors shape health and health inequities. The committee might consider requiring the use of Health Impact Assessments (HIA) to understand how federal policies and projects in a range of sectors influence health, and to consider options to enhance health and/or mitigate potential negative health influences. HIA is being used in a number of jurisdictions around the country, and brings public health issues to the attention of policymakers in areas that fall outside of traditional public health arenas, such as transportation or land use.

Strengthening the federal health research effort. Federal research on health inequities has expanded significantly in the last decade, but some of the problems found in the Institute of Medicine's 1999 report, *The Unequal Burden of Cancer*, remain. These problems include insufficient attention to the problem of health inequities and a lack of focused and coordinated effort to expand minority participation in research and minority investigators.[65] The committee might consider elevating the National Center on Minority Health and Health Disparities, which has led an impressive effort to improve research on health inequities at NIH, to Institute status. This action should be accompanied by an appropriate increase in research and administrative resources to ensure that health equity research receives the appropriate level of attention at NIH.

Strengthening federal data collection. The draft legislation takes an important step in that it would create an Assistant Secretary for Health Information, part of whose responsibility would be to ensure that data on race and ethnicity is consistent with 1997 OMB standards in consultation with the U.S. DHHS Office of Minority Health and Office of Civil Rights. But because these broad racial and ethnic categories often obscure subpopulation differences, it is important to go beyond these categories where possible. For example, Asian Americans appear to be among the healthiest populations in the nation when data are collected by OMB "race" categories. But several subpopulations face high risk for certain diseases, such as Vietnamese-American women,

who face the highest rates of cervical cancer in the nation.[66] Data for these subpopulations can be collected and "rolled in" to the OMB categories. In addition, because data are essential to track the use and quality of care, document disparities, and tailor interventions, the legislation could require and fund the standardized collection of race, ethnicity, and primary language data across all public and private health insurance plans and care settings, and fund the use of data to set benchmarks for improvement.

Ensuring that immigrants lawfully present in the United States face the same eligibility rules as citizens for public programs, including Medicaid, Medicare and CHIP, and that they have the same access as citizens to subsidies. Many lawfully present immigrants work in sectors of the economy that are less likely to provide employer-sponsored health insurance, and many are categorically barred from public insurance programs. As a result, 24 percent of lawfully present immigrant adults are uninsured, compared to 14 percent of US-born citizens.[67] As noted above, to the extent that many remain uninsured, we will continue to see inefficiencies in the delivery of care, higher costs, and unnecessary human suffering.

Conclusion

Health and health care access and quality are more often compromised for racial and ethnic minorities than for whites. These disparities have a long history in the United States and are both a symptom of broader structural inequality and a mechanism by which disadvantage persists. Moreover, they carry a significant human and economic toll; the Institute of Medicine estimates that 18,000 people die prematurely each year because they lack health insurance, and that the annual cost to the nation of the poorer health and shortened life spans attributable to uninsurance is between $65 and $130 billion.[68] Because people of color are disproportionately among the uninsured, these numbers carry a greater burden in minority communities.

Addressing these inequities requires comprehensive strategies that span community-based primary prevention to clinical services, a long-term commitment and investment of resources, and a focus on addressing equity in all federal programs and in all elements of health reform legislation. To fail to do so ignores the reality of important demographic changes that are happening in the United States, and fails to appreciate the necessity of attending to equity as a necessary step to help achieve the goals of expanding insurance coverage, improving the quality of health care, and containing costs. Encouragingly, the Tri-Committee draft bill recognizes the importance of achieving equity in health and health care and proposes a number of policy strategies to reach this goal. The authors of this legislation recognize that no single policy – such as expanding access to health insurance – will fully address health care inequality. Health care inequities are complex and are rooted in many causal factors that span across a range of levels – including institutional, governmental and individual levels. It is therefore important to identify, implement and evaluate multi-level strategies addressing health care financing, systems and workforce development. Such strategies should operate together to improve health care access and quality for vulnerable populations. The strategies identified here are only a first step toward creating a more equitable health care system for all.

[1] Harper S, Lynch J, Burris S, and Smith GD. Trends in the Black-White life expectancy gap in the United States, 1983-2003. *Journal of the American Medical Association*, 297(11):1224-1232.
[2] U.S. Department of Health and Human Services, 2007.
[3] U.S. Department of Health and Human Services, National Center for Health Statistics. 2007. *Health, United States, 2006*. Washington, DC: U.S. Department of Health and Human Services.
[4] *Ibid.*
[5] *Ibid.*
[6] Woolf SH, Johnson RE, Fryer GE, Rust G, and Satcher D. 2004. The health impact of resolving racial disparities: An analysis of US mortality data. *American Journal of Public Health*, 94(12): 2078-2081.
[7] *National Healthcare Disparities Report, 2006*. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/qual/nhdr06/nhdr06.htm, accessed June 28, 2007.
[8] *National Healthcare Disparities Report, 2006*. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/qual/nhdr06/nhdr06.htm, accessed June 28, 2007.
[9] Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Washington, DC: National Academy Press, 2003.
[10] Henry J. Kaiser Family Foundation and the American College of Cardiology, "Racial/Ethnic Differences in Cardiac Care: The Weight of the Evidence," October 2002.
[11] A.C. Klassen, et al., "Relationship Between Patients' Perceptions of Disadvantage and Discrimination and Listing for Kidney Transplantation," *American Journal of Public Health* 92.5 (May 2002).
[12] IOM, *Unequal Treatment*, 2003.
[13] Henry J. Kaiser Family Foundation and the American College of Cardiology, "Racial/Ethnic Differences in Cardiac Care"
[14] IOM, *Unequal Treatment*, 2003.
[15] *Ibid.*
[16] Akhter MN, Levinson AR, Eliminating health disparities associated with long-term care to promote graceful aging in place. *Care Management Journal*, 2003 Summer;4(2):88-93.
[17] Akamigbo AB, Wolinsky FD, New evidence of racial differences in access and their effects on the use of nursing homes among older adults. *Medical Care*, 2007 45(7):672-9.
[18] Howard DL, Sloane PD, Zimmerman S, Eckert JK, Walsh JF, Buie VC, Taylor PJ, Koch GG, Distribution of African Americans in residential care/assisted living and nursing homes: more evidence of racial disparity? *American Journal of Public Health*. 2002 Aug;92(8):1272-7.
[19] Mor V, Zinn J, Angelelli J, Teno JM, Miller SC. Driven to tiers: socioeconomic and racial disparities in the quality of nursing home care, Milbank Quarterly, 2004, 82(2):227-56.
[20] Grabowski DC, The admission of blacks to high-deficiency nursing homes. *Medical Care*, 2004, 42(5):456-64.
[21] US Department of Health and Human Services. (2000). *Oral Health in America: A Report of the Surgeon General-- Executive Summary*. Rockville, MD: US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health.
[22] Children's Dental Health Project. (n.d.) "Racial and ethnic disparities in oral health," available at http://www.cdhp.org/downloads/Disparityfactsheet.pdf, accessed March 22, 2009.
[23] Patrick DL et al. (2006). Reducing oral health disparities: a focus on social and cultural determinants, *BMC Oral Health*, **6**(Suppl 1):S4, available at http://www.biomedcentral.com/1472-6831/6/S1/S4, accessed March 22, 2009.
[24] Ibid.
[25] World Health Organization Commission on the Social Determinants of Health. (2008). *Closing the gap in a generation: health equity through action on the social determinants of health*, Final Report of the Commission on Social Determinants of Health, available at http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf, accessed March 22, 2009.
[26] Chiquita A. Collins and David R. Williams, 1998. "Segregation and Mortality: The Deadly Effects of Racism?" *Sociological Forum* 14(3): 495-523.
[27] Institute of Medicine, *Unequal Treatment*, 2003.

[28] *Ibid.*
[29] Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America.* Washington, DC: National Academy Press, 2003.
[30] People of color comprise only about 30% of the U.S. population, but over half of the nation's uninsured are racial and ethnic minorities. See U.S. Department of Health and Human Services, 2007.
[31] U.S. Department of Health and Human Services, *The National Healthcare Disparities Report*, January 2006, http://www.ahrq.gov/qual/nhdr05/nhdr05.htm (18 January 2006).
[32] Robert Wood Johnson Foundation, *Going Without: America's Uninsured Children*, www.rwjf.org (August 2005).
[33] The Urban Institute, "Fast Facts on Welfare Policy," www.urban.org 19 July 2005.
[34] The uninsurance rate among immigrants increased dramatically in the late 1990s, following passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which imposed a five-year limit on most new immigrants' ability to participate in public health insurance programs. Prior to and shortly following passage of the Act (between 1994 and 1998), immigrants accounted for about one-third of the increase in the number of uninsured individuals.
[35] Employee Benefit Research Institute, "The Impact of Immigration on Health Insurance Coverage in the United States," *Employee Benefit Research Institute Notes*, 26, no. 6 (2005).
[36] U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States, 2004* (Washington, D.C.: U.S. Government Printing Office, 2005).
[37] Bronx Health Reach, *Separate and Unequal: Medical Apartheid in New York City*, available at http://www.institute2000.org/policy/medical_apartheid.pdf, accessed July 30, 2006.
[38] Bach PB, Pham HH, Schrag D, Tate RC, Hargraves JL. (2004). Primary care physicians who treat blacks and whites. *The New England Journal of Medicine*, 351(6):575-84.
[39] Sarrazin MV, Campbell M, and Rosenthal GE. (2009). Racial differences in hospital use after acute myocardial infarction: Does residential segregation play a role? *Health Affairs*, 28(2): w368-w378.
[40] Hasnain-Wynia R, Baker DW, Nerenz D, Feinglass J, Beal AC, Landrum MB, Behal R, and Weissman JS. (2007). Disparities in health care are driven by where minority patients seek care, *Archives of Internal Medicine*, 167:1233-1239.
[41] Morrison, R.S., Wallenstein, S., Natale, D.K, Senzel, R.S., and Huang, L. (2000). "We Don't Carry That"— Failure of Pharmacies in Predominantly Nonwhite Neighborhoods to Stock Opioid Analgesics. *The New England Journal of Medicine* 342(14):1023-1026.
[42] The Henry J. Kaiser Family Foundation, "Racial and Ethnic Disparities in Women's Health Coverage and Access to Care: Findings from the 2001 Kaiser Women's Health Survey, available at www.kff.org, accessed September 25, 2004.
[43] Smith, DB. (2005). *Eliminating Disparities in Treatment and the Struggle to End Segregation* (New York: The Commonwealth Fund).
[44] Henry J. Kaiser Family Foundation, *Key Facts: Race, Ethnicity, and Health Care* (Menlo Park, CA: Henry J. Kaiser Family Foundation, June 2003).
[45] *Ibid.*
[46] *Ibid.*
[47] *Ibid.*
[48] *Ibid.*
[49] Lillie-Blanton, M, Martinez, R. M., & Salganicoff, A. (2001). Site of medical care: Do racial and ethnic differences persist? *Yale Journal of Health Policy, Law, and Ethics.* 1(1), 1-17.
[50] U.S. Census Bureau, "Ability to Speak English by Language Spoken at Home." Available at http://www.census.gov/population/cen2000/phc-t37/tab01a.pdf (Accessed 19 March 2007).
[51] Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington, DC: National Academies Press, 2003).
[52] Pew Hispanic Center and the Henry J. Kaiser Family Foundation, "Survey Brief About the 2002 National Survey of Latinos," March 2004, www.kff.org (23 January 2006).
[53] *Ibid.*
[54] IOM, *Unequal Treatment*, 2003.

[55] Green AR, Carney DR, Pallin DJ, Ngo LH, Raymond KL, Iezzoni LI, Banaji MR. Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients. Journal of General Internal Medicine, 2007, 22(9):1231-8.
[56] H. Boushey and M.M. Diaz, "Improving Access to Health Insurance," Health Insurance Data Briefs no.1 (Washington, D.C.: Center on Budget and Policy Priorities, April 13, 2004).
[57] For example, see: Doty MM and Holmgren AL, *Health care disconnect: gaps in coverage and care for minority adults. Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2005*, Issue Brief. New York: The Commonwealth Fund, 2006; Hargraves JL, and Hadley, J, The contribution of insurance coverage and community resources to reducing racial/ethnic disparities in access to care, *Health Services Research*, 2003, 38(3):809-29; Lillie-Blanton M, and Hoffman C, The role of health insurance coverage in reducing racial/ethnic disparities in health care, *Health Affairs*, 2005, 24(2):398-408; Weinick RM, Byron SC, Bierman AS, Who can't pay for health care? *The Journal of General Internal Medicine*, 2005, 20(6):504-9.
[58] Institute of Medicine, *Unequal Treatment*, 2003.
[59] Institute of Medicine. (2004). *In the Nation's Compelling Interest: Enhancing Diversity in the Health Professions*, B.D. Smedley and L.R. Bristow, eds., Washington, D.C.: National Academies Press.
[60] *Ibid.*
[61] *Ibid*
[62] Smith DB, 1999.
[63] The Public Health Institute, *Advancing the State of the Art in Community Benefit: A User's Guide to Excellence and Accountability*, November 2004, available at http://www.phi.org/pdf-library/ASACB.pdf (accessed August 30, 2007).
[64] U.S. Department of Health and Human Services Office of Minority Health. National Standards on Culturally and Linguistically Appropriate Services.
http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15
[65] Institute of Medicine, *The Unequal Burden of Cancer: An Assessment of NIH Research on Minorities and the Medically Underserved.* Alfred E. Haynes and Brian D. Smedley (Eds.), Washington, DC: National Academy Press, 1999.
[66] Ibid.
[67] Jeffrey S. Passel and D'Vera Cohn. A Portrait of Unauthorized Immigrants in the United States. Pew Hispanic Center. April 2009.
[68] Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America.* Washington, DC: National Academy Press, 2003.

Mr. PALLONE. Thank you, Dr. Smedley.
Dr. Kestner.

STATEMENT OF MARK KESTNER, M.D.

Dr. KESTNER. Good afternoon, Mr. Chairman and members of the committee, and thank you for the opportunity to be with you today. May name is Dr. Mark Kestner, and I am the Chief Medical Officer for Alegent Health.

Today I want to give you a brief overview of Alegent Health's experience with prevention and wellness. We are both the large employer and a substantial provider of health care, which gives us a unique perspective on these issues.

Alegent Health is a faith-based, not-for-profit healthcare system that serves eastern Nebraska and western Iowa. We have 9,000 employees and 1,300 physicians that are proud of the care we provide in our 10 hospitals and in our 100 sites of service. Alegent is the largest nongovernmental employer in Nebraska, and each year we serve more than 310,000 patients.

As a provider, we believe we are a model for post-reform health care systems. We employ substantial health care information technology to improve the quality and safety of the care we provide. Through the dedication and commitment of our physicians, a combination of both employed and independent physicians, we have standardized care and implemented evidenced-based care order sets across more than 60 major diagnosis fees that are continually raising the bar on the quality of care we provide.

Our CMS core measure and HCAP scores are consistently among the highest in the Nation. In June of 2008, the Network for Regional Health Care Improvement identified Alegent as having the best combined health care quality scores in the Nation. Through the implementation of health IT and adoption of evidence-based care, Alegent is increasing the quality of care we provide while simultaneously lowering the costs that we provide. Last year we reduced our resource utilization, and the cost of the care continues to decline.

We are proud to have shared these and other initiatives with Health and Human Services Secretary Kathleen Sebelius 10 days ago when she paid a visit to us. And yet, Mr. Chairman and members of the committee, in our estimation the efforts of providers to raise quality and lower costs is only a small portion of what we need to do. We adamantly believe that people must be more accountable for their health. And in doing so, we must incentivize them and give them good information.

We began our journey with greater consumer involvement in health care 3 years ago when we made a commitment as an organization to more fully engage our workforce and their health. We spent a year designing a new benefit plan that promoted health and wellness among our employees. In pioneering the new benefit plan, we identified incentives to encourage healthier behaviors and tools to provide meaningful costs and quality information as areas where Alegent could foster individual engagement in health care.

There are two important constructs to Alegent's employee health benefit plan. First, preventive care is free. This ranges from services like annual physicals and mammography to childhood immuni-

zations and colonoscopies. If it is preventative, it is free. As a result, our workforce is consuming more than two and a half times the preventive care than the Nation at large. That is an investment we are willing to make even without longitudinal studies to quantify the financial benefit to our organization.

Second, through an innovation called Healthy Rewards Program we pay people to make positive changes in their lifestyle. If an employee quits smoking, loses weight, more effectively manages their chronic diseases like diabetes, or makes other positive changes that affect their lifestyle, Alegent provides a cash reward. To encourage wellness and prevention and help our employees get healthy, we offer a variety of assistance programs free of charge, free weight loss counseling, free smoking cessation, and chronic disease management programs. For those who need a little bit of extra help, we offer free personal health coaches.

Our objective was first and foremost to improve the health of our workforce, and we believed by doing so our costs would decline. And while we are still building data on the effects of our efforts that had been on productivity and absenteeism and organizational health care costs, I can report that a majority of our employees take an annual health risk appraisal and today have lost 15,000 pounds as a workforce, and more than 500 of our employees have quit smoking.

Our approach has allowed us to substantially slow the growth of our health care spending. Over the first 2 years our cost increases were limited to an average of 5.1 percent despite trends in the 8 to 10 percent range. As we approach a new benefit plan year, we are carefully constructing a advanced medical home pilot for our chronically ill employees and several large employers in the community.

Key to our results was their use of the HSA and HRA accounts, which give employees better control in their health care dollars and allow us to directly reward people for changing unhealthy behavior.

The data we examined developing our benefits plan suggests to us that people would be more inclined to take advantage of health and wellness programs, even free ones, if they were incentivized to do so. For us the use of HSAs and HRAs facilitates this process and provides employees an immediate tangible benefit in the form of subsidized health care costs. But to give our employees more control required us as providers to make other dramatic changes. First and foremost, we created tools to provide meaningful and relevant cost and quality information. We have a quality Web site where we publicly report our 40 quality measures, CMS 20, the 10 skip and the 10 stroke measures, and our compliance with these measures ranges anywhere from 97 to 100 percent.

In January of 2007, we introduced a Web-based cost estimating tool called MyCost, which is the first of its kind in the country. By working with third-party payer insurance database, MyCost was able to verify insurance policies and deductibles in order to provide patients an extremely accurate price estimate on more than 500 medical tests and procedures. In a little over 2 years, 85,000 individuals, employees and members of our community, have used it.

In summary, Alegent Health began our health care reform several years ago when we made an organizational commitment to

dramatically improve quality, lower cost, and adopt health information technology. We knew that this would help us become more effective and efficient providers, and the data shows that we are becoming successful in reducing our costs and our resource utilization. And yet, Mr. Chairman and members of the committee, that was simply not enough. Our challenge as a country, as physicians, nurses, Members of Congress and employers, individuals, and families is to find a way to help people become more individually responsible for their health care.

Thank you.

[The prepared statement of Dr. Kestner follows:]

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Mark Kestner, M.D.
Written Testimony
June 23, 2009
Committee on Energy and Commerce Health Subcommittee

Good morning Mr. Chairman and Members of the Committee, thank you for the opportunity to be here with you today. My name is Dr. Mark Kestner, I am the Chief Medical Officer of Alegent Health; today I want to give a brief overview of Alegent Health's experiences with prevention and wellness. We are both a large employer and a substantial provider of healthcare, which gives us a unique perspective on these issues. In both roles, we have made it our goal to partner with people to proactively manage their health, as well as make better choices about the care they need.

Alegent Health is a faith-based, not-for-profit health care system that serves eastern Nebraska and western Iowa. Our 9,000 employees and 1,300 physicians are proud of the care we provide in our 10 hospitals and more than 100 sites of service. Alegent is the largest non-governmental employer in Nebraska and each year we serve more than 310,000 patients.

Health Information Technology

As a provider, we believe we are a model of a post-reform healthcare system. We employ substantial health information technology (HIT) to improve the quality and safety of the care we provide and to ensure a seamless transition for patients across the many services in our healthcare system.

The implementation of HIT enables both the delivery of traditional medicine in the acute care setting and facilitates the further development of telemedicine. We believe an investment telemedicine is the key in clinical integration across all sites, improved patient outcomes and effective evidence based medicine. That investment is not just the responsibility of the provider. We believe Medicare reimbursement should be available for telemedicine, which can help alleviate the national shortage of critical care physicians and intensivists, add enhanced coverage of intensive care units, dramatically increase outcomes, reduce mortality and length of stay. It can also give a level of medical care to rural hospitals that is often not available. At Alegent Health, we have a telemedicine team set up to monitor ICU patients 24 hours a day from an off-site location. It is staffed by a multidisciplinary critical care team, whose services bring comfort and reassurance to our families.

But nothing is more important to patients than their medical record, which chronicles their health history. It is absolutely essential that we develop electronic medical record systems that can cross hospital walls and follow each American no matter where they travel in the United States. That starts hospital by hospital. At Alegent Health we have

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fully digital hospitals that are implementing EMR. It is a complex and time-consuming process but one that is worth all of the human and financial investment required.

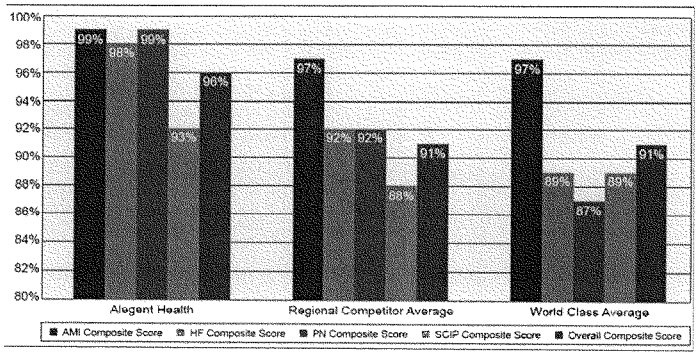
Evidence Based Care

Technology isn't the only change occurring in medicine. At Alegent Health our dedication and committed physicians – who are both employed and independent – have implemented evidence-based care order sets across more than 60 major diagnoses that are continually raising the bar on the quality of care we provide.

Evidence directs us to the science behind care decisions and the delivery provided, where the actual decisions, or the art of delivery, are developed by each care provider. Take OB/GYN as an example. Until recently, when a woman came in to one of our hospitals to be induced, the medical team had 117 order sets telling them how to care the patient. Today, there are four order sets. This standardization of the processes of care assists our physicians keeping up with best practices and applying them in the care of patients and contributes to the achievement of quality and patient safety goals.

Our CMS Core Measure and HCAHPS Scores are consistently among the highest in the nation. In June 2008, the Network for Regional Healthcare Improvement identified Alegent as having the best combined healthcare quality scores in the nation.

Health and Human Services "Hospital Compare"
Overall Composite Scores (24 Measures)
Data reported through September 2007



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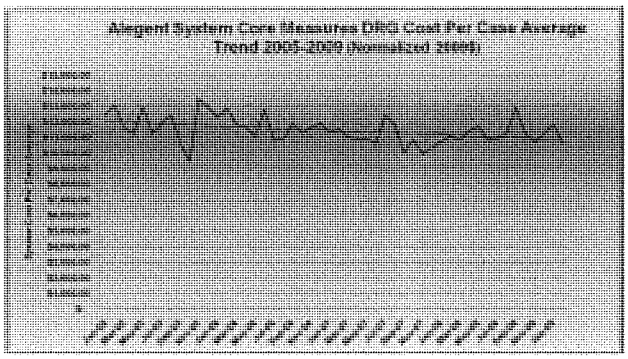
Through the implementation of health IT and the adoption of evidence based care; Alegent Health is increasing the quality of the care we provide, while simultaneously lowering the cost to provide care. Over the last several years we reduced our resource utilization and we continue to work to improve that metric to help lower costs.



Let me be clear, we are working hard to improve quality because it is the right thing to do.

And we are proud to have shared these and other initiatives with Health and Human Services Secretary Kathleen Sebelius just 10 days ago, when she paid us a personal visit.

And yet, Mr. Chairman and members of the Committee, in our estimation, the efforts of providers to raise quality and lower costs is only a small part of what it will take to actualize true healthcare reform. We adamantly believe that people must take more accountability for their health, and to do so they must have incentives and good information.

Consumer Engagement

We began our journey to greater consumer involvement in health care three years ago, when we made a commitment as an organization to more fully engage our workforce in

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their health. We spent a year designing new benefit plans that would promote health and wellness among our employees. Once we identified the direction we wanted to move, we spent a full year communicating with our employees what the changes would mean to them.

The results have been exceptional:

- Over the first two years, our health care costs increases were limited to an average of 5.1 percent, despite industry trends in the 8 – 10 percent range
- As we enter our third plan year, 92 percent of employees have enrolled in either an HSA or HRA plan.

In pioneering the new benefit plan, we identified incentives to encourage healthier behaviors and tools to provide meaningful cost and quality information as areas where Alegent could foster more individual engagement in health care.

Incentives for Preventive Care/Lifestyle Change/Chronic Disease Management

There are two important constructs in Alegent Health's employee health benefit plans. First, preventative care is free. This ranges from services like annual physicals, and mammographies to childhood immunizations and colonoscopies. If it is preventative, it is free. As a result, our workforce is consuming more than 2.5 times the preventive care than the nation at large. That's an investment that we're willing to make, even without longitudinal studies that quantify the financial benefit to our organization.

And second, through an innovative "Healthy Rewards" program, we pay people to make positive changes in their lifestyles. If an employee quits smoking, loses weight, more effectively manages their chronic disease like diabetes or makes other positive changes that affect their lifestyle, Alegent provides a cash reward. To encourage wellness and prevention and help our employees get healthy, we offer a variety of assistance programs free of charge – free weight loss counseling, smoking cessation programs and chronic disease management. For those who need a little extra support, we offer free personal health coaches.

Our objective was first and foremost to improve the health of our workforce, and we believed by doing so, our costs would decline. And while we are still building data on the effect our efforts have had on productivity, absenteeism and organizational health care costs, I can report that a majority of employees take an annual health risk appraisal and to date, we've lost 15,000 pounds as a workforce, and more than 500 of our employees have quit smoking. We have any number of stories of employees who say "Alegent

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Health believed in me, when I didn't believe I could stop smoking...lose weight....manage my asthma..."

And that was just the beginning. In January 2009, Alegent Health launched a new comprehensive wellness program for all employees (and spouses enrolled in an Alegent Health medical plan). The iClub provides extensive educational resources to engage and educate employees about health and wellness, and motivate them to lead healthier lifestyles. The program enhanced our onsite health screenings, weight loss, fitness and tobacco cessation programs, and access to health coaches to motivate employees in their designated programs – providing additional, expert support.

The foundation of the program includes a online health management wellness portal and the addition of a full-time health promotion director to administer the program. The iClub portal begins with an extensive Health Risk Questionnaire to establish health and safety risks and readiness-to-change. The wellness portal creates a customized Individual Action Plan based upon the participant's risk profile. The action plan includes online educational modules and decision support tools, appointment management, reminders, and health trackers for participants to manage their health. Throughout the annual program, participants are supported with coaching based on their specific risk level. Plus employees can still earn incentives for taking part in the program. In its first six months, 33% of Alegent Health employees and dependents have joined iClub (that is double of the number of employees who signed up in a wellness program last year). Our goal is 60% participation in iClub by end of the end of the calendar year.

Our approach has allowed us to substantially slow down the growth of our healthcare spending. Over the first two years, our cost increases were limited to an average of 5.1 percent, despite industry trends in the 8 – 10 percent range.

And, as we approach a new benefit plan year, we are carefully constructing an Advanced Medical Home pilot for our chronically ill employees and several other large employers in our community. Through a dedicated team of physicians, nurses, counselors and care managers, we believe we will have an even more profound impact on the health and quality of life of people living with chronic disease.

Key to our results was the use of HSA and HRA accounts, which give employees better control of their health care dollars and allow us to directly reward people for changing unhealthy behaviors. The data we examined in developing our benefit plans suggested to us that people would be more inclined to take advantage of health and wellness programs—even free ones—if they were incentivized to do so.

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For us, the use of HSAs and HRAs facilitates this process and provides employees an immediate tangible benefit in the form of subsidized health care costs. Too often prevention and wellness are hard to quantify for patients, providing cash incentives is a way to reward them for their efforts.

Tools to Facilitate Cost and Quality Transparency

But giving our employees more control required us, as providers, to make dramatic changes. First and foremost, we created tools to provide meaningful and relevant cost and quality information. What other good or service do people purchase in this country without knowing how good it is and how much it costs?

Nearly three years ago, we began sharing our quality metrics with both our employees and the public – the good and the bad – and since then, we've seen our quality scores soar. On our web site we currently reports 40 quality measures – the CMS 20 and the 10 SCIP and 10 Stroke measures.

Unlike most providers we did not stop there.

We believe today's consumer needs information that is relevant, meaningful and actionable to become engaged in their healthcare decisions. So, in January 2007, we introduced a web-based cost estimating tool called *My Cost*, which is the first of its kind in the country. By working with a third party insurance database, *My Cost* is able to verify insurance policies and deductibles in order to provide patients an extremely accurate price estimate on more than 500 medical test and procedures. In a little over two years, nearly 85,000 individuals – employees and members of our community - have used it.

When we say we are committed to putting consumers at the center of the healthcare equation, it is no idle exercise for our team at Alegent Health. For the past two years, they have continued to develop and refine *My Cost* in response to consumer inquiries and questions. Our objective is to continue to ensure we equip consumers with the necessary information to make every day healthcare decisions, understand their expenses and manage their budget in order to meet their medical needs.

To date, *My Cost* is the only fully-integrated, online cost estimating tool based on individual consumer health plan out-of-pocket costs. As the Chief Medical Officer of a health care provider, I understand the arguments against providing transparency on cost and quality and I reject them. Alegent Health is proof that you can share cost and quality information and not only be competitive, but excel in your marketplace.

Mr. PALLONE. Thank you. Thank all of you, and we will now take questions, and I will start with 5 minutes.

I wanted to really focus, if I could, on the questions to Dr. Smedley, because of the disparities issue. All of you talked about the importance of prevention and wellness, and that is certainly what we hear in regard to health reform. And specifically experts tell us we have to address prevention and wellness at the community level if we want health reform to lead to the best health outcomes for our constituents. That is definitely the case for elimination of health disparities. Disparities arise not just because of differences in medical care, but also because there are factors that make it harder for some people than others to make healthy choices.

Dr. Smedley, I have been most familiar with this with Native Americans because I am a vice chair of the Native American Caucus. I don't have any tribes in New Jersey, but over the years being on the Resources Committee, I have paid quite a bit of attention to the Native American issues. Best example probably was with the Pima, the Tohono O'Odham, where you saw that traditional diet, ranching, desert products were lost and they using, eating processed foods, and it was hard to go back to traditional diet because the ranches were gone and the desert had changed and it just wasn't possible to do that.

So in the draft proposal we target funds to community based interventions or services with the primary purpose of reducing health disparities. Can you tell us how the recommendations from the Community Prevention Task Force, that is housed at CDC and whose work is strengthened in the draft proposal, can be used to target health disparities? And anything else about addressing health disparities within the context of prevention and wellness. What do you see as some of the areas that require new or additional research?

All in about a minute because I have a second question to you.

Mr. SMEDLEY. Sure, Mr. Chairman, I will try to be very brief. As you pointed out, place matters for health. Where we live, work, study and play is very important. Certainly it is important that we all take responsibility for our individual health choices, but sometimes those health choices are constrained by the context in which we live, work, and play. Since you pointed out in many communities of color we face a number of health challenges, often the retail food environment is poor in segregated communities of color. You have a relative abundance of fast food outlets, poor sources of nutrition, a relative lack of grocery stores where you can get fresh fruits and vegetables. Similarly in many communities of color we lack safe places to play, recreational facilities, places to exercise. It is harder to encourage an active lifestyle under those conditions. So the CDC Preventative Task Force is an evidence-based process that tries to identify what are the kinds of community-based prevention strategies that will help to address these kinds of conditions. We think that is very important. So I certainly applaud the provisions in the draft bill that would strengthen that process.

Mr. PALLONE. Now on the workforce, again I will use American Indians because I am most familiar, I think there are maybe, over 2 million Native Americans and last count less than 500 American

Indian doctors, 400 something. They have an organization. I went to speak to them once, and that is the entire membership.

In the discussion draft there are a number of provisions that will increase representation of racial and ethnic minorities. We have additional investment in the National Health Service Corps. Basically, how would these workforce provisions help address health disparities? Why is increasing the diversity of the workforce and not just its scale important in reducing health disparities? You could argue why do you need more Native American doctors, why can't other people take care of Native Americans. But I know that there is an issue there, and I would like to you discuss it.

Mr. SMEDLEY. Absolutely. The research is very clear that when we increase the diversity of the health provider workforce all of us benefit. So for example, we know that providers of color are more likely to want to work in medically underserved communities. Their very presence increases patient choice. We talk a lot about many patient choice. For many patients of color it is often harder to bridge those cultural and linguistic barriers without a provider of your own racial or ethnic background.

It is also true that diversity in medical education and other health professions education settings increases the cultural competence of all providers. We need to be thinking about ways to improve the cultural competence of all of our health care systems, because as I mentioned in my testimony, very soon, in shortly over 30 years, this is about to be a Nation with no majority population. Our health systems need to be prepared to manage that diversity. And so this is one of the many reasons why diversity among health professions is important, and the provisions in the draft bill such as strengthening the title VII and VIII of the Health Professions Act are a very important toward increasing the diversity and distribution of providers.

Mr. PALLONE. Thank you.

Mr. Deal.

Mr. DEAL. Thank you, Mr. Chairman. This whole panel is supposed to be dealing with prevention and public health, and I appreciate all of you being here. But I have heard a lot of words and I have heard little examples of specifics on this thing. Because it seems to me if we talk about the words "prevention" and "wellness," we are talking about changing of lifestyles.

Now we heard Dr. Kestner talk about his company and the way that they incentivized wellness was through financial type rewards. We heard Dr. Smedley just a minute ago talk about community-based strategies and the fact that you don't have enough grocery stores in some communities to sell fresh fruits and vegetables, don't have safe playgrounds that cause us not to get enough exercise.

In a health bill, a health reform bill, what are the specifics we can do to change people's lifestyles? Because you don't think of that in the normal context of a health care reform measure.

Now specifically, and I am going to use this is a specific example of a question that I think we ought to address, in the Food Stamp Program, for example, we are pouring millions and hundreds of millions of dollars into it, and the recent stimulus package has powered even more money into the Food Stamp Program, but we don't have any guidelines like we have in the WIC Program, as I

understand it, to make sure that the taxpayers dollars that are helping fund the purchasing of food doesn't go to buy things that work at counter purposes with what we are talking about here of wellness.

Dr. Levi, let me start with you and ask if you would just comment on that.

Mr. LEVI. I think your point is very well taken. If we think of this as not a health care financing bill but a health bill, then we need to be addressing all of the elements that comprise helping people be healthier, and a lot of that is about exercising personal responsibility but then creating the environment where people can, not just through financial incentives, but really we change the norms of our society so people make healthier choices.

To that end, there is actually an experimental program now that is getting underway within the Food Stamp Program, so that people will be will in a sense get higher credit if they buy healthier food. So that is one way of incentivizing people. There are certainly other things that can be done within the Food Stamp Program that would incentivize the purchase of healthier foods.

But we also have to make sure those healthier foods are available, which is not the case in all communities. We need to make sure that people understand and know that the healthier foods are indeed what they should be eating. And so what it really takes is the kinds of community interventions that I think are envisioned in this legislation that, particularly under the concept of health empowerment zones, look at multiple aspects of the community. Is healthy food accessible? Do people know about the healthy foods? What is happening in the schools in terms of educating kids and changing norms? How active are kids able to be? How active are adults able to be? And taking all of those elements and developing comprehensive strategies. We have examples of successes like that. We have them in the Steps Program funded by the CDC, in the Reach Program funded by CDC, in the Pioneering Healthier Communities that are organized by YMCAs and other national organizations to bring communities together to identify what their communities need to make healthier choices, easier choices for the average person.

That is what is going to change. You know, we are talking about bending the cost curve. If we do that, we can have a dramatic impact on people's health and what they will be demanding of the health care system.

Mr. DEAL. I think we all agree we want our children and everybody to be healthier and exercise better choices in their lifestyles.

Dr. Smedley, are we talking about subsidizing grocery stores to come in to certain communities as a way of providing these kind of choices? Is that what you are talking about?

Mr. SMEDLEY. Well, Congressman, there actually are some very interesting initiatives that have leveraged public investment to stimulate private investment. For example, the Commonwealth of Pennsylvania has the Fresh Food Financing Initiative, which has provided that double bottom line of benefits both to private investors as well as to government investing in creating incentives so that we can create a healthier retail food environment.

I think that many of the examples that Dr. Levi just mentioned are important examples of comprehensive strategies, because often we find that there is not just one issue that is a problem in the community. It is not just a problem of food resources and food options, but there are many multiple and systemic problems. Addressing those comprehensively as the Reach Program does and other programs is the way to go.

Mr. DEAL. I think in our educational activities maybe we should teach people how to turn the television set off a little bit.

Mr. LEVI. Absolutely.

Mr. DEAL. Thank you.

Mr. PALLONE. Chairman Dingell, is he here? I am sorry, our Vice Chair, Mrs. Capps.

Mrs. CAPPS. Thank you, Mr. Chairman.

I would like to say, as someone who spent my life in the last couple of decades in public health as a school nurse, this is a panel that I really appreciate, the testimony of each of you, and I also look forward to this 5 minutes being just dedicated to proving the worth of prevention, in other words, my frustration with CBO for not being able or not scoring this topic.

And Dr. Levi, I will start with you, but I hope I give a chance for each of you to comment.

Your testimony mentions a report from Trust of America's Health released last year showing the return on investment from proven community level prevention. Can you explain briefly the methodology of this report if you think this could help me or help us all in our case towards scoring savings? We have to learn how to do this as government as well; otherwise, we are not going to be able to counter some of the front costs that are entailed here.

Mr. LEVI. I agree, and you know, I think making the case to the Congressional Budget Office is going to be critical at some point. I would preface my explanation of our report in our work by saying, whether or not CBO is convinced should not stop us from investing in prevention because whether we meet the narrow criteria that CBO is forced, in some respects, by law to address shouldn't mean that we don't see this as a worthwhile investment in improving the Nation's health.

We worked with the New York Academy of Medicine, Prevention Institute and, above all, the Urban Institute economists to develop a model that looked at successful community level prevention efforts, in other words, efforts that took place outside of the doctor's office, to see whether, through education, through changing the environment, changing policies, we could see improved health outcomes.

We focused ultimately on smoking cessation, physical activity, and nutrition, which are the drivers of some of the most expensive health care costs that we see today. And what we found was that there are, indeed, successful examples of those interventions. What we found also is that we probably can implement those at probably less than $10 per person, and even if we saw only a 5 percent impact of those interventions, which is very much on the conservative side in terms of what the evidence shows, we could see a $5.60 return for every dollar we invested.

The challenge here is that the winners in this, if you want to call it the winners, the people who save, are better care, the private insurers, and to some degree also, Medicaid. In the CBO scoring system, a discretionary investment that has pay off on the entitlement side can't be scored in anyone's favor, and that is actually a congressional rule. But just as importantly, I think what we need to think about is that those who benefit are not necessarily contributing, and so we need to think of this as a public investment that will ultimately reduce overall health care.

Mrs. CAPPS. My question to you now is very pragmatic, and I am going to expand it to all three of you, and time is of the essence. I mean, this is really an obstacle, in my opinion, to the pushback against the huge cost, as it is portrayed, of this health care legislation. Can you give us some advice, what can Congress do to facilitate the process of enabling CBO, or whatever term you want to use, to be able or have that capability of scoring prevention?

And you know, you are not even talking about quality of life for consumers of health. We will take that off the table, because that is probably hard to measure, or longevity, that has been held up by some to be a deterrent because as people live longer, they are going to get more chronic diseases over the course of their lifetime. You know, what should we do on this committee to begin that process? I will start with you briefly.

Mr. LEVI. Two very quick comments. One is, Congress can remove this firewall between discretionary investment and entitlement savings.

I think the second is to start a dialogue with the economics community and the Congressional Budget Office, because not everyone agrees with this notion that you just mentioned that if we reduce these chronic diseases, then people are going to live longer, and they are ultimately going to cost more. There is this whole concept we call compression of morbidity which suggests that if we actually reduce obesity, and there are a number of models from a number of different economists now that tend to show, for example, if you reduce obesity, you are not necessarily prolonging life, but you are improving the quality of life and reducing health care costs because the chronic diseases are additive. They don't necessarily shorten life, and so I think those are two examples. Start that dialogue and remove some barriers.

Mrs. CAPPS. Thank you. I know I have used my time. I don't know if there is a way for a quick response from the other two if they want to.

Mr. PALLONE. Go ahead, sure.

Mr. SMEDLEY. I would just add, I think that Dr. Levi answered that quite well. We also need to consider the next generation is likely to be less healthy than the current adult population.

Mrs. CAPPS. Why is that?

Mr. SMEDLEY. Because they are more obese. They are at risk for more chronic diseases. So we need to be considering the fact that this is the generation that will support my colleagues and I in our old age. So hopefully we will be forward thinking.

Mrs. CAPPS. Is that documented that they are less healthy?

Mr. SMEDLEY. Yes.

Mrs. CAPPS. Any further point from you?

Mr. SMEDLEY. Be happy to provide reference.

Mrs. CAPPS. Please do.

Dr. KESTNER. I would just comment that we have senior experience in showing that preventative care decreases our expenses.

Mrs. CAPPS. So there is data out there? Any of you want to supply any information, I would appreciate it very much.

Mr. PALLONE. Sure. Any follow-up in writing is appreciated.

Thank you.

Gentleman from Texas, Mr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman.

Dr. Smedley, I am very interested in some of the things to which you testified and may be beyond the scope of what we are doing and dealing with in these hearings, but I have similar neighborhoods in my district, and there is not a grocery store from one end of the community to the other. Plenty of places to buy alcohol, typically in 40-ounce containers, and plenty of places to buy fast food, and of course, cigarettes are available on every street corner.

This just points to one of the difficulties that we have, and we had worked with a group Social Compact. They are so far away from our last Census in 2000, it is very difficult to get private grocery stores interested in moving back to the area because they say, well, the demographics just won't support a grocery store, but in fact, the demographics have changed and the purchasing patterns have changed, and again, we are still far away from the Census. Social Compact was able to put out some data that showed perhaps this is worthwhile of a Wal-Mart Supercenter, for example, locating in the area. We are actively trying to push that, but it is just extremely difficult to get those things accomplished. No problem at all getting another liquor store to move in. It is really hard to keep them out in fact.

I just wonder if we shouldn't allow a little more flexibility in some of our Federal food stamp programs. You can't buy alcohol; that is correct. Can't buy cigarettes; that is correct. Can't buy hot food, but there are some hot foods like a rotisserie chicken, for example, that may serve a family's nutritional needs very well. And the fact that that activity is restricted may be putting an undue burden on people who are willing to move into the community.

And I don't purport to have any of the answers. I have worked with some of the people at Robert Wood Johnson in trying to craft language that we might put in a bill, but it is extremely difficult. But I appreciate what you are doing, what you are trying to do because I think that gets to the root of a lot of the problems that I know I see it at home. And you are correct; the next generation is only going to be successively less healthy because some of the learned behaviors that are going on today.

I want to talk about Alegent for just a moment because you are a success story, and we heard from a previous panel that maybe we should be pursuing evidence-based policy, and your policies at Alegent are clearly something that are worthy of not just our attention and study but perhaps our emulation. And you have showed rather dramatically, I think, you and Wayne Sensor have shown, you can't just make things free; you have got to make them important, and the way we make things important is attach money to them.

So I hope that this committee will look seriously at what you have done with your health reimbursement accounts and your health savings accounts and your ability to bring people in not just to affect things on a small scale but to affect things on a large scale. And the impressive thing is you did it with your 9,000 workforce first before you went forward and began to sell it to the rest of the community.

So, again, I hope we will look seriously at what you have done and what you have been able to accomplish. My understanding—and tell me if I am correct, Dr. Kestner—on the consumer based health plan, if you look at high-option at PPO plans, they are going at about a 7.5 percent year rate of growth as far as costs; Medicare and Medicaid, 7.3, 7.8 percent, depending upon who you want to read; but consumer directed health plans are growing at about 2, 2.25 percent a year. Has that been your experience as well?

Dr. KESTNER. Our cumulative 2-year experience is 1.5.

Mr. BURGESS. 1.5?

Dr. KESTNER. Excuse me, I am sorry, 5.1. And I think we recognize that the impact going forward will be on preventative measures. We still have patients that have problems with obesity, with smoking, and those are things that we are going to have to—that are going to be expensive for us in the long run. So, on the short term, we have already seen a benefit in implementing a strategy, and on the long term, we anticipate seeing an increasing decrease in our health care expenses.

Mr. BURGESS. Now, I don't know if you have had a chance to read the draft that is before us today for discussion, but as far as you are aware does the draft that has been proposed by the majority, does it increase or decrease your ability to do what you want to do particularly with health savings accounts?

Dr. KESTNER. Right. I think any strategy needs to engage the patient in the dialogue, empower them in economic decisions regarding access, but allowing open access. And I think the most important thing from my perspective is the ability to engage the dialogue when they are well. All too often we access health care at a point of sickness, and really preventative care is engaging people and starting the dialogue when they are well. So any strategies that focus on prevention and begins that dialogue early I think are benefits to the population at large.

Mr. BURGESS. Just one more brief question. Do you allow for partnering with your physicians and your facility at all? Are there like inventory service centers where there is physician ownership involved in any of Alegent's facilities?

Dr. KESTNER. Yes. We have joint ventures in ambulatory service centers.

Mr. BURGESS. Are you aware that the draft under discussion today would prohibit such activities in the future?

Dr. KESTNER. I am superficially aware of discussions that are going on.

Mr. BURGESS. Do you believe in the pride of ownership? I mean, when a physician has an ownership position in an entity, my feeling is it makes it run better.

Dr. KESTNER. I believe with the dialogue that we have had in our health system our physicians feel pride of ownership, whether they

have an investment interest or not. I think that has been part of our culture of giving physicians decision making and the ability to drive health care through evidence-based care and empowering them to make decisions for our health care delivery model. So, whether they have an investment interest or not, I think we have tried to make sure they have a pride of ownership in our system.

Mr. BURGESS. Do you think this bill before us today fosters that empowerment?

Dr. KESTNER. The one that is up for discussion at this point in time?

Mr. BURGESS. Yes.

Dr. KESTNER. Yes.

Mr. BURGESS. Thank you.

Mr. PALLONE. Thank you. Gentlewoman from the Virgin Islands, Mrs. Christensen.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman, and thank you for being here to all of the panelists.

Dr. Levi, we have really appreciated the work from the Trust for America's Health, and we appreciate also your support of the health empowerment zones.

One of the basic services that is not covered for adults is dental care. How important do you think that it is that it be included in terms of prevention or its impact on chronic diseases and other health care problems?

Mr. LEVI. We believe access to dental care is a vital component to keeping people healthy and keeping people functioning and economically productive. There is growing evidence, especially on preventive care, of links of good dental health with even heart disease. And so there is, indeed, a correlation with some chronic diseases, but just as importantly, I think, you know, good oral health keeps people healthier, keeps people functioning, keeps people out of pain and, therefore, probably more employable. So it is both a health benefit and an economic benefit.

Mrs. CHRISTENSEN. Thank you.

Dr. Smedley, welcome back.

Mr. SMEDLEY. Thank you.

Mrs. CHRISTENSEN. The Iowa Medical Treatment Report on equal treatment of which you are the lead author and editor was a landmark document, and the recommendations from that report have been held up as the standard for eliminating health disparities. You mentioned a few areas, but if there are any others, to what extent does this draft legislation meet and address those recommendations? And where are we falling short?

Mr. SMEDLEY. Sure, yes, thank you.

There are a number of provisions within this draft bill that address some of the provisions or the recommendations of the Iowa Medical Treatment Report. As I mentioned in my oral testimony, there are some areas where we can go further in terms of adopting the Federal Cultural and Linguistic Appropriate Services Standards, ensuring that we strengthen our Federal health research.

Data collection is also one of those areas where I think it is clear that we are going to have to have a much more robust systematized system of collecting data on race, ethnicity, primary language and probably other demographic variables in order to understand

when and under what circumstances we see inequality in both access to and the quality of care as well as outcomes.

I will even go a step further and suggest that we ought to publicly report these data because that will give us a level of accountability both for consumers, for providers and health systems, as well as government. One of the responsibilities of government, of course, is to ensure that there is not unlawful discrimination in the provision of care, and until we publicly report and more carefully collect this data, we will not know when that occurs.

Mrs. CHRISTENSEN. Thank you.

Dr. Kestner, I really applaud the fact that in the absence of the longitudinal data showing what that investment might pay back from providing that free preventative care, you did provide it for all employees. And you have talked about some of the shelter and benefits that you have already seen.

But in looking at the public plan that we are proposing, and the possibility that it would allow for innovation, you are a not-for-profit. Is there something in your experience that can inform and maybe support what we are trying to do in a public plan and its ability to do the kind of innovation that we see that you are doing at Alegent?

Dr. KESTNER. I would hate to see any plan be nothing more than a reproduction of what we already have, which is people seeking care when they hurt; people being given a pill and not understanding the cost of that pill; and then not returning unless they have been noncompliant or haven't gotten better.

And so I think that any plan that engages the consumer in the dialogue about not only the consequences of their health care decisions but the cost of their health care decisions is going to be important.

Mrs. CHRISTENSEN. Thank you.

And Dr. Smedley, in my last couple of minutes, we talked about diversity in the health care workforce. You weren't just talking about doctors and nurses, were you?

Mr. SMEDLEY. Yes. We need diversity in all of our health professions. Allied health professions, mental health fields, dentistry.

Mrs. CHRISTENSEN. What about some of those commissions and councils and tasks forces?

Mr. SMEDLEY. The CBC task forces—yes, absolutely, we need diversity on all of the policy-making bodies that are outlined either in this draft legislation, as well as existing bodies because, again, with the changing demographic of this Nation, with the importance of addressing demographic and equity issues, we need to put these issues front and center in all of our conversations around health policy. So I would strongly encourage diversity in all of its forms to be represented on these task forces and panels.

Mrs. CHRISTENSEN. Thank you.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you.

Gentleman from Georgia, Mr. Gingrey.

Mr. GINGREY. Thank you, Mr. Chairman.

Dr. Smedley, in your testimony you talked about racial and ethnic minorities and disparity in care. You state, a potentially significant source of racial and ethnic health care disparities among in-

sured populations lies in the fact that minorities are likely to be disproportionately enrolled, and I think we will quote, lower tier health insurance plans. There are large access problems in the Medicaid program where many beneficiaries are unable to find a doctor that accepts Medicaid because of inadequate reimbursement and high administrative burdens. Do you believe the government-run Medicaid program and how it is administered exacerbates health disparities?

Mr. SMEDLEY. Well, Congressman, I think that, in the case of Medicaid, you are absolutely right, that low reimbursement rates simply make it prohibitive for providers to accept, in some cases, Medicaid patients.

But this draft bill would increase reimbursement rates in ways that I think will hopefully encourage take up of Medicaid patients. Unfortunately, we have associated stigma with Medicaid, despite the fact that it is a very comprehensive benefit plan. As Ms. Wright Edelman pointed out earlier, it offers a number of very, very important benefits particularly for children who are at risk for poor health outcomes.

So I think we can build on the Medicaid program, improve it, and ensure that patients who have Medicaid coverage are actually able to get the care that they need.

Mr. GINGREY. Thank you for that response, and of course, you mentioned that there would be improved reimbursement. That is true for primary care physicians and medical home managers, but certainly, the reimbursement is likely to be less for specialists, general surgeons, OB/GYN doctors, et cetera. So you think if Medicaid beneficiaries had an opportunity, and we have suggested that from this side, our ranking member has suggested a number of times, if Medicaid beneficiaries had the opportunity to opt into a private policy with government assistance, so-called premium support, do you believe they would find it easier to find a doctor that would take them?

Mr. SMEDLEY. Congressman, I am not aware of any data that you would inform an answer. I know that some of the proposals that were offered in terms of tax credits and so forth were insufficient to cover the cost of private health insurance. I believe the cost estimates now for a family is about $12,000. So, clearly, we would need a sizeable tax credit for a low-income family to afford a private plan like that.

Unfortunately, I have no data.

Mr. GINGREY. Well, reclaiming my time, certainly, it would remove the stigma, and when you are talking about let's say the CHIP program, rather than having the child or children running all across town trying to find a doctor that would accept CHIP, it would be wonderful if they could, with premium support, be enrolled in a family policy so everybody could kind of go to the same medical clinic.

Let me switch over to Dr. Kestner for just a second because you were talking about HSAs. I think, Dr. Kestner, in your testimony, you credited HSAs and HRA's as keys to disease management lifestyle changes.

Earlier, I don't know if you heard on the first panel, Dr. Parente of the Medical Leadership Institute, he suggested that rather than

what is recommended in this 800-page draft document from the tri-committees that would require everybody to have first dollar health insurance and also for employers to provide it; his suggestion was, if there is going to be a requirement on the part of the so-called patient, maybe it should be a requirement for catastrophic coverage and not first dollar. The catastrophic coverage, of course, would prevent all these bankruptcies, these three out of five bankruptcies that people talk about that are brought about by basically serious medical illnesses that folks can't pay for. What do you think about that suggestion?

Dr. KESTNER. Well, our strategy has been to be transparent with costs so that consumers can make educated decisions. So, if I have a condition that requires immediate care, I have an option of going to an urgent care center, see my primary care doctor or an emergency department, and each of those costs something different.

Part of my decision-making will be, what is coming out of my pocket as far as the first dollars, and certainly, it is a more cost-effective strategy to go to a primary care physician, if I know I am paying $10 for that visit, as compared to an emergency department, where I potentially would be paying far more.

And so I think it is important for us to have a strategy that engages the consumer in the day-to-day decision-making that they have with regards to that.

Mr. GINGREY. Let me reclaim my time in the 1 second that I have got left, Mr. Chairman, if you will bear with me.

You know, it is estimated that of the 47 million or 50 million people that don't have health insurance in this country, that maybe 18 million of them are folks that make at least $50,000 a year, and I would suggest to you that a lot of them are going bare, opting out of getting health insurance because they feel like they don't really need it. They are 10 feet tall and bulletproof, and they are kind of wasting their money. And they know, at the end of the day, if they pay over a period of 15 or 20 years with an employer-based system, and then all of the sudden they get sick and they lose their job, that the insurance company is going to either say, you are not insurable, we are not going to cover you, or if we do, we are going to charge you 300 percent of standard rates.

Maybe, you know, there is a place here for insurance reform in regard to people like that who have done the right thing and have credible service, and therefore, they shouldn't have to pay these exorbitant rates or even get in a high-risk pool because they have done the right thing.

Mr. Chairman, I know I have exhausted my time. There is probably not time for a response unless you want to allow——

Mr. PALLONE. If you would like to respond, go ahead.

Dr. KESTNER. No, thank you.

Mr. LEVI. Mr. Chairman, if I can make one very short point.

The question was about first dollar coverage, but as I understand Alegent's program, there is first dollar coverage for preventive services, and since this is a panel about prevention and public health, I think it is really important to keep in mind that the things that are going to save people's lives and ultimately save health care costs are the things that really need to have first dollar coverage

without copayments because that is what is going to incentivize better.

Mr. GINGREY. Certainly with the preventive care I would agree with that.

Mr. PALLONE. Thank you.

Gentlewoman from Illinois, Ms. Schakowsky.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

I wanted to ask Mr. Kestner a question. Your Web site says, "we are proud to offer a generous financial assistance program." But then it goes on to say, "medical bills are limited to 20 percent of a total household family income."

So a family of four making $55,000 a year, with a $200,000 medical bill, my staff—they are always right—calculated that the family would have to pay $11,000. So as we are sitting here talking about affordability, do you think a family of four making $55,000 should be paying $11,000 in medical bills?

Dr. KESTNER. I believe we do have a very generous commitment to our community with regards to indigent care. We have contributed $60 million——

Ms. SCHAKOWSKY. But indigent—$55,000 is probably not indigent. So the statement that you have—I guess really what I am getting at, even with your program, which may be more generous than most, we are still talking about really significant out-of-pocket costs that could be overly burdensome for a family, right?

Dr. KESTNER. That could be, yes.

Ms. SCHAKOWSKY. Here is one of the things I want to get at. This issue of the necessity of patients to really understand the cost of health care presumes that medical decisions are mostly patient-driven, and I just—I unfortunately didn't hear your testimony. I was with a doctor. I just fractured my foot, and you know, I didn't go in there and say, give me some X-rays and I think I need a boot, which I now have, and you know, I mean these are things that the doctors tell us.

And when we looked at that article about McAllen, Texas, versus El Paso, probably everybody's read it in the New Yorker, about the amount of difference in Medicaid payments per patient, wouldn't you all agree that this is by and large overwhelmingly provider-driven as opposed to consumer-driven?

Dr. KESTNER. I will just comment on our experience. Since engaging our physician workforce in the discussion of evidence-based care and standardizing our processes and having a transparent, quality Web site, we have been able to demonstrate a decrease in our cost of care. I think that is where the discussion begins is when we have to engage people in the discussion about what the evidence shows, what is necessary, and have that healthy dialogue that we all loved in medical school, as compared to being driven by the decisions that are made today which may be fear of malpractice——

Ms. SCHAKOWSKY. May be self-referral and profit.

Dr. KESTNER. I think by and large most physicians want to do the right thing, but I think we have put them in a system where doing the right thing may not be evidence-based and, at times, may not be the best for the patient.

Ms. SCHAKOWSKY. So, Dr. Smedley, would you agree that mostly patients don't decide about their health care?

Mr. SMEDLEY. I think that is absolutely right. Patient decisions are often shaped by the options presented by doctors. In the cases of patients of color, which is my concern, there is some evidence that patients of color are not provided with the same range of options as the majority group patients. So if that is the case, then I think we need to be very concerned that these are not truly consumer-informed decisions.

Ms. SCHAKOWSKY. Also, one of the things that this article, if you handle it right, the way I read it, at McAllen, Texas, is that the doctors actually were not directing people to preventive care, that a decision had been made in certain places and I guess other places around the country, too, not to engage in preventive care. And again, I am assuming your testimony was even cost-wise, aside from health-wise, this is a bad decision.

Mr. SMEDLEY. That is correct.

Ms. SCHAKOWSKY. OK. Thank you.

Mr. PALLONE. Thank you.

Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman. And I would like to thank our panel for being here, the last panel.

We know that diabetes and obesity sometimes are economic-related, but we know in the minority community, whether it is African American, Hispanic, Asian American, it is almost an epidemic. And one of the best ways you deal with that is through prevention. Don't wait for that diabetic to know they are diabetic. Maybe it is pre-diabetes, and they have a diabetic episode before they go into an emergency room. That is what is so important about the prevention.

On our committee, I get frustrated because literally 2 years ago with our current OMB director, we were on a health care panel for U.S. News and World Report, like most Members of Congress get frustrated because we try and get a score on prevention, and he told me in front of all the other folks, this is not your—he was former CBO, Congressional Budget Office, director—he said, this is not your father's CBO. Send us those, and we will score them better.

We are not seeing any changes. Granted he is at OMB now, and I don't know if OMB has changed, but I would sure like it.

And that is our frustration, and Dr. Levi, you talked about it.

There are so many things we need to do for health care in our country that needs to push the envelope further back instead of waiting till someone finds out that they have these chronic illnesses.

Dr. Levi, as you know, school-aged children is the population group that is most responsible for transmission of contagious respiratory viruses like influenza. Just recently, I introduced a bill, H.R. 2596, the No Child Left Unimmunized Act, which would authorize HHS to conduct a school-based influenza vaccination program project to test the feasibility of using our Nation's schools as vaccination centers. And what are your thoughts on making it school-based vaccinations, especially for some of the influenza virus vaccines? We already use, in our district, and I know a lot of school

districts use their schools for vaccinations for the mandatory vaccination programs throughout the school. But what do you think about making them for other vaccines, including influenza?

Mr. LEVI. I think it is a very good idea, and I think we need to be as creative as possible to make sure that as many people as possible are immunized. I think, in reality, that as we are facing this pandemic of H1N1 influenza and seeing that young people may be among the most vulnerable, they may be highly prioritized for a pandemic vaccine come the fall, and using our schools may be one of the most effective ways of doing that, and that could be a wonderful proof of concept for your legislation.

Mr. GREEN. Any other from anyone else on the panel?

If not, thank you, Mr. Chairman.

Ms. SCHAKOWSKY. Will the gentleman yield?

Mr. GREEN. I would be glad to yield to my colleague from Chicago.

Ms. SCHAKOWSKY. This business of how we score is a really troublesome thing. I am just wondering, is there the kind of research conducted, not just on health outcomes where we concede prevention pays and it really works, but how it actually saves dollars? You know, I really think when we are talking about 10 years, you know, we are looking out into the future when we talk even about the costs, then we ought to have something. Is there some research that can help us quantify that?

Mr. LEVI. Well, ironically, the wider the net you cast, the more research there is, certainly in terms of productivity, in terms of contributing to a tax base, in terms of not requiring disability payments, all those kinds of things. You know, you can't mix and match those things in the scoring process, and I think I want to come back to——

Ms. SCHAKOWSKY. Did you say we cannot mix and match? Why not? I think we need some advocacy help here from those who believe that prevention is the key to help us do that.

Mr. LEVI. But some of these rules have been set and can be changed by Congress, and that is what—that may indeed be what it takes.

I think it is also important to think about sort of the evidence standard, and you know, we look for, you know, there are different levels of evidence that you may need to make it move forward with a decision. But I think when you have so many businesses voting with their feet around prevention programs, whether it is clinical preventive services or even nonclinical preventive services——

Ms. SCHAKOWSKY. By that you mean buying them?

Mr. LEVI. By buying it, investing in it, and saying they have the evidence for their stockholders that this saves them money. It seems odd that the private sector can be ahead of the public sector in recognizing the value.

Ms. SCHAKOWSKY. That is a really good point. Maybe we ought to enlist some of those findings. I know my nephew does preventing back injury at a lot of factories, and it works. Anyway, thanks.

Mr. GREEN. Mr. Chairman, I know I am out of time, but I would hope we would push back just what this panel is about and look at prevention and as best we can to fund that and use our own examples maybe over the next 10 years and show we can reduce obe-

sity, we can reduce diabetes, and some of things that we are going to pay a lot of money for if we don't in some type of national plan.

Mr. LEVI. And that is certainly part of the goal through the Recovery Act in terms of the community-based prevention programs that are being funded there, and that I know that HHS is working very hard to make sure that the evaluation system that is developed for that investment will be able to help us answer these questions.

Mr. PALLONE. Thank you.

Gentlewoman from Tennessee, Mrs. Blackburn.

Mrs. BLACKBURN. Thank you, Mr. Chairman.

You all must feel like you are batting cleanup. You have been here all day I bet listening to all of these, and I appreciate the focus that you have on prevention and wellness programs. I think many times we look at medical care, but we don't look at health care and don't look at health, and it is frustrating for us.

And so many times I have said I thought one of the greatest disservices that we have done to children is they no longer have physical education, and they don't take life—when they are all through school, they don't have physical education classes that they are attending, and then secondly when they get into high school, they don't have life skills classes, so they don't understand the impact of what they eat, of the different food groups or the food pyramid and how that affects their lives, the importance of the interface between exercise and also what they eat and how that weighs in on some of the health issues, as we have read in testimony that has been given to us today and heard from some of our witnesses.

Obesity, diabetes, chronic heart disease, if you address those, you would move a long way toward addressing some of our Nation's health care woes. And many times people say, well, change how you are looking at this; look at it as health, as opposed to looking at it with medical care delivery. And of course, having been—as someone who served in a State legislative body and looking at these issues and bringing that to bear here at the Federal level, sometimes, you know, you do stop and think a little bit about that.

What I would like to hear from each of you in the 3 minutes that I have, I want each of you to tell me if this 852-page bill, if you think, at the end of the day, it is going to provide a structure for Americans to be healthier and thereby need to consume less medical care, because the quality of life and the way this affects individuals should be a focus of the policy that we decide what is going to happen as we look at health reform. We all know that the system needs some reforms. I am one of those that favors handling it through the private sector so that it stays patient-centered and consumer-driven.

But I would like to hear from each of you, at the end of the day, the draft before you, would it allow for greater emphasis on wellness, for prevention, for healthier lifestyles, and individuals to consume less medical care?

Dr. Levi, we will start with you.

Mr. LEVI. Absolutely, on both the clinical side and the community side, and I will make three very quick points.

First, solid coverage there are no copayments of the evidence-based clinical prevention services I think is critical. Whether it is a public program, a private insurance plan, it has to be there.

Second, the investment in community prevention will get at the very things that you are talking about. Some of the best community-based prevention programs are the ones that target kids, get them to change their lifestyles, and through the kids, they educate their parents, because some of us are just over the hill and uneducable unless we are reached through kids. And we can make those permanent lifestyle changes, and that is why the investment in community preventive programs is going to be so important.

And third, and I think just as importantly is this investment in the core public health capacity because if we strengthen our State and local health departments then they will be able to provide the services that surround the normal health care delivery system.

Mrs. BLACKBURN. I need to move on. I am running out of time.

Dr. Smedley.

Mr. SMEDLEY. As you know, we spend less than 5 cents out of every health care dollar on prevention. This draft bill takes a step toward righting that equation.

It is also true that we have not paid enough attention to the issues of achieving equity, ensuring that everybody has access to primary care. These are all important elements that are reflected in this draft bill which I think are going to save costs.

Mrs. BLACKBURN. But should it be mandated or be personal choice?

Mr. SMEDLEY. I don't believe this bill creates that kind of mandate. But what it does, through the investment in prevention, is it creates healthier communities.

Mrs. BLACKBURN. OK.

Dr. Kestner.

Dr. KESTNER. I think the bill addresses the access issue as well as the investment in primary care and public health, and I think that is where the first relationship should be established with our citizenry is in a public health sector and primary care, as compared to outside of care that we experience today.

Mrs. BLACKBURN. Thank you very much.

I yield back.

Mr. PALLONE. Thank you.

Gentlewoman from Wisconsin, Ms. Baldwin.

Ms. BALDWIN. Thank you, Mr. Chairman.

I appreciate the fact that you have had this panel today devoted to public health and prevention and health care disparities.

I am introducing a bill today that is very relevant to this topic. What the bill does is it takes the first steps in identifying and addressing health care disparities faced by lesbian, gay, bisexual and transgender Americans. The bill is based in large part on the extraordinary work of the tri-caucuses on racial and ethnic health care disparities; the Congressional Black Caucus, the Congressional Hispanic Caucus, and the Asian, Pacific Islander Caucus have done extraordinary work teaming together to put together a bill that is called the Health Equity and Accountability Act which I believe will also be introduced this week.

We know that there are disparities in health care faced by the LGBT community, but we know this largely based on anecdotal information or some data derived from locally administered or privately administered health surveys. And I can tell you that it was, in some cases, quite challenging putting together this legislation because of the lack of data and the lack of evidence.

And so I want to just ask some very basic questions, starting with you, Dr. Smedley. Having studied racial and ethnic health care disparities, how important is data collection to understanding and addressing health care disparities?

Mr. SMEDLEY. It is absolutely vital.

In the case of LGBT populations, as you pointed out, lacking data, it is difficult to understand when and under what circumstances these populations face both health status and health care inequities. So it is very important to have that data. Once we have that data, we not only raise public awareness, but we can focus and target our intervention so we are addressing the problem successfully.

Ms. BALDWIN. The National Health Institute survey, which I understand to be the Federal Government's most comprehensive and influential survey, does not include any questions on sexual orientation or gender identity. Do you think it should?

Mr. SMEDLEY. Yes.

Ms. BALDWIN. And to my knowledge, actually, no Federal health survey at all includes any questions on sexual orientation or gender identity. Do you think this would be important as a routine inclusion in health surveys where we are trying to collect information?

Mr. SMEDLEY. Yes. I believe that, I may be mistaken about this, but I believe that BRFS, the Behavioral Risk Factor Study, may allow that as an option, but we should certainly ensure that we are understanding all of our populations where we see inequalities in health and health status.

Ms. BALDWIN. I would ask you also, Dr. Smedley, how important and relevant are goal setting and aspirational documents like Healthy People 2010? I know there is an effort under way to revise and update for Healthy People 2020 document. How important are these goal-setting documents to reducing health care disparities?

Mr. SMEDLEY. Again, vitally important. Some have criticized Healthy People 2010 for having goals that are difficult to attain, but unless we articulate what our vision is of a healthy society, it is going to be very difficult to put in place the policies and indeed to create the political to achieve those goals. I believe it is very important that we have strong aspirations for equity for millions of populations that face inequity.

Mr. LEVI. If I could just add one point here, I think one of the criticisms in the past of the Healthy People process has been we set goals, and we don't have the data sets to tell us whether we are even achieving those goals, and part of what is in this discussion draft is creating an assistant secretary for health information, which would increase I think the transparency of the data and create a process by which we would do a better job of answering some of the questions that you want to have answered.

Ms. BALDWIN. I would note, from the Healthy People 2010 document, this is sort of a vicious cycle because it is silent to LGBT

health issues because the authors of that document said, we don't have any data to point to any disparities, so we can't talk about how we need to address those disparities.

Dr. Levi, I know your organization has done terrific work on demonstrating that community-based prevention programs can have a significant return on investment, and it is also my understanding that different communities targeted often respond differently to different interventions.

So tell me a little bit about targeting those interventions, and how much do these programs need to be targeted or tailored to do different cultural subgroups?

Mr. LEVI. I guess I would answer it in two ways. One is we have a lot of evidence that from some national programs like the REACH program, Access program, or the Pioneering Healthier Communities Program, where there is an overall goal of trying to reduce the prevalence of certain conditions and a recognition on a community basis what is happening in that community. Some communities need more exercise promotion. Some people need more nutrition promotion. Some people have higher rates of smoking. Those kinds of particular issues need to be addressed in the context of the community.

And then there is a second part, which is what sub communities. That is thinking more geographically. And then when you are thinking about racial and ethnic communities or the LBGT communities, what particular issues do you also need to think about?

And I think the LBGT community is a perfect example. If we had thought about community prevention at the very beginning of the HIV epidemic, we would have been addressing what Ron Stall from, formally at CDC, talks about syndemics, which is, the risk for the disease you are wanting to prevent, in this case HIV, is related to other factors, such as experience of domestic violence, mental health issues, alcohol issues. It can be smoking, depending on what aspect you are looking at. That all needs to be addressed together.

And when you are thinking about community prevention, that is what you want to do; you want to bring all of these pieces together. But coming back to the beginning, you can't do it without data.

Ms. BALDWIN. Thank you.

Mr. PALLONE. Thank you.

Gentlewoman from Florida, Ms. Castor.

Ms. CASTOR. Thank you, Mr. Chairman. Thank you all for your testimony.

I am fortunate that back in my hometown I have a great College of Public Health, and the dean there is Dr. Donna Peterson. I have been keeping her informed all the way along during the health care reform discussion dialogue from the outline now and into the discussion draft.

And her initial comments were, boy, you all are on the right track when it comes to community health centers, and there is certainly a consensus in the Congress, many of them rooted on issues of Chairman Waxman, Chairman Pallone, Mr. Clyburn, the Whip. We are on track with workforce issues. Everyone, there is great consensus around improving the primary care of the workforce, and the SGR, how we are going to compensate those folks.

She expressed some concern on whether or not we are really doing enough for community's public health initiative. We see the initial draft here, the discussion draft, and I thought that Ranking Member Deal raised a good point, too, about personal responsibility and how we get parents to turn off the TV and encourage their kids to exercise. And it can't just be that we hope that people see President Obama and the First Lady work out in the morning, and that is going to be a great inspiration. We need a Surgeon General, I think, that is going to be very proactive. And we don't have that yet. We need the CDC to take an even more proactive role.

We know back home, our local governments and school districts and States, many are in severe budget crises, and oftentimes, the first things to go are the sidewalks, the other—the parks initiatives, summer programming for kids.

Tell me, what is out there right now, what do local communities depend on right now from the Federal Government on those community public health and investing in infrastructure initiatives? What grants are there now? And then we can talk about what is in the discussion draft and where we need to go.

Mr. LEVI. There certainly are Federal programs that will support this kind of community prevention, but we are talking a fraction of the level of investment that is in the discussion.

Ms. CASTOR. And it is out of which—is it out of HHS?

Mr. LEVI. Mostly out of HHS and mostly out of CDC, but the budgets for those programs have either been relatively flat or declining over the last 5 years. Our entire effort around chronic disease prevention has been declining over the last 5 or 6 years. Obesity is a perfect example where we recognize that this is a huge public problem, and we haven't even found the resources to fund every State to have an obesity program, and particularly now, in a time of economic crisis, it is not like State and local governments have the resources to backfill. And in an economic recession, it becomes even more important for us to be thinking about those issues because it is harder to eat healthier——

Ms. CASTOR. I have a limited time. Is there another Federal pot of money or initiative you identified besides this CDC?

Mr. LEVI. The other pot of money, the big pot of money is the $650 million in community prevention that is in the Recovery Act and that will be released shortly.

Mr. SMEDLEY. If I could add, not only are those funds from the prevention and wellness also good, I think the entire stimulus package can be looked at as a public health intervention because of the many provisions around housing, transportation, early education. We know that early start, healthy start programs work. They save money, as Dr. Levi indicated.

So if we can think about the stimulus dollars as a public health intervention and ensure that those dollars are going to communities to create safe public transportation to stimulate healthy lifestyles, then this can meet multiple purposes.

Ms. CASTOR. And in your health reform bill, we need to build upon those historic investments that come out of the Recover Act. I mean, Donna Christensen has a great empowerment zone initiative, but it seems like our local communities need a new healthy communities block grant initiative that is consistent over time that

maybe doesn't compete with the other—if there is anyone from the Association of Counties Or League of Cities that you all work with, I would like to investigate that.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you, and I think we are done for today.

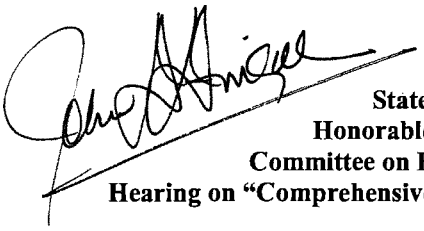
I want to thank all of you, and again, as I mentioned, you will probably get some written questions that we would like you to get back to us as soon as you can, but again, this is a very important part of what we are doing, the prevention and the public health provisions. So thank you as we proceed.

And let me remind Members we are going to recess because we will be reconvening tomorrow as well as Thursday. Tomorrow, at 9:30, the full committee will meet to hear from Secretary Sebelius, but after that is done, we will reconvene as a subcommittee and have a number of panels to continue with the subcommittees activities.

So, without objection, this subcommittee will recess and reconvene tomorrow following the conclusion of the full committee hearing that begins at 9:30 a.m.

[Whereupon, at 3:25 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]



Statement of the
Honorable John D. Dingell
Committee on Energy and Commerce
Hearing on "Comprehensive Health Reform Discussion Draft"

June 23, 2009

Mr. Chairman, thank you for holding this important hearing. I want to acknowledge Secretary Sebelius who is making her first appearance before this Committee. I am confident you bring the right experience and expertise to help us solve the health care problems we are faced with. I would also note that Secretary Sebelius' father, John Gilligan, was a distinguished Member of this Committee. This week marks the beginning of a truly historic process, an opportunity to fulfill our moral and economic obligation to provide quality affordable health care coverage for all Americans.

There is general consensus around the fact that the current health care system is not working—it is not working for American families, business, or government. 47 million Americans are currently without health care and upwards to 86 million will be without health care at some point during the year.

More and more Americans are being forced to make decisions they should never be forced to make—do they pay their monthly health

insurance premium or pay the utility bill? Do they pay the copayment for their prescription drugs or doctor visit or put gas in the car so they can get to work? Many Americans are putting off going to the doctor because they cannot afford to do so. It is no wonder that the leading cause of personal bankruptcy is medical bills.

American business owners are facing the tough decision of whether to meet the monthly payroll or pay the health insurance contribution for their employees. They find themselves at a disadvantage in trying to compete with business in other countries.

The federal budget simply can not sustain our current health care spending. If health care costs grow unabated, the country is on track to spend more than 20% of its GDP on health by 2018.

The discussion draft, I stress "discussion draft", we are considering is a uniquely American solution to this crisis. I have enjoyed working with Chairmen Waxman, Rangel, and Miller on putting this draft together and I commend all parties for the unprecedented cooperation and coordination that went into producing this single discussion draft for the three committees of jurisdiction. Much hard work and good faith effort has gone into this document. It is truly remarkable that we have been able to operate, for all intents and purposes, as one committee with

the single goal of taking President Obama's health care reform principles and turning them into the starting point for legislation.

We have all worked hard to get to this point, but now the real work begins. Chairman Waxman has pledged to follow regular order as much as possible, given our very tight time frame set out for us by President Obama. I thank him for that, because it is through this process that we must listen, negotiate and work with all interested parties to create the best possible bill – one that is truly an American Solution.

I have been working on health care reform for more than 50 years, building on the work of my father before me. The stars have aligned in favor of health care reform in a way that I have never seen. The President wants it, the Congress wants it, and the American people are desperate for it. This process is going to be hard. Our timeline is short, and we all won't agree on everything. However, we must keep the end goal in mind. We must not let ourselves get so mired that we never come up for air and remember that our current health care system is failing us and we cannot delay reform for another Congress, another decade, or another century.

Let me be clear:

- This discussion draft is NOT an attempt to create a single payer system nor is it a <u>first step</u> towards a single payer system.

- This discussion draft is NOT an attempt to ration care. I would commit that the draft is an attempt to get rid of the rationing that takes place every day because people cannot afford care or are denied care because of pre-existing conditions.
- This discussion draft is NOT an attempt to destroy the private market or the system of employer sponsored health care many Americans enjoy today.

That being said, each of us in this room has our own vision of what ideal health care reform looks like. While, the specifics may be different, we all share four common goals:

- We must pass legislation that reduces the costs of health care for families, businesses and government;
- We must pass legislation that makes quality, affordable health insurance available for all Americans;
- We must pay for this legislation;
- We must pass legislation now.

The choices that we make over the coming months will be historically significant. If we are courageous, and enact comprehensive health care reform, our product will sit among the ranks of Social Security, a program that my Dad helped pass in 1935, and Medicare, which the *New York Times* noted on its editorial page on Saturday is

"only short of the flag in its popularity." If we are not courageous, we will have failed this generation and the generations to come.

Opportunities of this magnitude to help the American people do not come around often, and if we do not have the courage to move forward, this unique opportunity will pass us by. I argue that the task of reforming health care is probably one of the most important duties any of us will face in our careers. It will take courage to fight back against the naysayers who claim that we are trying to do too much, too quickly. It will take courage to stand up to the false cries of socialism and those who say that reform will lead to a government take over of health care. And it will take the courage of all of us to listen to each other, to work in good faith and put the interest of the American people ahead of the benefit of any one industry or interest group.

We must not lose sight of the people we were elected to represent – the family who has health insurance but is worried that with rising costs they will no longer be able to afford it; the small business owner who wants to provide her employees with quality coverage, but the costs prevent her from doing so; and our American companies who find it harder to remain competitive in the global economy due to the escalating health care costs.

If we keep these people at the heart of the process, I am certain this year we will pass comprehensive health care reform legislation that will build on the existing system, keep intact the that which is working in our system, and will give people the peace of mind that no matter what life changes they face, they will always have access to health insurance. The American people deserve nothing less.

Thank you, Mr. Chairman.

Statement of the Honorable Anna G. Eshoo
House Committee on Energy and Commerce, Subcommittee on Health
Hearing on Health Reform
June 23, 2009

Thank you, Mr. Chairman, for holding this hearing today, the first in a series of hearings on health reform. Many of us have been waiting years for an historic opportunity like this one and I'm proud and honored as our distinguished Committee takes a primary role in shaping the legislation.

As the list of uninsured, and underinsured, grows every day, we know we cannot continue to operate under the status quo. A first-world, industrialized nation like the United States owes more to its people than leaving 50 million people without care and millions more unable to pay their deductibles. With healthcare costs accelerating at a rate that far outpaces inflation, we will buckle under the weight of our own inaction.

The bill before us makes great strides not only toward the goal of universal healthcare, but for improving preventive healthcare. We all know that preventing an illness before it happens is not only better for patients but saves money and resources. Unfortunately, we have a perverse payment system that pays doctors more if their patients are sicker. We must change this system and reward 'wellness' in order for real health reform to work.

I'm pleased that this draft prohibits lifetime caps on any insurance plan. I have been working on this issue since 1996 when I introduced the *Christopher Reeve Health Insurance Reform Act*, to raise lifetime caps. For those with a chronic disease, or even a serious one-time illness, medical costs can be exorbitant. If you have a *lifetime* cap on medical costs your insurance plan will cover, children can "run out" of insurance by the time they're 12. This is can devastate families, leaving people with gaps in their coverage, and even forcing them into poverty to become eligible for Medicaid.

I'm also pleased that the Geographical Price Cost Index, or GPCI, was fixed for those California counties where physicians who accept Medicare have been severely underpaid for their services due to an erroneous locality designation that classifies the county as "rural." Santa Cruz County in my Congressional District has been suffering under this wrongful designation for years. It's unfair to the doctors and unfair to patients and I look forward to a more equitable payment system.

I am concerned that there is no mention of a new pathway for biosimilars in the draft legislation. Along with the support of 105 of my colleagues, I have introduced H.R. 1548, the *Pathway for Biosimilars Act* to protect patients, promote innovation, and save the American healthcare system billions of dollars. The Senate HELP Committee has already indicated that it will take action on this issue in health reform and the President has called for reform on this issue. I believe it's important that we work on this critical matter before health reform legislation in the House and Senate goes to Conference.

U.S. Representative Kathy Castor
Committee on Energy and Commerce – Hearing Opening Statement
"Health Care Reform Draft Legislative Proposal"
June 23, 2009

- Mr. Chairman, the American people are depending on us to stand up for them and enact health care reform once and for all so I thank you for the opportunity to examine our health care reform discussion draft with experts and advocates.

- The New York Times/CBS News poll last week found that 72 percent of Americans support a public option for health care to compete with private insurers – and most Americans believe that such a nonprofit organization would do a better job than private insurance companies to keep costs affordable.

- This is the top issue in my district and all across Florida.

- Last Wednesday evening I held a telephone townhall meeting that focused solely health care. Nearly 4,500 people in my district participated to share their health care experiences and ask questions about how we will change health care to help their families.

- The ongoing theme of each of the callers that I spoke to was that their insurance companies were discriminatory, unaffordable or did not provide what they needed.

- Mrs. Machado, a 62 year old woman, not quite eligible for Medicare, and currently covered by a major private insurance company said that she is paying over $900 a month for her premium because she had bypass surgery. While she is in good health now, with no complications, her premium has gone sky-high because she is considered a health risk. She admitted that she is fortunate because she is able to make the

payments, but she understood that most of her neighbors would not be able to afford such a premium.

- Mrs. Machado said that although she maintains her coverage at such a high rate, it would be better for her family if she was able to put that money into a college savings plan for her grandchildren. She asked if there will soon be coverage for someone like her—coverage that would not cost her family $900 each month because of a previous condition.

- Over the weekend, while shopping for a father's day gift with my daughter at home in Tampa, I was stopped four times in the mall by my neighbors who asked me when health care would be "fixed."

- One of my neighbors that stopped me said that she was a bit too young for Medicare, and she wanted to know if there would soon be a plan that she could turn to for coverage.

- Another woman, Gloria Santiago, featured in the St. Petersburg Times last week, said that at age 52 she has not been without a job since age 19, and is for the first time facing the reality of being unemployed and consequently uninsured.

- She is frustrated that after three decades of consistent hard work and contributions to our nation's economy there was no where for her to turn when she unexpectedly found herself in need of help.

- Gloria is unable to afford necessary medication, and after paying bills her retired husband's small pension and Social Security benefits leave only about $50 for groceries each month. As a result, Gloria recently ended up in a local free

clinic after her blood sugar had risen to a dangerously high level.

- Some may say that Gloria is lucky that here in America, she has access to a free clinic or an emergency room if she is dangerously sick, but I say that we can do better by my neighbor and the millions of others just like her that need help. Families should not wait until it's an emergency to seek care or until it's too late to get help.

- Too many families are being forced to choose a meal over medication to monitor manageable health conditions or other more serious issues.

- Getting health care reform right will mean that millions of Americans with stories just like those of my neighbors will be less likely to end up in trouble because they didn't have access to routine, preventive care and medications. Folks will be able to have a benefit plan that suits them and provides their families with the coverage that they need to stay healthy.

- Providing a pathway to consistently healthy lifestyles is not only a cost saver for our country, but for every family that has ever had to miss a mortgage payment or not send their child to college because someone was sick and every dime they had went to treatment.

- I am so very proud that we are on the verge of making a real difference in health care for American families and look forward to the coming months when we will finally meet the needs of our communities by giving them affordable access to quality care that they can depend on.

June 23, 2009

Congressman Bruce Braley
Statement Submitted for the Record

House Energy & Commerce Committee and Subcommittee on Health
Hearing on *Comprehensive Health Reform Discussion Draft*

Thank you Mr. Chairman, and thank you for holding this series of hearings. I commend you and the Committee staff for their hard work over the last few months drafting the comprehensive health reform discussion draft. I also appreciate your willingness to work with me throughout this process, and I hope to continue making improvements to this draft.

As we look at ways to design comprehensive health care reform, I want to draw everyone's attention to a number of issues that I've been focused on, and that directly impact the overall health of our nation and performance of our system: 1) the considerable variation in health care quality and cost across the country; 2) wide geographic disparity in access to care; 3) the need for a comprehensive, interdisciplinary health workforce; 4) ongoing efforts to improve the health and quality of life of our nation's seniors; and 5) the application of 'plain language' principles to health insurance documents, to improve transparency and understanding of coverage and benefits.

First, I'd like to address the significant variation in health care quality and cost around the country. While Iowa's cost to our health care system ranks very low, the state's quality of care consistently ranks right at the top. Iowa physicians, hospitals, and health care personnel are unrivaled, and are a primary reason why Iowa consistently ranks in the top 10 healthiest states. Unfortunately, though, our current health care system does not reimburse based on quality of care, nor on keeping costs down and eliminating waste, but instead incentivizes quantity. As a result there is considerable variation in quality around the country, and areas which create the most waste and have highest costs often have some of the worst quality of care. The discussion draft under consideration takes incremental steps towards improving quality and keeping down costs, but falls short of any true reform in this area. While models such as Accountable Care Organizations are a step in the right direction, the discussion draft does not take many more much-needed steps to significantly bring down costs, eliminate waste in Medicare, and increase quality of care. I hope that this committee takes a serious look at proposals to incentivize quality and efficiency, such as the Medicare Payment Improvement Act, which I introduced with Rep. Ron Kind, to finally put quality of care over quantity of care.

I feel that this fundamental shift in our reimbursement system would lead to tremendous spikes in the quality and performance of American health care. Instead of a business model that encourages doctors and hospitals to get a patient in and out as quickly as possible, we'd have a system that encourages them to make sure the patient is healthy. That's what really matters.

Second, our current system has built-in geographic inequities, which result in a lack of access to care for residents in many rural states like Iowa. An example of this can be found in the Geographic Practice Cost Indexes, or GPCIs. These antiquated figures ensure that some parts of the country receive drastically lower Medicare reimbursement rates than other parts, and have led to a tremendous shortage of doctors in certain parts of the country.

In an attempt to achieve some leveling of the geographic inequity of physician reimbursement, the Medicare Modernization Act of 2003 established a temporary floor of 1.0 to the Work GPCI, which helps level the playing field for physicians in Iowa and other rural states. Congress has had to extend this floor repeatedly, and I'm glad that the discussion draft does include a 2-year extension of the Work GPCI floor. However, the floor on the Work GPCI still does not go far enough. Despite the well-documented efficiency of Iowa's health care system, Iowa health care providers still lose millions of dollars because they choose to care for Medicare patients. There is already a physician shortage in Iowa, and the existence of the GPCIs only serves to further disincentivize the treatment of those who often need it most – Medicare patients.

Earlier this year, I re-introduced H.R. 2201, the Medicare Equity and Accessibility Act, which addresses the GPCI problems. I will continue fighting for a permanent Work GPCI floor, as well as a Practice Expense GPCI floor, but, frankly, this is only a band-aid for a broader problem, which is the fundamental waste and poor quality of the fee-for-service system, which I already outlined.

Third, I'm glad to see that the discussion draft takes significant steps towards comprehensive, interdisciplinary care for American patients. I have long felt that we need to move away from a system that reacts to illness and injury and towards a system that works to keep people healthy, and has the network to do this while also reacting to emergencies as necessary. That's why I introduced H.R. 2891, the Access to Frontline Health Care Act, which would ensure that communities have access to a wide array of health care services. This legislation will help make certain that patients can receive comprehensive care, and incentivizes the transition to an interdisciplinary approach to health care. I'm thankful that the Committee included part of my legislation in Section 2211 – Frontline Health Providers. I look forward to continuing to work with the Committee to specify which professions should be eligible under Section 2211, and to ensure that we are truly working towards comprehensive, interdisciplinary recruitment of health care professionals.

Next, I'm proud to have introduced H.R. 2852, the Project 2020: Building on the Promises of Home and Community Based Services Act of 2009. This legislation will improve the quality of life for America's seniors and individuals with disabilities through consumer-centered, cost-effective long-term care, allowing them to stay in their homes as they age. As many of my colleagues are aware, the fastest growing segment of the aging population is individuals over 85, the most vulnerable older adults who tend to need long-term care and whose numbers are expected to double by 2020. My legislation will make sure that resources exist to assist these seniors as they age, keep them healthy, and allow

them to stay in their homes and communities. In addition, Project 2020 will save the Medicaid system over $1.1 billion. This bill is a win for seniors and a win for taxpayers, and I thank the Chairman for continuing to work with me to try to include this language in Health Care Reform.

Finally, I'm glad that the discussion draft takes great strides towards proper transparency and disclosure in the insurance market, and I appreciate that the Committee has adopted my concept of plain language. Just this week, I'm introducing the Plain Language in Health Insurance Act, which would create significant, enforceable requirements to ensure that insurance documents are clear, concise, easy-to-read, and follow plain language principles. For too long, insurance enrollees have struggled to understand their coverage and benefits, and this bill would solve that problem. Not only will it increase transparency, but it will save money, as plain language principles have proven to lead to decreases on administrative paperwork, consumer inquiries, and the need for assistance. My bill would apply to both private insurance and any public insurance programs, and will make Americans better informed about their insurance choices. I'm hopeful that language will be added to the House proposal reflecting these principles, and I thank the Committee for working with me on this issue.

Thank you, Mr. Chairman, for tackling the important issue of health care reform. I look forward to continuing to work to improve the discussion draft, as we move forward in Committee.

Rep. Joseph R. Pitts
Opening Statement
Energy and Commerce Committee Subcommittee on Health

Hearing on Comprehensive Health Reform Discussion Draft

June 23, 2009

- Mr. Chairman, I would like to thank you for convening this week of hearings on a discussion draft in which the Minority had absolutely no input.

- This 852-page bill that was released last Friday afternoon has no score and an entire section in Title IV – "Subtitle D-Other Revenue Provisions" – is left blank.

- Now, I know that this section falls under the jurisdiction of the Ways and Means Committee, but it would be nice to know exactly how the Majority intends to pay for overhauling our health care system before the witnesses begin testifying – that is if the Majority does intend to fully offset the entire bill.

- I would ask the Chairman for a commitment that we not move to subcommittee or full committee markup on this draft bill before CBO reports out an official score.

- Health care reform in this country is too important to debate proposals with only half the picture and half the information.

- I ask for this commitment because the Majority appears wedded to an artificial timeline of House passage by July 31, rather than taking the time to have thoughtful and informed discussion and consideration.

- In three days this week, we will hear from 11 panels comprised of at least 47 witnesses, according to the latest witness list provided to Members less than two hours before the beginning of this hearing.

- Most of these panels deserve a separate hearing in their own right; however, the Majority's timeline does not accommodate such thoroughness.

- Mr. Chairman, I look forward to hearing the thoughts and testimony of our many witnesses.

- Thank you, and I yield back my time.

COMPREHENSIVE HEALTH CARE REFORM DISCUSSION DRAFT—DAY 2, PART 1

TUESDAY, JUNE 24, 2009

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The committee met, pursuant to call, at 9:41 a.m., in Room 2123, Rayburn House Office Building, Hon. Henry A. Waxman [chairman of the committee] presiding.

Present: Representatives Waxman, Dingell, Markey, Rush, Eshoo, Engel, Green, DeGette, Capps, Harman, Schakowsky, Gonzalez, Inslee, Baldwin, Matheson, Melancon, Barrow, Hill, Matsui, Christensen, Sarbanes, Murphy of Connecticut, Sutton, Braley, Welch, Barton, Hall, Upton, Stearns, Deal, Whitfield, Shimkus, Buyer, Pitts, Walden, Terry, Murphy of Pennsylvania, Burgess, Blackburn, Gingrey, and Scalise.

Staff Present: Karen Nelson, Deputy Committee Staff Director for Health; Andy Schneider, Chief Health Counsel; Purvee Kempf, Counsel; Sarah Despres, Counsel; Jack Ebeler, Senior Advisor on Health Policy; Robert Clark, Policy Advisor; Tim Gronniger, Professional Staff Member; Stephen Cha, Professional Staff Member; Allison Corr, Special Assistant; Alvin Banks, Special Assistant; Jon Donenberg, Fellow; Camille Sealy, Fellow; Karen Lightfoot, Communications Director/Senior Policy Advisor; Caren Auchman, Communications Associate; Lindsay Vidal, Special Assistant; Earley Green, Chief Clerk; Jen Berenholz, Deputy Clerk; Mitchell Smiley, Special Assistant; Miriam Edelman, Special Assistant; Ryan Long, Minority Chief Health Counsel; Brandon Clark, Minority Professional Staff Member; and Chad Grant, Minority Legislative Analyst.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. In February, President Obama called upon the Congress to enact legislation to reform America's health care system. In April, Governor Kathleen Sebelius was sworn in as Secretary of Health and Human Services. Her Department has the lead responsibility for improving the health of the American people.

Last Friday, I joined with Chairman Rangel and Chairman Miller and Chairman Emeritus Dingell to propose a discussion draft on health reform. This morning, we have the honor of hearing Sec-

retary Sebelius present the administration's views on the discussion draft.

Based on her contributions today and on what we will hear and learn from the 50 stakeholders appearing before the Health Subcommittee this week and on the input from the Members, we will revise the discussion draft and introduce a bill for consideration by the three committees.

Our legislation will reduce health care costs. It will cover all Americans. It will improve the quality of care. And it will be fully paid for. The lead author will be John Dingell, chairman emeritus of this committee, who has faithfully carried on his father's legacy as an undisputed leader in the struggle for health reform.

I want to emphasize a few important points about the discussion draft. First, it is just that, a draft for discussion for the legislation. We are seeking input from the administration and others because we want to improve the draft before introducing legislation.

Second, the draft builds on what works in our uniquely American system. It builds on the employer-based system for providing health coverage to workers and their dependents. It relies on and improves Medicare as a source of health coverage for the elderly and the disabled. It builds upon Medicaid to extend coverage to low-income Americans.

Third, the draft fixes what is broken. It fixes the broken individual health insurance market by creating a new insurance exchange through which uninsured Americans can enroll in their choice of health care plan. Those who cannot afford to purchase the coverage available in the exchange will receive assistance.

A public option will be available within the insurance exchange to give consumers an alternative to private health insurers for their health care coverage. This public option will be self-supporting, will not receive ongoing subsidies from the Federal Government. The public option will compete. No one is obligated to sign up for the public option. No provider is obligated to provide medical services under the public option. But the public option will provide competition so that we can make the market work and keep everybody honest.

The draft contains provisions to reduce rural, racial, and ethnic disparities in disease incident and treatment. The draft fixes a broken Medicare physician payment system and prevents the irrational cuts that are scheduled under current law from going into effect.

The draft takes the steps necessary to fix the shortage of primary care practitioners and nurses and other providers. And, finally, the draft ensures that people have a choice: choice of doctors, choice of benefits packages, and choice among insurance plans.

This approach builds on what works and fixes what is broken and makes sure that people have choices. It is pragmatic, and it will produce the results the Nation's health care system so desperately needs: lower costs, broader coverage, and better quality.

Today we will continue on a journey that began over a hundred years ago to provide health insurance for all Americans. Some of our greatest Presidents of the 20th century—Teddy Roosevelt, Franklin Roosevelt, and Harry Truman—were advocates for health insurance for all Americans. President Clinton fought hard for his

administration's proposal. Those initiatives may have failed, but the hope that inspired them was never defeated. The time has finally come to redeem that hope and to deliver true health reform.

In my conversations with colleagues and constituents, I am getting the clear sense that there is now a willingness to tackle this issue and to resolve the problems and bring forward a much better health care system for all Americans. With President Obama in the White House, we now have the best opportunity ever to enact health reform. I am determined that we not let this opportunity slip from our grasp.

I look forward to this morning's testimony and continue with urgent pragmatism to send health reform legislation to the President for his signature this year.

I want to recognize for an opening statement the ranking Republican member of the committee, Mr. Barton.

[The prepared statement of Mr. Waxman follows:]

Opening Statement of Rep. Henry A. Waxman
Chairman, Committee on Energy and Commerce
Health Care Reform Draft Proposal, Day 2
June 24, 2009

In February, President Obama called upon the Congress to enact legislation to reform America's health care system.

In April, Governor Kathleen Sebelius was sworn in as Secretary of Health and Human Services. Her Department has the lead responsibility for improving the health of the American people.

Last Friday, I joined with Chairman Rangel and Chairman Miller, and Chairman Emeritus Dingell to propose a discussion draft on health reform.

This morning we have the honor of hearing Secretary Sebelius present the Administration's views on the discussion draft.

Based on her contributions today, and on what we will hear and learn from the 50 stakeholders appearing before the Health Subcommittee this week, and on the input of the Members, we will revise the discussion draft and introduce a bill for consideration by the three committees.

Our legislation will reduce health care costs, it will cover all Americans, it will improve the quality of care, and it will be fully paid for.

The lead sponsor will be John Dingell, Chairman Emeritus of this Committee, who has faithfully carried on his father's legacy as an undisputed leader in the struggle for health reform.

I want to emphasize a few important points about the discussion draft.

First, it is just that — a draft for discussion. We are seeking input from the Administration and others because we want to improve the draft before introducing legislation.

Second, the draft builds on what works in our uniquely American system:

- It builds on the employer-based system for providing health coverage to workers and their dependents.

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- It fixes the broken individual health insurance market by creating a new insurance Exchange through which uninsured Americans can enroll in their choice of health care plan. Those who cannot afford to purchase the coverage available in the Exchange will receive assistance.

- A public option will be available within the insurance Exchange to give consumers an alternative to private health insurers for their health care coverage. This public option well be self-supporting and will not receive ongoing subsidies from the federal government.

- The draft contains provisions to reduce rural, racial, and ethnic disparities in disease incidence and treatment.

- The draft fixes the broken Medicare physician payment system and prevents the irrational cuts that are scheduled under current law from going into effect.

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This approach — build on what works, fix what's broken, and make sure people have choices — is pragmatic, and it will produce the results the nation's health care system so desperately needs: lower costs, broader coverage, and better quality.

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In my conversations with my colleagues and my constituents, I am getting the clear sense that there is now a willingness to tackle the issues, resolve them, and bring forward a much better health care system for all Americans.

With President Obama in the White House, we now have the best opportunity ever to enact health reform.

I am determined that we not let this opportunity slip from our grasp.

I look forward to this morning's testimony, and continuing with urgent pragmatism to send health reform legislation to the President for his signature this year.

OPENING STATEMENT OF HON. JOE BARTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BARTON. Thank you, Mr. Chairman.

You and I, earlier this year, attended several White House health care summits. At those summits, both in the large meetings and in the working group meetings, I said that the Republicans in the House and the Republicans on this committee were very ready and very willing to work with the President, with you and Mr. Pallone and other members of the majority to create a new health care system for America.

There is no Member of Congress on either side of the aisle that is opposed to improvements and reforms in our current health care system. So we were ready to work. You told me repeatedly that you were ready to work with myself and the other Republicans.

Having said that, actions speak louder than words. While you and I have held several meetings, personal meetings—and we held one meeting with Chairman Pallone and Ranking Member Deal of the subcommittee, we agreed to work together. The brown bag lunch that was supposed to occur because of that was scheduled and rescheduled. And, finally, last week, we were supposed to have had it last Friday at noon. We were called the afternoon before and told that that brown bag lunch on a bipartisan basis could not be scheduled because you were attending a press conference to unveil the Democratic health care bill.

That is not bipartisanship. That is not inclusiveness. It sure made me feel like the young woman who was being wooed by a young man and the young man kept promising to take her out on a date, and he finally called her up and said, "Well, I know we had a date tomorrow, but I can't do it because I am getting married to somebody else." I guess there are some people that do both, but luckily you are not one of them and I am not either.

But it is what it is. So we now have a bill. We have the Secretary of Health and Human Services here to probably wax eloquent in support of your bill. I haven't read her testimony, but I bet it is going to be supportive.

The good news is we are going to have a series of hearings, and we will, at some point in time, go to markup. Hope springs eternal on our side that some of our ideas may yet be included.

The bill in its current form—I have not read all 805 pages of it; I am not going to fib about that. But I have seen summaries, and it is a massive government involvement in Americans' health care. It is hugely expensive. I have seen estimates as high as $3 trillion over 10 years. I am told that the word "shall" is mentioned over 1,300 times. I am told that there are 38 new mandates, that there are dozens of new bureaucracies.

I listened to your opening statement, Mr. Chairman, and heard you say that nobody has to take the government plan who doesn't want it. That may well be true, technically, but if you put so many mandates on private insurance that it becomes cost-prohibitive, and if you raise the Medicaid eligibility to 400 percent, there are going to be millions of Americans that lose their coverage because the private businesses that offer it can't afford it, and then there are going to be millions of Americans who say, why should I pay a monthly premium of X dollars when I can go on Medicaid and

pay little or nothing? You know, the short of it is that, if your bill were to become law, we wouldn't have much of a private health care system in America within 10 to 20 years.

So put me down as undecided, Mr. Chairman. We will work with you. We have a number of amendments. We have a Republican alternative that is private-sector-based, lets the individuals maintain their choice. We do some of the things that you do in your bill. We do have a permanent physician reimbursement fix. We do have a tax credit, reimbursable tax credit for low-income Americans.

But the big difference between the Republican bill and the Democratic proposal is that on the Republican side we still believe in the marketplace, we don't have all the mandates, we don't force Americans into a government plan that we think is not very good for America.

With that, Mr. Chairman, I will submit the rest of my statement for the record, and look forward to these hearings.

Mr. WAXMAN. Thank you, Mr. Barton. And I am sincere in saying I want to work with you and share a brown bag lunch with you. And this bill is a draft.

I want to recognize Mr. Dingell, the chairman emeritus of the committee, the champion of health care reform, and the man who will be the first name on the legislation that will produce health care reform.

Mr. Dingell.

OPENING STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. DINGELL. Mr. Chairman, first, thank you for holding this important hearing. And thank you for your remarkable leadership on moving forward towards resolution of the health care problems we have in this country.

I want you to know that I am grateful and proud, and I am particularly appreciative of the kind words you said about my dad. And on behalf of my dad and I, I want to thank you for your kind words and thank you for your friendship.

I also want to do something of a personal character here, and that is to welcome Secretary Sebelius to the committee.

Your father was a valuable member of this committee and sat in this room for a number of years, and we were always proud to have him here. And your father-in-law was a valuable Member of the House, as you will recall, and was a man who was much respected. So your coming is like coming home, and we hope you feel that way, Madam Secretary.

This week marks the beginning of a truly historic process, an opportunity to fulfill our moral and economic obligations to provide quality, affordable health care coverage for all Americans.

The current system is not working. When my dad started on this years ago, it was a matter of humanitarian concern. Americans were dying for want of health care, and health care was not available to most Americans. Today, that still is true to one degree or another, but it is now an economic necessity, something which must be done to enable the United States to continue to compete in the world marketplace. And our industries are being killed by

the lack of this kind of support in a fiercely competitive world economy.

Forty-seven million Americans are currently without health care, and upwards of 86 million will be without health care at some point during this year. More and more Americans are being forced to make decisions they never should be forced to make: Do they pay their monthly health insurance premium, if they can get a health insurance policy, or do they pay the utility bills, the mortgage, or do they buy food for the family?

American business owners are facing a tough decision as to whether to meet the monthly payroll or to pay health insurance contributions for their employees. And if you look at the American automobile, it has $750 worth of steel in it and $1,600 worth of health care. Foreign competitors don't confront that problem.

The Federal budget can no longer sustain our current health care spending. If health care costs grow unabated, the costs to the country will be more than 20 percent of its gross domestic product on health by 2018.

The discussion draft—and I stress the words "discussion draft"—we are considering is a uniquely American solution to this crisis.

It has been a privilege for me to work with you, Mr. Chairman, with Chairman Rangel and Chairman Miller on putting this draft together. And I want to commend all of those, including the subcommittee chairmen of the three committees, who have worked so hard to bring about unprecedented coordination that went into producing this single discussion draft for the three committees of jurisdiction.

And I want to make some things clear. The discussion draft will not create a single-payer system. It will not ration care. It will not attempt to destroy the private-market system or the system of employer-sponsored health care many Americans enjoy today. And anybody who says otherwise simply hasn't read the bill or is not being truthful either with himself or anybody else.

That being said, each of us in this room has our own vision of what ideal health care reform looks like. While the specifics may be different, we all share some common goals. First, we must pass legislation that reduces the cost of health care for families, businesses, and government. Second, we must pass legislation that makes quality, affordable health care available to all Americans. And we must pay for this legislation, and we must pass the legislation now.

The choices we make over the coming months are going to be historically significant, and they will rank with the passage of Social Security and Medicare. If we are courageous and enact comprehensive health care reform, our product will meet the test of history and, I would note, will rank, as I mentioned, with Medicare and with Social Security.

Medicare was mentioned on the editorial page on Sunday of the New York Times. It is only short of the flag in its popularity. If we are not courageous, we will have failed this generation and generations to come, and the country will suffer for it.

I am certain this year that we will pass comprehensive health care reform that will build on the existing system and keep intact that which is working in our system, and give people the piece of

mind that, no matter what life changes they face, they will always have access to health insurance. The American people deserve nothing less.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Mr. Dingell.

I now want to recognize Mr. Deal. Mr. Pallone, as the chairman of the subcommittee, gave his opening statement yesterday. Mr. Deal did not have that opportunity. And I want, by unanimous consent, that all members have an opportunity to submit a written statement, opening statement for the record.

Mr. Deal, for the last opening statement.

OPENING STATEMENT OF HON. NATHAN DEAL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. DEAL. Thank you, Mr. Chairman. And thank you for holding this hearing, a series of panels today and tomorrow.

I want to welcome all of the witnesses who are joining us. Especially express my appreciation and welcome to Dr. Todd Williamson, who is the president of the Georgia Medical Association. Certainly, as we consider this draft this week, hearing from these witnesses is important.

Mr. Chairman, I think we have reached consensus that appropriate reforms are necessary, but we differ with respect to the right methods of reform which will yield cost and higher-quality savings and the decisions that should be left to doctors and patients and not Federal bureaucrats as they make choices about health care for our people. More government, in my opinion, is simply not the answer, but the draft before us seems to think that that is the answer.

As far as the Republican views are concerned, we have seen thus far an attempt to approach health care reform in a bipartisan fashion that has resulted in what we consider to be a partisan proposal which refuses to address the concerns of Members on our side of the aisle. Last Friday, we received an 852-page reform draft. That is merely 1 legislative day before the committee began its hearings.

We are concerned about the cost. The Congressional Budget Office has yet to weigh in on those costs. Early analysis by Mr. Steve Parente, who testified before our Health Subcommittee yesterday, scores the legislation at a whopping $3.5 trillion over the next decade. We need to come up with real solutions to improve health care that American families can afford.

The promise of the Obama administration and the leadership here on the Hill has been that if you like what you have, then you can keep it. I believe that is simply a play on words, because if this draft does what I think it will do, it will destroy that private health insurance market and will ultimately lead to what I consider a one-size-fits-all government plan.

If we focus on reforming the health care delivery system with the benefit of the American people in mind, then we should not focus our efforts on things that will destroy the private insurance market. I believe we should be encouraging physicians to enter into the field of medicine as the demand for health-care-related services will continue to grow.

But with the proposal before us today, which benchmarks public plan reimbursements to Medicare, that in itself continues to drive providers out of the system. And I believe we will fall short of the objective that all of us share: of having a system that encourages doctors to enter, it promotes physician-patient-driven decisions, and allows everyone to gain access to health care coverage.

Mr. Chairman, we all agree that changes to our health care delivery system have the potential to yield significant savings and improvements in the efficiency of delivery of care, but we must ensure that reforms that we put into place promote competition and transparency.

As we move forward, I hope we will get that CBO score. I think it is important to the deliberations that lie before us.

And, Mr. Chairman, I want to reiterate again that those of us on our side of the aisle look forward to being able to work in a bipartisan fashion as we consider the potential for amendments that will obviously be suggested.

Thanks again to our witness, our Secretary, and thanks to all the witnesses who will make up the panels that will follow.

With that, I yield back.

Mr. WAXMAN. Thank you very much, Mr. Deal.

Well, it is my pleasure to welcome Kathleen Sebelius to our committee for the first time as our Nation's Secretary of Health and Human Services. And it is highly appropriate that your first testimony is on the reforming of the Nation's health care system. That is the President's highest priority and is a subject on which the Secretary brings a unique breadth of experience, most recently as a two-term Governor of Kansas, service for 8 years as Kansas State Insurance Commissioner—exceptionally valuable experience as we proceed with enacting and implementing health care reform—and, before that, 8 years in the Kansas House of Representatives.

Madam Secretary, I want to welcome you. We look forward to working with you and to your testimony today. Your full prepared statement will be in the record, and we would like to recognize you to proceed as you see fit.

STATEMENT OF THE HON. KATHLEEN SEBELIUS, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretary SEBELIUS. Thank you, Chairman Waxman, Chairman Emeritus Dingell, Ranking Member Barton, Chairman Pallone, Ranking Member Deal. Thank you for this opportunity to join you for a critical conversation about health reform in America.

As the chairman emeritus has already recognized, my father did serve on this committee, and he was here when Medicare was passed. So I feel privileged to be part of this historic conversation and delighted to have the chance to work with you on this critical issue.

No question that your release of a discussion draft last week with your colleagues from Education and Labor and the Ways and Means Committees represents an historic moment in this debate. We not only appreciate the hard work you have already done but are grateful for all the work that you are about to do as we work together to, at long last, enact reform.

Health reform constitutes one of our most important domestic priorities, and we know the cost of doing nothing is simply too high. As the President has said, unless we fix what is broken in our current system, everyone's health care is in jeopardy. Reform is not a luxury, it is a necessity.

Today in America we have, by far, the most expensive health system in the world. We spend 50 percent more per person than the average developed country, spending more on health care than housing or food. Health insurance premiums have doubled since 2000, and the high cost of care is crippling businesses who are struggling to provide care to their employees and stay competitive in this global world.

Small businesses and their workers, the backbone of the American economy, are clearly suffering. As recently as 16 years ago, 61 percent of small businesses offered health care to their employees. Today, only 38 percent do.

Last week, I was in Congressman Pallone's district with business owners in New Jersey who met with me about the sacrifices they have to make in their companies in order to provide health benefits to their employees. Even then, some of their employees can't afford the care they need.

We spend more on health care than any other Nation but aren't any healthier. Only three developed countries have higher infant mortality rates. Our Nation ranks 24th in life expectancy among developed countries. More than one-third of our citizens are obese. And we know that 75 percent of our health costs are spent on chronic disease.

Without reform, these problems only get worse. In 2008, we spent an estimated $2.4 trillion on health care. If we do nothing, by 2018 we will spend $4.4 trillion. Today, we spend about 18 percent of our GDP on health costs. Doing nothing, those costs reach 34 percent of GDP by 2040, and 72 million Americans will be uninsured. The CBO has recently estimated that, by 2025, 25 percent of America's economic output will be tied up in the health system, limiting all our other investments and priorities.

So there are many problems with our health system today, but there is also a reason for optimism. Across this country there are lots of examples of hospitals and providers who are using new technology, cutting costs, and improving the quality of care.

Two weeks ago, I was in Omaha, Nebraska, at Lakeside Hospital, an Alegent health care system, one of the Nation's first fully digital hospitals, and saw firsthand how health information technology can help doctors and patients. Health care providers like the Kaiser system in California, the Mayo Clinic, Geisinger, Intermountain Health Care, have lowered costs but, more importantly, have improved outcomes for their patients. I have spoken to community health center providers from Ohio, Tennessee, and Pennsylvania who have helped outline how health information technologies helped them save resources and provide better care. Our challenge is how to take the best practices and spread them across the entire country.

I have every confidence we can meet the challenge and achieve the goals of achieving of reducing costs for families, businesses, and government, protecting people's choices of doctors, hospitals, and

health plans, and, at long last, assuring affordable, quality health care for all Americans. And we can do it without adding to the deficit.

Now, the President is open to good ideas about how we finance health reform, but we are not open to deficit-spending. Health reform will be paid for, and it will be deficit-neutral over 10 years.

The President has already introduced his proposals that provide about $950 billion over the next decade to finance health reform. Many of the resources come from wringing waste out of the current system and aggressively prosecuting fraud and abuse. We are currently paying for strategies which don't work or overpaying for medicines and equipment. It is time to make a better use of these dollars.

We know that reform can reduce costs for families, businesses, and government, protect people's choice, and assure affordable health care. As we move forward, we will be guided by simple principles: protect what works about health care, and fix what is broken.

We have reviewed the key features of the tri-committee draft proposal, Mr. Chairman, from you and your House colleagues, and it is clear that you and your committee have embraced these principles.

By creating a health exchange that will ensure numerous private insurance plan options along with the public insurance option, the plan promotes choice and competition. By lowering health costs and providing premium credits, the plan makes health care affordable for all Americans. By investing in prevention and wellness initiatives, we help to prevent disease and illness and allow Americans to live longer, healthier lives. And with meaningful delivery system reforms, your policies offer lower-cost yet higher-quality health care.

Under the plan you have proposed, Americans will no longer have to worry about being denied care because of a pre-existing condition. They will have easier access to tools that can help them prevent disease and stay healthy. Investments in primary care and underserved areas will improve all Americans' access to care. And the Medicaid reforms proposed in this bill have taken important steps to improve the critical safety net program, making it an income-based program and improving reimbursement for primary care.

This discussion draft represents an historic step forward. And while we are still examining all the details, I agree with the President, who said this proposal represents a major step toward our goal of fixing what is broken about health care and building on what works.

So, Mr. Chairman, I am eager to work with this committee and your colleagues in the House and colleagues across the aisle in the Senate to deliver the reform we so desperately need. And I appreciate the opportunity to engage in this discussion, and look forward to your questions.

[The prepared statement of Secretary Sebelius follows:]

Testimony
Committee on Energy and Commerce
U.S. House of Representatives

Health Reform in the 21st Century

Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services

June 24, 2009

Chairman Waxman, Ranking Member Barton, Chairman Emeritus Dingell, Chairman Pallone and Ranking member Deal, members of the Committee, thank you for this opportunity to join you for a critical conversation about health reform in America. Health reform has advanced thanks to your work and willingness to move forward together with other House Committees. Your bill represents a tremendous step forward on the road to health reform, and this hearing is an historic moment in the debate. We appreciate your hard work to enact reform. It is urgently needed.

Health reform constitutes our most important domestic priority and is an integral part of economic recovery. Since 2000, health insurance premiums have almost doubled, growing three times faster than wages. A Kaiser Family Foundation survey found over half of all Americans, insured and uninsured, cut back on health care in the last year due to cost. This means foregone opportunities for chronic disease management and prevention. We will surely pay a price later for this postponed care now. And behind these statistics are stories of struggles for too many American families – unaffordable employer-sponsored insurance premiums of over $12,000 a year on average and rising – competing with education and housing.

As the American economy continues to transform, it is expected that fewer and fewer employers will offer coverage. And we know that during this recession, many people are losing health insurance as they lose their jobs. Even families who do have some coverage are suffering. From 2003 to 2007, the number of "under-insured" families – those who pay for coverage but are unprotected against high costs – rose by 60 percent. Small

businesses and their workers are suffering. From 2000 to 2007, the proportion of non-elderly Americans covered by employer-based health insurance fell from 66% to 61%.[2] Much of this decline is attributed to small businesses dropping coverage. The percentage of small businesses offering coverage dropped from 68% to 59% over the same period, according to a Kaiser Family Foundation survey of small businesses.

We have by far the most expensive health system in the world. We spend 50 percent more per person than the average developed country -- spending more on health care than housing or food. And the situation is getting worse. Without reform, according to the Medicare actuaries, we will spend about $4.4 **trillion** on health care in 2018 and CBO estimates that the number of uninsured will grow to 54 million people by 2019. By 2040, health care costs will reach 34 percent of our GDP and 72 million Americans will be uninsured.

As the Rand report documented, we have a system with over-utilization, under-utilization, and inconsistent quality. Less than half of our population gets appropriate care at the right time. The payment incentives reward waste, duplication, and lack of coordination. We know that there are substantial savings to be gained just from making our healthcare system more efficient and responsive.

Rising health costs represent the greatest threat to our long-term economic stability. The CMS Office of the Actuary estimates that by2018, over one-fifth (20.3 percent) of our economic output will be tied up in the health system, limiting other investments and

priorities. Solving this problem is essential to job growth, productivity, and economic mobility. We simply cannot become the nimble economy we need to be without health care reform.

We have certainly received a poor return on all of our spending. In the industrialized world, we have the highest rate of medically preventable deaths and almost 100,000 people die every year from medical errors and poor quality. That's the equivalent of two jumbo jets falling out of the sky every day. Meanwhile, the health status of our citizens declines, with chronic disease accounting for 75 percent of our health care costs and 96 percent of Medicare costs.

There are many problems with our health system today. But there is also reason for optimism. In America today, there are already examples of hospitals and providers who are using new technology, cutting costs and improving the quality of care. Two weeks ago, I was in Omaha, Nebraska at one of the nation's first paperless hospitals and saw first-hand how health information technology can help doctors and patients.

I have spoken to community health center operators from Ohio, Tennessee and Pennsylvania who have outlined how health information technology has helped them save resources and provide better care to their patients. Our challenge now is to take these best practices and spread them across the entire country. But I have every confidence that

we can meet this challenge and achieve our goals. And we can do this without adding to the deficit.

The President is open to good ideas about how we finance health reform. But we will not add to the deficit in the next decade.. The President has introduced proposals that will provide nearly $950 billion over 10 years to finance health reform.Much of these resources come from increasing efficiency and wringing waste out of the current system. We are currently paying for strategies that don't work or overpaying for medicines and equipment.

It's time to make better use of these dollars. We know reform can reduce costs for families, businesses and government; protects people's choice of doctors, hospitals and health plans; and assure affordable, quality health care for all Americans.

And as we move forward, we will be guided by a simple principle: protect what works about health care and fix what's broken.

This is why I share the President's conviction that "health care reform cannot wait, it must not wait, and it will not wait another year." Inaction is not an option. Every delay raises the price tag. The Obama Administration is focused on passing health reform legislation that will end the unsustainable status quo and adhere to eight basic principles.

First, we must pass comprehensive reform that makes health care affordable for businesses, government, and families. The high cost of care cripples businesses struggling to provide care to their employees and remain competitive. It drives budget deficits and weakens our economy.

Second, we must protect families from bankruptcy or debt because of health care costs. Today, many patients worry more about being able to pay their medical bills than worry about restoring their health. They have reason to be concerned. In America, half of all personal bankruptcies are related to medical expenses. It's time to fix a system that has plunged millions into debt, simply because they have fallen ill.

Third, we must assure affordable, quality health coverage for all Americans. The large number of uninsured Americans impose a hidden tax on other citizens as premiums go up and leave too many Americans wondering where they will turn if they get sick. The lack of continuity of coverage affects individual health and our national health status. Lack of insurance and interruptions in coverage take their toll by reducing our ability to effectively address chronic disease and improve prevention. They affect our ability to control the spread of infectious diseases. And they affect our productivity. According to the Institute of Medicine, employers lose billions of dollars of productivity each year from uninsured workers with unnecessarily prolonged and untreated illnesses.

No one is immune from the risk of becoming uninsured. No American is guaranteed that they will have the same health insurance benefits next week that they have today. In its

effects on the health care system, on the health of our society, and on our economy, the risk of being uninsured affects us all.

Fourth, we will guarantee choice of doctors and health plans. No American should be forced to give up the doctor they trust or the health plan they like. If you like your current health care, you can keep it. And if you like your doctor, you need to be able to keep that doctor.

Fifth, we will make sure that Americans who lose or change jobs can keep their coverage. Americans should not lose their health care simply because they have lost their job or want to pursue better opportunities.

Sixth, we must end barriers to coverage including prohibitive insurance premiums for people with pre-existing medical conditions. In Kansas and across the country, I have heard painful stories from families who have been denied basic care or offered insurance at astronomical rates because of pre-existing conditions from cancer to childhood ear infections. Insurance companies should no longer have the right to pick and choose. We will not allow these companies to insure only the healthy, leaving families stranded in planning for their health care.

Seventh, we must make important investments in prevention and wellness. The old adage is true – an ounce of prevention truly is worth a pound of cure. But for too long, we've sunk all our resources into cures and shortchanged prevention. Preventing disease and controlling its effects over time need to be the foundation of our health care system.

And finally, any reform legislation must take steps to improve patient safety and the quality of care in America. Our country is home to some of the finest, most advanced medicine in the world. But today, healthcare-associated infections – infections caught in a hospital or other settings -- are one of the leading causes of death in our nation. More Americans die each year as a result of these and other quality deficiencies than die from car accidents, breast cancer, or AIDS. These numbers are not acceptable for the world's richest nation. Despite the best efforts of business purchasers and private quality improvement initiatives and the development of standards, both government and private, recent reports indicate that the quality of care has actually declined in recent years. We will not be able to achieve the quality we need without the major reforms the President seeks. It will take a comprehensive approach to provide the leverage needed to improve care.

In reviewing the key features of the Tri-Committee draft proposal, it is clear that you and your Committee, Mr. Chairman, have embraced all 8 principles. As we work to enact policies that adhere to these principles, the President is committed to hearing from people in communities across the nation and on both sides of the aisle. To be sure that the American people are engaged in the process, the President has appeared at or sponsored regional forums around the country in places like Wisconsin, Michigan, Iowa, Vermont, North Carolina and California. And he will sponsor a national town hall at the White House tonight. These events bring together people from all perspectives – across the political spectrum and representing different stakes in the system.

I look forward to continuing this process and I am eager to work with this Committee and your colleagues in the House and Senate to deliver the reform we so desperately need. Again, Mr. Chairman, thank you for the opportunity to participate in this conversation with you and your colleagues. I look forward to taking your questions.

Mr. WAXMAN. Thank you very much, Secretary Sebelius, for your testimony.

I want to start off the questions period myself.

This issue of health care reform was part of the campaign President Obama waged in order to be elected President. And if there is any issue for which he has a clear mandate, it is to work on this very issue. And he has made this his number-one domestic priority. And I want to underscore, in questioning you, some of the aspects of what he hopes to accomplish and what he wants us to do in this effort.

Based on the President's approach, our draft—and it is just a draft—sets out a comprehensive approach to reform. It addresses prevention and wellness; the health care workforce; quality of care; broad-based, shared responsibility in dealing with the costs; and coverage through insurance reforms; a new exchange for people to go to get their insurance; affordability credits; improvements in Medicaid; substantial savings and improvements in Medicare.

Is this what the administration is committed to, or should we approach this in a more compartmentalized manner? Should we approach this in a comprehensive way?

Secretary SEBELIUS. Well, Mr. Chairman, as you said, this was one of the key priorities of then-Senator Obama and now-President Obama, and he believes strongly that we can't fix the economy without fixing health care. And so a comprehensive approach to a reform of the system is what is required and, I think, is what this legislation addresses in many of its components.

There is no question that you can't do just one thing at a time in order to have the system work for all Americans and fundamentally lower costs. There is no question that we can't continue on the cost curve that we are on right now. It is unsustainable and will not serve anyone well. Those who have health insurance now are a month, a year, 2 years away from not being able to afford the coverage they have. Those who don't have coverage can't access some of the best technology and the best medical care in the world.

So we need a comprehensive approach, and we need to essentially shift the system toward wellness and prevention and away from the sickness system that we have. So I think the elements that you have put forward in the discussion draft do just that.

Mr. WAXMAN. Undertaking this kind of comprehensive reform is pretty complicated, and it is going to require an enormous amount of effort from Members of Congress, some of whom will say, "Well, maybe we should delay, maybe we should go slower, maybe we should do it next year or the year after."

What is the administration's view of the timetable for action and the need for action?

Secretary SEBELIUS. Well, I think the President feels strongly that there is an enormous urgency about this issue which has directly to do with our economic well-being as a Nation and our competitiveness in a global society; that our workers are less competitive with their colleagues across the world because of the increasing costs of health care borne by individual business owners.

Small-business owners, the engine of our economy in States across this country, the fastest growing segment of our economy, are often less competitive to have high-quality workers, talented

workers because they seek to have health care provided along with their wages, and too many small employers can't any longer do that.

Our focus on prevention and wellness needs to be dramatically increased so we not only have a healthier society and lower costs, but have a society where our children are not facing the prospect, which currently American children face, where we are seeing the first generation who may live shorter lives than their parents based on the rise in diabetes.

So we have some challenges, Mr. Chairman, that cause us to enact legislation this year, to urge the action of both the House and the Senate on this important issue. It is difficult, it is complicated. If it were easy, as the President likes to say, it probably would have been done a long time ago.

Mr. WAXMAN. Let me ask you one last question, because my time is almost out. We have businesses who pay too much; we have government that is paying too much. We have small businesses who can't afford it at all for their employees. And, of course, if you are without insurance and you have to go pay for your health care bill, it is impossible. So a lot of people go without the needed services.

Do you think we need a shared responsibility for every sector—individuals, employers, providers, and government—to move forward together and that everyone has to share in the cost? No particular sector says somebody else will pay for me, but we all have to be in there and share in the costs? And, collectively, we are all better off as a society.

Secretary SEBELIUS. Well, I don't think there is any question that, if you build on the current system, which is absolutely what the President wants to do and what the discussion draft proposes, then there is a shared responsibility.

Over 99 percent of large employers provide health care coverage. A lot of small employers already do, but some don't. We have situations where some Americans opt in and some opt out of the insurance market. We need more personal responsibility, certainly, in the life choices we make, which can help lower health costs. We need parents to get involved and informed. We need more preventive care.

So there is certainly a sense that we are in this together. This is a fundamental issue. It is probably the most personal issue to every American, what happens to their health care, their family's health care. And I think there is no question that it needs to be comprehensive and it needs to involve everyone.

Mr. WAXMAN. Thank you very much.

Mr. Barton?

Mr. BARTON. Thank you, Mr. Chairman.

Thank you, Madam Secretary, for being here.

You said in your opening statement that there would be no deficit-financing as a result of this health care reform package if it became law. Is that literally true?

Secretary SEBELIUS. Mr. Chairman, I was quoting the President. The President has said consistently that he will not sign a bill unless it is paid for.

Mr. BARTON. So, we just want it established on the record right off the bat that there will be no increase in the deficit as a result

of a comprehensive health care package if it does become law? That is just, I mean, plain language.

Secretary SEBELIUS. That is what the President has stated as one of his top priorities: It will be paid for within the period.

Mr. BARTON. OK.

Let me walk through just one part of your program. Creates a new category of coverage under Medicaid at 133 percent of poverty, which will be 100 percent paid for by the Federal Government, no State match, for childless adults between the ages of 19 and 64. This one provision, if I understand it correctly, could add as many as 20 million Americans to the Medicaid program.

Now, I don't know what the cost number is for coverage per person under Medicaid, so I just picked a number. And if my number is wrong, correct me. But I said $6,000 a year for insurance. That may be too high. But if you cover 20 million people at $6,000 per year, that is $120 billion right there per year.

How do you pay for that? What are some of your pay-fors? Because, in the bill, they are to be determined later. So give me an example of a pay-for that is $120 billion a year.

Secretary SEBELIUS. Congressman Barton, the President has proposed about $660 billion in savings from the current Medicare and Medicaid program. In addition, he has proposed revenue enhancers of about——

Mr. BARTON. That is over a 10-year period.

Secretary SEBELIUS. Yes, sir. And I think your figure is——

Mr. BARTON. Per year. $120 billion per year.

Secretary SEBELIUS. Well, I would start with the premise that, first of all, I don't know the numbers accurately, and I assume that your $20 million is within the ballpark.

I just can tell you that, whatever the proposal that comes forward, the President has insisted that the bill will be paid for. The measures that are proposed will be paid for.

Mr. BARTON. You are a former Governor, I believe. Isn't that correct?

Secretary SEBELIUS. Yes, sir, two-term.

Mr. BARTON. I believe of Kansas, is that——

Secretary SEBELIUS. Kansas is the State.

Mr. BARTON. Governor of Kansas. Does Kansas have a balanced budget requirement for its State budget?

Secretary SEBELIUS. Yes, sir.

Mr. BARTON. It does. OK. When you were Governor of Kansas, by law, you had to submit pay-fors when you submitted a budget that spent money. Isn't that correct?

Secretary SEBELIUS. Well, we spent money within the revenues we had.

Mr. BARTON. Yes, ma'am. Now, again, my numbers may not be the number, but they are definitely in the ballpark. If I give the President the benefit of the doubt that there are out there $600 billion over 10 years in savings, $60 billion a year, this one expansion in Medicaid is still $60 billion a year short.

You are the Secretary of Health and Human Services. I assume you have had some interaction with Chairman Waxman and Chairman Rangel, Chairman Miller in providing this draft bill. You have to have some idea of how you are going to pay for it.

And, again, I am giving you the benefit. If the President says he can save $60 billion a year, I will stipulate, for purposes of this hearing, he saves 60. But I think you need to put $60 billion more in savings or in tax increases on the table.

Secretary SEBELIUS. Well, Mr. Barton——

Mr. BARTON. You had to do it when you were Governor.

Secretary SEBELIUS. That is true, sir. And this is a discussion draft. What I can assure you is, at the end of the day, the bill that passes will be paid for. We will work closely with the chairman here in the House and the Senators on the other side to come up with strategies to do just that.

Mr. BARTON. Well, shouldn't we tell them upfront?

Secretary SEBELIUS. We don't have a CBO score yet for this bill nor a score for the various proposals that are in this bill. But I can——

Mr. BARTON. But at least you have to put on the table where you are going to get the money.

Secretary SEBELIUS. I understand.

Mr. BARTON. It is not a box of chocolates, you don't know what you are going to get, and you just pull it out, "Oh, there is $60 billion." Whatever.

Well, Mr. Chairman, my time has expired. But I think we have established a basic point. I mean, it is a good thing if you are going to have no deficit-financing. I commend the President for that. But it is a bad thing if you don't shoot straight with the American people where you are going to get the money.

And nobody says that we are going to be able to save money to pay for these huge expansions, totally by savings pay for these huge expansions. I just pointed out one part of the bill, and already we are at least, in my numbers, $60 billion per year short.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Barton.

Mr. Dingell.

Mr. DINGELL. Mr. Chairman, I thank you.

Madam Secretary, again, welcome. My questions will, I hope, evoke a yes or no answer.

Would it be appropriate to state that the tri-committee discussion draft that was released last week aligns with the health reform principles the President has outlined earlier this year? Yes or no?

Secretary SEBELIUS. Yes, sir.

Mr. DINGELL. Now, Madam Secretary, there has been quite a bit of discussion about the inclusion of a public health insurance option in the reform legislation. Does President Obama support the inclusion of a public health option in the reform legislation?

Secretary SEBELIUS. Yes, he does.

Mr. DINGELL. Madam Secretary, hospitals and doctors are not required to participate in the public option. Is that correct?

Secretary SEBELIUS. That is correct.

Mr. DINGELL. Premiums and co-payments under that part of the proposal will cover the claims, will they not?

Secretary SEBELIUS. I am sorry, sir?

Mr. DINGELL. I said, premiums and co-payments under the public option will cover the costs.

Secretary SEBELIUS. That is my understanding.

Mr. DINGELL. The public option must adhere to the same rules and regulations as all other plans.

Secretary SEBELIUS. That is correct.

Mr. DINGELL. The public option will be administered by a separate agency from the one that runs the exchange.

Secretary SEBELIUS. That is the way the draft is written, yes, sir.

Mr. DINGELL. The public option will offer the same minimum benefit design as all other plans in the exchange.

Secretary SEBELIUS. Yes, a level playing field.

Mr. DINGELL. Individuals and families will be permitted to apply subsidies towards both public and private plans in equal fashion.

Secretary SEBELIUS. Yes, sir.

Mr. DINGELL. And I apologize, too, Madam Secretary, but we have a lot of business to do here, and I hope I am not being discourteous.

Madam Secretary, there has been justified concern over the consolidation of the health insurance market and the impact it has on health insurance claims. According to the American Medical Association, 94 percent of the insurance markets in the United States are now highly concentrated. This has decreased the amount of competition, and this is a major cause of spiraling health concerns. Yes or no?

Secretary SEBELIUS. There is a monopoly in much of the country in the private insurance market, yes.

Mr. DINGELL. Now, this is a serious concern then. How does the public plan address this concern? And this is not yes or no.

Secretary SEBELIUS. I appreciate that.

I think what the public option within the marketplace, within the new health exchange, does is use market principles—competition and choice—to lower costs and provide consumers a choice of plans.

So I think that the public option—absent a public option, in many areas in the country, two-thirds of my State, for instance, and States around this country, there would be only one choice, which is not terribly effective in terms of holding costs down and certainly does not provide consumer choice of a side-by-side plan, which is why States in State employee plans create public options standing side by side with private, why many States have done that in the children's insurance program, side-by-side options, to give choice and provide some competition.

Mr. DINGELL. Now, Madam Secretary, as a former Governor and a former insurance commissioner, you are able to speak to this question. State insurance regulators are not able to regulate except as regards solvency of the insurance companies. Is that not correct?

Secretary SEBELIUS. Sir, they can regulate solvency and also have some cost regulation, but, frequently, if there is no choice in the market, cost regulation is almost irrelevant.

Mr. DINGELL. So competition being put into the market would be the one thing that would make this system work by having the public option there. Is that correct?

Secretary SEBELIUS. Well, again, it is a marketplace strategy that competition is often much more effective than heavy-handed regulation.

Mr. DINGELL. Now, Madam Secretary, there are questions about whether the tri-committee proposal is a complex concept. It includes exchanges, a public health option, subsidies, Medicare and Medicaid improvements, responsibilities for individual employers.

Will the administration be able to fully implement and administer this proposal?

Mr. WAXMAN. Thank you, Mr. Dingell.

Secretary SEBELIUS. Yes.

Mr. WAXMAN. Your time has expired, but we do want the to get the answer.

What is the answer?

Secretary SEBELIUS. Yes, sir.

Mr. WAXMAN. That is it?

Mr. DINGELL. That is why I asked it that way, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Dingell.

The gentleman from Georgia.

Mr. DEAL. Thank you, Mr. Chairman.

Madam Secretary, our esteemed chairman made a comment back during the markup of the American Recovery and Reinvestment Act, which said, "I think it is highly unlikely that you are going to find millionaires who would like to go on Medicaid."

One of the concerns that this bill arises in the minds of many of us is whether or not we are treating low-income citizens as second-class citizens by automatically enrolling them in Medicaid.

So my question would be this: Why do you believe that a family making $29,000 a year is not as able to make choices as a family making $30,000 a year? And why would it be better to simply automatically enroll them, with no choice, in Medicaid, as opposed to giving them a subsidy to allow them to go into the private insurance market?

Secretary SEBELIUS. Well, Congressman, some of those families, a limited number, are in jobs right now where they have employer-provided coverage, and they certainly would not shift that coverage.

But a large number, particularly of, not families, but single adults who are at 100 percent or below the poverty line, who are making often a very small amount of money, have no coverage at all. They are uninsured and find themselves not in an ownership capacity.

So I think the committee's look at expanding Medicaid to 133 percent also follows the experience of many States that have already done that and found that the most effective strategy to expand coverage. It is a larger market. It often provides a benefit package that is cost-effective and, frankly, is often far less expensive than the private options that exist, which is why States who have expanded coverage have chosen the Medicaid route instead of the private insurance route.

Mr. DEAL. As I understand the draft, it would propose that everyone under the age of 65 who is under the 133 percent of the Federal poverty level would be enrolled in Medicaid.

Can you give us, first of all, how many people do you think that that encompasses? And how many of those people currently have private health insurance?

Secretary SEBELIUS. Sir, I don't want to cite numbers off the top of my head. And I can easily return to you with those numbers. I apologize.

I know that there are a fairly significant number of the so-called childless adults, not parents, typically because a number of States, again, have taken steps for parents whose children are eligible for the CHIP program to actually provide expanded family coverage, because they found that a very effective strategy when enrolling children.

But I think we are talking primarily about childless adults often below that—I think they make less than $6,600 a year if you are at 133 percent of poverty. And I can get back to you with those specific numbers. I apologize.

Mr. DEAL. Would you please do that?

Secretary SEBELIUS. Yes.

Mr. DEAL. On page 73 of the bill, there is a provision that provides for automatic enrollment——

[Interruption in hearing room for medical emergency. Brief recess.]

Mr. WAXMAN. The committee will come back to order.

A young woman who is an intern here on the Capitol got dizzy, fell down, and hit her head. And she was attended to by a number of members and staff who are medical people, doctors, and the emergency assistance at the Capitol. So hopefully she will be fine, God willing, and there will be no consequences as a result of it.

But I do want to make that comment. And as we get any further reports, I will inform everybody of the situation. We are distressed about this incident, but with good medical care and the resilience of youth, even the President's health care bill will not scare her from recovery. Maybe the hope of it will spur her on.

Mr. Deal, you were in the middle of your questions, and I want to recognize you for 2 minutes.

Mr. DEAL. Thank you, Mr. Chairman.

Madam Secretary, on page 73 of the bill, it provides for the automatic enrollment of individuals into the Medicaid program.

I want to just ask you if the citizenship and identity verification requirements that are in the current law will still appertain into the automatic enrollment processes.

And will you assure us that individuals who are illegally in our country or otherwise ineligible for taxpayer-supported Medicaid will not be enrolled under this provision of this bill while you serve as our Secretary?

Secretary SEBELIUS. Mr. Deal, I can assure you that States now, because of the various Federal rules requiring verification of identity, have those systems in place and really have, I think, developed systems to verify identity not only of existing clientele but of enrolling clientele. And that would certainly be in place as we move forward.

Mr. DEAL. So it would not be your intention or something that you would not allow to happen that the automatic enrollment process would not overlook or override those current verification requirements.

Secretary SEBELIUS. That is correct.

Mr. DEAL. Thank you, Madam Secretary.

And I yield back my time, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Deal.

Mr. Pallone, the chairman of the subcommittee.

Mr. PALLONE. Thank you, Mr. Chairman.

And thank you, Secretary, for being with us today.

I wanted to take my time just to ask about Medicare and Medicaid. I think there is a certain amount of confusion because, obviously, in this discussion draft, and the President has stressed, that we can save money that would be used to pay for this plan through savings in Medicare and Medicaid. But, at the same time, there are major enhancements and improvements in both programs that are in the discussion draft. And I think there is a certain amount of confusion about that.

Overall, I think that if you view the combination of the Medicare and Medicaid savings and the benefit enhancements, overall there is a marked improvement in both Medicare and Medicaid. But I wanted to just ask you questions about that.

In other words, the draft proposes to begin filling in the donut hole in the Medicare prescription drug benefit, to eliminate cost-sharing on preventive services, to expand the eligibility and accessibility of Medicare subsidies for low-income enrollees.

Taken as a whole, how do you view the combination of these Medicare savings proposals and the benefit enhancements as an improvement in the Medicare program?

Secretary SEBELIUS. Well, Congressman, I think that there is no question right now that there are areas where we are spending money that don't result in higher-quality care or better results for patients. I think what this discussion draft puts forward is a way, as you have suggested, to enhance the current program, to put dollars into areas where we think there will be much better results for patients.

Hospital re-admissions is a category that is targeted for some focused attention. One out of every five patients leaving the hospital is re-admitted within a series of weeks. That is not good for the patient, and it certainly costs a lot of money to the system. So, coordinating post-release care, actually providing incentives for follow-up care is a significant improvement that will not only lower cost for re-admissions but actually provide a lot better care for the patients.

And those, I think, are the kinds of examples that the discussion draft incorporates. Better quality in the long run, following what we know are best practices that are in some parts of the system but not appearing throughout the system, and, frankly, not continuing to overpay for services that have no shown benefit or result.

Mr. PALLONE. Did you want to talk about filling the donut hole in this context? Because I know that is very much on the minds of the seniors, and we do propose to do that in this discussion draft.

Secretary SEBELIUS. Well, I think that is a huge step forward. As you saw, the chairman of AARP recently endorsed the strategy that is appearing in both the House and the Senate to fill the donut hole.

It is a huge issue. I can tell you, as an insurance commissioner, we used to face this situation with citizens who had no idea or really hadn't counted on the fact that their benefits would suddenly

cease and their premiums would continue on. They hadn't saved appropriately for it. And often they were the—I mean, the first people to hit the donut hole were the folks who had the highest cost in prescription drugs. And it was not only a huge shock but something that forced a lot of people to stop buying their medications, to stop following the doctor's prescriptions, to end up in the hospital again without the care to keep them well.

So this is a huge issue for seniors across this country who have benefitted greatly from lower-cost drugs but, when they hit the barrier, are really in worse shape than they were in the beginning because they are still paying premiums and they have no health prescription benefit.

Mr. PALLONE. Now, what about Medicaid? There is a major expansion here in terms of increased reimbursement rate, covering people in many States that, you know, that are below the 100 percent or the 133 percent with Federal dollars. Would you want to comment on that?

Because I just want to stress how, even though we are having savings from Medicare and Medicaid, we are really improving the programs significantly.

Secretary SEBELIUS. Well, there, again, a lot of the conversation with providers, at least in my home State, was not really focused on Medicare, which is often a very popular program, but on Medicaid, which often under-reimburses doctors and particularly primary care and family providers. So, enhanced reimbursement for primary care, I think, is a huge step forward.

And, frankly, having a situation where, if you are an adult or a family below 133 percent of poverty, wherever you go, you would have the same benefits. If you move across the State line, if you need to travel with your family elsewhere, you would have similar benefits, the kind of portability that currently is not available to a lot of people because the benefits change each State at a time. So that is a significant step forward.

Mr. Pallone, while you are discussing Medicaid, I just wanted to share with the committee that at least my staff has told me that the number, at least that we have been given by CBO, for childless adults, non-disabled childless adults who are in Medicaid is really a $3,000-a-person average cost, not $6,000 as was suggested.

Mr. PALLONE. Thank you very much.

Mr. WAXMAN. Thank you, Mr. Pallone.

I want to now recognize Mr. Whitfield.

But I do want to announce to members there is pending on the House floor a Republican motion to adjourn. We are going to continue the hearing, so those who want to respond to that vote should do so and then come back. But we will proceed.

Mr. Whitfield.

Mr. WHITFIELD. Mr. Chairman, thank you very much.

And, Madam Secretary, we are pleased that you are with us here today.

You know, the question about the prescription drug benefit reminds me that, of course, before we passed the prescription drug benefit, most citizens on Medicare did not receive that benefit, and so they were paying for those medicines. And now we are trying to fill the donut hole so they don't have to pay for that either.

So, as politicians, you know, we like to expand coverage and give coverage and make it—it sounds like that we don't want anyone to pay for anything. And yet, I know your father was involved with Medicare, according to your testimony, and I was looking at some of the debate about Medicare when it was adopted in 1965, and they were making some of the same arguments that you were making, really, in your testimony. And in 1965 they projected that, by 1990, the cost of Medicare would be $9 billion. As it turned out, it is almost $200 billion.

And so, we all like to—we know that our health care needs to be reformed. And then when you talk about it being paid for, it is going to be budget-neutral, and then when they talk about, well, we are going to get a lot of money out of increasing efficiencies, wringing waste out of the current system, and being more aggressive to stop fraud, you know, it is so nebulous.

And you are a very practical person. You have had experience as a governor. Do you honestly think that we can reform this system and actually save money and yet provide better quality health care?

Secretary SEBELIUS. Congressman, I do. And I do so not based on some hypothetical situation, but based on visiting health systems throughout this country, in the middle of the country, on the coasts, that do just that: who have higher-quality outcomes time-in and time-out for their patients, who have used technology and the provider protocol provided to make sure that the results are better each and every time, and who lower cost.

I have seen it in systems around the country, and I am absolutely confident that we can do it throughout the United States.

Mr. WHITFIELD. Well, I am glad you are confident, but, you know, I really am skeptical about it. But I hope you are right.

But when we talk about being budget-neutral, that is good for the government, and, of course, the taxpayers pay for the government. But then this bill has a pay-or-play mandate on employers, requiring them to provide a minimum benefit, as established by the Health Benefits Advisory Council, of 8 percent of wages paid. So there is a mandate there for small-business people to pay 8 percent of wages to provide a benefit defined by a commission that is established in this bill. So, for these small-business people, I mean, if someone has wages they are paying $500,000 a year, that is going to cost them $40,000.

Now, are you concerned about the ability of small businesses to be able to continue to be competitive and provide jobs for the employees and pay this, as well?

Secretary SEBELIUS. Well, absolutely, I am concerned about the competitiveness of our small-business owners. And I think health care costs are one of the areas that is a huge challenge for every small-business owner I talk to. They can't get great employees without offering health benefits. They are priced out of the market.

So, several things in this bill. First of all, the discussion draft makes it clear that there will be a specific small-business exemption from the pay-or-play. It is my understanding that the committees are still working on the language. So that will occur. It is in the Massachusetts——

Mr. WHITFIELD. No, I know that there is an exemption, but there are going to be some people that will be hit by this.

Secretary SEBELIUS. And the——

Mr. WHITFIELD. And that is OK.

Secretary SEBELIUS. —creation, though, in the marketplace, I would suggest, actually gives them a cost advantage that they don't have now, pooling larger risk, giving affordable coverage.

Mr. WHITFIELD. Let me ask you just one other question, because my time is about expire. One of the criticisms we always hear about a one-payer, single-payer system and universal health coverage in other countries is that it rationalizes health care. And, in America, our most expensive part of health care deals with end-of-life care. That is a big percentage of the way we spend money.

And I am not saying there is anything wrong with rationalizing health care. But, to really get big savings, do you think that we should be rationalizing health care in the U.S.? Many countries do because that is the way they control their costs. I mean, do you think that we should be doing that?

Secretary SEBELIUS. Absolutely not. I think that, again, the creation of a health exchange marketplace is not a single-payer system. And I think you will hear today from some proponents who will strongly suggest that we should be looking at a single-payer system, but that is not what the President, that is not what the chairman have put forward. They have put forward a plan that builds on the current system.

Rationing care, frankly, is something that happens each and every day under our current system, and it is often done by private insurers who get between a doctor and their patient and decide which practices can be met, which procedures can be paid for, what prescriptions.

I think this is an opportunity, really, to make sure we have more patient-centered care, that we follow the protocols that work.

Mr. WHITFIELD. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Whitfield.

Mr. Markey.

Mr. MARKEY. Thank you, Mr. Chairman, very much.

Last year, Madam Secretary, I introduced legislation with then-Congressman Rahm Emanuel and Congressman Chris Smith from New Jersey called the "Independence at Home Act." And the bill created a Medicare pilot project focused on improving the coordination of care and reducing costs for the most vulnerable Medicare beneficiaries, those with multiple severe, chronic conditions, such as Alzheimer's, ALS, Parkinson's, and other complex, debilitating diseases, who also need help with two or more activities of daily living, such as dressing, feeding, et cetera.

CBO has reported that 5 percent of Medicare beneficiaries account for 43 percent of overall Medicare spending. And CMS has noted that approximately 20 percent of Medicare beneficiaries with five or more chronic conditions, account for 66 percent of program spending.

Could you talk a little bit about how we can focus on those Medicare beneficiaries with multiple chronic diseases and how perhaps a program like that, focusing on home and better coordination, can help to reduce the costs?

Secretary SEBELIUS. Well, we have not only the demonstration that you are responsible for but, I think, a number of projects under way looking at coordinating care, particularly for the vulnerable, high-cost individuals. And, certainly, having an opportunity to do that in a home base instead of a hospital-based service is not only better for the patient but may provide some enhanced cost savings.

So we are eager to work with you, Mr. Markey, to continue to figure out better ways to not only coordinate care for individuals who suffer from various chronic diseases and have ongoing underlying conditions, but also to make it a more patient-centered system, which would lead us to more home care delivery.

Mr. MARKEY. OK. So, in terms of home-based programs for the beneficiary population, do you see a shifting in that direction to make sure that, you know, we try to reduce costs by trying to stabilize these people at home?

Secretary SEBELIUS. Well, as you know, there is a lot of effort under way, and a lot of it has been at the State basis, and I am hoping that with health reform we can have a real collaborative partnership on rebalancing care, both not only trying to prevent hospitalizations before they occur and provide care at home but also the nursing home. A number of the patients that you are describing often end up in a nursing home setting because they don't have access to the wrap-around services that they need.

So we would like to enhance that sort of home-based care, the care that really allows people to not only be more independent but also at a lower cost than in a hospital or a nursing home.

Mr. MARKEY. Our bill also would enable teams of primary care doctors, NPs, pharmacists, and other care providers to form an organization to contract with HHS to provide services to these chronically ill beneficiaries in their homes as part of a 3-year demonstration.

The organizations would be required to achieve savings of at least 5 percent compared to what these beneficiaries would cost if they were served by these coordinated care organizations. If they don't, they must repay Medicare. If they achieve more than 5 percent, they can keep 80 percent of these savings, with 20 percent of the savings returned to Medicare.

Do you think that makes any sense, to have cost-savings sharing as a system that we could construct in the country?

Secretary SEBELIUS. Well, I certainly support the notion of beginning to pay for outcomes and not for contact. Too much of the Medicare system is driven right now by the number of times a provider touches a patient, not necessarily what happens at the end of the day.

So the system you describe, which not only would provide for a coordinated strategy, which is really what we need to occur throughout the country, but also save money, it makes sense to provide those incentives to providers.

Mr. MARKEY. Great.

Thank you for your service. Thank you for being here.

Mr. WAXMAN. Thank you, Mr. Markey.

Mrs. Christensen.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman.

And I guess there is some benefit, I guess, at least in this instance, to being a delegate and not having to go to vote.

Welcome, Madam Secretary. It is good to see you.

Last week, we had some very good conversations on health disparities, but I note that, at least in reading your testimony, because I had to step out, both in the Senate and here, there was very little, if any, reference made to this very important issue that, by itself, results in close to 100,000 premature, preventable deaths every year.

So I hope that you will work to ensure that your entire Department is very sensitive to this critical issue and that the Office of Minority Health and, in particular, the National Center for Minority and Health Disparity Research will be elevated to an entity that is very critical to achieving the goals of eliminating health disparities.

The bill directs that a national prevention and wellness strategy initiative be in place, and you will be responsible for identifying the key health and health care disparities. Could you discuss briefly how you plan to fulfill this requirement and ensure that all areas of concern be identified?

And how will the Agency for Healthcare Quality and Research be involved, since they have been doing national health disparity reports for the last 5 years?

Secretary SEBELIUS. Well, as I shared with you, Congresswoman, last week, I am, as the new Secretary, concerned that we make sure we do a lot more than publish the yearly reports, which have alarming statistics about health disparities. And, frankly, they are not getting any better; the gap is, in fact, widening.

Health reform is a piece of the puzzle. I don't think there is any question that having access for everyone to higher-quality preventable care, a health home, is a step in the right direction.

But I had a recent very productive meeting with stakeholders representing a lot of the groups who are often underserved and assured them that we not only wanted a one-time meeting but I want an ongoing strategy.

I have met with our team at our Center for Research and Quality about how it is that we are going to actually begin to close this gap, because just providing reform and continuing the gap doesn't work.

So we are aggressively taking on not only what has been already reported as effective strategies, but want the new team to be particularly focused on the issue of great concern to you and to me.

Mrs. CHRISTENSEN. I have another issue of great concern that really relates to territories. In your testimony, you said that reform is not a luxury, it is a necessity, and I definitely agree with that. And, because it is a necessity, I think that certain issues, like equitable coverage for all Americans, should not really be held hostage to cost. And we discussed that a lot at the hearing yesterday.

That said, I am interested in hearing your thoughts about the treatment of the U.S. territories in the current draft. We have been working for years to remove the Medicaid cap. The bill, while it does provide additional funding to the territories, does not move us in that direction at all. And we are not eligible for subsidies.

So, to me, it makes it far less possible for men and women, American citizens, legal residents living in the territories to

achieve the benefits that this bill will provide for the rest of Americans. So I would like to hear your thoughts on that.

Secretary SEBELIUS. Well, Congresswoman, I would like to provide an opportunity for you to have that discussion with me and our staff and really would like to work with you as this process—this is a work in progress, and it is a discussion draft. And I would just like to work with you to see how we can help enhance the areas that you have identified as problematic.

Mrs. CHRISTENSEN. Thank you.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Mrs. Christensen.

Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman.

Madam Secretary, I note that you earlier said that, with the donut hole, that the benefits stop and the payment continues. But, of course, you understand that is for a small amount of time until they get above a certain amount, and then almost 100 percent of their benefits are paid for.

I think you understand that. So it is not proper to say that their benefits stop, because their benefits——

Secretary SEBELIUS. Well, they stop for a substantial period of time, depending on how fast——

Mr. STEARNS. Yes, yes, but—anyway, I have two questions, Madam Secretary.

The President has indicated that if you—he said, quote, "If you like your health care plan, you will be able to keep your health care plan, period. No one will take it away from you, no matter what."

I have here—The Lewin Group has done a study, and it is a bipartisan study, which found that 120 million people, nearly 67 percent of non-Medicare Americans, would lose their current coverage and be forced into a government-run insurance if a government plan was included.

Do you have any evidence that, if a government plan is offered, that 120 million people will be able to keep their current insurance?

Secretary SEBELIUS. Well, Congressman, it is my understanding that that Lewin study has been updated or at least disputed by a number of people, that those numbers were significantly higher than folks——

Mr. STEARNS. So your answer is that you dispute the Lewin plan.

Secretary SEBELIUS. I do.

Mr. STEARNS. OK.

The next question is then, I have here a study by the HSI Network, LLC, June 24, 2009. Their study said that the bill we are discussing today would cost an astounding $3.5 trillion. Do you dispute that fact?

Secretary SEBELIUS. Sir, I am waiting to see what the CBO score says. I don't know the figures that you have just quoted. I don't know who the group is.

Mr. STEARNS. Have you seen this report?

Secretary SEBELIUS. No, I have not.

Mr. STEARNS. OK.

Now, the President has indicated that if any bill arrives from Congress that is not controlling cost, that is a bill he can't support.

So the first question is, you don't agree this report; you don't know about it. They say it is going to cost $3.5 trillion. Where, if it is not 3.5 or 3.2 or, let's say, 2.8, where are you going to get the money to pay for this bill?

Secretary SEBELIUS. Again, Congressman, I think that once the bill is scored and once the proposals are put forward, I am eager to work with the committees in the House and the committees in the Senate to identify the cost savings.

The President has proposed about a billion dollars' worth of revenue enhancements and cost savings that he feels are appropriate to spend on this. There are other ideas that are being proposed by Members of the Senate and Members of the House, and we are eager to work on paying for the bill.

Mr. STEARNS. Well, of course, $1 billion is not going to approach $3.5 trillion.

Secretary SEBELIUS. But, sir, I——

Mr. STEARNS. So $1 billion is just a pittance compared to the 3.5 that this report shows it is going to cost.

Another question is that you really don't have any idea where you are going to get the money to pay for this. Do you have any evidence that shows if the government spends $3.5 trillion that it will save money? Let's not take the $3.5 trillion, let's just ask you, if we spend all this money, where are you going to save it?

Secretary SEBELIUS. Sir, I think you start from the premise that we can't afford what we are doing. So not doing anything is not an option. $2 trillion-plus a year is being spent, and Americans are less healthy than they were years ago. So we have to change what currently is happening.

And I think there is every evidence that the combination of health technology, driving quality, and actually beginning to pay for prevention and wellness, promoting primary care instead of disease care, is a huge cost-saver over time. It is effective to have Americans in healthier conditions. It is good for our businesses, it is good for our workforce. So it will save money.

Mr. STEARNS. Well, I think all the things you suggested both sides would agree on. What the question is is, how do we do that? How do we reform the system so that there is universal access, universal affordability, but at the same time, we don't have a government program that is going to cost $3.5 trillion that is not paid for, with no statistics to show that it is going to save money?

There could be an alternative suggestion. And I just suggest, Madam Secretary, that you read the HSI Network, LLC, report that came out and go back with the latest report from The Lewin Group. And I think certainly before you come up here, you should have some answer how you are going to pay for this.

And, with that, I yield back.

Mr. WAXMAN. Thank you, Mr. Stearns.

Ms. DeGette.

Ms. DEGETTE. Thank you very much, Mr. Chairman.

Madam Secretary, one area that I have been working extensively with Chairman Waxman and also Senators Rockefeller and Whitehouse on is legislation that would strengthen the Federal health care quality infrastructure in order to identify and track key health indicators, as well as to develop and implement new science across

the States. What this bill does that we introduced would establish national priorities for health care quality, and it specifies that pediatric health care quality is one of the first.

And a lot of this legislation has now been incorporated in the discussion draft that we are talking about today. But the draft bill also contains a provision that requires the director of the Agency for Healthcare Research and Quality to work with you, as Secretary, to develop quality measures for the delivery of health care services in the United States.

And I think this is an important requirement, but I am worried about the implications for pediatric health care quality measures, because even though the discussion draft requires the measures to be designed to assess the delivery of health care services to individuals, regardless of age, the section is funded with Medicare dollars. And so, under the previous administration, HHS determined that Medicare dollars could not be used for pediatric measures.

I am wondering if you can comment on this and what plans the administration has to address pediatric health care quality and what the view of the agency is going to be.

Secretary SEBELIUS. Well, Congresswoman, I think that we are convinced that Medicare can be a leader in improving quality of care for all Americans. And, certainly, the development of quality standards, I think, is appropriately done under that umbrella.

But all Americans definitely includes children, and that is a huge priority of the country's moving forward. So there will be a coordinated effort to make sure that the pediatric standards are very much developed in terms of quality outcomes.

Ms. DEGETTE. And do you think that can be done with the Medicare dollars? Or is that something we are going to have to explore, as we move forward to the final legislation?

Secretary SEBELIUS. In the discussions with our current leadership team at CMS, they are confident that we could fulfill the mandate that is in the bill right now to develop standards, including pediatric standards.

Ms. DEGETTE. OK. Because there is—I know you recognize, the medical establishment, and, of course, our icon who was here, Marian Wright Edelman, who was here yesterday: Children are not just mini-adults. So we have to develop separate standards.

Secretary SEBELIUS. That is right.

Ms. DEGETTE. I wonder if you could talk for a minute about the administration's view on the title 7 health workforce dollars that are included in the discussion draft.

Secretary SEBELIUS. Well, I think, as you look toward the future of a reformed health system, workforce issues are hugely important. And I think that a step was taken, a significant step, in the stimulus act, beginning to fund the pipeline of critical health care workers: doctors, mental health providers, nurse practitioners, additional nursing staff.

And this discussion draft, I think, takes that to the next chapter, which recognizes not only a shift in incentives for doctors to focus on primary care, but also has enhanced workforce capacity, again, with a whole series of initiatives that would provide for more health care providers in more parts of the country.

Ms. DEGETTE. Thank you.

One last question. One of the provisions I was really pleased to have included in the discussion draft was the idea of auto-enrollment at birth for children whose parents don't have insurance plans, to put those babies in, and then 12-month continuous eligibility for children.

I am wondering if you can comment on the administration's position on that kind of auto-enrollment.

Secretary SEBELIUS. Well, I think it has been shown that the enrollment efforts vary from State to State, often. And some still require a face-to-face visit; others have various complicated forms.

So what has been proven as best practices, I think, is an easier presumptive enrollment when kids show up at the hospital. Certainly, auto-enrollment at the time of birth would facilitate including children in the system and make sure they get a healthy start on life. So I think that is a big step forward.

Ms. DEGETTE. Thank you.

Thank you very much, Mr. Chairman.

Mr. WAXMAN. Thank you, Ms. DeGette.

Mr. Buyer.

Mr. BUYER. Thank you very much.

Madam Secretary, what type of revenue enhancers have been discussed?

Secretary SEBELIUS. Well, at this point, Congressman, the President has proposed a return to the itemized deduction that was present in the days of Ronald Reagan and feels that that would be an appropriate way to raise additional revenues.

Mr. BUYER. How much? About how much revenue would that raise?

Secretary SEBELIUS. $340 billion is my recollection.

Mr. BUYER. OK. What are some other ideas that have been discussed?

Secretary SEBELIUS. That is the revenue enhancer that the President has proposed.

Mr. BUYER. That is $340 billion. What else?

Secretary SEBELIUS. That is the revenue enhancer that the President has discussed. He has also proposed over $660 billion worth of saving. So we are at about just under a trillion dollars.

Mr. BUYER. OK. And we are still looking for another $2 trillion?

Secretary SEBELIUS. Sir, I don't know—I have never had anybody discuss a $3 trillion bill, so I am not really prepared to talk about a $3 trillion bill. I don't think there is a score on this bill. It is my understanding——

Mr. BUYER. Going to the itemized deduction, could you talk about that just a little bit further? Who would that impact?

Secretary SEBELIUS. It would impact basically the wealthiest Americans, who currently are paying a different level of tax rate on their itemized deduction than middle-income Americans. And it would, again, restore the rates——

Mr. BUYER. OK. At that would be set—at what adjusted gross income level would that be set?

Secretary SEBELIUS. Pardon me?

Mr. BUYER. At what adjusted gross income level would that be set? In other words, you are either going to deny additional itemized deductions—is that what you are discussing?

Secretary SEBELIUS. It just readjusts the rate. They continue to itemize deductions, the highest-income Americans——

Mr. BUYER. So if an American family making $80,000——

Secretary SEBELIUS. No, sir. It is my understanding that it is over $200,000, the last time I saw the proposal, but that could have changed.

Mr. BUYER. At $200,000. But then what happened to the President's promise and assurance to the American people that he would not increase taxes on anyone making below $250,000? Aren't you going to set 250? Otherwise, he breaks his promise to the American people.

Secretary SEBELIUS. Sir, he has put forward this proposal, and he is eager for Congress to talk about it. He thinks this is a way to raise additional revenue for——

Mr. BUYER. So it is OK for him to promise one thing to the American people and do another, just like what George Bush did. "I won't increase taxes," and he did it anyway. So that is what your boss is proposing.

Did you say, to remind your boss, "Wait a minute, I am your Cabinet Secretary, I am responsible for this. Do you realize you are about to break your promise to the American people if you do this?"

Secretary SEBELIUS. I did not say that to the President.

Mr. BUYER. What did you say to the President? What did you advise the President?

Secretary SEBELIUS. I told him I was eager to help him pass health reform, and I was eager to help fulfill his commitment that it would be paid for within the period of time that the bill proposes, over a decade. I think that is a fair promise to the American people, that it won't increase the deficit. And I am eager to work with you, sir, to help get that done.

Mr. BUYER. Medicaid, when you were Governor and as a commissioner of Medicaid, States get a grade with regard to the administration of Medicaid by the States. What was your grade when you were the commissioner and Governor with regard to the administration of the Medicaid plan?

Secretary SEBELIUS. Grade by whom?

Mr. BUYER. Pardon?

Secretary SEBELIUS. Who is grading me? I don't know what you are talking about. But, I mean, I guess the people of Kansas thought I got a pretty good grade because I got re-elected as insurance commissioner and as Governor.

Mr. BUYER. OK. Well, you got a D. Maybe you thought that was good and that was acceptable. I am only concerned that, if you think that a D is good and acceptable and you are glib about it here today, Madam Secretary——

Mr. WAXMAN. Will the gentleman yield?

Secretary SEBELIUS. Sir, I don't know what you are talking about.

Mr. WAXMAN. Will the gentleman yield? Who graded——

Mr. BUYER. No, I am not going to yield.

The question I have here is, if we are going to say unto our States that we are going to—the Federal Government will pick up additional cost on Medicaid, aren't we sending a signal unto the States that if the Federal Government is going to pick up addi-

tional costs, that they don't have to be as concerned and cost-conscious? Should I worry about that?

Secretary SEBELIUS. Well, I would say that the bulk of the Medicaid beneficiaries will still have a very significant State share. And I don't know any Governor in the country who is not concerned about the cost of Medicaid.

Mr. BUYER. One of the other things that does concern me, though, is with regard to doctors, you say that everyone will be guaranteed their choice of their doctor. Yet, when we are going to have some shifting that, in fact, will occur—and that, in fact, is recognized. So an individual who likes going to their doctor, now all of a sudden, their plan may not be—their doctor may say, "I am not going to participate in the government option." Then they lose their choice of doctor.

Would that be correct under this plan?

Mr. WAXMAN. The gentleman's time has expired.

Secretary SEBELIUS. Only if the individual chooses the public option.

Mr. BUYER. Say again?

Secretary SEBELIUS. Only if the individual chooses the public option.

Mr. BUYER. Right. Then they lose their choice of doctor if the doctor does not participate.

Secretary SEBELIUS. Well, that is the individual's choice. Doctors would not be mandated to be in the program, that is correct.

Mr. WAXMAN. And that is true of private insurance, as well.

Secretary SEBELIUS. That is true.

Mr. WAXMAN. The gentleman's time has expired.

Mrs. Capps.

Mrs. CAPPS. Welcome, Madam Secretary. And thank you very much for being here today and for your testimony.

I just want to make one brief comment about a population, about a group of people being discussed earlier in the conversation, those who will be covered, the childless adults who would be covered under Medicaid in this legislation, with the cost amount. You are being asked about it. It is not as though these are folks that we are not paying for already and the kind of health care they receive currently, which is most often way expensive and inappropriate for their health needs—no prevention and so forth. I think that needs to be part of the discussion.

But my questions to you have to do with the part of the country you come from, Kansas, as well as part of my district, which is rural America, and some of the barriers to care there.

But, first, I want to take advantage of your expertise as insurance commissioner for a State and have you share with us briefly about some of the types of reforms that are needed to improve our current insurance market, some of the common abuses that you have seen, and how you believe this bill will address—and that will actually be a big cost savings, as well.

Secretary SEBELIUS. Well, thank you, Congresswoman.

I think there is no question, particularly in the individual market but also often in the small-business market, there are constantly cherry-picking activities by private insurers, which do one of two things and often both simultaneously: Costs can be dramatically in-

creased year after year, driving people out of the marketplace. But also, in the individual marketplace, the pre-existing condition barriers often either make insurance impossible to obtain or totally unaffordable to obtain.

So it is a huge barrier to Americans accessing quality health care.

Mrs. CAPPS. And are there provisions specifically in this legislation that you believe will address this?

Secretary SEBELIUS. Absolutely. Not only the kind of—you have a couple of provisions. You have a loss ratio provision, which would allow a different oversight to medical loss ratios, helping to eliminate some of the overhead cost. There is a provision that would exclude insurers any longer from denying people coverage based on pre-existing conditions. And there is a much more community-rated aspect to the health exchange, which would, again, limit the kind of spikes in cost that small-business owners often see driving them out of the marketplace.

Mrs. CAPPS. Thank you.

Now, to a part of my district, I represent a county in California, San Luis Obispo, in which one company, WellPoint, has way more than 50 percent of the market. It is the only private insurer. And the county also has a shortage of primary physicians because of a locality or reimbursement issue that is far different from what the cost of living in the area really is. But this county also doesn't quite qualify for a health professional shortage area. So there are these traps that many of the folks feel like they are existing in.

Could you talk about your experience, maybe, that is similar, but also how this legislation could improve the choice of health plans for consumers in a county such as the one I have described; and how, also, we really need to be able to attract new physicians to certain areas like the one I mentioned and many others in rural America, as well as some underserved areas in metropolitan areas, as well?

Secretary SEBELIUS. There is no question, I think, that the public option in the marketplace achieves the very goals that you just described, where consumers would have choice and there would also be cost competition—two principles, I think, that the administration very much believes in.

In terms of the workforce issue, again, the initial investment in the stimulus act began the pathway to enhancing workforce, particularly in underserved areas, with a doubling of the Commissioned Corps. But I think this bill takes an even bigger step forward, recognizing that loan repayment is an effective strategy. It attracts people to underserved areas.

I would say the implementation of health IT will be a significant enhance factor for providers who often don't want to be isolated but, with health IT, can be in frequent consultation with specialists and with colleagues in various parts of the country, in various parts of the State, so they are not in isolated practices.

So there are a number of features that are not only in this discussion draft but in the bills that you have previously passed that I think really help to address the workforce issue.

Mrs. CAPPS. Thank you very much.

I yield back.

Mr. WAXMAN. Thank you, Mrs. Capps.

We now go to Mr. Burgess.

Mr. BURGESS. Thanks, Mr. Chairman.

Madam Secretary, I am over here in the broom closest, behind the kids' table, which is where they keep me on this committee. And welcome to our committee this morning.

During your confirmation hearing before the Senate, I believe the statement was made that you said, "If confirmed, I will not only be an eager partner to work with Congress, but that I understand bipartisanship." Is that a reasonable facsimile of the testimony that day?

Secretary SEBELIUS. Yes, sir.

Mr. BURGESS. Now, I know that the Senate HELP Committee, the ranking member has sent a letter, June 16th, in a follow-up to a request submitted June 10th sent by the ranking member of the Senate HELP Committee, where they note that despite providing technical assistance to the majority regarding the Affordable Health Choices Act, that same courtesy had not been made available to the minority of the committee.

When can we tell the Senate to expect that you are going to help them, the Republicans on the Senate HELP Committee, with the same technical assistance that you have provided to the majority on the Senate side?

Secretary SEBELIUS. Sir, it is my understanding that our staff and Nancy-Ann DeParle, who is the White House head of the Health Reform Office, have been in the House and in the Senate on a daily basis, providing information and expertise, modeling, a whole variety of situations.

I am not sure specifically what was requested that has not been provided, but I know that they have been available, accessible, and very present day-in and day-out.

Mr. BURGESS. Well, Mr. Chairman, I would ask unanimous consent to make the Senate letter part of the record.

And then, just a follow-up: For our committee here, on the House side, will that same technical expertise be made available to the minority in the House?

Secretary SEBELIUS. Sir, as much as we can provide background information and assistance, we stand ready to do that.

Mr. BURGESS. And we stand ready to access that.

Let me ask you a question. In your prepared testimony this morning, there is a discussion about the President has introduced proposals that will provide nearly $950 billion over 10 years to finance reform. That is following the statement, the President is open to good ideas on how we finance—will not add to the deficit.

Now, in a world in which 96 percent of people have health coverage, am I correct in presuming that the money that is afforded for disproportionate-share hospitals and upper payment limits, that those fund will no longer be necessary for our safety net hospitals? And is that where a portion of this $950 billion is coming from?

Secretary SEBELIUS. There is a proposal as part of the package that at least a reduction in the DSH payments be anticipated as health reform is fully implemented.

I don't think anybody anticipates a world in which there would be no additional help and assistance to those hospitals that are

providing the bulk of care to people who are uninsured, but hopefully the uninsured will go down.

There are additional, I think, features about that—cultural competency—a range of additional services that have to be provided.

Mr. BURGESS. And just to point out, in my home State of Texas, a significant number of the uninsured are in the country without benefit of a Social Security number. And until we resolve that issue, the need for safety net hospitals is going to continue, because I suspect that there will be some people who are left out of the 96 percent who actually have health coverage.

Now—and I was glad to hear you re-emphasize this morning that the President wanted to protect what works and fix what is broken. I am glad you went to Omaha. I went to Omaha earlier this year. In fact, Alegent came here last year and did an event with us. They are one of the forward-looking institutions in this country, and there are many others.

But testimony at this committee yesterday really—without the ability to have the health savings account and the health reimbursement account to be able to provide the correct incentives for their patients to access the preventive care that we all want people to feel is important, without those tools it would be very difficult for them to operate the kind of facility that they have today.

Secretary SEBELIUS. I am sorry. Without the health savings——

Mr. BURGESS. Without the health savings accounts and the money made available through health reimbursement accounts.

And I guess what I am getting at is, could we get this morning a definitive answer? From my read of this bill that is before us, it appears that health savings accounts are not going to count as qualified coverage. Is that correct, from your reading of the bill?

Secretary SEBELIUS. Sir, I can't—I will go back and make absolutely sure. I don't—I know that there is no intent to eliminate health savings accounts. How they are actually defined I need to recheck. But health savings accounts would still be available to Americans as they are today.

Mr. BURGESS. I am not certain that that is correct under the language of the bill. And I think the President could do a good service by instructing us to help people avoid a penalty for not having credible coverage or qualified coverage if they choose to get their insurance through a health savings account and, again, that have the——

Secretary SEBELIUS. You are saying a health savings account absent another insurance policy.

Mr. BURGESS. That is correct.

Mr. WAXMAN. Will the gentleman yield to me? Your time has expired, but I did want to clarify——

Mr. BURGESS. No, my time is just starting. It hasn't gone green yet.

Mr. WAXMAN. Well, I don't want to dispute with on you that, but——

Mr. BURGESS. I will be happy to yield to the chairman.

Mr. WAXMAN [continuing]. I want to clarify that I do believe that health savings accounts are not adversely affected in the draft bill. That would be a ways and tax issue. But I don't think that is the

intention. And we will get a clarification because you raise an important question.

Mr. BURGESS. Just briefly reclaiming my time, if you look at the rate of increase of all of the different products out there—high option PPO, Medicare, Medicaid—all increase at a rate of 7.5 percent a year. We heard testimony from the chief medical officer at Alegent yesterday that their rate of increase was about 5 percent a year.

So it seems to me that, if we want to figure out what works, we would look at those types of programs, give people an incentive to select healthy behaviors, make it important to them, and I think we will find that people, by and large, will do the right thing. It is not for everyone——

Mr. WAXMAN. Mr. Burgess, thank you very much. Other members are waiting, and the Secretary is going to have to leave, so I do——

Mr. BURGESS. I yield back.

Mr. WAXMAN [continuing]. Want to get to some of the others.

Ms. Matsui.

Ms. MATSUI. Thank you, Mr. Chairman.

And welcome, Madam Secretary. We are so happy to see you here.

Secretary SEBELIUS. Thank you.

Ms. MATSUI. I was pleased to see that components of legislation that I authored in the Public Health Workforce Investment Act were incorporated into the draft bill before us today. The creation of a public health workforce corps is a major step forward and will revolutionize public health forever.

It is also, as you know, a necessary step because we are staring a public health workforce crisis directly in the face. In order to satisfy our future public health needs, we will need to train three times as many public health workers as we are today. Otherwise, the rates of obesity, diabetes, and other chronic diseases will likely rise. And we need to reinvest in this crucial part of our public health infrastructure so that we can take community-based action to prevent a long-term public health crisis.

Secretary Sebelius, you are head of what I figure is the largest public health agency in the world. You probably know as well as anyone that the public health workforce is rapidly aging. By 2012, half of the public health workforce, in some States, will be ready to retire.

In my opinion, our public health system did a good job in managing the recent H1N1 flu outbreak, but this incident has shown us how critical it is to not let our public health workforce deteriorate any further. And I am pleased that my piece of it was incorporated into the draft bill.

Madam Secretary, I want my colleagues to understand how critical the public health workforce is. Will you please outline for the benefit of this committee how your job is dependent on having a robust public health workforce backing you up?

Secretary SEBELIUS. Well, Congresswoman, first of all, thank you for your leadership in this area and your longstanding expertise and insistence that the public health infrastructure has to be part of this dialogue and discussion.

And I think you appropriately identified the recent situation, still with us, of the H1N1 virus and the anticipation that we will need additional activity points to the need for a robust infrastructure. And, as you correctly point out, in many parts of the country, it is not robust enough now, and we are facing a looming retirement of lots of individuals.

So having not only the pipeline—you know, the Commissioned Corps has doubled—there are efforts to enhance, again, through the Recovery Act, the community health center aspect of the public health backbone in this country. And I think that is an important step forward.

No question that we need not only further attention to workforce issues, but also further attention to quality standards in public health agencies throughout the country. And I can assure you that our new leadership of Dr. Tom Frieden at the Centers for Disease Control is a huge believer that the people health infrastructure needs to be enhanced and needs to be improved and needs to be focused on. And he is coming to this job as a new CDC leader with that agenda at the forefront of his priorities, and it is one that I share.

Ms. MATSUI. Well, why are we facing such a crisis in the public health workforce today? I know part of it is that we need more graduates from public health programs. But I think the other part of it is that we may not have the right incentives for the graduates we do have to enter public service.

Secretary SEBELIUS. Well, I think the whole incentive system in health care is one that is on the table for review as we look at the reform agenda, how we not only attract more students to medicine in the first place, but how we attract more of those students to the appropriate shortages.

Ms. MATSUI. But do you think that the scholarship and loan repayment provisions in the draft bill will help incent public health graduates to the public workforce?

Secretary SEBELIUS. I don't think there is any question that those strategies have been proven to be enormously effective.

Students, unfortunately, today are emerging with mountains of debt, and often public health officials aren't paid as handsomely as some in the private sector. So helping to retire that debt, helping to erase that debt, is an enormous step to allowing students to actually make choices that they might find more rewarding but currently find financially out of reach.

Ms. MATSUI. OK. I thank you very much.

I yield back the balance of my time.

Mr. PALLONE [presiding]. Thank you.

The gentleman from Georgia, Mr. Gingrey.

Mr. GINGREY. Madam Secretary, thank you for being with us this morning. You were asked a little bit earlier about your grade as Governor. I would say that your grade so far this morning has been pretty good. So hopefully you won't mind a couple of tough questions from me.

Quoting in your testimony, "Without reform, according to the Medicare actuaries, we will spend about $4.4 trillion on health care in 2018. And, by 2040, health care costs will reach 34 percent of GDP."

Madam Secretary, these numbers are, indeed, staggering, and I share your concerns. However, I have another concern; I need to be reassured that you share that.

The Medicare trustees report that the Medicare program will become insolvent by 2016. Roughly 45 percent of Americans currently receive their health care from a government payer, and yet your testimony focuses almost exclusively on the private sector, private-sector health insurance companies, and ways in which they should be reformed.

Since his inauguration, President Obama has spoken of the need for entitlement reform. Certainly, President Bush did the same. So, given that 45 percent of all Americans get their health care from a government program and the fact that your Department oversees the largest government program tasked with insurance that quality health care for our seniors is available both today and in the future, shouldn't entitlement reform be an integral part of this legislation?

Secretary SEBELIUS. Yes, sir, I think it definitely should. And that is why I am confident that not only a number the proposals to enhance quality for seniors are important—and we have talked a bit about closing the donut hole, which is a huge issue—but also the savings that are proposed by the President will enhance the lifetime of the Medicare program that you have just cited and also lower premium rates, Part B premium rates, for the seniors who are paying them.

So it is a win-win-win situation. It helps to pay for a longer life, frankly, of the program that is so important to millions of American seniors——

Mr. GINGREY. Well, Madam Secretary, reclaiming my time since it is so limited, I would have to tell you that I think that is nibbling around the edges when the latest Medicare trustee report says that, by 2083, we will have $37.8 trillion worth of unfunded liability in the Medicare program.

You state that, since 2000, the year 2000, private health insurances premiums have almost doubled, growing three times faster than wages. Madam Secretary, do you know what percentage Medicare Part B premiums have increased since 2000? You just referenced that just a second ago.

Let me just tell you if you don't have it on the tip of your tongue, they have more than doubled since 2000; 11.7 percent. That is how much Medicare Part B premiums have gone up since 2000. So I would suggest to you that the parity between Medicare Part B premium increases and insurance, private insurance premium increases suggest that high health care costs are rampant, and they are integrated. So it is not just private, but it is public as well. So we need both private insurance reform and Medicare reform. Simply to turn the system over to the government I think will not solve this problem and, without addressing Medicare reform, will leave many seniors without quality health care coverage.

Let me just real quickly, if I might, Mr. Chairman.

Secretary, you quote in your testimony that, reform will guarantee choice of doctors and health plans. No American should be forced to give up the doctor they trust or the plan they like. If you like your current health care, indeed you can keep it.

Do I take it from your testimony that you mean all Americans will be able to keep the health plan that they like, including the 11 million seniors who get their Medicare from Medicare Advantage?

Secretary SEBELIUS. Well, sir, I certainly hope so.

The proposal to stop overpaying for Medicare Advantage is one that is included in the President's cost savings. After years of examination, there are no enhanced benefits, and they are being paid at about a 14 percent higher rate than other programs. As you know, the Center for Medicare Services has proposed that there be fewer plans this year because of the proliferation of plans and the fact that consumers often didn't choose them. We have got a bunch of plans that have fewer than a hundred people choosing them, and that is not a very cost-effective way to run a system. So there will be a consolidation. But, ideally, the doctors and the networks will remain available.

Mr. PALLONE. The gentleman's time has expired.

Mr. GINGREY. Mr. Chairman, I thank you for your patience.

Madam Secretary, I thank you for your response.

Mr. PALLONE. Thank you.

Next we have the gentleman from Ohio, Mr. Space.

Mr. SPACE. Thank you, Mr. Chairman.

Thank you, Madam Secretary, for joining us today. And as a native Ohioan, I want to welcome you as well.

There are so many different areas worthy of discussion that it is difficult for me to define one to ask you about. But given the rural nature of my district and Ohio generally, and given the special challenges that those in rural America face when accessing health care and the barriers that we have got, and given that one of those challenges happens to be attracting and retaining sufficient workforce, specifically primary care doctors, specialists, some adolescent specialists, in particular, what in your assessment does the President's initiatives and what does this bill do with respect to attracting and retaining quality workforce in rural areas where that has historically been a problem?

Secretary SEBELIUS. Well, Congressman, I share your concerns about rural access. It certainly is something I worked on as Governor of a State like Kansas, where two-thirds of our population is in very rural areas.

I think there is no question that the incentives for enhanced workforce is a step in the right direction. I think that telemedicine, which is on the horizon and certainly an important component of health IT, is a huge step forward. A lot of providers in Kansas, and I am sure in Ohio, are concerned about their isolation and want to make sure they are able to access colleagues and access consultation. And I think the steps that are included in this legislation that pay for student loans and encourage additional incentives for primary care and family care doctors also enhance the workforce in rural as well as urban areas.

Mr. SPACE. And I just have a couple more minutes, and I want to just make a comment as a followup. You mentioned telemedicine, and I guess I want to take this opportunity to explain to you as a member of the administration just how important it is to access broadband and high-speed Internet in those areas that can

benefit from telemedicine; that bridging that digital divide is so very important in so many areas, including accessing quality health care.

One other area I wanted to bring up has to do with some of the geographic disparities pertaining to chronic disease. And coming from Appalachia, one of the things we see, for example, is a higher rate than average or normal in diabetes incidents. How do we make wellness and prevention programs address these specific regional disparities when it comes to chronic diseases like diabetes?

Secretary SEBELIUS. Well, there is a new grant that we just made available which actually focuses specifically on areas with the highest rates of diabetes and chronic disease in terms of providing incentives and providing additional resources, to not only coordinate care but do much more effective monitoring of conditions. I think that there is no question that preventive care at a much earlier stage helps. But also what helps to prevent hospitalizations, amputations, a variety of things, is to make sure that those suffering from diabetes actually are staying on an appropriate regime, and that monitoring is what the grant is designed to do. I think we are trying to follow some best practices which have proven to be very effective. And my guess is that your area is likely to be, unfortunately, rising high on the list of an area that is likely to be one of the—I think there are 133 communities that will have additional resources to focus just on this effort.

Mr. SPACE. Thank you, Madam Secretary.

And I yield back my time.

Mr. PALLONE. Thank you.

Mr. Walden.

Mr. WALDEN. Thank you, Mr. Chairman.

Madam Secretary, thanks for being here today and the work that you are doing. I have some questions.

I, like many of my colleagues, am just starting to look through the discussion draft that is out. And I know that you have undoubtedly played a role in working with some members of the committee on this. So if you can help me on some of these things.

Is it true that, under the bill, an employer could be subject to an 8 percent tax even if they offer a worker an employer-sponsored health care policy?

Secretary SEBELIUS. Yes, I think that is accurate; that there are some ways, if it isn't determined to be credible coverage, that you could have the pay-or-play provision.

Mr. WALDEN. And I think, if I am reading it correctly, isn't it also true that if the employee decided to go through their own plan, the employer could still end up having to pay, if they went through the exchange, I guess it is? Tell me how that process works. Because an employee could refuse the plan from the employer. Correct?

Secretary SEBELIUS. I must confess, Congressman.

Mr. WALDEN. The people behind you are shaking their head yes.

Secretary SEBELIUS. I am not familiar with that specific provision. I would be glad to get back. If you want to give me the questions, I will immediately respond. I am just not——

Mr. WALDEN. Well, my understanding is that an employer could offer an employee—employer sponsored health coverage, and then

the worker could turn it down and enroll in an exchange plan. The employer would still be liable for the 8 percent tax even though providing the employer-sponsored care could be cheaper, is what I understand. So if you could take a look at that.

Secretary SEBELIUS. I will definitely take a look at that.

Mr. WALDEN. And is it true that, in order for the employer to avoid paying the 8 percent tax, the employer has to offer a plan that the new commissioner deems to be a qualified health benefit plan?

Secretary SEBELIUS. That is correct.

Mr. WALDEN. Can an employer require an employee to accept the employer-provided health care coverage?

Secretary SEBELIUS. Can you require an employee to accept it? I don't know again how the provisions are drafted. I am not aware of any mandatory—in a private insurance market, how you mandate that anyone accept a plan. But I haven't read the outline of the bill. Sorry.

Mr. WALDEN. Do you know if, in these provisions, are States and Federal Government considered employees under this draft?

Secretary SEBELIUS. States and Federal Government?

Mr. WALDEN. Considered employers.

Mr. PALLONE. Mr. Walden, can I just—I am not trying to stop you, but I mean, the draft—the discussion draft is put together by the Members, and I don't know that she can necessarily be the person to comment on what is in it. But if you want to continue.

Mr. WALDEN. Well, we are on my time here.

Mr. PALLONE. I am going to give you some extra time. But I just want you to understand that we didn't ask her here to comment on the provisions of the draft, per se.

Mr. WALDEN. Oh, I thought earlier she was indicating that the administration supports this draft or concepts of this draft. Is that not true?

Secretary SEBELIUS. Sir, I said that we support the principles that prompted the draft. I am sorry, I am not—the draft came out on Friday, and I didn't write the draft, and I am not intimately familiar. But I would be happy to answer questions if you have questions for me. I would be——

Mr. PALLONE. I mean, I don't want to stop you.

Mr. WALDEN. Reclaiming my time, if I could. So you haven't read this draft either then?

Secretary SEBELIUS. I have read it. I can't—I don't have it memorized.

Mr. WALDEN. No, I appreciate that. You are ahead of me. I haven't read it fully. But I also know the way this committee has been operating of late, it moves rather rapidly. So I doubt we will have a chance to ask you these questions before we suddenly have to vote on this. So that is why—I don't mean to be disrespectful. I know that others on the committee have asked you a pretty specific set of yes-or-no questions.

Secretary SEBELIUS. Again, I am just trying to be honest with you. If I don't know the answer, I will be happy to get it for you.

Mr. WALDEN. Let me go to another point then, and that was a comment you made about Medicare and Part D. And this I don't think is necessarily in the draft. Do you know what the Medicare

Part B premium was in 2000? I am not going to play a gotcha game here, but it was about $45.50. In 2008, it was $96.40. Medicare Part D for 2009 was $29, which was 30 percent lower than the original projected when we passed Medicare Part D in 2003.

I understand you issued a report yesterday showing that employer-sponsored premiums for health care doubled between I think it is 2000 and 2008 for health insurance. Medicare Part B premiums have more than doubled, 110 percent increase, in the same time span.

I think what a lot of people are asking me about, when I was home in Rufus and Arlington and Fossil out in my district, they are saying, if Medicare is going broke by 2017 and we are just going to expand and add all of these people into a government-run system, but we can't get access to providers now in the government-run system, which as you know is a big issue in rural areas, getting access to a doctor if you are on Medicare. They are saying, how is this new government-run plan going to hold down costs? And how is it going to expand? How are we going to pay for this, is the underlying issue here. And the estimates, they are just saying, you know, you talked about health insurance could cost us, or health coverage, $4 trillion or something. This plan alone I think some estimates are that. So people at home are really struggling with the dollar amounts here.

Secretary SEBELIUS. Well, Congressman, the plan, again, at least the payments the administration has put forward, not only saves dollars in Medicare but helps to expand the life expectancy of the Medicare trust fund, an important feature, and lower overall costs in the Part B premium for the beneficiaries who are currently paying, as you say, a higher cost.

I am a believer that Medicare has to get at the front of the lower-cost, higher-quality care for the beneficiaries of the system, and that we can be not only innovative but help to drive the best practices which exist now in various parts of the country to scale. So that is really one of the intents of the new program moving forward.

Mr. WALDEN. All right.

I appreciate that, and I will close with this, that I spent 5 years on a small community hospital board, and it seemed that Medicare gave us the most headaches, not the least reimbursement but second to least reimbursement, and there was enormous cost shift going on when the Federal Government was involved. And now you have got this access issue, trying to get physicians that will even take Medicare patients.

I don't want us to just create a government-run system that mirrors one that isn't sustainable right now. And you know as well as I do that some of the goofy rules in Medicare that drives seniors to the hospital to get an injection when they should be able to get it at home. Telemedicine is a great thing. But if you are a provider and you are on the other end of the telemedicine, you don't get reimbursed for that consultation under Medicare. So there is a disincentive to doctors to participate.

There are some things, irrespective of this debate, we could do to really improve Medicare, I think.

Mr. Chairman, thanks for your generosity on the time.

Mr. PALLONE. Sure.

Now, let me just remind members—we mentioned this earlier, but I want you to know that the Secretary has to leave at 12:00. Now, of course, we are going to have written questions from many members, including those who have already spoken and those who have not, to follow up, and she will get back to us.

Mr. DEAL. Mr. Chairman.

Mr. PALLONE. Yes.

Mr. DEAL. Could we ask the Secretary if she could have the answers back by July 6? I think that would give about a week.

Mr. PALLONE. Normally we submit the questions within 10 days. So that would—I am trying to figure this out here. If you all agree to send her the questions within 10 days, then I think she has to have at least—I don't know. July 6 is kind of early, isn't it?

Mrs. BLACKBURN. Mr. Chairman. Just as a form of suggestion to this, maybe with the remaining time, those of us that do have specific questions, if we can just address our question to her and then not get a response but get the response in writing.

Mr. PALLONE. This is what I am going to do. She has about 5 minutes left or 10 minutes left. I have Mr. Engel is next, and then I have you, the gentlewoman from Tennessee. I think that is all we are going to be able to do. I am not going to put a timetable on when you get back to us with the written responses at this time.

Mr. SCALISE. Mr. Chairman. I would like to be on that list, too, for questions.

Mr. PALLONE. All right. Let me explain again. Anyone can submit written questions. Normally the committee asks——

Mr. TERRY. I think, on something this important, I am just really offended that we don't have the opportunity to ask questions to her.

Mr. PALLONE. I don't know what to tell you. I just don't want to waste the time that we have remaining.

Mr. TERRY. Other directors and Secretaries came in when we were the majority, and you raised holy hell if they didn't stay here for every question.

Mr. PALLONE. Well, there is not much I can do about that now.

I am going to ask Mr. Engel—you are next. Go ahead.

Mr. ENGEL. Thank you.

Thank you very much, Mr. Chairman.

Madam Secretary, first of all, welcome. I heard your opening statement, and I was delighted when President Obama selected you, and I think you are doing and will continue to do a great job. So welcome.

I want to call two things to your attention, which are two health priorities of mine.

Firstly, I was pleased to see that my legislation, the Early Treatment for HIV Act, which I introduced with Speaker Pelosi, was included in the House Tri-Health draft. We call the bill ETHA. And ETHA, in conjunction with the House's proposal to cover all low-income people under the Medicaid program up to 133 percent of the Federal poverty level, is a significant step towards reducing the number of uninsured people with HIV in our country.

As you know, ETHA, this bill, addresses a cruel irony in the current Medicaid system. Under current Medicaid rules, people must

become disabled by AIDS before they can receive access to Medicaid. This is care that could have prevented them from becoming so ill in the first place. In other words, Medicaid won't help you unless you have full blown AIDS. And as you know, if someone tests positive for HIV, it could be a number of years before they have full blown AIDS, so it makes much more sense to help those people once they test positive, to try to stave off the full blown AIDS. And it is an irony that you couldn't do it.

So what ETHA does, it gives States the option to provide people living with HIV access to Medicaid before they become disabled by AIDS. President Obama repeatedly in his quest for President said that he supports it; when he was in the Senate, he cosponsored the bill. And I just want to ask you if I can continue to count on the administration to continue to support ETHA? And will you work with the States to take up this option if it is included in the final reform package?

Secretary SEBELIUS. Yes.

Mr. ENGEL. Thank you. That is the answer I was looking for.

And secondly, the second priority is home infusion. And we know that some delivery system changes need to be part of our health reform package. And this legislation, the second piece, addresses an anomaly in the Medicare program that forces patients into hospitals and nursing homes to receive their multi-week infusion therapy when the same care could be delivered safely in the patient's home where the patient prefers to be without standing, results in lower costs and virtually no risk of health care acquired infections.

So I believe that it makes no sense that Medicare pay pays for all costs associated with infusion therapy when it is provided in far more costly hospital and nursing home settings but will not pay for the cost of home infusion.

For decades, private health insurance has covered home infusion therapy. It is used extensively by Medicare Advantage plans. Medicaid programs cover it, but Medicare fee-for-service stands alone in the failure to cover the services, equipment, and supplies needed for home infusion therapy.

So my bill, which is the Medicare Home Infusion Therapy Coverage Act, I have introduced with 92 Members of Congress, I have introduced it with my Republican colleague Tim Murphy, and 20 members of the Energy and Commerce Committee are sponsors. So I am going to ask you the same question: Can I have your commitment that your staff will work with me and Chairman Waxman's staff on meaningful legislation to close the Medicare home infusion benefit gap?

Secretary SEBELIUS. We will certainly look forward to working with you and seeing what can be done about this area.

Mr. ENGEL. I thank you, and returning back my time 1 minute and 17 seconds, I want it duly noted, Mr. Chairman, to give someone else a chance.

Mr. PALLONE. It is duly noted.

The gentlewoman from Tennessee, Mrs. Blackburn.

Mrs. BLACKBURN. Thank you so much, Mr. Chairman.

And Madam Secretary, thank you very much for taking your time to be here. I understand you have to go to the White House for a taping. And I would hope that——

Secretary SEBELIUS. With the Attorney General, but——

Mrs. BLACKBURN. I am sorry then, I was misinformed.

But I would certainly hope that you will be able to return and answer the questions that those on the committee have about the health care plan. Could you give us a commitment to answer these before the markup?

Mr. PALLONE. Let me—Mrs. Blackburn, I am not going to take away from your time; I will give you an extra minute or so. I know that members are interested in getting timely responses, but we are not—we don't have the opportunity at this point to say that the Secretary is going to come back. So what I am going to ask is that members submit their questions as quickly as possible, and I would ask the Secretary to respond to those questions as quickly as possible.

Mr. TERRY. Will the gentleman yield?

Mr. PALLONE. No. I want to get through this.

Mr. TERRY. So are you telling the witness not to answer the questions? Parliamentary inquiry, are you telling the witness not to answer that question?

Mr. PALLONE. No. I thought I said the opposite.

Mr. TERRY. No, you didn't. You told her not to answer is the way I interpret it.

Mr. PALLONE. Let me start over again. Mrs. Blackburn has the time. We are going to start again.

Mrs. BLACKBURN. I would like to reclaim my time, Mr. Chairman, as soon as you finish your speech.

Mr. PALLONE. What I am saying is we are not asking the Secretary to come back at this time. We are asking——

Mr. SHADEGG. Mr. Chairman, point of order.

Mr. PALLONE. Yes.

Mr. SHADEGG. The Secretary is here to speak on the single most important piece of legislation, most far-reaching piece of legislation in my 15 years in the United States Congress. There are at least four members here, at least four, maybe five or more, who have not had an opportunity to question her.

Mr. TERRY. And have been here since the beginning.

Mr. SHADEGG. And would like to be able to do so. We fully understand her schedule. She has important things to do. That is perfectly all right.

But I think it would be reasonable for this committee, given the scope of the legislation that it is moving, to ask the Secretary to come back sometime before this bill moves through full committee.

Mr. PALLONE. What I am saying to you, and I will repeat again, is the following: The Secretary is here to give the administration's response to the discussion draft. I am not asking her to commit at this time to come back because, first of all, I don't know her schedule and I don't know whether that is possible.

Mrs. Blackburn can ask, but I don't want her to feel that she has to commit to this at this time because I don't know her schedule.

Mr. WALDEN. Point of order, Mr. Chairman.

Mr. PALLONE. I will now ask Mrs. Blackburn to continue.

Mr. SHADEGG. I think we are on my point of order.

Mr. PALLONE. And when sheis done, we are going to have to ask the Secretary to leave because she has to leave.

So I will go back to Mrs. Blackburn. We will start the clock again. It is the gentlewoman's time.

Mrs. BLACKBURN. And thank you, Mr. Chairman.

And Madam Secretary, I hope that we will be able to resolve this.

You know, when my constituents talk to me about this issue, they are fearful of what may be included in this plan. And coming from Tennessee, and you having been a Governor, I think you can understand that.

And when they hear remarks about it being deficit-neutral, not increasing the debt; you have made statements that it would be paid for; you have talked about reducing the itemized deductions, my constituents are very, very concerned about how this would be paid for.

The other members of this committee have constituents who are equally concerned about this. Of course, our concern in Tennessee finds its nexus in the problems that existed with TennCare. I know Governors have many times gone to school on what happened with TennCare and used that as an example of what they did not want to do.

I would like to have a response from you. You can submit it to me in writing. You can begin the response here, because I do have more questions, on what you would see as the lessons learned and what you would not want to do that was from the TennCare template. What were the lessons that you learned in looking to that? Do you realize that you can't provide gold-plated, all health care for free for everybody? Do you realize that a public option which is government-run, government-financed, does not work in competition with the private option? That is one question I have to present to you.

The second one is Medicare Advantage. And I know you have a heart for dealing with health care for seniors, and I appreciate that. My constituents—I have 56,000 seniors in Tennessee that are on Medicare Advantage. They very much want to keep those options, and I would like to hear from you what you envision a Medicare Advantage program looking like once the Obama plan goes into place, how you see that being delivered, what you think the options are going to be.

It is of concern that those options are going to be restricted. And, again, when individuals—when members of this committee sit here, when we hear from our constituents the panic that they feel, especially from seniors who say, look, I have got—I am seeing this being taken away.

Mr. PALLONE. If the gentlewoman would hold for a second.

Mrs. BLACKBURN. My mike is not being touched.

Mr. PALLONE. Now it is OK.

Mrs. BLACKBURN. But seniors are very fearful that they have paid into a system; this was a part of their retirement security, a part of their savings, if you will, because it was money that the government took first right of refusal on their paycheck, took that money out. Now you have got somebody in their 70s; they have got their doctors set. They have got their Medicare Advantage set. They have their system in place, and they are seeing this savings devalued and finding out now it is all going to be a one-size-fits-

all program. And this causes tremendous concern from them. So, your response as to what Medicare Advantage would look like would be appreciated.

Secretary SEBELIUS. Congresswoman, I would be happy to answer both of those questions. I can't do it now in person; as you said earlier, you wanted to address the question and have me respond, and I will do that promptly.

Mrs. BLACKBURN. Thank you. I appreciate that.

And at this time I will yield the balance of my time, if I can, Mr. Chairman.

Mr. PALLONE. I couldn't hear you. Who is she yielding to? Mr. Pitts.

Mr. PITTS. Thank you, Madam Secretary.

Section 222 of the bill states that there is an amount that is going to be appropriated to the Secretary for the purposes of starting up the government plan. And that number is, quote, to be supplied in the text of the bill.

Do you have any idea how much it will cost you to start up this government-run plan?

Secretary SEBELIUS. No, sir, I do not.

Mr. PITTS. You mentioned the President's repeated promise that the health reform bill will be deficit neutral. Are there any other deal breakers for the administration? Does the legislation have to include a government plan? Does it have to include an individual mandate? Does it have to include an employer mandate? Can it increase taxes on families making under $250,000 per year, for example?

Secretary SEBELIUS. Sir, I think that the President's principles are that the plan needs to lower costs for everyone, needs to improve quality of care, needs to provide coverage for all Americans. And around those principles, that he—and be paid for within the period of time. Those are the fundamental principles that he has articulated. And he has, during the course of the discussion, had various proposals on some of those areas.

I need to mention that I misspoke earlier to the Congressman; proposal that he had for the itemized deduction return is for families making 250 or more—$250,000 or more. I was corrected, and I will be happy to provide that additional information.

Mr. PALLONE. The gentleman's time—or the gentlewoman's time has expired.

Now, again, I am just going to repeat. I know you have to leave. Members will get back to you as quickly as possible with written questions, and we would ask, Madam Secretary, that you try to respond to those as quickly as possible.

Secretary SEBELIUS. Very quickly.

Mr. PALLONE. And thank you so much for being here today. We appreciate your time. Thank you.

Now, let me explain. We are going to adjourn the full committee, and then the subcommittee reconvenes, the Health Subcommittee reconvenes at 1:00, and we have three panels for the rest of the day.

Mr. WALDEN. Point of order.

Mr. DEAL. Point of order.

Mr. PALLONE. Mr. Deal.

Mr. DEAL. Mr. Chairman, with all due respect to the Secretary, this was billed as a legislative hearing on a draft.

Mr. PALLONE. Yes.

Mr. DEAL. We have heard the Secretary say that she did not participate in that draft preparation, nor has she apparently, as she said, had the opportunity to read it, which is one of the limitations that we all labor under in this time frame.

I would simply urge you to urge our full chairman of the full committee that it would be almost mandated, I think, that she return to answer questions when we move to a legislative proposal. We are talking about a draft. But here, when it moves to a legislative proposal, that we be allowed the opportunity to ask and to have answered questions.

You made the statement that she was speaking on behalf of the Obama administration as it relates to the draft. I know that she has done so in general terms, but I think there are some specifics that we should have the opportunity to ask specifics about. I would urge you to urge our chairman to ask her to return to this committee. I think it is due diligence for all of us to have the opportunity to explore these questions in person with her.

Mr. PALLONE. Well, let me just say I can't make that commitment, Mr. Deal, and for various reasons. I think a part of it is the fact that we have a draft, and obviously, there are going to be changes to that based on your input, the input from both sides of the aisle.

And we really asked her here today to comment on what the administration thought about the draft. There has never—the bill is never going to be exactly what the President wants or doesn't want. But I just can't make that commitment. So I appreciate your asking, but I can't.

Mr. SHADEGG. Mr. Chairman, you are saying you can't commit to ask?

Mr. PALLONE. I can't commit the administration——

Mr. SHADEGG. No. His request is that you ask the full chairman.

Mr. PALLONE. Look, she has been here. She has testified. You can ask her questions. I am going to leave it at that. And we are going to adjourn and start the subcommittee hearing at 1:00.

Mr. SHADEGG. There are 12 Republicans who have not even had a chance to speak and ask her questions.

Mr. PALLONE. Members were told that she was going to leave at 12:00.

Mr. SHADEGG. We understand that. We are simply asking that she come back on a piece of major legislation.

Mr. PALLONE. I can't make that commitment at this time.

Mr. SHADEGG. So you are refusing to allow us to ask questions?

Mr. PALLONE. I can't make that commitment, and we are going to adjourn at this time.

Mr. SHADEGG. Can you at least commit to ask the chairman?

Mr. TERRY. Parliamentary inquiry. I request a recorded vote.

Mr. PALLONE. Look, I am going to certainly express your views, but I can't commit the Secretary to anything at this time. I am going to express the views.

Mr. TERRY. I request a recorded vote on a motion to adjourn. We can ask for a recorded vote.

Mr. PALLONE. You can make that request. All those in favor on the motion to adjourn. Let me just ask.

Mr. WALDEN. We already have a motion before us, which is a motion to adjourn. The chairman has entered that motion.

Mr. PALLONE. I think what we will do at this time, we had a vote, and it was defeated, to adjourn. So at this time, we are just going to recess.

Mr. TERRY. We asked for a recorded vote.

[Recess at 12:13 p.m.]

Mr. WAXMAN. Before we go to the hearing in the Health Subcommittee, I would like to reconvene the full committee, which had an opportunity to hear from Secretary of HHS Sebelius. And not all Members were able to ask her questions or explore all the concerns that they had. So I would like to suggest that we will ask her to respond in writing to any questions that any Member wishes to submit. We will request that she respond in a timely manner so that Members can receive her responses before we go to markup in our committee. We will urge her to do that. We can't force her to do that, but we will urge it.

And I understand some Members may wish to meet with her, and of course I don't know her schedule, but I think it is always helpful to have people available to meet with Members.

So without objection, what we will do is hold the record open for responses from the Secretary to written questions from the members of our committee. And we would urge the Secretary to respond for the record before we get to the markup in this committee. Without objection, that will be the order.

So that the subcommittee can now meet and further have a hearing on the issue, I would like to ask that the full committee now be adjourned. And without objection, that will be the order.

[Whereupon, at 1:10 p.m., the committee was adjourned.]

[Material submitted for inclusion in the record follows:]

Secretary Sebelius Questions for the Record–Set 2
House Committee on Energy and Commerce
June 24, 2009

The Honorable Gene Green

1. Secretary Sebelius, I read an article last week entitled Kids May be First in Line for Swine Flu Shots in which you are quoted as saying "If you think about vaccinating kids, schools are the logical place."

I am the sponsor of H.R. 2596, the No Child Left Unimmunized Against Influenza Act of 2009, this bill would allow HHS to perform a multi State demonstration project test of the feasibility of using the nation's elementary schools and secondary schools as influenza vaccination centers in coordination with school nurses, school health care programs, local health departments, community health care providers, State insurance agencies, and private insurers.

Unfortunately, this bill was not included in the discussion draft although I feel it is important to perform a demonstration project before fully implementing a nationwide influenza vaccination program.

Do you intend to conduct a pilot program before requesting a nationwide school based vaccination program?

Answer: To date, school-located seasonal influenza vaccination has been undertaken by a number of States and counties throughout the country. CDC has sponsored the publication of a supplement to the journal *Pediatrics* featuring articles relaying lessons learned from several of these programs. This supplement is slated for publication in 2010. These school programs were conducted using donated vaccine or vaccine purchased with State funds. CDC is funding two demonstration projects that focus on the feasibility of billing public and private insurers for the cost of seasonal influenza vaccine and its administration to school children at school. These projects are similar to those described in H.R. 2596 with the exception that arrangements with third party payers are made at the State level with no involvement from the Secretary. These projects are entering year 2, which is the implementation phase. The ability to conduct the demonstrations this year in the context of the H1N1 campaign may be variable. If that is the case, the demonstrations will be extended through 2010.

The decision to provide seasonal influenza vaccination to children at school is a decision that will be made locally; the CDC does not plan to request a nationwide school-located influenza vaccination program.

1-A. What type of school based program would you like to implement and would it be similar to the demonstration program outlined in H.R. 2596?

Answer: Because of the challenges associated with covering the costs of vaccine and vaccine administration in school settings, the school-based programs CDC is exploring are similar to the

demonstration outlined in H.R. 2596, as discussed above. Costs for children covered under Federal programs (Vaccine for Children Program) will be covered by those programs, costs for privately insured children would be covered by insurers, and other State or Federal funding will be used for children who are not covered by above mechanisms.

2. Another important vaccination issue I would like to discuss related to adult vaccinations. Under our reform plan we will be providing more insurance to individuals, but even if these individuals are insured, we have no guarantee they will get vaccinated. Adults do not necessarily go to the doctor for vaccinations and unlike children, there are no mandates for adult vaccinations. How can we broaden adult immunization? Do you have any plans to try to address this public health issue and what can Congress do to encourage more adult vaccinations?"

Answer: There are many barriers to adult immunization, including lack of access, such as insurance and limitations on Medicare/Medicaid coverage of adult vaccines, as well as awareness of and knowledge about recommended adult vaccinations among the public and health care providers.

CDC FY 2009 and FY 2010 budget includes resources for increasing adult vaccinations to:

- Provide funding to immunization grantees to hire adult immunization coordinators to establish and enhance a coordinated State-wide effort to increase adult immunization.
- Continue to fund and provide technical assistance to immunization grantees to develop, enhance, and maintain immunization information systems across the life span.
- Promote use of certified electronic medical records.
- Increase CDC's communication and educational activities around adult immunization.
- Support partners, such as the National Association of County and City Health Officials (NACCHO) and the Association of State and Territorial Health Officials (ASTHO), to increase the promotion of and education about adult immunization activities.

What Congress can do to encourage more adult vaccinations includes:

- As part of health reform, mandate that all health insurance companies provide immunizations and include first dollar coverage.
- Require medical facilities receiving Federal dollars to require that health care workers receive annual influenza vaccinations unless the worker opts out.
- Include all recommended adult vaccinations under Medicare Part B. Currently some important adult vaccines are reimbursed under Medicare Part D, which can pose financial and other barriers for some adults to get important recommended vaccinations like zoster vaccine. For instance, under Medicare Part D, a beneficiary has to go to the pharmacy

with a prescription for the vaccine and then, in many cases, take it back to their providers office for administration. Some providers are not comfortable with this practice, known as "brown bagging" and there are concerns about the beneficiary being able to appropriately store and handle the vaccines from the pharmacy to the provider's office.

- Support and encourage Medicare's efforts to communicate with and remind its beneficiaries and participating health care providers about the importance of immunizations for older adults and the elderly.

- Specify or strongly encourage the percent or specific amount of Section 317 immunization funding that should be directed toward adult immunization.

It is also important to note that some critical activities to support adult immunization are under the purview of States, and not CDC or Congress. The activities that States can do to encourage more adult vaccinations include:

- Legislation allowing pharmacists to give adult vaccines, such as influenza and pneumococcal vaccines.

- Encourage acute care health care facilities and long-term care facilities to have standing orders regarding immunizations.

- Mandate that all insurance companies, including ERISA plans, provide immunizations and include first dollar coverage.

3. For five years I have sponsored H.R. 1708, the Ending the Medicare Disability Waiting Period Act, which would phase out the 24 month disability waiting period for disabled individuals under 65. When President Obama was in the Senate he was a cosponsor of the companion bill S. 2102.

The 24 month waiting period policy affects approximately 1.8 million individuals and 13 percent of individuals in the waiting period die before they can even get Medicare coverage. Does the Administration support the elimination of the 24 month disability waiting period and would the Administration support inclusion of language eliminating the 24 month waiting period in the House health reform bill?

Answer: The Administration values the contributions of all of our nation's citizens and residents, including the 54 million people in this country living with disabilities. This is demonstrated in the American Recovery and Reinvestment Act of 2009, which includes a number of provisions supporting people with disabilities such as $500 million to help Social Security Administration to reduce its backlog in processing disability application, $12.2 billion in funding to the Individuals with Disabilities Education Act (IDEA) and $87 billion to States for their Medicaid programs to provide additional help during these economic times. Furthermore, comprehensive health reform that provides all Americans with stable and reliable access to quality and affordable health care is a top priority on the Administration's agenda. The Administration is committed to working with Congress to build on programs that work,

including programs that are important for people with disabilities.

The Honorable Nathan Deal

1. Secretary Sebelius, currently Medicare Part D plans are required to establish Medication Therapy Management Programs (MTMPs). Plans are required to make MTMPs available to targeted beneficiaries – those with multiple chronic conditions who take multiple prescription drugs, and whose drug spending is likely to reach a designated amount. Because these requirements are vague, the quality and availability of MTM services for Medicare beneficiaries in inconsistent nationwide. In addition to being unfair to Medicare beneficiaries, I also believe this lack of standardization is resulting in missed opportunities to improve care and maximize savings for the Medicare program as a result of improved health outcomes.

CMS recently took steps to improve the MTM program by issuing guidance to plans requiring some standardization in how they target eligible beneficiaries. Additionally, CMS has called for a defined menu of MTM offerings including an annual comprehensive medication review, quarterly targeted reviews and follow-up reviews that plans must offer.

Obviously, CMS understands the value of MTM services, and I applaud you and CMS for making changes that will make this service available to more seniors. Can you explain for the committee your views on the benefits of this program, including any information you have on the savings that MTM can provide? I assume that CMS has evidence of savings; otherwise it would not have expanded access to the benefit. Finally, how can Congress strengthen the current MTM requirements in Medicare to ensure we are providing the very best care for beneficiaries?

Answer: CMS' recently released new Medication Therapy Management (MTM) guidance reflect our commitment to ensure that Part D plans are implementing effective MTM programs consistent with the statutory goal of improving therapeutic outcomes.

The new MTM guidelines stem from a comprehensive analysis of the MTM programs that Part D plans have offered to date. With several years of program data now available, CMS was able to establish new standards related to enrollment methods, targeting mechanisms, eligibility criteria and beneficiary and provider interventions based on the best practices we observed through our analysis. We do not have data on the cost impact of MTM on the Medicare program. However, it is clear that MTM has the potential to reduce the incidence of issues such as adverse drug events and therapy noncompliance as well as the negative health outcomes and increased care often associated with these events.

At this time, HHS and CMS do not need additional statutory authority to allow us to make further changes to MTM requirements. Moving forward, I believe that it is important to continue to review Part D plans' MTM programs and shape future policy changes on the practices that show the most evidence of meeting the needs of the program's most vulnerable beneficiaries.

The Honorable Joseph Pitts

1. Can you guarantee that late-term or partial-birth abortions will not be covered as a mandated benefit? How does that interact with the current ban on Federal funding being used for abortions?

Answer: As the President has said, under the legislation, no Federal funds may be used to pay for abortions except in the case of rape, incest, or to protect the life of the woman.

2. Under the legislation that you support, will doctors be allowed to refuse to perform or refer for abortions?

Answer: The legislation in the House, with Energy and Commerce amendments, ensures that no doctor or hospital or insurance plan can be required to participate in providing or covering abortion services. In fact, the legislation as amended includes a provision stating that nothing in the bill will be construed to have any effect on existing Federal laws regarding conscience protection. In addition, the bill contains another provision stating that plans participating in the Health Exchange may not discriminate against a health care provider or facility because of its willingness or unwillingness to provide, pay for, cover, or refer for abortions.

3. Under the legislation that you support will the rights of parents to consent to treatment for their minor children be protected?

Answer: Under the legislation, no State laws are affected about abortion coverage, funding, procedural requirements, parental notification or consent.

4. Is there anything in the bill prohibiting CMS from revoking all Medicare Advantage plan contracts for no reason other than a desire to have everyone in a government run plan?

Answer: I am not aware of any such provision in the proposed health reform bills; under current law CMS administers the Medicare Advantage program which provides private plan options in Medicare for eligible individuals. CMS will continue to administer this program in accordance with the law.

5. According to a report for the Kaiser Family Foundation, the number of Medicare beneficiaries in a Medicare Advantage plan increased by more than a million people compared to last year and well over 11 million people – a quarter of all Medicare beneficiaries – are in a Medicare Advantage plan. What is the State-by-State impact of the House legislation on Medicare Advantage? Given your authority over the Medicare Advantage program and your support of the legislation, I trust that you are familiar with these figures. If you don't have these figures, when can we expect to receive them?

Answer: The Administration supports a Medicare private plan option, provided that these plans are efficient and paid appropriately. As part of the Administration's budget we proposed setting benchmarks equal to the average MA plan bid in each county through the use of competitive

bidding. Both the President's proposal and House legislation would bring MA payments to an equitable level. Unfortunately, CMS does not have State-by-State impacts of the House legislation on Medicare Advantage and our current modeling does not support producing them.

The Honorable Michael Burgess

1. My reading of the draft legislation seems to preclude high deductible plans with an HSA from being counted as qualified coverage for the purposes of an individual avoiding the 2 percent penalty under the individual mandate. So while HSAs could still exist, for all practical reasons, if my reading is correct – would be driven from the marketplace because an individual would still need to go out and purchase another policy. What is HHS's reading of the legislation in this regard?

Answer: An HSA could satisfy the mandate if it meets the standards for a qualified health benefits plan. This includes covering essential benefits such as preventive services and hospitalizations, limiting annual out of pocket expenses, having no cost sharing for preventive services, and no annual or lifetime limits to benefits.

The Honorable Cliff Stearns

1. What are the Administration's views on the future of two programs intended to support hospitals with high indigent population: Disproportionate Share Hospital (DSH) payments and the 340B pharmaceutical price discount program under the Public Health Service Act (PHSA)? Specifically, how do these two programs fit into the Administration's comprehensive health reform goals? Does the Administration envision a phase out of DSH payments and of the 340B program corresponding inversely with now uninsured Americans gaining health care coverage?

Answer: These programs provide a key support for America's safety-net providers, which provide health care to millions each year. As health coverage expands under health insurance reform, the health care needs of people and the funding needs of providers will change. We look forward to working with Congress to ensure that DSH and 340B are carefully evaluated to determine what changes are necessary to continue to provide assistance to those providers that need them.

2. The President, in his radio address Saturday, June 13, 2009, remarked that "if more Americans are insured, we can cut payments that help hospitals theat patients without health insurance." And, an accompanying table enumerated "Reduce hospital subsidies for treating the uninsured as coverage increases" as saving $106 billion over ten years. Finally, a talking point was provided stating "Instead of paying hospitals to treat patients without health insurance, we should give people coverage so that they have insurance to begin with. As health reform phases in, the number of uninsured will go down, and we would be able to reduce payments to hospitals for treating those previously uncovered. This would be done by establishing a new mandatory mechanism to better target payments to hospitals for unreimbursed care remaining after coverage increases. Beginning in FY 2013, payments would be gradually phased down so that by 2019, funding would equal 25 percent of Medicare/Medicaid Disproportionate Share Hospitals (DSH) funding in 2013, and updated by inflation." Please elaborate on plans both for DSH and 340B in the context of health care reform.

Answer: H.R. 3200 tasks the HHS Secretary with submitting a report to Congress examining the changing need for support programs such as DSH, and would modify payments in response to health care coverage expansion while ensuring that the program continues to provide assistance to those providers that need it. Currently, the 340B discounts are expanded for certain rural and other hospitals in draft House legislation. As health insurance reform legislation undergoes vigorous debate, we look forward to working with Congress on these and other issues.

The Honorable Marsha Blackburn

1. What, specifically, are those lessons that you have learned?

Answer: One of the problems TennCare has experienced is large-scale cost increases that have made the program an ever-expanding part of the State budget. That is one reason why it is critically important that health reform lower the health care cost curve so that States, businesses and families can better afford health care. In addition, the President is committed to ensuring that the program the government passes is deficit neutral so that it does not burden the government with additional debt.

2. If TennCare is not a traditional public option that we should look to as an example of how government run care works, what "traditional" examples would you have us look to? Is there a system that better resolved the kinds of delivery problems and cost overruns that TennCare experienced?

Answer: As you know, TennCare relies on private managed care companies that now bear the risk for insurance coverage. They have used a capitated payment system. Some concerns have been raised in the past about private managed care companies' abilities to serve this particular population. A traditional public plan, as has been discussed by those authoring proposals in the House, has tended towards an insurance option run by the government, with government representatives overseeing the program directly. While there are many different models for a public option, one model that has been much discussed is Medicare, under which the government bears the risk of insurance and pays claims to doctors.

3. Will Medicare Advantage continue to exist in its current form under the plan we are examining today?

Answer: Medicare Advantage will continue to exist just as any private plan will continue to exist under health reform.

4. What options do you support to pay for health legislation?

Answer: There are many avenues that can be taken to save money to help pay for needed health reform, many of which were detailed in the President's budget. For example, as you mentioned, cutting waste, fraud, and abuse will play a key role. Also, reducing overpayments to Medicare Advantage plans, reducing preventable hospital readmissions, and bundling provider payments will all streamline our health care system, producing scorable savings that can be used to pay for health reform.

COMPREHENSIVE HEALTH CARE REFORM DISCUSSION DRAFT—DAY 2, PART 2

TUESDAY, JUNE 24, 2009

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 1:15 p.m., in Room 2123, Rayburn House Office Building, Hon. Frank Pallone, Jr., [chairman of the subcommittee] presiding.

Present: Representatives Pallone, Dingell, Gordon, Eshoo, Engel, Schakowsky, Weiner, Matheson, Gonzalez, Castor, Sarbanes, Green, Space, Sutton, Waxman [ex officio], Whitfield, Shadegg, Buyer, Pitts, Myrick, Blackburn, and Gingrey.

Also present: Representative Hill.

Staff Present: Karen Nelson, Deputy Committee Staff Director for Health; Andy Schneider, Chief Health Counsel; Purvee Kampf, Counsel; Jack Ebeler, Senior Advisor on Health Policy; Robert Clark, Policy Advisor; Tim Gronniger, Professional Staff Member; Stephen Cha, Professional Staff Member; Allison Corr, Special Assistant; Alvin Banks, Special Assistant; Jon Donenberg, Fellow; Camille Sealy, Fellow; Karen Lightfoot, Minority Communications Director/Senior Policy Advisor; Caren Auchman, Minority Communications Associate; Lindsay Vidal, Minority Special Assistant; Early Green, Minority Chief Clerk; Jen Berenholz, Minority Deputy Clerk; and Miriam Edelman, Minority Special Assistant.

Mr. WAXMAN. And I want to call on Mr. Pallone to convene the subcommittee so that we can get a further record from witnesses on the health care issue.

Mr. PALLONE. The hearing of the Health Subcommittee is reconvened. And we are now going to our next panel which is the Panel on Single-Payer Health Care. And I would like to start by introducing each of the witnesses.

Beginning on my left is Dr. Sidney M. Wolfe, who is Director of Health Research Group at Public Citizen. And then we have Dr. Steffie Woolhandler, who is Associate Professor of Medicine at Harvard Medical School and Co-Founder of Physicians for a National Health Program. And, finally, Dr. John C. Goodman, who is President and CEO of the National Center for Policy Analysis.

STATEMENTS OF SIDNEY M. WOLFE, M.D., DIRECTOR, HEALTH RESEARCH GROUP AT PUBLIC CITIZEN; STEFFIE WOOLHANDLER, M.D., ASSOCIATE PROFESSOR OF MEDICINE, HARVARD MEDICAL SCHOOL, CO-FOUNDER, PHYSICIANS FOR A NATIONAL HEALTH PROGRAM; AND JOHN C. GOODMAN, PH.D., PRESIDENT AND CEO, NATIONAL CENTER FOR POLICY ANALYSIS

Mr. PALLONE. And I think you know how we proceed, but I will mention that we ask you to give us a 5-minute, approximately 5-minute opening statements. So your full testimony is submitted for the record, and when you are done we will have questions from the subcommittee.

And I will mention again that, because of the importance of this issue, we are having full committee members participate. They will be after the subcommittee members, but they will participate with their questions as well. And we will start with Dr. Wolfe.

Mr. BUYER. Mr. Chairman, may I ask unanimous consent to speak out of order for 1 minute?

Mr. PALLONE. Sure.

Mr. BUYER. I want to thank you. What I want to do is I want to extend my apology to the Secretary. In the last hearing during my questions to the Secretary, I had stated that the State of Kansas Medicaid program had received a D rating when she was the Governor of the State. According to the health reform dot org Web site run by the Department of Health and Human Services, she was given—a D rating had been given to the U.S. health care system. And I meant to ask the Secretary whether the Kansas Medicaid program merited a D rating.

I misspoke and created the impression that while she was Governor that she specifically—her program had been rated a D. That is wrong. And with that I extend my deepest and sincerest apologies to her for creating such an impression. And for that I apologize personally to the Secretary.

Mr. PALLONE. Well, thank you. I thank the gentleman.

Dr. Wolfe.

STATEMENT OF SIDNEY M. WOLFE, M.D.

Dr. WOLFE. Thank you. What if you picked up the morning paper tomorrow and saw the following headline: 50 People Died Yesterday Because They Lacked Health Insurance? The next day the same headline, and the next as well.

This is the average number of people in the United States who, according to a 2004 report from the National Academy of Sciences, die each day; more than 18,000 a year, because they lack health insurance.

How should we respond to this unacceptable and embarrassing finding? Not by saying, as President Obama has said, that if we were starting now from scratch we would have a single payer, but it is too disruptive. Or as the health insurance industry said last week, having the public option that is just an option would be too "devastating". What could be more disruptive and devastating than being one of 45 million people who are uninsured, from whose ranks come 18,000 people who die each year because of that dangerous status?

The real question is why should we tolerate the fragmented, highly profitable, administratively wasteful private health insurance industry any longer?

In this regard, the public is way ahead of either President Obama or most people in the Congress in its distrust of the health insurance industry.

In a recent national Harris poll last fall, the following question was asked: Which of these industries do you think are generally honest and trustworthy so that you normally believe a statement by a company in that industry? Only 1 in 14 people, or 17 percent, thought that the health insurance industry was honest and trustworthy. The only industries that were worse than the health insurance industry were HMOs, 7 percent; oil, 4 percent; and tobacco, 3 percent.

The Congress, on the other hand, trusts the health insurance industry and feels compelled to come up with a solution that avoids a big fight with them, not only writing them into the legislation, but assuring further growth of that industry. The Congress wants to believe that the health insurance and pharmaceutical industries will be good citizens and voluntarily lower their prices to save some of the money that is necessary to fund health insurance.

Several weeks ago, the collective forces of the health industry promised that they could voluntarily save $2 trillion over the next 10 years. But the amount that can be saved over the next 10 years by just eliminating the health insurance industry and the $400 billion of excessive administrative costs it causes every year is $4 trillion, in one fell swoop. This would be enough to finance health care for all, without the additional revenues the Congress and the administration are desperately seeking.

As an example of administrative waste, over the last 30 years or so, there may have been two to three times more doctors and nurses, pretty much in proportion to the growth of the population. But over the same interval of time, there are 30—30—times more health administrators. These people are not doctors. They are not nurses. They are not pharmacists. They are not providing care. Many of them are being paid to deny care. So they are fighting with the doctors, with the hospitals, to see how few bills can be paid. That is how the health insurance industry thrives, by denying care, paying out as little as it can.

There is no question that we have a fragmented health insurance industry and it thrives on being fragmented, avoiding any kind of serious centralized examination or control which could affect—improve quality, costs and everything.

The drug companies make much more money with this insurance fragmentation because there is no price control. The insurance companies make much more money because they can push away people who aren't going to be profitable, let public programs take care of those patients who are "unprofitable".

What the President and the Congress are really realistically advocating, since there is absolutely no possibility of having enough money to cover all people in this country as long as the private for-profit health insurance industry is allowed to exist, is more incremental reform, not national health insurance.

It is now 44 years since Medicare and Medicaid. In the interim there have been many experiments in this country and abroad to try and provide universal health coverage. Other countries have uniformly rejected the private for-profit insurance industry and have adopted national health insurance.

There are little experiments going on in Germany and Australia, but mainly it is national health insurance. Is everyone else wrong and only the United States is right?

A recent study by OECD, which is the Europe-based Organization for Economic Cooperation and Development, provided health insurance data from its 30 member countries, including Europe, the United States and others. The latest data showed that 27 of the 30 countries had health insurance coverage for more than 96 percent of the population, with only Germany having any non-public coverage, 10.3.

The other three that didn't have 96 percent coverage were Mexico, with 60.4 percent; Turkey, with 67.2 percent; and the United States, with 84.9 percent, of which 27.4 percent was public coverage.

In Canada back in 1970, they were spending the same percentage of their gross national product as we were on health. They also had millions of uninsured people and many of the same insurance companies, such as BlueCross BlueShield. They decided to just get rid of the health insurance industry. They had experimented with it in Saskatchewan ten years earlier and it had worked so well they couldn't wait to do it nationally. So where there is a will there is a way.

There is no way we are ever going to get to having good health insurance for everyone as long as there is a health insurance industry in the way of obstructing care.

One more recent experiment abroad includes Taiwan, where in 1995 they said we don't like the fact that 40 percent of our population are uninsured. They passed essentially a single-payer plan, and within a few years, 90 to 95 percent of people were covered.

In the U.S. we have had experiments as well, with seven States having instituted various versions of the public-private combination that this legislation seeks to provide. In none of these States has this worked. Once several years had elapsed with little improvement in insurance coverage, it was back pretty much to where it started, despite initial enthusiasm and short-lived decreases in uninsured.

So as we consider what to do, which experiments do we follow? The ones that were successful, all of which for practical purposes eliminated the private insurance industry, or the failed U.S. State examples, all of which were built on this industry?

If instead of saying that a single-payer program is not politically possible, the President and the Congress need to say it is not only politically possible, politically feasible, but it is the only practical way national health insurance will ever happen. And anything short of that is essentially throwing tens of billions of dollars at the insurance industry. And if you are afraid of the insurance industry, then you are afraid of doing the right thing, which is having everybody in and nobody out.

[The prepared statement of Dr. Wolfe follows:]

Testimony of Sidney M. Wolfe MD
Acting President, Public Citizen and Director, Health Research Group at Public Citizen
Before the Subcommittee on Health
House Committee on Energy and Commerce
Hearing on Health Insurance
June 24, 2009

What if you picked up the morning paper tomorrow and saw the following headline: **"50 People Died Yesterday Because they Lacked Health Insurance"?** The next day, the same headline----and the next as well. This is the average number of people in the United States who, according to a 2004 report by the Institute of Medicine of the National Academy of Sciences, die each day---more than 18,000 a year---because they lack health insurance. How should we respond to this unacceptable and embarrassing finding?

Not by saying, as President Obama has said that if we were starting now from scratch, we would have a single-payer, but it's too disruptive or, as the health insurance industry recently said, having the public option would be too "devastating". What could be more disruptive and devastating than being one of 45+ million people who are uninsured, from whose ranks come 18,000 people who die each year because of this dangerous status?

The real question is why should we tolerate the fragmented, highly profitable, administratively wasting private health insurance industry any longer? In this regard, the public is way ahead of either President Obama or the Congress in its distrust of the health insurance industry.

A recent national Harris Poll (October, 2008) asked the following question: "Which of these industries do you think are generally honest and trustworthy – so that you normally believe a statement by a company in that industry?" Only one out of 14 people (7%) thought that the health insurance industry is honest and trustworthy. The only industries in the survey that were even more distrusted than the health insurance industry were HMO's (7%), oil (4%) and tobacco (3%).

The Congress, on the other hand, trusts the health insurance industry and feels compelled to come up with a "solution" that avoids a big fight with them, not only writing them into the legislation but assuring further growth of that industry. The Congress wants to believe that the health insurance and pharmaceutical industries will be good citizens and voluntarily lower their prices to save some of the money that is necessary to fund health insurance. Several weeks ago, the collective forces of the health industry promised that they could voluntarily save two trillion dollars over the next 10 years

But the amount that can be saved over the next ten years by just eliminating the health insurance industry and the $400 billion of excessive administrative costs it

causes each year is $4 trillion, in one fell swoop. This would be enough to finance health care for all without the additional revenues the Congress and the Administration is desperately seeking.

As an example of administrative waste, over the last 30 plus years there have been maybe two and a half, three times more doctors and nurses, in proportion with the growth in population. But over the same interval, there are 30 times more health administrators. These people are not doctors. They're not nurses. They're not pharmacists. They're not providing care. Many of them are being paid to deny care. So, they are fighting with the doctors, with the hospitals to see how few bills can be paid. That's how the insurance industry thrives by denying care, paying as little out as it can, getting the healthiest patients.

There is no question that we have a fragmented health insurance industry. And it thrives on being fragmented, avoiding any kind of serious centralized examination or control. The drug companies make much more money with this insurance fragmentation, because there's no price control. The insurance companies make much more money, because they can push away people who aren't going to be profitable, let public programs take care of these patients who are "unprofitable".

What the President and the Congress are really, realistically advocating----since there is absolutely no possibility of having enough money to cover all people in this country as long as the private, for-profit health insurance industry is allowed to exist ---is more incremental reform, not National Health Insurance. It is now 44 years since Medicare and Medicaid came into existence. In the interim, there have been many experiments in this country and abroad to try to provide universal health coverage.

Other countries have uniformly rejected the private for-profit insurance industry and have adopted National Health Insurance. Is everyone else wrong and only the US is right?

A recent study by the international OECD (Organisation for Economic Co-operation and Development)[1] provided health insurance data from its 30 member countries (Europe, Korea, Japan, Mexico, Canada, the U.S. and others including Australia, New Zealand and Iceland). The latest data from those countries showed that 27 of the 30 had health insurance coverage for more than 96% of the population; with only Germany having any non-public coverage (10.3%). The other three were Mexico with 60.4% covered---all with public coverage, Turkey, with 67.2% covered, also with public coverage and the U.S. with 84.9% covered 57.5%with private and 27.4% with public coverage.

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[1] OECD Health Working Papers: Measuring Disparities in Health Status and Access and Use of Health Care in OECD Countries. 3/9/09

In Canada, back in 1970, they were spending the same percentage of their gross national product as we were on health. They also had millions of uninsured people and many of the same insurance companies such as Blue Cross, Blue Shield. They decided to just get rid of the health insurance industry. They had experimented with it in Saskatchewan ten years earlier and it had worked so well, they couldn't wait to do it nationally. So, where there's a will, there's a way. There is no way we are ever going to get to having good health insurance for everyone, as long as there's a health insurance industry, in the way, obstructing care.

Other more recent experiments abroad include Taiwan. In 1995, Taiwan had said, we don't like the fact that 40 percent of our people are uninsured. They passed, essentially, single-payer plan and within a few years 90-95 percent of the people were covered.

In the U.S. we have had experiments as well with seven states having instituted various versions of the public/private combination that this legislation seeks to provide. In none of these states has this worked, once several years had elapsed, despite initial enthusiasm and short-lived decreases in the uninsured.

So as we consider what to do, which experiments do we follow? The ones that were successful, all of which, for all practical purposes eliminated the private for-profit insurance industry, or the failed U.S. state examples, all of which were built on this industry?

If instead of saying that a single payer program is <u>not</u> politically possible, the President and the Congress need to say, "It is not only politically possible, politically feasible, but it's the only practical way national health insurance will ever happen. Anything short of that is essentially throwing tens of billions of dollars at the insurance industry. And if you're afraid of the insurance industry, than you're afraid of doing the right thing: Having everybody in, and nobody out of having health insurance.

Mr. PALLONE. Dr. Woolhandler.

STATEMENT OF STEFFIE WOOLHANDLER, M.D.

Dr. WOOLHANDLER. Members of the committee and Mr. Chairman, I am Steffie Woolhandler, a primary care doctor in Cambridge, Massachusetts, and associate professor of medicine at Harvard. I also co-founded Physicians for a National Health Program, and our 16,000 physician members support nonprofit single-payer national health insurance because of overwhelming evidence that lesser reforms, even with robust public plan option, lesser reforms will fail.

Private insurance is a defective product. Unfortunately, the tri-committee plan would keep private insurers in the driver's seat and, indeed, require Americans to buy their shoddy products. Once failure to buy health insurance is a Federal offense, what comes next? A Ford Pinto in every garage, lead-painted toys for every child, melamine chow for every puppy?

Even middle-class families with supposedly good coverage are just one serious illness away from financial ruin. My colleagues and I recently found that medical bills and illness contribute to 62 percent of all personal bankruptcies, a 50 percent increase since 2001. Strikingly, three-quarters of the medically bankrupt had health insurance when they first got sick. In case after case, the insurance families bought in good faith failed them when they needed it most. Some were bankrupted by copayments and deductibles and loopholes that allowed their insurer to deny coverage. Others got too sick to work, leaving them unemployed and uninsured. And insurance regulations like those in the tri-committee bill cannot—cannot—fix these problems.

We in Massachusetts have seen in action a plan virtually identical to the one you are considering. In my State, beating your wife, communicating a terrorist threat, or being uninsured all carry $1,000 fines. Yet despite these steep penalties, most of the new coverage in our State has come from expanding the Medicaid-like programs at great public expense.

According to the State's disclosure to its bondholders, our health reform has cost $5,000 annually for each newly insured adult. That is equivalent to over $200 billion annually to cover all Americans with this style of program, or about $2 trillion if you want to do it over 10 years.

But even such vast expenditures haven't made care affordable for middle-class families in Massachusetts. If I were to lose my Harvard coverage, I would be forced to lay out $4,800 for a policy with a $2,000 deductible before the policy paid a penny, and a 20 percent copayment after that.

The skimpy, overpriced, private coverage like this left one in six Massachusetts residents unable to pay their medical bills last year. One in six unable to pay their medical bills.

Meanwhile, rising costs have forced our legislature to rob Peter to pay Paul. Funding cuts have decimated safety-net hospitals and clinics. Today the State announced that health reform funding would be cut by $115 million as of July 1. Only 115 million. And our State Treasurer Cahill opines that Massachusetts could no longer afford reform. That is in today's Boston Globe.

As research I published in the New England Journal of Medicine showed, a single-payer reform could save about $400 billion annually by shrinking health care bureaucracy enough to cover the uninsured, and to provide first-dollar coverage for all Americans. A single-payer system would also include effective cost containment mechanisms, like bulk purchasing and global budgeting. As a result everyone would be covered, with no net increase in U.S. health spending.

But these savings aren't available, are not available unless we go all the way to single payer. Adding a public insurance plan option cannot fix the flaws in Massachusetts to our reform. A public plan might cut private insurer profits, which is why private insurance companies hate it, but their profits account for only about 3 percent of the money squandered in bureaucracy. Far more goes for marketing, to attract healthy profitable members, and demarketing, to avoid the sick. And tens of billions are spent on the armies of insurance administrators who fight over payment, and their counterparts at hospitals and doctors' offices. All of these would be retained in the public plan option. And overhead for even the most efficient competitive public plan would be far higher than Medicare's, which automatically enrolls seniors when they turn 65, disenrolls them only at death, deducts premiums automatically from Social Security checks, et cetera.

Unfortunately, competition in health insurance involves a race to the bottom, not the top. Competition in health care is a race to the bottom and a competing public plan would be pushed to the bottom. Insurers compete by not paying for care, by denying payment and shifting costs onto patients or other payers. These bad behaviors confer a decisive competitive advantage. A public plan option would either emulate them, becoming a clone of private insurance, or simply go under.

A kinder, gentler, public plan option would quickly fail in the marketplace, saddled with the sickest, most expensive patients, whose high costs would drive premiums to uncompetitive levels.

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

Eight decades of experience teaches that private insurers cannot control cost or provide American families with the coverage they need. A government-run clone of private insurer, a government-run clone of private insurers called a public plan option cannot fix these flaws. Only single-payer insurance can. Thank you.

Mr. PALLONE. Thank you.

[The prepared statement of Dr. Woolhandler follows:]

Testimony of Steffie Woolhandler, M.D., M.P.H.
Before the Health Subcommittee of the Committee on Energy and Commerce
June 24, 2009

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you.

Mr. PALLONE. Dr. Goodman.

STATEMENT OF JOHN C. GOODMAN

Mr. GOODMAN. Thank you, Mr. Chairman, members of the committee. Every single health care system in the world today faces three fundamental problems: cost, quality, and access. In our own country, health care spending is rising at twice the rate of growth of income, and has been doing so for 40 years. If that continues, clearly health care will crowd out everything else that we care about.

But we are not worse in this respect than other developed countries. Over the last 40 years the real rate of growth of health care spending per capita in the United States has been just slightly below the OECD average. We have quality problems in this country. But despite those problems, we appear to, overall, deliver a higher level of quality than just about any other country. We are number one in the world, for example, in survival of cancer patients.

We have access problems in this country, but I think we do better than just about any other country with a heterogeneous population. The U.S. population gets more preventive care by far than Canadians, for example. Americans get more mammograms, more Pap smears, more PSA tests, more colonoscopies, by quite a considerable margin than the Canadians do.

Low-income white Americans appear to be in better health than low-income white Canadians. The minority population of the United States seems to do better in our health care than the Inuits or the Crees in Canada, or the Aborigines in Australia, or the Maori of New Zealand.

Now, what about the proposals being considered by Congress right now? What will they do for the problems of cost, quality and access? When Peter Orszag was head of the Congressional Budget Office last year, he examined all of the major proposals that can Candidate Barack Obama was making to lower health care costs, preventive medicine, coordinated care, electronic medical records, evidence-based medicine and so forth. And what the CBO concluded was that none of these proposals would make any significant difference in rising health care costs.

On the other hand, if we spend an additional $150 billion a year on health care, that almost certainly will contribute to health care inflation, making the problem of cost worse, not better.

What about the problem of quality? Well, there is nothing that I have seen in any of the proposals being seriously discussed that would appear to make any significant difference in the quality of care that Americans receive.

But on the other hand, if we create an artificial market in which insurance companies are forced to community rate their products to millions of people and do so annually, they will very quickly discover that they want to seek to attract the healthy and avoid the sick. And once enrollment occurs, they will seek to overprovide to the healthy and underprovide to the sick. That is good if you are healthy. It is not going to be good if you are sick.

So we are setting in place an artificial market in which the incentives to underprovide are going to be very strong. And the more

competitive that market is, the more insurers will be inclined to act on those financial incentives.

What about access? Well, again, we do have access problems in this country. No doubt about it. But we are not going to solve those problems by putting millions of people into Medicaid and encouraging private—people with private plans to drop their private coverage and enroll in Medicaid, as a number of the proposals now would do. Basically that is what Massachusetts did. Massachusetts cut its uninsured rate in half, and it did so by putting thousands of people into Medicaid and thousands more into private plans that are paying Medicaid rates. And those people are finding they have difficulty in obtaining access to care.

A study just last month concluded that the wait to see a new doctor in Boston is more than twice as long as it is in any other U.S. city. And for Massachusetts as a whole, the number of people who go to hospital emergency rooms today for non-emergency care is as great as it was 3 years ago, before the Massachusetts health care plan was started. Medicaid is not a solution for the problems of the uninsured.

The cancer studies show that in terms of delays in treatment and delays in detection, being on Medicaid is only marginally better than being uninsured. And when people drop private coverage to join Medicaid, they are leaving a plan which allows them to see almost any physician, go to almost any facility, get care fairly promptly, and go into a system where there are long delays and where there are much fewer choices.

So the real danger, Mr. Chairman, is that we are about to pass legislation that will not only not lower the cost of care, but will make it higher; that will not improve quality, and may actually cause quality of care to go down; and may even make health care less accessible for millions of people. Thank you.

Mr. PALLONE. Thank you, Dr. Goodman.

[The prepared statement of Mr. Goodman follows:]

Statement of

John C. Goodman, Ph.D.
President & CEO
Kellye Wright Fellow
National Center for Policy Analysis

Linda Gorman
Independence Institute

Devon Herrick
National Center for Policy Analysis

Robert M. Sade
Department of Surgery and Institute of Human Values in Health Care,
Medical University of South Carolina

on

Health Care Reform: Do Other Countries Have the Answers?

Energy & Commerce Subcommittee on Health
United States House of Representatives
June 24, 2009

The health care systems of all developed countries face three unrelenting problems: rising costs, inadequate quality, and incomplete access to care. Much analysis published in medical journals suggests that other countries have found superior solutions to these problems.[1] This conclusion is at odds with economic research that is published in journals physicians seldom read, using methodologies that are unfamiliar to physicians. In this essay, we attempt to shed light on topics frequently discussed in proposals for health care reform, drawing on the relevant medical and economics literature.

Does the United States Spend Too Much on Health Care?

International statistics show that 2005 United States (US) per capita health care spending was 2.3 times greater than the median Organization for Economic Cooperation and Development (OECD) country ($6,401 vs. $2,759, based on purchasing power parity) and 1.5 times larger than Norway, the country that followed Luxembourg in the spending ranking.[2] However, normal market forces have been so suppressed throughout the developed world that purchasers rarely see a real price for any medical service. As a result, summing over all transactions produces aggregate numbers in which one can have little confidence. In addition, other countries more aggressively disguise costs, especially by suppressing provider incomes.

Economists have long known that international health care spending comparisons are fraught with potential error. Even for uncomplicated dental fillings, reimbursement data underestimate total costs by 50% in nine European countries.[3] Countries account for long term care and out-of-pocket spending differently. The accounting treatment of overhead and capital costs also varies.[4] An OECD project to harmonize national accounting methods began in 2000, but even when methods are harmonized, the choice of a price adjustment method can alter hospital cost estimates by as much as 400%.[5]

The US compares more favorably when real resources are measured rather than monetary accounts. Per capita, the US uses fewer physicians, nurses, hospital beds, physician visits, and hospitals days than the median OECD country.[6]

Even taking the monetary totals at their face value, the US has been neither worse nor better than the rest of the developed world at controlling expenditure growth. The average annual rate of growth of real per capita US health care spending is slightly below OECD average over the last decade (3.7% vs. 3.8%), and over the past four decades (4.4% vs. 4.5%).[7] Despite common perceptions, a country's financing method—public vs. private financing, general revenue vs. payroll taxes, third-party vs. out-of-pocket spending—is unrelated to its ability to control spending.[8]

For the US, the practical question is, can the adoption of another country's health care system offer a reasonable chance of improving US private sector methods? An answer in the negative is suggested by a comparison of the British National Health Service and California's Kaiser Permanente found that Kaiser provided more comprehensive and convenient primary care and more rapid access to specialists for roughly the same cost.[9]

Finally, international spending comparisons typically ignore costs generated by limits on supply. In 2002-2004, dialysis patients waited 16 days for permanent blood vessel access in the US, 20 days in Europe, and 62 days in Canada.[10] Waiting for care has economic costs in terms of sick pay and lost productivity, as well as negative health consequences. In the late 1990s, an estimated 5 to 10% of English waiting list patients were on sick leave. Norway is trying to reduce waiting times for patients "in order to reduce the cost of sickness benefits." Finland calculates that the cost of waiting (sickness benefits, medicines, and social welfare expenses) can exceed the cost of treatment.[11]

Are US Outcomes No Better and in Some Respects Worse Than Those of Other Nations?

Analyses that answer this question in the affirmative are often based on data showing that US life expectancy is similar to that of other developed countries and that its infant mortality rate is among the highest.[12] Yet within the US, life expectancy at birth varies enormously among racial and ethnic groups, from state to state, and across US counties.[13] These differences often are attributed to such lifestyle choices as diet, exercise and smoking rather than to differences in the quality of health care.[14] Similarly, US infant mortality varies by a factor of two or three to one across racial and ethnic groups, across the largest cities, and across the states for reasons apparently having little to do with health care.[15] The low US international ranking reflects national differences in the definition of a live birth.[16] Eberstat finds that US infants, stratified by birthweight, have a high likelihood of survival, regardless of race or economic circumstances.[17]

Health care likely plays a leading role in determining outcomes for diseases such as cancer, diabetes, and hypertension. Comparing cancer outcomes, the largest international study to date found that the five-year survival rate for all types of cancer among both men and women was higher in the US than in Europe.[18] US women have a 63% chance of living at least five years after a cancer diagnosis, compared with 56% for European women. Survival after diagnosis of breast cancer was 90% and 79%, respectively. Men in the US have a five-year survival rate of 66%, compared to only 47% for European men. Survival after diagnosis of prostate cancer was 99% and 78%, respectively.[19]

Higher US spending on prescription drugs may explain why there is a steeper increase in blood pressure with advancing age in Europe and a 60% higher prevalence of hypertension.[20] While half of all diabetics have high blood pressure, it is controlled in 36% of US cases compared with only 9% in Canada.[21] The rate of adverse events in US hospitals is only about half that in England, Australia, and New Zealand.[22] The aggressive treatment offered US cardiac patients apparently improves survival and functioning compared with Canadian patients.[23] Fewer health and disability related problems occur among US spinal cord injury patients than among Canadian and British patients.[24]

The US has better relative survival rates than Norway for colorectal and breast cancer, lower rates of vaccine-preventable pertussis, measles, and Hepatitis B, and shorter waiting lists.[25] In 2000, Norwegian patients waited an average of 133 days for hip replacement, 63 days for cataract surgery, 160 days for a knee replacement, and 46 days for bypass surgery after being approved for treatment.[26] Short waits for cataract surgery produce better outcomes; prompt

coronary artery bypass reduces mortality; and rapid hip replacement reduces disability and death.[27]

Britain has only one-fourth as many CT scanners as the US and one-third as many MRI scanners. The rate at which the British provide coronary bypass surgery or angioplasty to heart patients is only one-fourth of the US rate, and hip replacements are only two-thirds of the US rate. The rate for treating kidney failure (dialysis or transplant) is five times higher in the US for patients age 45 to 84 and nine times higher for patients 85 years of age or older.[28] Overall, nearly 1.8 million people are waiting to enter hospitals or for outpatient treatments at any given time.[29]

Canada is often said to deliver comparable care, produce comparable outcomes, and still spend less than the US.[30] However, the proportion of middle-aged Canadian women who have never had a mammogram is twice the US rate, and three times as many Canadian women have never had a pap smear. Fewer than 20% of Canadian men have ever been tested for prostate-specific antigen, compared with about 50% of US men. Only 10% of adult Canadians have ever had a colonoscopy, compared with 30% of US adults. These differences in screening may partly explain why the mortality rate in Canada is 25% higher for breast cancer, 18% higher for prostate cancer, and 13% higher for colorectal cancer.[31]

In view of such differences, it is not clear whether the U.S. spends too much on health care or other countries spend too little.

Is the Large Number of Uninsured in the US a Crisis?

The US is the only developed country in which a substantial subpopulation is nominally uninsured. Although this is said to be a crisis because the uninsured lack access to health care, the number of uninsured, and its consequences, are not clear.

The most widely used estimates of the number of US uninsured are from the US Census Bureau's Current Population Survey (CPS). It estimates that 47 million people were uninsured for the entire year in 2005.[32] The Survey of Income and Program Participation (SIPP), another Census Bureau survey, estimates about half that number. The Medical Expenditure Panel Survey (MEPS) and the National Health Interview Survey (NHIS) also generate lower estimates.[33] Many experts believe the CPS estimate is actually an estimate of the number of uninsured at a point-in-time. It is similar to the point-in-time estimates of SIPP (43 million in 2002), MEPS (48 million in 2004) and NHIS (42 million in 2004).[34]

Like unemployment, uninsurance is often transitory: 75% of uninsured spells last one year or less and 91% last two years or less.[35] Although the fraction of the population with health insurance rises and falls with the business cycle, since 1990 the CPS estimate has fluctuated between about 83 and 86% insured, despite an unprecedented influx of immigrants with uninsurance rates 2½ times that of the native-born population.36 Guaranteed issue laws, state high risk pools, and retroactive Medicaid eligibility make it increasingly easy to obtain insurance after becoming ill.[37]

Of the 46 million nominally uninsured, about 12 million are eligible for such public programs as Medicaid and the State Children's Health Insurance Program (SCHIP).[38] They can usually enroll even at the time of treatment, arguably making them de facto insured. About 17 million of the uninsured are living in households with at least $50,000 annual income. More than half of those earn more than $75,000, suggesting that they are uninsured by choice.[39] Although 36% of people in families with incomes under 200% of the poverty level are uninsured, 44% have private coverage, and there are reasons to believe that expansion of private coverage is a better avenue to greater access to care than expansion of public programs.[40]

Does Lack of Health Insurance Cause Premature Death?

A number of studies suggest that the uninsured are more likely to suffer complications of preventable illnesses and more likely to die from them.[41] However, the case is much less solid than most studies in the medical literature have suggested. The consensus among economic studies is that "insurance has a relatively small effect on health."[42] Moreover, the uncertainties about who is uninsured, for how long, and for what reasons suggest that generalized claims about the nationwide impact of uninsurance should be greeted with skepticism.

An Institute of Medicine report in 2002 claimed that 18,000 deaths a year in the US could be attributable to a lack of health insurance.[43] The Urban Institute updated that number to 22,000 in 2006, and Families USA raised it to 26,260 in 2008.[44] However, these reports arrived at their results by extrapolating from an estimate made in a 15-year-old study, using 37-year-old data, and employing questionable methodology.[45] In fact, we do not know how much morbidity and mortality is attributable to lack of health insurance.

Once people see a provider, a RAND study suggests that insurance status has little effect on receipt of recommended care.[46] However, the uninsured and those on Medicaid may be more likely to delay seeking care.[47] An American Cancer Society study found that, relative to people with private insurance, the uninsured and Medicaid-insured were more likely to present with advanced-stage cancer at diagnosis.[48]

Many proposals for universal health care coverage envision enrolling more people in Medicaid, in SCHIP plans paying Medicaid rates, or in private plans paying Medicaid rates. [49] Such efforts encourage people to drop their private coverage. Cutler and Gruber estimate that every extra $1 spent on Medicaid reduces private health insurance by 50-75¢.[50] For SCHIP, the Congressional Budget Office projects a crowd-out rate of 25% to 50% and Gruber estimates it at 60%.[51] Unfortunately, this substitution may lead to worse health outcomes. Low Medicaid reimbursement is associated with lower quality care.[52] Perhaps because of nonprice barriers and low reimbursement for some types of care, being enrolled in Medicaid is only marginally better than being uninsured.[53]

Are Medical Bills Causing Bankruptcy?

A study claiming that more than half of all bankruptcies are caused by medical debt[54] is often cited, but the claim conflicts with four decades of economic research. The label "medical

bankruptcy" was applied if out-of-pocket medical bills exceeded $1,000, even though out-of-pocket expenses of the average US household were $2,182 in the year studied.[55] Recalculating the study's data, Dranove and Millenson conclude that only 17% of the sample "had medical expenditure bankruptcies."[56] Well-designed economic studies have found no statistical link between bankruptcies and health problems.[57] In fact, household consumption is largely unchanged even in the face of very large medical bills.[58]

Are Administrative Costs Higher for Private Insurance Than Public Insurance?

The Congressional Research Service has estimated the administrative costs of Medicare at 2% of the total program costs, compared to 10% for private insurance and 12% for HMOs. Some single-payer advocates have used this estimate as an argument for a universal Medicare program.[59] These estimates ignore hidden costs shifted to the providers of care, and the social costs of collecting taxes to fund Medicare. A Milliman & Robertson study estimates that, when these costs are included, Medicare and Medicaid spend two-thirds more on administration than private insurance spends on administration: 27 cents, compared to 16 cents, respectively, for every dollar of benefits.[60]

According to Himmelstein and Woolhandler, if the US adopted the Canadian system, the savings on lower administrative costs could pay for insuring the uninsured.[61] Their calculation includes the cost of private insurance premium collection (advertising, agents' fees, etc.), but ignores the cost of tax collection to pay for public insurance. Danzon estimates the deadweight cost of tax finance in Canada to be at least 17% of claims.[62] Using the most conservative estimate of the social cost of collecting taxes, Zycher calculates that the excess burden of a universal Medicare program would be twice as high as the administrative costs of universal private coverage.[63]

Are Low-Income Families More Disadvantaged in the US System?

Aneurin Bevan, father of the British NHS, declared, "the essence of a satisfactory health service is that rich and poor are treated alike, that poverty is not a disability and wealth is not advantaged."[64] More than thirty years after the NHS founding an official task force found little evidence that the creation of the NHS had equalized health care access.[65] Another study fifty years after the NHS founding concluded that access had become more unequal in the years between the two studies.[66] Other scholarly studies have come to similar conclusions.[67]

In Canada, the wealthy and powerful have significantly greater access to medical specialists than less-well-connected poor.[68] High-profile patients enjoy more frequent services, shorter waiting times and greater choice of specialists.[69] Moreover, among the nonelderly white population, low-income Canadians are 22% more likely to be in poor health than their US counterparts.[70]

For OECD countries generally, among people with similar health conditions, "higher income people use the system more intensively and use more costly services than do lower income people." [71] It seems likely that the same personal characteristics that ensure success in a market economy also enhance success in bureaucratic systems.[72]

Can the Free Market Work in Health Care?

The US system is often portrayed as more market-based than the systems of other countries, but this portrayal may be more perception than reality. While 13 cents of every dollar is paid out-of-pocket by US patients, the OECD average is 20 cents.[73] Throughout the developed world, third-party payers set fees and pay fees, perversely encouraging patients to overconsume and providers to manipulate reimbursement formulas to increase their incomes.[74] When third-party payment is not a factor, medical markets more closely resemble markets for other goods and services.[75]

In cosmetic surgery, virtually all payments are out-of-pocket and transparent package prices covering all services are the norm. Even though technological progress is frequently assumed to increase health care costs, the real price of cosmetic surgery has declined over the past 15 years, despite substantial technological progress and a six-fold increase in demand and.[76] In corrective vision surgery, out-of-pocket payments and package prices are the norm, and the real price has declined by 30% over the past decade.[77] Price transparency is absent in virtually every other kind of surgery.

Most walk-in clinics in drug stores and shopping malls began outside the third-party payment system. They have already achieved many of the goals included in most reform proposals: they post prices, keep electronic medical records (EMRs) and can prescribe electronically, taking advantage of error-reducing software.[78] Teladoc, which also developed outside the third-party payment system, offers telephone consultations. It maintains personal and portable EMRs, and its physicians prescribe electronically.[79]

Largely because so many drugs are purchased out-of-pocket, Rx.com began selling prescription drugs online, encouraging price competition in a national marketplace. Wal-Mart, a company in search of profits, has expanded its nationally advertised program of low cost generic drugs. Its efforts have spurred other retailers to engage in price competition as well.[80]

Outside the US borders, a vibrant, competitive international marketplace appears to be developing for all manner of medical services.[81] Package prices are customary, as are EMRs, and information on quality. Moreover, many health centers abroad are affiliated with high-quality US facilities including the Cleveland Clinic, Mayo Foundation, Harvard Medical International, and Johns Hopkins Medicine International.[82]

CONCLUSION

Although national health insurance has considerable support within the medical profession, the degree to which patient empowerment, individual choice, competition, and market incentives are being consciously and successfully used to solve health care problems is far more extensive than is commonly realized. More than 10 million US families are managing some of their own health care dollars through Health Savings Accounts (HSAs) and Health Reimbursement Accounts.[83] More than half the states have Medicaid Cash & Counseling pilot programs underway, allowing the disabled to manage their own supportive care budgets. The satisfaction rate approaches 100%.[84] Internationally, Singapore has had a system of compulsory Medisave Accounts since 1984. China has initiated a pilot program based on the Singapore model.[85] In South Africa, HSA plans have captured more than half the private insurance market.[86] Switzerland, considered by

many to have the most egalitarian health care system in the developed world, relies largely on private (although government-mandated) insurance.[87]

In some respects, support for government regulation of health care financing and delivery has been based on a narrow construal of selected data, while all too often ignoring contrary data. We have attempted to correct the record by discussing some specific gaps, and suggest that the discussion of US health care reform would benefit greatly from a careful examination of the current successes and future potential of market-based reforms.

Notes

[1] American College of Physicians, "Achieving a High-Performance Health Care System with Universal Access: What the United States Can Learn From Other Countries," Annals of Internal Medicine 148, no. 1 (2008): 55-75.

[2] "OECD Health Data: Specialists Outnumber GPs in Most OECD Countries," OECD Health Data 2007 (Paris: Organization for Economic Co-operation and Development, 2007) Chart 4: Health expenditure per capita, public and private, OECD countries, 2005. 2007, http://www.oecd.org/dataoecd/52/34/38976588.pdf (accessed 19 May 2008).

[3] S.S. Tan, WK Redekop and FFH Rutten, "Costs and Prices of Single Dental Fillings in Europe: a Micro-Costing Study," Health Economics 17, 1 Supplement (2008): S83-93.

[4] O. Tiemann, "Variations in Hospitalisation Costs for Acute Myocardial Infarction - a Comparison Across Europe," Health Economics 17, 1 Supplement (2008): S33-45.

[5] E. Orosz and D. Morgan, "SHA-based national health accounts in thirteen OECD countries: a comparative analysis," Health Working Papers no. 16 (Paris: Organization for Economic Co-operation and Development, 2004). "Note On General Comparability of Health Expenditure and Finance Data in OECD Health Data 2007," (Paris: Organization for Economic Co-operation and Development, 2007), http://www.ecosante.fr/ OCDEENG/411.html (accessed 19 May 2008). E. Orosz, "The OECD System of Health Accounts and the US National Health Account: Improving Connections Through Shared Experiences," (2005). Draft paper prepared for the conference on "Adapting National Health Expenditure Accounting to a Changing Health Care Environment" (Washington, D.C.: Centers for Medicare & Medicaid Services), http://www.cms.hhs.gov/NationalHealthExpendData/ downloads/confpaperorosz.pdf (accessed 19 May 2008); Jonas Schreyogg, etal., "Cross-Country Comparisons of Costs: The Use of Episode-Specific Transitive Purchasing Power Parities with Standardised Cost Categories," Health Economics 17, 1 Supplement (2008): S95-103.

[6] G.F. Anderson, B.K. Frogner and U.E. Reinhardt, "Health Spending in OECD Countries in 2004: an Update," Health Affairs 26, no. 5 (2007):1481-1489.

[7] Anderson, Frogner and Reinhardt, "Health spending in OECD countries in 2004: an Update;" Gerard F. Anderson, et al., "Health Spending and Outcomes: Trends in OECD Countries, 1960–1998," Health Affairs 19, no. 3 (2000):150-157.

[8] S.A. Glied, "Health Care Financing, Efficiency, and Equity," NBER Working Paper 13881 (Cambridge, MA: National Bureau of Economic Research, 2008).

[9] R.G. Feachem, H.K Sekhri and L.K. White, "Getting More for their Dollar: a Comparison of the NHS with California's Kaiser Permanente," BMJ 324, no. 7330 (2002):135-143.

[10] D.C. Mendelssohn et al., "Haemodialysis Vascular Access Problems in Canada: Results from the Dialysis Outcomes and Practice Patterns Study (DOPPS II)," Nephrology Dialysis Transplantation 21, no. 3 (2006): 721-728.

[11] J. Hurst and L. Siciliani, "Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries," OECD Health Working Paper no. 6 (Paris: Organization for Economic Co-operation and Development, 2003).

[12] P.S. Hussey et al. "How Does the Quality of Care Compare in Five Countries?" Health Affairs 23, no. 3 (2004):89-99. C. Schoen and S.K.H How and S.C. Schoenbaum, National Scorecard on U.S. Health System Performance: Technical Report (New York: Commonwealth Fund, 2006). R.L. Lichtenstein, "The United States'

Health Care System: Problems and Solutions," Survey of Ophthalmology 39, no. 2 (1994):166-167. L. Champlin "Call for health system reform reaching grassroots level," (Leawood, KS: American Academy of Family Physicians, 8 November 2006), http://www.aafp.org/online/en/home/publications/news/news-now/health-care-reform/20061008grassroots.html (accessed 1 October 2008).

[13] H.C. Kung et al., "Deaths: Final Data for 2005," National Vital Statistics Report 56_10 (Hyattsville, MD: Centers for Disease Control and Prevention, 2008); Harvard University Initiative for Global Health, cited in M. Hitti, "Top States for Life Expectancy," WebMD Medical News, 2006, http://www.webmd.com/news/20060913 /top-states-for-life-expectancy (accessed 1 October 2008); C.J.L. Murray et al., "Eight Americas: Investigating Mortality Disparities across Races, Counties, and Race-Counties in the United States," PLoS Medicine 3, no. 9 (2006): e260 doi:10.1371/journal.pmed.0030260.

[14] "Growing Disparities in Life Expectancy," Economic and Budget Issue Brief (Washington, DC: Congressional Budget Office, 2008).

[15] T.J. Mathews and M.F. MacDorman, "Infant Mortality Statistics from the 2004 Period Linked Birth/Infant Death Data Set," National Vital Statistics Report 55_14 (Hyattsville, MD: Centers for Disease Control and Prevention, 2007); V. Haynatzka et al., "Racial and Ethnic Disparities in Infant Mortality Rates --- 60 Largest U.S. Cities, 1995-1998," Morbidity and Mortality Weekly Report 51, no. 15 (2002): 329-332,343; T.J. Mathews and M.F. MacDorman, "Infant Mortality Statistics from the 2004 Period Linked Birth/Infant Death Data Set," National Vital Statistics Report 55_14 (Hyattsville, MD: Centers for Disease Control and Prevention 2007).

[16] E.M. Howell and B. Blondel, "International Infant Mortality Rates: Bias from Reporting Differences," American Journal of Public Health 84, no. 5 (1994):850-852; S. Sepkowitz "International Rankings of Infant Mortality and the United States Vital Statistics Natality Data Collecting System - Failure and Success," International Journal of Epidemiology 24, no. 3 (1995):583-588; M. Muller et al., "Liveborn and Stillborn Very Low Birthweight Infants in Switzerland: Comparison between Hospital Based Birth Registers And The National Birth Register," Swiss Medical Weekly 135, no. 29 (2005):433-439.

[17] N. Eberstadt, The Tyranny of Numbers: Mismeasurement and Misrule (Washington, DC: The AEI Press, 1995) 43-73.

[18] A. Verdecchia et al., "Recent Cancer Survival in Europe: a 2000–02 Period Analysis of EUROCARE-4 Data," Lancet Oncology 8, no. 9 (2007):784-796.

[19] Verdecchia et al., "Recent Cancer Survival in Europe: a 2000–02 Period Analysis of EUROCARE-4 Data."

[20] J.A. Staessen, T. Kuznetsova and K. Stolarz, "Hypertension Prevalence and Stroke Mortality Across Populations," Journal of the American Medical Association 289, no. 18 (2003):2420-2422. (Online edition, accessed 10 March 2006). K. Wolf-Maier et al., "Hypertension Prevalence and Blood Pressure Levels in 6 European Countries, Canada and the United States," Journal of the American Medical Association 289, no. 18 (2003):2420-2422.

[21] M.R. Joffres et al., "Distribution of Blood Pressure and Hypertension in Canada and the United States," American Journal of Hypertension 14, no. 1 (2001):1099-1105.

[22] G.R. Baker et al., "The Canadian Adverse Events Study: The Incidence of Adverse Events among Hospital Patients in Canada," Canadian Medical Association Journal 170, no. 11 (2004):1678-1686.

[23] P. Kaul et al., "Long-Term Mortality of Patients with Acute Myocardial Infarction in the United States and Canada: Comparison of Patients Enrolled in Global Utilization of Streptokinase and t-PA for Occluded Coronary Arteries (GUSTO)-I," Circulation 110, no. 13 (2004):1754-1760, http://circ.ahajournals.org/cgi/content/full Page 16

/110/13/1754 (accessed 27 January 2006); J.L. Roleau et al., "A Comparison of Management Patterns After Acute Myocardial Infarction in Canada and the United States. The SAVE Investigators," New England Journal Medicine 328, no. 11 (1993): 779-784.

[24] M.A. McColl et al., "International Differences in Ageing and Spinal Cord Injury," Spinal Cord 40, no. 3 (2002):128-136.

[25] E. Kelley and J. Hurst, "Health Care Quality Indicators Project Initial Indicators Report," OECD Health Working Papers no. 22 (Paris: Organisation for Economic Co-operation and Development, 2006).

[26] L. Siciliani and J. Hurst, "Explaining Waiting Times Variations for Elective Surgery Across OECD Countries," OECD Health Working Papers no. 72003 (Paris: Organisation for Economic Co-operation and Development, 7 October 2003).

[27] W. Hodge et al., "The Consequences of Waiting for Cataract Surgery: A Systematic Review," Canadian Medical Association Journal 176, no. 9 (2007):1285-1290; B.G. Sobolev et al., "The Risk of Death Associated with Delayed Coronary Artery Bypass Surgery," BMC Health Services Research 6, no. 85 (2006), http://www.pubmedcentral. nih.gov/ picrender.fcgi? artid=1574305&blobtype=pdf (accessed 30 September 2008); E.M. Koomen et al., "Morbidity and Mortality in Patients Waiting for Coronary Artery Bypass Surgery," European Journal of Cardio-Thoracic Surgery 19, no. 3(2001):260-265; D.S. Garbuz et al., "Delays Worsen Quality of Life Outcome of Primary Total Hip Arthroplasty," Clinical Orthopaedics and Related Research 447 (2006):79-84. A.M. Davis et al., "Waiting for Hip Revision Surgery: the Impact on Patient Disability," Canadian Journal of Surgery 51, no. 2 (2008):92-96. V. Novack et al., "Does Delay in Surgery after Hip Fracture Lead to Worse Outcomes? A Multicenter Surgery," International Journal for Quality in Health Care 19, no. 3 (2007):170-176.

[28] H.J Aaron, Can We Say No? The Challenge of Rationing Health Care Health Care (Washington DC: Brookings Institution Press, 2005).

[29] NHS Wales Waiting Times: At End March 2008. Stats Wales 2008. SDR 58/2008. Patients Waiting (Edinburgh: National Services Scotland, 2008). NHS Inpatient and Outpatient Waiting Times Figures, 29 February 2008 and Revised Data for April 2006 – January 2008 (London: Department of Health, 2008).

[30] Physicians for a National Health program, "Proposal of the Physicians' Working Group for Single-Payer National Health Insurance," Journal of the American Medical Association 290, no. 3 (2003):798-805.

[31] J.E. O'Neill and D.M. O'Neill, "Health Status, Health Care and Inequality: Canada vs. the U.S." NBER Working Paper 13429 (Cambridge, MA: National Bureau of Economic Research, 2007).

[32] C. DeNavas-Walt, B.D. Proctor and J. Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2006," Current Population Reports no. 60-233 (Washington DC: U.S. Census Bureau, 2007).

[33] N. Chockley, H. Pirani and K. Kushner, "A Primer on the CPS Estimate of America's Uninsured," NIHCM Brief (Washington DC: National Institute for Health Care Management, 2006).

[34] Chockley, Pirani and Kushner, "A Primer on the CPS Estimate of America's Uninsured."

[35] R.J. Mills and S. Bhandari, "Health Insurance Coverage in the United States: 2002," Current Population Reports no. P60-223 (Washington DC: U.S. Census Bureau, 2003).

[36] C.H. Lee and S.M Stern, "Health Insurance Estimates from the U.S. Census Bureau: Background for a New Historical Series," (Washington DC: U.S. Census Bureau, 2007), http://www.census.gov/hhes/www/hlthins /usernote/revhlth_paper.pdf (accessed 23 May 2008). "National Health Interview Survey. Early release," Page 17

(Hyattsville, MD: Centers for Disease Control and Prevention, March 2007) Figure 1.1 Percentage of persons of all ages without health insurance coverage at the time of interview: United States, 1997-September 2006, http://www.cde.gov/nchs/data/nhis/earlyrelease/200703_01.pdf (accessed 23 May 2008); C. DeNavas-Walt, B.D. Proctor and J. Smith, "Income Poverty, and Health Insurance Coverage in the United States: 2006," Current Population Reports no. P60-233 (Washington D.C: U.S. Census Bureau), p. 19.

[37] L. Wachenheim and H. Leida, The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets (Brookline, WI: Milliman, 2007).

[38] "The Uninsured in America," R30-03-014 (Chicago: BlueCross BlueShield Association, 2003).

[39] C. DeNavas-Walt, B.D. Proctor and J. Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2007," Current Population Reports no. 60-235 (Washington DC: U.S. Census Bureau, 2008); H. Kuttner and M.S. Rutledge, "Higher Income And Uninsured: Common or Rare?" Health Affairs 26, no. 6 (2007): 1745–1752 (published online November 2007; 10.1377/hlthaff.26.6.1745).

[40] M.K. Bundorf and M.V. Pauly, "Is Health Insurance Affordable for the Uninsured?" Working Paper no. 9281 (Cambridge, MA: National Bureau of Economic Research, 2002); J.C. Goodman et al. Handbook on State Health Care Reform (Dallas: National Center for Policy Analysis, 2007).

[41] J. Hadley and J. Holahan, "How Much Medical Care do the Uninsured Use, and Who Pays for it?" Health Affairs 22 (2003):w3250-w3265. (published online 12 February 2003; 10.1377/hlthaff.w3.66). J. Hadley, "Sicker and Poorer—The Consequences of Being Uninsured: A Review of the Research on the Relationship Between Health Insurance, Medical Care Use, Health, Work, and Income," Medical Care Research and Review 60, no. 2 supplement (2003):3S-75S.

[42] R. Kronick, "Commentary—Sophisticated Methods but Implausible Results: How Much Does Health Insurance Improve Health?" Health Services Research 41, no. 2 (2006):452–460.

[43] Institute of Medicine, Care without Coverage: Too Little, Too Late (Washington, DC: National Academy Press, 2002).

[44] S. Dorn, Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality (Washington, DC: Urban Institute, 2008); "Dying for Coverage," (Washington, DC: Families USA, 2008), http://familiesusa.org/issues/uninsured/publications/dying-for-coverage.html (accessed 1 October 2008).

[45] P. Franks, C.M. Clancy and M.R. Gold, "Health Insurance and Mortality. Evidence from a National Cohort," Journal of the American Medical Association 270, no. 6 (1993):737-741; L. Gorman, "Dying for (Media) Coverage," Health Alert (Dallas: National Center for Policy Analysis, 2 May 2008), http://www.john-goodman-blog.com/dying-for-media-coverage/ (accessed 1 October 2008).

[46] S.M. Asch et al., "Who is at Greatest Risk for Receiving Poor-Quality Health Care?" New England Journal of Medicine 354, no. 11 (2007):1147-1156.

[47] J.S. Weissman at al., "Delayed Access to Health Care: Risk Factors, Reasons, and Consequences," Annals of Internal Medicine 114, no. 4 (1991):325-331.

[48] M.T. Halpern, E.M. Ward and A.L. Pavluck, "Association of Insurance Status And Ethnicity With Cancer Stage At Diagnosis For 12 Cancer Sites: A Retrospective Analysis," Lancet Oncology 9, no. 3 (2008):222-231. Page 18

[49] L. Dubay, C. Moylan and T.R. Oliver, "Advancing Toward Universal Coverage: Are States Able to take the Lead?" Journal of Health Care Law and Policy 7, no. 1 (2004):1-41. M.G. Bloche, "Health Care for All? New England Journal of Medicine 357, no. 12 (2007):1173-1175.

[50] D.M. Cutler and J. Gruber, "Does Public Insurance Crowd Out Private Insurance?" The Quarterly Journal of Economics 111, no. 2 (1996):391-430.

[51] N. Duchovny and L. Nelson, "The State Children's Health Insurance Program," CBO Pub no. 2970 (Washington, DC: Congressional Budget Office, 2007); J. Gruber and K. Simon, "Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Heath Insurance?" Working Paper no. 12858 (Cambridge: National Bureau of Economic Research, 2007).

[52] J.D. Reschovsky and A.S. O'Malley, "Do Primary Care Physicians Treating Minority Patients Report Problems Delivering High-Quality Care?" Health Affairs 27, no. 3 (2008):w221-w231 (published online 22 April 2008; 10.1377/hlthaff.27.3.w222); J.E. Calvin et al., "Insurance Coverage and Care of Patients with non-ST Segment Elevation Acute Coronary Syndrome," Annals of Internal Medicine 145, no. 10 (2006):739-748.

[53] M.T. Halpern, E.M. Ward and A.L. Pavluck, "Association of Insurance Status And Ethnicity With Cancer Stage At Diagnosis For 12 Cancer Sites: A Retrospective Analysis," Lancet Oncology 9, no. 3 (2008):222-231. B.R. Asplin et al., "Insurance Status and Access to Urgent Ambulatory Care Follow-Up Appointments," Journal of the American Medical Association 294, no. 10 (2005):1248-1254.

[54] D.U. Himmelstein, etal., "MarketWatch: Illness and Injury as Contributors to Bankruptcy," Health Affairs 24 (2005): w63-w73 (published online 2 February 2005; 10.1377/hlthaff.w5.63).

[55] T.J. Zywicki, "An Economic Analysis of the Consumer Bankruptcy Crisis," Norwest University Law Review 99, no. 4 (2005):1463-1542.

[56] D. Dranove amd M.L. Millenson, "Medical Bankruptcy: Myth Versus Fact," Health Affairs 25, no. 2 (2005):w74-w83 (published online 28 February 2006; 10.1377/hlthaff.25.w74).

[57] S. Fay, E. Hurst and M. White, "The Household Bankruptcy Decision," American Economic Review 92, no. 3 (2002):706–718.

[58] H. Levy, "The Economic Consequences of Being Uninsured," ERIU Working Paper no. 12 (Ann Arbor, MI: University of Michigan, 2002), http://www.umich.edu/~eriu/pdf/wp12.pdf (accessed 1 October 2008).

[59] S. Woolhandler, T. Campbell and D.U. Himmelstein, "Costs of Health Care Administration in the United States and Canada," New England Journal of Medicine 349, no. 8 (2003):768-775.

[60] M. Litow et al. "Rhetoric vs. Reality: Comparing Public and Private Administrative Costs," (Washington DC: Council for Affordable Health Insurance, 1994).

[61] S. Woolhandler and D.U. Himmelstein, "Paying for National Health Insurance—and not Getting It," Health Affairs 21, no. 4 (2002):88-98.

[62] P.M. Danzon, "Hidden Overhead Costs: Is Canada's System Really Less Expensive?" Health Affairs 11, no. 1 (1992):21-43.

[63] B. Zycher, "Comparing Public and Private Health Insurance: Would a Single-Payer System Save Enough to Cover the Uninsured?" Medical Progress Report no. 5 (New York: Manhattan Institute for Policy Research, 2007).

[64] Economic Models Ltd. The British Health Care System (Chicago: American Medical Association, 1976).

[65] P. Townsend and N. Davidson, Inequities in Health Care, Black Report (Harmondsworth: Penguin, 1982). Page 19

[66] Independent Inquiries into Inequity and Health: The Acheson Report (London: Stationary Office, 1998).

[67] R. Mitchell and M. Shaw, Reducing Health Inequities in Britain (York, North Yorkshire: Joseph Roundtree Foundation, 2000).

[68] D.A. Alter et al., "Effects of Socioeconomic Status on Access to Invasive Cardiac Procedures and on Mortality after Acute Myocardial Infarction," New England Journal of Medicine 341, no. 18 (1999):1359-1367.

[69] S. Dunlop, P.C. Coyte and W. McIsaac, "Socio-Economic Status and the Utilisation of Physicians' Services: Results from the Canadian National Population Health Survey," Social Science & Medicine 51, no. 1 (2000):123-133.

[70] J.E. O'Neill and D.M O'Neill, "Health Status, Health Care and Inequality: Canada Vs. The U.S.," NBER Working Paper no. 13429 (Cambridge, MA: National Bureau of Economic Research, 2007).

[71] S.A. Glied, "Health Care Financing, Efficiency, and Equity," NBER Working Paper no. 13881 (Cambridge, MA: National Bureau of Economic Research, 2008).

[72] J.C. Goodman, G.L. Musgrave and D.M. Herrick, Lives at Risk: Single-Payer National Health Insurance around the World (Lanham, MD: Rowman & Littlefield, 2004), Chapter 21.

[73] C.L. Peterson and R. Burton, "U.S. Health Care Spending: Comparison with Other OECD Countries," (Washington DC: Congressional Research Service, 2007).

[74] J.C. Goodman, G.L. Musgrave and D.M. Herrick, Lives at Risk: Single-Payer National Health Insurance around the World (Lanham, MD: Rowman & Littlefield, 2004),

[75] J.C. Goodman and G.L. Musgrave, Patient Power: Solving America's Health Care Crisis, (Washington, D.C.: Cato Institute, 1992).

[76] D.M. Herrick, "Update 2006: Why Are Health Costs Rising?" Brief Analysis no. 572 (Dallas: National Center for Policy Analysis, 2006).

[77] H.T. Tu and J.H May, "Self-Pay Markets in Health Care: Consumer: Nirvana or Caveat Emptor?" Health Affairs 26, no. 2 (2007):w217-w226 (published online 6 February 2007; 10.1377/hlthaff.26.2.w217).

[78] K.J. Alexander, "Health Plans Embrace Retail Clinics," Managed Care 17, no.3 (2008):32-4, 43.

[79] D.M. Herrick, "Convenient Care and Telemedicine," Policy Report no. 305 (Dallas: National Center for Policy Analysis, 2007).

[80] "Use of Generic Prescription Drugs Prompts Decrease in Inflation," Kaiser Daily Health Policy Report (Menlo Park, CA: Henry J. Kaiser Family Foundation, 26 September 2007).

[81] M.D. Horowitz, J.A. Rosensweig and C.A. Jones, "Medical Tourism: Globalization of the Healthcare Marketplace," Medscape General Medicine 9, no. 4 (2007):33.

[82] D.M. Herrick, "Medical Tourism: Global Competition in Health Care," Policy Report no. 304 (Dallas: National Center for Policy Analysis, 2007).

[83] "January 2008 Census Shows 6.1 Million People Covered By HSA/High-Deductible Health Plans," (Washington DC: Americans Health Insurance Plans, 2006).

[84] B.C. Spillman, K.J. Black and B.A. Ormond, "Beyond Cash and Counseling: An Inventory of Individual Budget-based Community Long Term Care Programs for the Elderly," Issue Paper no. 7485 (Washington DC: Kaiser Page 20

Family Foundation, 2006). Also see Robert Wood Johnson Foundation, "Cash & Counseling," http://www.cashandcounseling.org/ (accessed 1 October 2008).

[85] N.C. Chia and A.K.C. Tsui, "Medical Savings Accounts in Singapore: How Much is Adequate?" Journal of Health Economics 24, no. 5 (2005): 855-875; "Health Care Trends. International Comparisons: Impact of HSAs on Costs and Utilization in Three Countries," Annual Report on Health Care (Milwaukee: Health Care Trends, 2005).

[86] "Health Care Trends. International Comparisons: Impact of HSAs on Costs and Utilization in Three Countries;" S. Matisonn, "Medical Savings Accounts in South Africa," Policy Report no. 234 (Dallas: National Center for Policy Analysis, June 2000).

[87] R.E. Leu and M. Schellhorn, "The Evolution of Income-Related Inequalities in Health Care Utilization in Switzerland over Time," IZA Discussion Paper no. 1316 (Bonn: Institute for the Study of Labor, 2004), http://ssrn.com/abstract=596941 (accessed 1 October 2008).

Mr. PALLONE. Thank all of you.

Now we will take questions. We will give you questions from individual panel members. We have 5 minutes each, and I will start with myself.

And this is about the public option. As you know—and this is to Dr. Wolfe or Dr. Woolhandler, or both of you—as you know, the discussion draft would create a public option to compete with private plans to offer coverage within the new health insurance exchange. Uninsured Americans would choose to enroll in any of the plans in the exchange, either public or private, and there has been concern expressed in some quarters that this public option would inevitably evolve into a single-payer system.

For example, last Friday, when the discussion draft was released, Scott Sirota, the head of BlueCross and BlueShield Association warned—and I will quote—that the proposed creation of a government-run health plan would jeopardize the coverage of 160 million people who receive their benefits through their employer today.

An independent analysis by the Lewin Group estimates that tens of millions of people would shift to a government plan, dismantling the private market that is free to innovate without the political pressures that often stifle efforts to innovate in government programs like Medicare.

Now, we are going to have BlueCross BlueShield and the Levin Group here tomorrow. But what I wanted to ask you today is whether you think Sirota is right. Will the public option strangle the private health insurance industry and become a single-payer system?

I will start with Dr. Wolfe and Dr. Woolhandler.

Dr. WOLFE. We have heard the same things that you have heard, Congressman Pallone, that somehow or other the public option is really a Trojan horse or a stalking horse for the single payer. What that would mean would be that if a public option were to pass, alongside with the private, that it would allow the public option to be as good as it can be. And essentially, if that were the case—which I don't think is going to happen—it might in fact lead to single payer.

I think there is zero possibility that anything that anyone is remotely considering as the public option would lead to a single-payer program. I think that it is more likely that it would give bad word or bad reputation to a public option because it would be so emasculated. I mean, at this point, I would say that the chances are 50/50 that either the public option would be completely scuttled—which I think is possible, President Obama said yesterday he wouldn't be opposed to signing a bill even it if didn't have that—or it would be so emasculated that it won't be competitive as it should be with the private plan. So I just don't think that that is realistic at all. I think that this is sort of scare tactics from the right, which includes the entire health insurance industry.

Mr. PALLONE. And Dr. Woolhandler, because I want to get to another question.

Dr. WOOLHANDLER. A public plan option is not single payer, nor would it lead to a single payer. As you have envisaged it in the tri-committee report, it is going to be an identical clone of private health insurance with a public label on it. And that still might be

OK if competition and health care were about giving people care. But competition health insurance is about not giving people care, about competing to enroll a lot of people and not cover them. And if you don't behave like that, if you don't misbehave like that, you go out of business in a competitive market.

So a private insurance clone with public label is not going to solve this problem. It is really irrelevant to the problem of access to care. And I appreciate the private insurance industry doesn't want it. They don't want any new competitors. But they are wrong when they say that what is here in this bill is going to lead to single payer. That is not true.

Mr. PALLONE. Well, I am probably going to say something that you won't want to hear. But I am beginning to feel more and more that, since I am getting so much opposition from the insurance industry that the public option is going to hurt them, and so much opposition from single payers that the public option won't work, that I actually now believe that we have a great discussion draft because neither group likes it. But that is not a question. That is just my comment.

I wanted to ask Dr. Woolhandler, on the bankruptcy issue, I know you did this important study on bankruptcies and health insurance, and as you testified this afternoon, your study found that medical bills and illnesses contribute to over 60 percent of all personal bankruptcies. Three-quarters of people with these medical bankruptcies have insurance at the start of their illness. It was a real eye-opener for me.

In the discussion draft, we have consumer protections that would prevent the abuses of the past, practices like medical underwriting and preexisting conditions exclusion and rescissions which deny or take away coverage just when it is needed most. So I am happy with these consumer protections in our discussion draft.

And I wanted to know, you know, whether you thought the House discussion draft addresses some of these critical consumer protections adequately, based on your research.

Dr. WOOLHANDLER. There is nothing in the draft that would have protected families from bankruptcy. The average family in medical bankruptcy had unpaid medical bills of about $17,000. And in your draft you would allow people to have out-of-pocket expenses of about $10,000 per family per year. So in less than 2 years, if you had a serious illness, you could accumulate $17,000 in out-of-pocket expenses that bankrupted families in our study.

So the protections you have, maybe they are better than no protections, but based on the actual circumstances that drove people to bankruptcy in our study, no, the bill would not protect people from bankruptcy.

Mr. PALLONE. OK. I know we are not going to agree on everything, but I do think that it is important that these insurance abuses be eliminated, and we are certainly making an effort in that regard. Thank you very much.

The gentleman from Indiana, Mr. Buyer.

Mr. BUYER. Thank you very much.

Dr. Goodman, the legislation mandates a massive expansion of the Medicaid program that some believe could lead to well over 20 million Americans becoming enrolled, then, into the Medicaid pro-

gram. First of all, I would like to know your thoughts about this as a proposal. And do you believe that there will be a similar crowd-out effect as is currently being seen in the SCHIP program?

Dr. GOODMAN. Well, I do. And I think that is what is intended; that when you make something available for free, even if the quality is not as good, people will tend to drop the high-priced alternative. That is what happened in SCHIP. That is what happened in TennCare in Tennessee. That is what happened in Hawaii. So we have quite a number of examples of people dropping private coverage to take advantage of public plans.

What happens in Medicaid is that it is really an inferior insurance plan. It pays, in many places, 40 percent below what the private market is paying. And so the Medicaid patient is the last patient the doctor wants to see at the end of the day. So you have increasingly long waits to see doctors, difficulty finding new doctors that will even see Medicaid patients, and pretty poor results when it comes to serious health care like cancer care.

Mr. BUYER. And in those cases that you just discussed, where the crowd-out effect had occurred within the SCHIP program, what was the impact upon insurance premiums because of the crowd-out? Did they increase or decrease?

Dr. GOODMAN. I don't know what the effect has been on insurance premiums. On the crowd-out, the Congressional Budget Office estimated that the bill that Congress passed in January, that would put 4 million new children into SCHIP, as many as half those children would leave private coverage in order to enroll in that coverage.

Mr. PALLONE. Dr. Goodman, I am told your microphone may not be on. Is it?

Dr. GOODMAN. Can you hear me now?

Mr. PALLONE. I was more concerned about the transcription. OK. Thank you.

Dr. GOODMAN. When those children had private insurance they could see almost any doctor, go to almost any facility in the area where they live. Once they go into Medicaid they could see far fewer physicians, go to fewer facilities, and their choices are more limited and their wait for care is longer.

Mr. BUYER. There have been some comments with regard to—that a public option plan would be able to compete on a level playing field with private insurance. Are you familiar at all at the tax revenues that are paid into the States and the Federal Government because of the insurances, the tax on their revenues? I mean, I guess if we were to have a public plan that would compete equally with private plans, my question would be, would we need to exclude these companies from State and Federal taxes in order for us to be able to compete on a level playing field?

Dr. GOODMAN. What a level playing field means to me is that the public plan doesn't get any advantages. It cannot do what Medicare now does and use the monopoly buying power of the State to push the rates it pays down below 30 percent below market. It can't use the criminal law to enforce its contracts when everybody has to use the civil law. And it can't avoid the payment of taxes on revenues. And it is allowed to go bankrupt. But if you protect it the way

Medicare is protected, having protections that private insurance does not have, then that is not a level playing field.

Mr. BUYER. And that public option with regard to the coverage of health would be far greater than perhaps a private plan, would it not?

Dr. GOODMAN. Well, I don't know. I wouldn't object to competition if it is a real level playing field. If it is a real level playing field, you just create a corporation; you can call it a corporation, let it sink or swim on its own, and I don't think it would much matter. But if it has advantages that Medicare now has over private insurers, it would matter a lot. And when you hear these estimates from Lewin and others, they are assuming it would have the advantages that Medicare has that private insurers do not.

Mr. BUYER. It is hard for me to imagine this competition, to create a public option and say that it will be on an equal plane with private insurance. And the reason I say that is I am sitting here with my colleague, John Shadegg—and Joe Barton was here. There were five of us that worked really hard when we were creating the Medicare drug discount card program, and then our analysis into the Medicare Part D, and we were trying to create choice and competition in the marketplace. At the same time, my Democrat colleagues were questioning whether or not that would be ever be successful. In particular, the Chairman, Henry Waxman, was very critical of what we were doing, and wanted a government position in there.

But in the end, we went pro-market forces and were able to reduce the price. As a matter of fact, we got all the estimates all wrong. In the end, we were able to save tens and billions and billions of dollars. And now trying to provide that same analysis into this one, to me, it creates a heterodox. And you are taking doctrine which people know and understand, and giving it a completely different definition. And so we are screwing up words, languages, and it just doesn't fit. I yield back.

Dr. GOODMAN. May I answer that?

Mr. PALLONE. Was it a question? Go ahead.

Before you go, let me just mention we are going to have—well, we have three votes pending. I will hear from a couple more members and then we will recess. But go ahead, Doctor.

Dr. GOODMAN. Part B competition I think is working well, better than anyone predicted that it would work. But that is different than what we are now talking about. What most people don't realize is that Medicare is, almost everywhere, administered by BlueCross. Now, do we really think that BlueCross administering Medicare is any more efficient than BlueCross administering other plans? No, of course not.

So why is it that Medicare has an advantage? It is because of advantages that are created by government, by law. So a level playing field would mean that anything administered by BlueCross plays by the same rules. And then I think it really wouldn't matter whether we call it public or not.

Mr. PALLONE. Thank you. Chairman Dingell. Questions?

Mr. DINGELL. Not at this time, Mr. Chairman. Thank you.

Mr. PALLONE. Ms. Eshoo?

Ms. ESHOO. Thank you, Mr. Chairman, for holding these series of hearings. And to all of the witnesses, I respect and admire the work that you have done and your testimony here today. There are great passions around single payer. I know that from some people in my own district, others in California, and certainly people across the country.

Let me ask you about something that I think important to the American people. In fact, I think they kind of have it in their DNA. Nobody likes—no American, I don't think, really likes a one-size-fits-all. They really like to have choice. So I know that—I mean, single payer doesn't provide that.

But I am asking you very sincerely, do you believe that this would—do you think that single payer could in any way preserve choice for patients? Because as I understand single payer, it is just—it is the one system that is paid by one outfit, the Federal Government, and that is it.

Dr. WOOLHANDLER. OK. Well, from the patient's point of view——

Ms. ESHOO. And we have learned a lot from—and I was here, I was here for the health care debate in 1993–1994. And if there was anything that I heard from my constituents it was, don't force me into a plan. If I have what I have and I like what I have, that is what I want to stay with.

Dr. WOOLHANDLER. Well, the choice that patients care about is that they are able to choose any doctor or hospital they want. And of course, that kind of choice is enhanced and expanded in single payer. In a single-payer system you go to any doctor, you go to any hospital. So that is the choice patients care about. Once they know the bill is going to get paid, they don't care about how the insurance person is. They care about the doctor and the hospital.

From the doctors' point of view, the choice we want is to be able to do what is best for our patients and not have to ask permission from some private insurance bureaucrat or be told we can only refer patient X to doctor Y because of restrictions. So choice is actually bigger.

The important choice, the choice of doctor is hospitals is bigger.

Ms. ESHOO. What the Democrats are proposing in the bill does preserve some choice that matches somewhat what you just described. And that is that they have a choice of doctors, they have a choice of hospitals.

Dr. WOOLHANDLER. But that is actually generally not a characteristic of private HMO coverage in this country.

Ms. ESHOO. Well, as it stands today. But I think that we have to ramp-up what we are talking about, because we are comparing and contrasting new ideas. We know what is broken. I mean, we don't need panels of people and all kinds of hearings to reiterate what is broken. We are looking at how to fix this thing.

So, you know, again, I mean I admire your work. I really think that if we were starting from scratch, from total scratch in the country, probably what you all described today is what would be built. But we are not starting from scratch, and that is why I think a public option is so important.

Can you tell the committee how you think a single-payer system would affect innovation in health care, which I think is so impor-

tant because we constantly have to be pushing the edges of the envelope out in our country on this? It is what makes the best part of caring for people in our country, the high end of it, something that is admired by people in different parts of the world.

So can you enlighten us on that and how you think your proposal would do that?

Dr. WOLFE. One of the things that gets focused on so much with single payer is that the government collects the money and pays the bills. Anyone can go to any doctor and hospital. But the very important element that doesn't get talked about very much is that you have a single data system. So for example, in Ontario, they can easily look at every patient in Ontario who got a certain prescription drug over a 2-year period, and then look to see how many of them had to get hospitalized because of something that is suspected to be an average reaction.

Ms. ESHOO. That is tracking the statistics. I am talking about innovation in medical devices and biotechnology.

Let me ask one last question here because I only have 17 seconds left. How do you pay for your system that you are advocates of?

Dr. WOOLHANDLER. Well, the beauty of single payer is it contains its only funding.

Ms. ESHOO. How do you pay for it?

Dr. WOOLHANDLER. You simplify administration. Currently, administration——

Ms. ESHOO. What is the savings over 10 years?

Dr. WOOLHANDLER. It is $400 billion a year. So that is 4 trillion. You don't really save it because you take that same 4 trillion and use it to cover the uninsured and plug the holes in coverage for people who now have these crummy private policies. But you don't raise total health spending by a single penny. You just simplify administration, capture just under 400 billion annually by administrative simplification, and then you use that to provide care.

Ms. ESHOO. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. I am going to ask Mr. Gingrey next, and then we will recess after him.

Dr. GINGREY. Mr. Chairman, thank you. I am going to go straight to Dr. Goodman with my questions, because I don't think any constituents in the 11th of Georgia, or any stakeholders, whether they are doctors or hospitals or especially insurance companies, would want to hear me ask any questions of Dr. Wolfe or Dr. Woolhandler, based on their testimony. I would like to address a couple of questions, though, to Dr. Goodman.

Dr. Goodman, many of my constituents fear that a government-run council making health coverage determination for a government-run insurance plan will impede or stop their ability to receive quality health care and eventually result in a government-run health care system where it is bureaucrats in Washington controlling their health care decisions.

Some of my Democratic colleagues say that a government-run plan will only provide choice and not lead to a single-payer system.

Now, my concern, of course, is that it will—and the old expression, if it walks like a duck and it quacks like a duck, you can bet that it probably is a duck. And speaking of ducks, you mentioned long wait times in other foreign countries like Canada.

In Norway, for instance, patients can expect to wait an average of 133 days for a hip replacement, 63 days for cataract surgery, 160 days for knee replacement, 46 days for bypass surgery, after having been approved for the procedure.

Well, Dr. Goodman, it seems that quality health care is not only the doctor you see, but the amount of time it takes to get through the door. In your opinion, are waiting times symptomatic and consistent with a government-run health care system?

Dr. GOODMAN. Well, yes. And you get long waits because you make medical care free to the patient, and you limit resources. And so demand exceeds supply at every margin. So you wait for everything.

I might point out that we are getting a waiting problem in our health care system, too. We are inching toward Canada without changing anything about how we pay for health care, and I am concerned about that. On the Health Board, you know, I have to rely on Senator Daschle and the book he wrote and what he said about——

Dr. GINGREY. The book titled Critical? Is that the book?

Dr. GOODMAN. The book that Senator Daschle wrote about health care.

Dr. GINGREY. Critical, I think, was the name of that book.

Dr. GOODMAN. Now, Senator Daschle pointed to the British example of the Health Board with the acronym NICE and he said, what do they do? They compare treatments and they compare costs, and they compare benefits and they look at effectiveness. And quite frankly, in Britain there is sort of a cutoff point. They don't want to spend much more than $35,000 to save a year of life. And that means that in Britain, people often do not get cancer drugs that are routinely available in the United States and on the European Continent.

So yes, I am very concerned about that. And I am concerned, not that the government is going to tell doctors what to do, because even in Britain it doesn't always tell doctors what to do, but that it will give cover to health plans that already have an economic incentive to underprovide to the sick anyway. And if the Health Board is saying, you know, that expensive drug is experimental and we really don't need to buy it, that is all the health plan would need by way of guidance in order to deny coverage.

Dr. GINGREY. Well, let me reclaim my time, because I did want to put out some statistics which speaks to exactly what you are saying, because you stated in your testimony that health care plays a leading role in determining the outcomes for diseases such as cancer, diabetes and hypertension. As a physician, practicing 26 years, OB–GYN, I cannot agree with you more.

Focus on cancer just for a moment. You mentioned that the 5-year survival rate of women diagnosed with breast cancer in the United States is 90 percent, versus 79 percent for women in Europe. You also mentioned the United States has a better relative survival rate than Norway for colon, rectal and breast cancer, lower rates of vaccine preventable pertussis, measles, Hepatitis B. Given that we do live in a global economy where breakthroughs in medical science and technology can be shared with patients in other

countries half a world away, I am curious as to your thoughts for this disparity. What is the difference?

These survival rates are significantly different.

Dr. GOODMAN. In the first place, there is a difference in diagnosis. And remember—take mammograms. American women get more mammograms than Canadian women do. They get more Pap smears than Canadian women.

Then there is the treatment. And regardless of the state of medical science, people in other countries may not get the same treatment that we get.

And then there is access to expensive but effective drugs. And in other countries, that is controlled more than it is in the United States. So those are three things I would point to.

Dr. WOOLHANDLER. I would just like to go on record as saying I disagree completely with what Dr. Goodman is saying. I don't think that is supported by the scientific evidence.

Dr. GOODMAN. Well, I would like to say that I have a paper here with more than 100 peer-reviewed studies that we drew on to make these statements.

Mr. PALLONE. We are going to have to——

Dr. GINGREY. Mr. Chairman, thank you. I realize my time has expired. And I appreciate Dr. Woolhandler's comment. And Dr. Goodman, thank you for responding to those two questions.

And I yield back, Mr. Chairman.

Mr. PALLONE. Thank you. We have three votes and we will be back maybe half an hour or so. The subcommittee stands in recess.

[Recess.]

Mr. PALLONE. The hearing of the Subcommittee on Health will reconvene. And I apologize. What did I say, we would be back in half an hour? I obviously misjudged that. Hopefully we will have some time now, though.

And our next member for questions is the gentlewoman from Illinois Ms. Schakowsky.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman. I regret that I didn't hear all the testimony, but I am quite familiar with both Dr. Wolfe and Dr. Woolhandler. And I also want to refer a bit to Dr. Goodman's testimony which has been told to me.

I am a supporter of a single-payer, something that has been used to sort of beat me over the head, because I understand that it is going to—I believe that the compromise that we have that—that the President and the bill, the draft bill, endorses is something that I endorse as well, because I think that it is an important beginning to controlling costs and to providing—and to providing good service.

But I do find it pretty ironic, when I say "beaten over the head," I am talking really about the other side of the aisle, and people who, I can't quite figure it out, find that it is quite all right—and I don't know what the public interest rationale is—is to defend the private insurance industry, which has had their way with us for all these years without much accountability and gotten us into this mess, and why those of us who are single-payer advocates who are willing to compromise, but the other side who are all for just the insurance industry are not, talking about giving Americans a choice. And I find it not very collegial and certainly not in the best interest of providing health care to all Americans, which, after all,

is the goal of the exercise, not to figure out how we can prop up the private insurance industry. Those of us who have agreed to the compromise think that they ought to be able to compete. But that is not the principal goal here. And we are willing to set up a situation where it is—you know, maybe it is easy enough for them to do, but not if they continue to do what they have been doing. They are going to clearly have to change their ways in order to compete. I am really sorry, I guess—I am not—about that, but that is the reality.

I was just talking to a representative of Cook County Hospital, Dr. Goodman, who was telling me that in Cook County Hospital, which is our public hospital, the wait for colonoscopies, hip replacements, and certain gynecological services is up to 2 years. So let us be clear that there are certainly people waiting in line now.

And I have to tell you, my understanding is— you can correct me if I am wrong—that you said if you compare white patients in the United States to white patients in Canada, the outcomes are the same; but if you compare minority patients to Aborigines, we are doing better. Oh, my God. I cannot believe that you said that in a public hearing. We are all Americans, and to somehow separate out those minorities and compare them to Aborigines as opposed to white Americans, minority Americans, all Americans, Canadian Americans—Canadians, et cetera, that would be reasonable. The other comparisons are offensive. And I don't know if you want to comment on that or defend yourself on that.

Mr. GOODMAN. I am not sure you heard my testimony. I said we have access problems. And there have been lots of studies that show that——

Ms. SCHAKOWSKY. Did you make that comparison?

Mr. GOODMAN. These problems are more severe for minorities in the United States than the white population. But it is also true in Canada, it is also true in New Zealand, it is also true in Australia. And if you compare our progress to theirs, we are ahead of them. We are doing better than they are doing.

Ms. SCHAKOWSKY. Well, let me ask about this. Dr. Wolfe and Dr. Woolhandler, Dr. Goodman has testified that, again, if you compare whites to whites, that we are—it is about even. But I wondered if you could actually talk to us about how we are doing compared internationally to other countries that actually do provide health care for all of their citizens.

Dr. WOLFE. Well, in my testimony I referred to what percentage of people in the 30 OECD countries have insurance. And as I said, for 27 of the 30, it was over 96 percent. But in the same report, which just came out a few months ago, they also asked the question: How many people in various countries have an unmet care need? And that is sort of what they are talking about. Unmet care need was defined as unfilled prescriptions or missed medications; medical problems; didn't visit a doctor; missed tests, treatment or follow-up. And here the comparisons are really striking.

In the United States, for people who were below average income, below average income, over half of them had an unmet care problem, 52 percent; whereas, in Canada, it was 18 percent, just about a third as much. And even for the people with—that was below average income. For people with above average income, again, it was

three times more likely in the United States to have an unmet care problem.

When you look at these seven countries——

Ms. SCHAKOWSKY. So what you found contradicts what Dr. Goodman just said, that we are doing better.

Dr. WOLFE. That is right. OECD—and this is generally agreed upon, and the United States is one of 30 countries that belong to it. They produce very interesting data not only on health, but other measures, and they put these out frequently. These are valid comparisons, interestingly, and they really go against what Dr. Goodman said earlier, a couple hours ago, that there are more access problems here, there—that there are more access problems in other countries than here. There are more access problems whether you are above average income or below average income in the United States than in other countries. And obviously one of the reasons is that people are all insured, and they don't get thrown out of emergency rooms as people frequently do in the United States, violating the patient dumping law.

Mr. PALLONE. We are going to have to move on.

Mr. Shimkus.

Mr. SHIMKUS. Mr. Chairman, can I defer and come back in the next Republican round so I can listen? Can I just defer, whoever is next on the list?

Mr. PALLONE. You want Mr. Shadegg to go first? Sure.

Mr. Shadegg.

Mr. SHADEGG. Thank you, Mr. Chairman.

Mr. Goodman, do you agree with the statement of Mr. Wolfe that there are frequent violations of the laws requiring the treatment of patients at hospital emergency rooms in the United States? And are you aware of any studies that show that?

Mr. GOODMAN. I am not, but——

Mr. SHADEGG. I don't think your microphone is on.

Mr. GOODMAN. No, I am not. But I do concede we have an access problem, and I think the waiting in hospital emergency rooms in this country is atrocious. We had in Dallas a man who waited 19 hours and died before he ever got care. So I don't know if any law was violated, but I don't think that should be happening.

Dr. WOLFE. If I could respond.

Mr. SHADEGG. I am sorry, my time is limited.

I would agree with that. Can you tell me, since he challenged you on the point made earlier, would you reiterate the point made earlier and explain to me or contrast for me waiting times or waiting periods in the United States under the current system versus those experienced in England or Canada?

Mr. GOODMAN. Well, see, what I think is happening in our hospital emergency rooms is exactly what happens in Toronto and exactly what happens in London. We are rationing care here just like they are rationing care in other countries. And to talk about everybody having access to care just because they are paper insured is nonsense. The reality is that lots of people aren't getting care they need when they need it in a timely way around the world. And I think that if you look at the data, we do a reasonable job with a heterogeneous population compared to other countries. We could do

a lot better, but let us not pretend that they are way ahead of us, because they are not.

Mr. SHADEGG. Let me make a statement. I am unaware of waiting periods in the United States at any facility, emergency room or otherwise, of months. And I am very much aware of waiting periods in Canada for various procedures that go more than a month. That is not a question; that is my statement.

What is your suggestion or what would you do as opposed to—I presume you do not favor a public plan?

Mr. GOODMAN. No, I don't.

Mr. SHADEGG. What would you suggest we do rather than moving to a public plan?

Mr. GOODMAN. I think we ought to focus with the problem we began with, and that is the uninsured. What should we be doing for them? Right now, if they buy their own insurance, they get no tax relief whatsoever. Right now, if your employer—your employer is not allowed to buy for you insurance that you can take with you when you leave a place of employment. It is illegal in every State to buy personal portable insurance, which is the only kind of insurance that people can take with them in and out of the labor market and from job to job.

Mr. SHADEGG. You are familiar with the legislation that I introduced that would allow individuals to buy health insurance that was qualified under a Federal law, and then written to comply with one State's law and then be sold in multiple States?

Mr. GOODMAN. I am, and I think that is a good idea.

Mr. SHADEGG. And would that bring down the cost of insurance?

Mr. GOODMAN. I think it would.

Mr. SHADEGG. And would that reduce the number of uninsured?

Mr. GOODMAN. I think it would.

Mr. SHADEGG. What would be the best mechanism you think for making insurance portable for those Americans who do not have health insurance? And would it include a refundable tax credit as I have proposed and others such as Congressman Ryan and Senator Coburn?

Mr. GOODMAN. The Coburn bill is a wonderful bill, but even without going that far, we need to give tax relief to people who buy their own insurance. We need to allow employers to buy the kind of insurance that people can take with them and is individually and personally owned. And we need to get rid of a lot of these State regulations which force up the price of insurance and price way too many people out of the market.

Mr. SHADEGG. That last point is exactly what we were doing with my legislation that would let you buy a policy essentially filed in 1 State and then sold in the other 49.

Mr. GOODMAN. That would be the practical effect of it. Yes.

Mr. SHADEGG. It would be the practical effect of reducing those mandates and thereby bringing down the cost of health insurance?

Mr. GOODMAN. That is right.

Mr. SHADEGG. You and I have talked about refundable tax credits and about the outrage of a current American law which says that if you get tax—if you get health insurance through your employer, it is pretax, but if you buy it on your own, it is taxed. We have been talking about that for how many years now, John?

Mr. GOODMAN. At least two decades.

Mr. SHADEGG. It seems to me——

Mr. GOODMAN. And it is just as bad now as it was two decades ago.

Mr. SHADEGG. If we just changed that law and said we are going to allow all Americans who want to buy health insurance to do so on the same tax-favored basis as businesses can do, that would create dramatically more competition in the health insurance industry, wouldn't it?

Mr. GOODMAN. Well, but, more importantly, it would allow people who are on their own to have tax relief and would encourage them to buy insurance which they are not now buying.

Mr. SHADEGG. If we coupled that with a refundable tax credit for those who can't afford health insurance, which is what I would propose doing, we would both bring down the cost of health insurance for all Americans and drive up quality; would we not?

Mr. GOODMAN. That would be the most important thing, most important change in the health care system: Give every American a refundable tax credit. Let it be the same for everybody. And in the latest Coburn bill I think it is $5,700 for a family. So the first $5,700 is effectively paid for by the government for everybody. And then additional insurance comes, after tax, out of our own pockets. It would radically change the kind of insurance we have. It would change everyone's incentives. Nothing would—that I can think of that has been proposed recently would have a bigger impact on the health care system.

Mr. SHADEGG. The Republican-proposed refundable tax credit for health care has been on the table for years by Senators, like Senator Tom Coburn, and I, who have been advocating it. That would have solved the problem of America's uninsured a long time ago; Would it not?

Mr. GOODMAN. It would go a long way toward it.

Mr. SHADEGG. Thank you very much.

I thank you, Mr. Chairman, for your indulgence.

Mr. PALLONE. Mr. Weiner.

Mr. WEINER. Thank you, Mr. Chairman.

Is there consensus of the three of you on the panel that the administrative costs for private insurance claims is much higher than what it is for the Medicare system? We will start with you, Mr. Goodman.

Mr. GOODMAN. There probably isn't a consensus here, because the statistics that you heard earlier count the private insurers' costs of collecting premiums, but they ignore the government's cost of raising taxes. If you want to make a fair comparison, you have to compare apples with apples and oranges with oranges.

Mr. WEINER. So the administrative costs, you mean the IRS?

Mr. GOODMAN. Yes.

Mr. WEINER. If you back out the IRS for the purpose of this conversation, then it is obviously—is there any disagreement that the Medicare system is much more administratively efficient than private insurance?

Mr. GOODMAN. Well, if you mean by backing out the IRS, we ignore the cost of getting public funds, but we count the cost of getting private funds, then, yes, Medicare would be cheaper.

Mr. WEINER. Is there anything that we can learn from how Medicare does things administratively? Is there an obvious place that we can find that that efficiency is found? Dr. Woolhander, would you have a sense of is there something in that? I know, for example, that insurance companies benefit to some degree monetarily from delays and inertia. Right? If they don't pay, for example, a doctor, reimburse a doctor or a hospital for a 30- or 60-day period of time, they make money on the money that they are not allocating. There are things like that.

But are there other elements that we can learn if we wanted to teach the private insurance companies? Which is what President Obama said the other day in his press conference, he thought it might be instructive for the private guys to copy some of the things that the public model does. Is there any one or two things that jumps out at you that makes Medicare more efficient?

Dr. WOOLHANDLER. There are a lot of things, but you couldn't transplant them to private insurance, because private insurance makes their money by not paying the bill, by collecting lots of premiums and not paying. So there is lots of expenses they have that are essential to their competitive strategy. So they want to be very, very careful to recruit healthy people.

Mr. WEINER. I understand that, but you are answering a different question. I understand they are not going to want to do it. I am asking you, if you were to say, here are two or three things that Medicare does that they do more efficiently than private insurance, like are there a couple that may come to mind that might inform the committee's deliberations here?

Dr. WOOLHANDLER. Medicare is universal, and it does use the IRS to collect money and the Social Security System, which is a very efficient way to do it because those things exist already anyway, and they are not going to disappear or get any smaller.

Mr. WEINER. So their building apparatus is much more efficient.

Dr. WOOLHANDLER. They are collecting of—the equivalent of premiums is much more efficient. Also, Medicare doesn't do any cherry-picking. They don't try to attract healthy people and keep sick people out. They can't. It would be illegal. They take everyone. So they don't have any so-called marketing expenses, which is really about recruiting healthy people and keeping sick people out.

Mr. WEINER. Dr. Wolfe, let me ask you this question. Doctor, feel free to weigh in when he is done. The argument made against single-payer—and I don't know how persuasive it is, and, frankly, I plan on offering single-payer as an option here when we mark up the bill. But the argument that is made is there are a lot of people for whom their present insurance plan is satisfactory. They say that they are satisfied with it, they like the doctor relationship, they don't mind getting the bills. They like what they have chosen.

And a political argument is made that essentially says don't, when you are trying to do something this big and difficult, pursue what Dr. Goodman has been pushing; try to solve the problem without creating the big tumult around people who don't generally see there would be a problem. That is a pretty persuasive argument on a political level; I mean, to say to 120-, 130-, 140 million people, we are not going to touch your thing that you have.

How do you respond as an advocate for single-payer for the idea that while it might be more efficient for the reasons you stated in your testimony, we may be permitting the perfect to be the enemy of the good by creating an untenable political dynamic? Why don't you give us your response for that.

Dr. WOLFE. I think the main response is that people would be concerned if you thought they were going to disrupt the relationship they had with their doctor, with their dentist, with their physical therapist, with their hospital. And the single-payer is looking only at how the money is collected and how the bills are paid. There is no reason why anyone who is going to Dr. A would not be allowed to go to Dr. A if there was a single-payer system. In fact, they might also want to go to Dr. B, who they would have liked to go before.

Mr. WEINER. Because, in your vision of the single-payer, a doctor would be compelled to participate; otherwise, they wouldn't be able to be a doctor in the United States because they would be opting out so many patients?

Dr. WOLFE. Right. In Canada and lots of other countries, if you are going to receive money for delivering medical care, you can't discriminate against this or that kind of patient, so that, if anything, the doctor-patient relationship would be enhanced instead of disrupted. A patient could go to a doctor that they couldn't have gone to before because that doctor wasn't in their pool. There is no such thing as your limited pool of doctors or hospitals, for that matter, you can go to.

So in terms of—the disruption is really a disruption of the health insurance industry, not of the doctors, not of the patients. I mean, the reason why 60 percent of the doctors in Massachusetts in a study published a couple years ago support single-payer is that they are getting sick and tired of spending so much time in their offices fighting with insurance companies to pay bills, hiring people that are not delivering medical care, but are just sort of engaging in phone or e-mail or fax wars. So I think that if the focus is the patient, then it is less disruptive.

Mr. WEINER. I thank you. And my time has expired. I would just caution you, Dr. Wolfe, that what you are answering is a substantive question, and mine was a political one. Someone who has Oxford who then is going to go to a single-payer is going to lose their Oxford whether they get the same doctor or not. That is the rhetorical challenge that we have as advocates for a better system. But I appreciate the candor of your answer.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you.

I am just going to ask Members, I know we each have 5 minutes, but this is the first of three panels. Just try to at least end your questions within the 5 minutes. I don't have a problem if the panelists' answers go beyond the 5, but I want our questions or comments to end at the 5 minutes, otherwise we are going to be here until 8:00 or 9:00 tonight.

Next is Mr. Shimkus.

Mr. SHIMKUS. Thank you, Mr. Chairman.

There are a couple ways that Members could come to these hearings. This is a very important issue. And I think we all come in all the seriousness that we should.

You know, first, just on this rush to move, I have talked about in the energy bill having a discussion draft that people can't really talk about because we know the discussion draft will not be the bill. It is not going to be it. So when we end up marking the bill, we are going to get a bill on a Friday, just like the energy bill, which will have 300 more pages that my staff will try to e-mail me at home that they hope that I will read and go over to be prepared for a markup.

So this process is—the health care is broken, this legislative process. Now, we can do it in this committee. We did it in FDA reform. We really did. Democrats worked with us, we compromised, we got a good bill. We got a bill that passed out on a voice vote. Major reform in the Food and Drug Administration. And I think people are—you win some, you lose some. Overall we are pretty happy. We didn't have that in energy, and we are going to have a Texas death match fight on the floor come Friday. We are not going to have it here, and so we are going to have another Texas death match fight whenever this moves to the floor. And it is just too important of an issue to do that.

So I have always been struck by why don't we move—I mean, there is an incremental process, and people understand that, and call our bluff. Let us get insurance to more people. Let us try associated health plans. Let us try giving people tax incentives. Prove us wrong that a private system doesn't work, and then the public option might be the default. Maybe a one-payer might be the default.

I was in Chicago at the American Society of Plastics, and I talked to a legislative luncheon with some of my colleagues. One of the guys there whose spouse was attending sold medical technology, and he had just come back from Canada. This hospital was excited to buy their second MRI, and they are going to reduce their wait list from 8 months to 4 months for an MRI. I am not making this up. We all know, there are horror stories on both sides. So my plea is for us to try to move in a way that we can try to cover people before we bring what I believe is the heavy hand of government.

Let me go to questions. Let us talk about this, Mr. Goodman, first, and I will let people chime in. I am not really trying to incentivize one side or the other. Usually I do that, but not here. Let us talk about this Medicare thing, and let us address—every time politicians talk about saving the government money, what is the first thing off our lips? Waste, fraud, and abuse. And where do they point that this waste, fraud, and abuse is? Medicare and Medicaid. And my friend from New York talked about the cost of this. Shouldn't the cost of waste, fraud, and abuse be part of this calculation if we are going to compare private insurance with a government-backed product?

Mr. GOODMAN. Well, it should be. And in my opinion, the thing that Dr. Woolhandler praises about Medicare and Medicaid is, in fact, one of its faults. It spends too little on the administration. You ought to spend some resources watching where the dollars go. And

apparently there is an enormous amount of fraud in Medicaid and Medicare, and you are not going to get rid of it if you don't spend some resources to find out where the dollars are going.

Mr. SHIMKUS. And the percentages of like 30 percent claims, that are paying claims that shouldn't be paid. So 10 percent. I can't even read my notes anymore. But there is a credible cost, if you are going to claim you are going to save money on waste, fraud, and abuse, that it ought to go into. That would be good money to go after, the return on the investment.

Let me just finish with this in my time, and I want to be respectful to the Chairman. The Massachusetts example just recently released, what are they doing? They are going to raise their costs, they are going to cut services, they are going to reduce their beneficiaries. That was just announced today. What does it make us feel like that is not where we are going to be if we move to a one-payer system or a public option?

Dr. WOOLHANDLER. The one aspect of Massachusetts that is very prominent, and it is actually in this bill, in the tri-committee bill that we haven't discussed much——

Mr. SHIMKUS. The draft language. There is no bill. A bill is a bill when you actually drop it and it gets a number.

Dr. WOOLHANDLER. The tri-committee draft includes an individual mandate, just like Massachusetts, which is, of course, what the private insurance industry wanted. They said that was their number one thing that they wanted was an individual mandate. And it is here in this bill called "individual responsibility."

Mr. SHIMKUS. But Massachusetts is cutting benefits, raising premiums, and reducing—cutting service.

Dr. WOOLHANDLER. Absolutely. Absolutely. Because it is not affordable what they have done. And the individual mandate piece hasn't worked. It has been very punitive, and it is here in the tri-committee draft. And it is a complete gift to the private health insurance industry, just as it was in Massachusetts, because it is saying that the government is going to make it illegal not to buy private insurance. And that is actually something that needs to be discussed and is really totally caving in to the insurance industry no matter what else is in this bill.

Mr. PALLONE. Mr. Deal.

Mr. DEAL. I would like to follow up, Dr. Wolfe, on something that you said about how your world of a single-payer would work. And I believe you said it in response to an earlier question that, in a single-payer world, physicians would either be in the system accepting the payments that the system dictates that they are entitled to, or else they would not be able to practice, period. Is that correct?

Dr. WOLFE. Well, they can practice privately and collect money from patients. There is nothing to stop that. In the United Kingdom the so-called Harley Street physicians are physicians who aren't part of the national health service. They practice. They have expensive practices for patients who can pay them.

The only point I was making is that the Canadian system, which is called Medicare for everyone in the country, is one that if a physician wants to take care of patients who don't have money to go to a private doctor, then that physician needs to participate.

The physicians in Canada actually make reasonably large amounts of money with the kinds of prices that are placed on the services by the government. So it is not—it is restrictive only to the sense that if someone really wants to practice medicine for someone other than a group of very wealthy people, they participate in the program. Again, they are in private practice; they are not working for the government, they are just getting paid by the government.

Mr. DEAL. One of the concerns that we currently have is doctors who will not take Medicare patients simply because reimbursement rates they consider are not adequate.

Under the proposal that we are looking at, the public option plan, as I understand it, keys reimbursements to Medicare reimbursement rates. Now, one of two things is going to happen. Either the public option plan is not going to be able to get any doctors to sign up to participate without coercion to do so, or the private plans are going to decide that the only way they can compete with the government is to ratchet down their reimbursements to the Medicare levels; and, therefore, the private insurance market providers are going to have the same complaints that they currently have in our Medicare reimbursement system.

Dr. Goodman, maybe I could ask you to comment on that.

Mr. GOODMAN. Well, I think you are exactly right, except I don't think it will be all one way or the other. With that kind of system, what we will gravitate to is a public system in which most people will be enrolled, and the doctors will be paid below-market rates. And then there will be a private system, just like they have in the United Kingdom, or some version of that, and anyone who has the money will buy better coverage, and they will be seen first by the doctors, and they won't wait as long. And Britain has a two-tier system, and what you are pointing toward would be a two-tiered system for the United States.

Dr. WOLFE. Could I just respond briefly to that? Which is, one of the reasons that we are opposed to this public-private option is that it does cause some of the exact things you are talking about. Why should it be that a given doctor should not get the same amount of money for seeing patient A versus patient B versus patient C versus patient D? In other words, what I am saying is that under a single-payer system, the doctor could see any patient they want; the patient could go to any doctor they want without the fear that this doctor won't see them because they are not getting paid as much as they would be paid if they had some other insurance.

It is bewildering to a doctor and their staff to have to look at a patient and say, do they have this plan or plan number 10 or plan number 20? And if they have that, does it cover this or that or whatever? It is just an unbelievably complicated matrix, as opposed to just saying you go to the doctor, and whenever you are or whoever you are, the doctor gets reimbursed the same amount. I think that that kind of twofold system that is possibly built into the draft bill that we are discussing isn't a good idea. But it is not the only reason the draft bill is not a good idea.

Mr. DEAL. We agree on that last statement.

Dr. WOOLHANDLER. I would just have to say as a practicing physician in Massachusetts not only do I take Medicare and welcome it, but essentially every doctor in the State of Massachusetts takes

Medicare. And, you know, none of us are going to the poorhouse. So I know there are people who can command even higher payments than Medicare pays, but Medicare payment is generally compatible with a pretty good standard of living for the medical profession. So I wouldn't worry too much about that issue, personally, coming from Massachusetts.

Mr. DEAL. Well, coming from Georgia, I can tell you firsthand that we are having physicians who will refuse to continue to treat long-term patients that they have had for many, many years when those patients become Medicare-eligible simply because of the reimbursement rates, and they consider them to be inadequate. And my State at least, I think, is experiencing that kind of problem currently, and I just don't want to see us magnify that problem.

I believe my time is up. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you.

Dr. Burgess.

Dr. BURGESS. Thank you, Mr. Chairman. You had no choice but to come to me, and I appreciate the time. And just for the record, I always saw Medicare patients in my practice in Louisville, Texas, because my mother told me I had to, and it made it very simple to follow that rule.

Dr. Goodman, Dr. Wolfe testified just a moment ago that, in Canada, the doctor-patient relationship is enhanced by having a single-payer system. Is that your opinion also?

Mr. GOODMAN. No. No. No, it is not. I think in general third-party payment undermines the doctor-patient relationship, and that the ideal relationship is for the patient to control the dollars, and that is why I have advocated for many years the health savings account. I would like to see patients control a third or fourth of all the dollars. And for chronic patients, they can control even more than that.

And we are doing this in Medicaid, by the way. We have a cash and counseling pilot program under way in more than half the States where the Medicaid homebound disabled control their dollars. They can hire and fire the people who provide them with services. There is 98 percent satisfaction. Well, there isn't any health care system in the world where you get 98 percent satisfaction.

So we know that health care can be more satisfying, and we can meet the needs of patients in a better way if we reduce the role of the third-party payer, whether it is government or private.

Dr. BURGESS. And I actually agree with that as well, and I have often wondered why we don't construct a system where it is possible for an individual to have more of a longitudinal relationship with their insurance company. If an insurance company or a Medicare system is a necessary evil, why would we not construct one where there is some sensitivity to the purchaser on the part of the seller just like there would be in any other transaction?

We heard just a moment ago from the gentleman from New York about there being a policy versus a political question. I also wonder if the back door into the policy that is desired, which may be a single-payer system, is to not involve ourselves in political incrementalism at this point in order to achieve that desired goal.

Dr. Wolfe, I wonder, do you see that as being part of the trajectory or part of the desired outcome of the—I realize it is not a bill, but the draft that we have in front of us this afternoon?

Dr. WOLFE. I think I alluded a little bit to this earlier, but I think that we now have essentially 44 years since the last health insurance was passed, Medicare and Medicaid. And many people hoped, and I think sincerely, that somehow during the 44 years we would incrementally be able to cover more people with health insurance, and it just hasn't happened. I mean, we have the same insurance companies, some new ones that are more HMOs and so forth than there were back then, but I think the incrementalism just hasn't worked, and particularly compounded by the economic problems of the last year or two, things are getting tougher and tougher. I would expect that the number of uninsured will rapidly go over 50 million, it is close to that now, if we had numbers from 2009.

So I don't see—back to your question directly. I don't see anything in this draft bill, as we are correctly talking, it is a draft bill. It is. And there is a lot of distance between here and, if anything—I say "if anything" seriously—is going to come to the floor. But I don't think there is anything that is in the draft bill that, to me, could be rationally viewed as a stalking horse as a way towards a single-payer. If anything, one could argue that it is away from a single-payer. Because if it is changed and comes to the floor with some form of a public partnership with the private, it is going to be so bad that, if anything, it will move away from the single-payer rather than towards it.

Dr. BURGESS. Like Ranking Member Deal, I do agree on that last point.

Let me just ask you a question, because my time is going to run out. There has been some allusions to Canada versus the United States. My understanding, correct me if I am wrong, the Canadian system, their health care system, is on a budget. Their Parliament passes a budget every year, just as we do, and their health care expenses are going to be budgeted. Ours, in this country, we have the largest single-payer system in the world. It is called Medicare and Medicaid. We don't budget for that; we just simply say, send us your bills, and we are going to pay them, and we will draw down the Federal Treasury or expand the deficit in order to do that.

Do you think we should look more at Canada's budgetary system as a way to controlling some of our costs in our public system, in our Medicare and Medicaid system?

Dr. WOLFE. Well, one of the advantages of having a single-payer, single-insurer collector of money is that you can more easily do what is called in Canada global budgeting. So for a given hospital, for instance, instead of counting every——

Dr. BURGESS. But you have already got 50 percent.

Dr. WOLFE. But I am saying they are not doing it.

Mr. PALLONE. Can I just ask Dr. Wolfe to answer the question, because the time has expired.

Dr. WOLFE. The answer to the question is in Canada global budgeting is a good idea. We could benefit from it here. I don't think that Medicare has been run as efficiently as it could be. The ad-

ministrative costs are certainly low, and there have been some forms of price control on everything other than prescription drugs. So I think we could learn from that. But Medicare has now been around for 44 years, and, if anything, for a bunch of reasons it is getting worse than it was at the beginning. So we need to go back to some of the original principles of Medicare.

Dr. BURGESS. Some of our distributional issues would become greater, though, with a budgetary constriction.

Mr. PALLONE. Dr. Burgess, you are a minute over. You can't ask any more questions. We have got to move on. Thank you.

Let me thank all of you. We appreciate it, and I think it was a good discussion. I am sorry that you were interrupted so long with the votes.

Mr. PALLONE. Let us ask the next panel to come forward, please. This panel is on State, local, and tribal views. I ask our panelists to be seated.

Now, let me just warn everyone that you are seated out of order, so I am not going to ask anybody to change, but I am going to call Members to speak on the order that I have here. So let me introduce everyone.

First is Honorable Michael Leavitt, who is former Secretary of U.S. Department of Health and Human Services. Thank you for being with us. I know you can't stay the whole time, but that is fine. We have you first.

Second is my good friend, the Honorable Joseph Vitale, who is chairman of the Committee on Health, Human Services and Senior Citizens of the New Jersey State Senate, who his district is in my congressional district, and he has been here before, and we appreciate your coming today as Senator Vitale.

Then I have W. Ron Allen, who is the chairman of the Jamestown S'Klallam Tribe.

And then we have the Honorable Jay Webber, who is a State assemblyman from my State of New Jersey. Welcome.

And then is Dr. Raymond S. Scheppach, who is the executive director of the National Governors Association.

Then we have Robert S. Freeman, who is deputy executive director of CenCal Health, California Association of Health Insuring Organizations.

And finally is Ron Pollack, who is executive director of Families USA, again, a frequent visitor to this subcommittee.

So we will start with the Secretary Leavitt. Thank you for being here.

Let me mention again, I think you have probably heard it enough times, but 5 minutes. We ask you to speak for 5 minutes. Keep it to that. Your written testimony will become part of the record. And, of course, after you are finished, we will have questions from the panel.

Secretary Leavitt.

STATEMENTS OF MICHAEL O. LEAVITT, FORMER SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; JOSEPH VITALE, CHAIRMAN, COMMITTEE ON HEALTH, HUMAN SERVICES, AND SENIOR CITIZENS, NEW JERSEY STATE SENATE; W. RON ALLEN, CHAIRMAN, JAMESTOWN S'KLALLAM TRIBE; JAY WEBBER, STATE ASSEMBLY, STATE OF NEW JERSEY; RAYMOND C. SCHEPPACH, PH.D., EXECUTIVE DIRECTOR, NATIONAL GOVERNORS ASSOCIATION; ROBERT S. FREEMAN, DEPUTY EXECUTIVE DIRECTOR, CENCAL HEALTH, CALIFORNIA ASSOCIATION OF HEALTH INSURING ORGANIZATIONS; AND RON POLLACK, EXECUTIVE DIRECTOR, FAMILIES USA

STATEMENT OF MICHAEL O. LEAVITT

Mr. LEAVITT. Thank you, Mr. Chairman. And thank you for your acknowledgement of my inability to stay the whole time. But I am pleased to be here.

My formal statement, I will summarize it by saying I have listed 10 things in this draft that I believe could be unifying principles, I have listed 10 things that I believe are serious problems, and 10 ways I think those could be resolved. So the committee will have access to that. And to the extent that you have questions for me, I would be happy to respond to them either in writing or later publicly.

I was intrigued, however, by conversation in the earlier panel, and I would like to take my time to respond to the question of Medicare's efficiency. I suspect I am the only, or at least one of the only, people in this room who has actually overseen Medicare, and I would like to answer the question as to its relative efficiency, if I could.

If the question is does Medicare issue checks on a more efficient basis than anyone else, I think it is important to answer that: Yes, Medicare issues checks more efficiently than anyone else on the planet. And we should, because Medicare issues about 1 billion of them a year.

The problem isn't its administrative efficiency. The problem is what it pays and how it pays it.

Medicare has three fundamental problems, in my assessment. The first I call silo syndrome. Silo syndrome is a function that everything is paid without coordination. So it isn't how efficiently it pays; it is the fact that it pays the wrong things and pays too many things, and does not require any level of coordination.

If we were to impose on, say, the automobile industry the process of finance in the health care industry, you would walk into a car dealership and you would say, I want to buy a car. The dealer would say, we can see you do. Pick one out, and we will send you the bills later. And a few months later or weeks later, you would get one from the chassis maker, you would get one from the tire manufacturer, you would get one from the dashboard people, one from the windshield, and one from the dealer. And the dealer would say, you were in the showroom for a while, then you went to the salesman's office, and then there was that $21.97 cup of coffee you thought you were getting because you thought you were thirsty.

The point is that if there was a steering wheel that was $800, the manufacturer of the car under the current system would say, we can't afford that because we have got to deliver it for $23,000.

In the health care system, if the crutch's provider in a knee operation says, we want $400 for the crutches, we just provide it. There is no coordination.

So it is not the fact that we are able to issue checks efficiently; it is that all of the care is siloed and uncoordinated, and that runs up the costs. So what might look like efficiency, I would suggest to you, is not.

The second problem with Medicare is that it has what I call chronic more. Everything is oriented to more.

And the third point I would say is that it is quality indifferent.

So it isn't efficient because it can issue more checks than anyone on the planet. It is inefficient because it is siloed, because it is quality indifferent, and because every incentive leads to more. And I suspect you will see that reflected in my testimony as to why I oppose and why I hope our country will not go to a public option plan. For us to adopt a system that has moved our country financially toward what I believe will be its most devastating financial crisis and then put more people in it is like suggesting that we are going to cure obesity with a perpetual regimen of double calories.

That is not the solution, and I have listed in my testimony a series of suggestions on how I believe this bill could unifying, how the bill could become a bipartisan proposal, and I am very hopeful that that can occur. This country badly needs for every American to have access to insurance. We desperately need to reform the system. And I hope very much that this will be a moment where we can do so on a bipartisan basis. Thank you.

Mr. PALLONE. Thank you, Mr. Secretary.

[The information follows:]

Testimony by the Honorable Michael O. Leavitt before the House Energy and Commerce Committee

June 24, 2009

Mr. Leavitt was the Secretary of Health and Human Services from 2005-09, was the Administrator of the Environmental Protection Agency from 2003-05, and was the Governor of Utah from 1993-2003.

Mr. Chairman, Mr. Barton, and Members of the Committee:

I have been involved in the national health debate since the early 1990s. For eleven years as governor, I worked continually — and with significant success — to expand access to insurance, increase quality of care, and reduce costs in my state. Additionally, for the better part of a decade, I was part of a bipartisan group through the National Governors Association that worked on health care issues, particularly Medicaid.

Between 2003 and 2009, I served in two health-related Cabinet positions: first as head of the Environmental Protection Agency and then as Secretary of Health and Human Services. In those roles, I appeared before this Committee many times to discuss this topic, and I appreciate having been invited here to offer my observations today.

Health is a universal language. Illness and frailty are universally unwelcome, and we all worry about our mortality. No one has a monopoly on compassion, or on concern for protecting the interest of workers and their families.

We all know how politics works. We know that the majority party can always impose its will. A bill can be passed. But without broad bipartisan support, it won't last.

I welcome the chance to address both the bill's overarching themes and its finer points during discussion with the Committee. However, in the interest of brevity, I will proceed by listing ten principles in the bill that I believe have the potential to unify; ten outcomes of the bill that I believe to be serious problems; and ten suggestions on ways to achieve bipartisan support.

First, the potential unifying principles:

1. There is a widely held aspiration that every American should have health insurance.
2. Insurance exchanges can provide access to people for whom employer-sponsored insurance is not an option.
3. Risk-pooling is at the heart of the access discussion, and without an honest discussion of this subject, there can be no health insurance reform.
4. Affordability credits, when coupled with choice, are an effective tool to provide subsidies.
5. It is a responsibility of citizenship for each of us to do all that we can to procure health insurance, and state-based mandates are one way to address this concern.
6. Community health centers are a proven means of delivering primary care to underserved populations.

7. Reliable health data in the hands of patients, providers, and payers, about the costs and quality of health care, will increase transparency and facilitate the pursuit of value — the pursuit of the highest-quality care at the lowest-possible prices.
8. Innovation in the payment system for Medicare is essential.
9. Fraud and abuse can be reduced.
10. It is better to prevent illness than to treat it.

Negative outcomes of the bill:

1. The public option will result in millions of employers abandoning the private insurance system and millions of Americans losing the option of private insurance.
    - As employers and their private plans flee the market, providers will have nowhere to shift costs, and many community hospitals will fail.
    - Medicare-like reimbursement levels will cause many doctors to leave the system, and getting an appointment with a doctor will get harder except for those willing to pay out of pocket for a doctor outside of the system.
    - Cost-containment goals will inevitably lead to further reductions in reimbursement rates and further losses of doctors, and the result will be a two-tiered structure: one tier for the very rich (operating outside of the system), the other for everyone else (operating within).
    - Costs will continue to increase because doctors who stay in the system will make up for the financial difference as they always have: by doing more procedures.
2. The bill will increase the federal deficit by an unknown amount.
    - The Senate bills are being scored at $1.3 to $1.6 trillion over the next decade, and this bill's score will certainly be higher.
3. Increasing the deficit is financially and politically irresponsible.
    - Our deficits will already be higher, this year and next, than our deficits at the height of the Great Depression — even as a percentage of the gross domestic product.
4. The bill will raise our health-care costs as well as our debt.
    - Some have argued that additional debt-spending is necessary to curb future health costs, but government-run health costs have risen far more than the costs of privately purchased care.
    - As a new study by Jeffrey H. Anderson of the Pacific Research Institute shows, since 1970, Medicare's costs have risen 34 percent more, per patient, than the costs of all health care in America apart from Medicare and Medicaid — rising $2,511 more per patient.
5. Medicare is already drifting toward disaster, and launching a new vessel into the same dangerous waters will not slow the current.
6. Narrowly banded community ratings will create debilitating cost-increases for young and healthy people — and this, in addition to greatly increased debt, will make this bill a massive redistribution program from younger to older Americans, and from future to current Americans.
7. Adding large populations to Medicaid will prove to be an impossible burden on state budgets.
8. The play-or-pay provision for employers is nothing more than a new tax, and it will result in lower wages and the loss of American jobs.

9. Prohibiting cost-sharing provisions for preventative care is a recipe for fraud by physicians and inefficient use by patients.
10. The bill will lead to politicized health care, encouraging unjust benefits for the few — such as those with strong unions and/or strong lobbyists — at the expense of the many.

Recommended improvements to achieve bipartisan support:

- Abandon the idea of a public option plan.
- Have state-organized exchanges rather than federally controlled exchanges.
- Give states the task of solving the pooling problem, through mandates if they so choose, or without them if they choose a different course.
- Give states a time-ceiling (3-4 years) to solve the pooling problems; if they refuse, systematically reduce the federal Medicaid matching rate.
- Drop the proposal to tax employers; it will reduce wages and kill jobs.
- By requiring plans to be the actuarial equivalent of Medicare, simplify the standards of coverage for plans eligible for affordability credits; and give states flexibility in pricing bands.
- Provide a means for each insurance provider to be able to offer a plan that is free of state-imposed mandatory benefits.
- Subsidize those who have a hard time becoming insured because of their income or health, rather than subsidizing families with moderate incomes who have private insurance already.
- Allow Medicare to require providers to accept bundled payments, and reward providers who provide high-quality services at affordable rates.
- Expand competitive bidding for durable medical equipment, and make the Medicare Advantage bidding process more like the bidding process for the Medicare Part D prescription drug program.

Mr. Chairman, if we proceed in a bipartisan manner, we can achieve real reform. We can accomplish our shared goal of seeing every American have an affordable health-insurance policy. We can increase quality and reduce costs — by focusing on value over volume, and by providing incentives for others to do the same. We can enlist the states as allies, collaborating with them in a federalist spirit, and sharing with them the risks and rewards. We can promote state-based reforms and learn from those experiences, rather than engaging in a high-stakes game of trial and error in Washington — trying to cross from here to there without an estimate of costs, a clear vision of the future, or a net. By enlisting the states rather than going it alone, focusing on value over volume, and taking aggressive but responsible action, we can get every American insured without breaking the bank — or the back of the current system.

But we cannot afford to jeopardize the private insurance of millions. We cannot in good conscience shift massive costs to younger Americans — as this bill would do — nor shackle future generations of Americans with an even greater inheritance of debt. We cannot just keep spending. More government-run health care will not reduce costs; it will raise them. Experience has shown us this. We need health care that people can afford — and reform that our nation can afford.

Thank you.

Mr. PALLONE. Senator Vitale.

STATEMENT OF JOSEPH VITALE

Mr. VITALE. Thank you, Chairman Pallone and members of the committee. I am Joe Vitale. I chair the Senate Health Committee in New Jersey, and pleased to be here again. I was here a couple years ago when we were debating the reauthorization of SCHIP and what it meant to my State and to the millions of parents and children who we are now blessed to cover under that program.

I wanted to highlight some of the sentinel points of New Jersey's journey toward health care reform as well as my personal view as a State legislator, a leader in health care reform, and as a small business owner as well, to discuss the access to affordable and dependable health care for not just the 1.3 million uninsured New Jerseyans, but the remaining 45-some million Americans.

New Jersey has learned many lessons as we grappled with the complexity of reform over the past several years. Our State's reform efforts will benefit the proposals being discussed here in Washington now.

When SCHIP was first adopted in 1998, New Jersey initially offered enrollment for children whose family income did not exceed 200 percent of the Federal poverty level. Shortly thereafter, we increased eligibility to 350 percent of Federal poverty for those kids, recognizing that we needed to do more, that New Jersey was an expensive place to be low-income, and we needed to get those kids insured because the parents couldn't afford the insurance on their own or through their employer.

In addition to expanding affordable access to kids, we also began to welcome parents into our program through a waiver by CMS whose families' income did not exceed 150 percent of the Federal poverty level. These legislative initiatives became the foundation upon which we in New Jersey have begun to build a framework for providing universal, portable, affordable, and sustainable health care access to New Jersey's remaining 1.3 million uninsured.

Our efforts began nearly 3 years ago with the formation of a working group comprised of 22 policy experts representing a wide variety of experience and professional background. I believed then, as I do today, that New Jersey could not have enacted our most recent reforms without taking the necessary time to painstakingly understand the complexity of reform's impact on the diverse group of stakeholders health care encompasses.

Our working group met for 2½ hours every week, worked on a daily basis with staff to process the input from those sessions, and traveled the country from San Francisco to Chicago to Washington to meet with other States actively reforming their systems. We shared the reform efforts each of us were undertaking and met with national policy groups with expertise in health care access, quality, cost modeling, efficiency, and insurance reform. It was through those efforts that we were able to offer a thorough and well-planned legislative proposal that enjoyed overwhelming bipartisan support approval moving from announcement to passage into our law in a short 4 months.

Our most recent initiative accomplished much. It increased eligibility for more working parents whose income did not exceed 200

percent of the Federal poverty level. We established a buy-in program for children whose families' income exceeded our SCHIP cap of 350. This program was created after negotiating with two of our State's leading health plans, who agreed to offer an excellent benefit design at a very low price. This program does not use any State or Federal dollars.

We implemented a kids first mandate that required all eligible children to enroll in either a free or very low-cost health insurance program in our State. It required the Department of Treasury to include a check-off on all State income taxes, tax returns that seeks information on filers regarding the health insurance status of household dependents. This provision enabled New Jersey to be the first State in the Nation to utilize the express enrollment process approved here in Washington and CHIPRA. It also directed our State Department of Human Services to design a cost-effective and thorough enrollment outreach program, and to design a minimum hardship exclusion or premium hardship exclusion that does not allow an enrollee to jump out of coverage, that provides for an income set-aside that can lower their premium to an affordable level, but also maintains them in coverage and not out of coverage.

It also instituted a number of reforms so individuals or employer market that made those policies more affordable will dedicate a larger percentage of collected premiums to the actual provision of care.

I am proud of what we have accomplished in New Jersey. We have been one of the most progressive States in offering expanded access to hundreds of thousands of children and working parents, and we are currently well on our way toward comprehensive and transformational reform. But, as you know all too well, States can only do so much. We have limited finances. We have limited political will. And with States having different programs at different levels for children and for parents in some States, it becomes just undependable and unreliable.

We in New Jersey, though we are proud of the work we have done and the great steps and strides we have made to insure hundreds of thousands of kids and many parents in our State, we need the Federal Government. We need your leadership and the leadership of your colleagues and the President to make sure that the remaining 1.3 million who are uninsured today and those who will become uninsured have access to the same kind of health care that we all enjoy; that they will have the same kind of card that we all have. And, in some cases, I know we all take for granted maybe the health care that we do have, but for them, they wake up every day with the fear that they will get sick, their kids will get sick, they won't have the ability to pay. And a national program that brings together in a large group those millions of Americans who need our help is well justified and well needed. And I want to thank you for the effort.

Mr. PALLONE. Thank you, Senator.

[The prepared statement of Mr. Vitale follows:]

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U.S. House of Representatives
Committee on Energy & Commerce
Subcommittee on Health Hearing
Tuesday, June 24, 2009

Testimony of Joseph F. Vitale
New Jersey Senate

Good afternoon, Chairman Pallone and members of the committee. My name is Joe Vitale. I serve in the New Jersey Senate as the Chair of the Health & Human Services Committee and as the Deputy Majority Leader.

I want to thank Chairman Pallone for inviting me to speak with you today but, more importantly for his leadership on this difficult to resolve, yet critical issue for our nation. Every member of this committee can be proud of your recognition that health care is a serious national priority. Your tireless work toward finding comprehensive reform is no less critical.

I would like to highlight for you some of the sentinel points in New Jersey's journey toward health care reform as well as my personal view as a state legislator leading health care reform, small business owner and private citizen of our efforts to expand

access to affordable and dependable health care. New Jersey has learned many lessons as we grappled with the complexity of reform over the past several years. Our state's reform efforts will benefit from the proposals being discussed in Washington.

When the SCHIP program was first adopted in 1998, New Jersey initially offered enrollment for children whose total family income did not exceed 200% FPL. Shortly thereafter, we increased that eligibility to 350% FPL. In addition to expanding affordable access for kids, we also welcomed working parents into our program whose family income did not exceed 150% FPL. These legislative initiatives became the foundation upon which we in New Jersey have begun to build a framework for providing universal, portable, affordable and sustainable health care access to New Jersey's remaining 1.3 million uninsured.

Our efforts began nearly three years ago with the formation of a working group comprised of twenty-two policy experts representing a wide variety of experience and professional background. I believed then, as I do today, that New Jersey could not have enacted our most recent reforms without taking the time to painstakingly understand the complexity of reform's impact on the diverse group of stakeholders health care encompasses.

Our working group met for two and a half hours every week, worked on a daily basis to process the output from those sessions and traveled around the country - from San

Francisco to Chicago to Washington DC - to meet with other states actively reforming their systems. We shared the reform efforts each of us were undertaking, and met with national policy groups with expertise in health care access, quality, cost-modeling, efficiency, and insurance reform.

It was through those efforts that we were able to offer a thorough and well planned legislative proposal that enjoyed overwhelming bi-partisan approval moving from announcement to passage into law in four months.

Our most recent initiative accomplished much:

- It increased eligibility for working parents with income up to 200% FPL

- It established a "buy-In" program for children whose family income exceeded our SCHIP cap of 350 FPL. This program was created after negotiating with two health plans who agreed to offer an excellent benefit design at a very low price. This program does not use any Federal or State dollars.

- It implemented a "Kids First" mandate that required all eligible children to enroll in either a free or very low-cost health insurance program.

- It required our Department of Treasury to include a check off on all state income tax returns that seeks information from filers regarding the health insurance status of household dependants. This provision enabled NJ to be the first state in the nation to utilize the "Express Enrollment" process approved here in Washington in CHIPRA.

- It directed our Department of Human Services to design a cost-effective and thorough enrollment outreach program, and to design a premium hardship exclusion that does not allow an enrollee to drop out of coverage, but provides for an income set-aside that could lower their premium to an affordable level.

- It instituted a number of reforms to our individual and small employer market that made those policies more affordable while dedicating a larger percentage of collected premiums to the actual provision of care.

I am proud of what we have accomplished in New Jersey. We have been one of the most progressive states in offering expanded access to hundreds of thousands of children and working parents and we are currently well down the road toward comprehensive and transformational health reform.

But, as you know all too well, there is only so much that we can afford to do on our own in this difficult economic climate. Our hard work to date, in partnership with the Federal

Government, has assisted countless families and children who would have otherwise had their health jeopardized because they were uninsured. We need your leadership again to make affordable and dependable health care commonplace for the remaining 1.3 million New Jerseyans and 47 million Americans who remain uninsured.

Although states across America have stepped up to offer coverage and assistance to millions of their citizens, I believe a state-by-state solution will ultimately prove inconsistent and unreliable.

In the course of the recent debate over national reform, there are those who believe that a government baked plan will be too expensive, leave millions of Americans behind, dictate the amount of health care apportioned to the newly insured, and destroy the competitive advantages that privately offered insurers offer. Respectfully, I disagree.

I believe that the House bill simply does what government was designed to do. It fills the void that has been left by the private sector. It does so by leveling the playing field and ensuring that health coverage remains a partnership between individuals and their employers. It does not expand Government's role and it's certainly not a government take over of the health care industry – it is an assurance that the dollars on the table today, remain on the table tomorrow.

Government is already the largest payer of health care. Taxpayers already finance subsidies to companies who provide health care to their employees through generous tax breaks. We also fund a considerable amount of health care research and development. The Government invests in building the infrastructure for which health care is delivered, and in the educations of those that deliver it. Taxpayers pay for services for the elderly, disabled and poor; while also providing billions of dollars to hospitals to care for the uninsured. The House Bill simply balances these resources so all Americans benefit from our Government's investment in our Nation's health care.

At the end of the day, the interest of American consumers must remain at the nexus of your debate.

I read comments from some who worry that a government plan will cause prices to be controlled. The irony in their commentary is that they completely ignore the fact that the single largest problem with our health care system *is* COST. We spend more in the United State on health care and get less than any other industrialized nation. It's time we demand value for our dollar.

For as long as I can remember, high cost, waste, inefficiency, medical errors, antiquated medical records, and a lack of comprehensive, reliable prevention have driven costs in the existing marketplace to ever-growing, unsustainable levels. Those Americans who struggle ever day, work hard for their families and do the right thing, will

by and large never afford the cost of health insurance and the care that all of us with our card enjoy. They can't even afford to fill the prescription a doctor writes them.

I would leave you with a final thought. Past comprehensive health reform pursuits have stopped when they met a stalemate. We cannot afford to turn away again. If you can get any element of reform in place you should do so and then turn to the states – the "laboratories of democracy" - to build working models and study solutions where there is not yet national consensus. It may take time, but we cannot afford to fail. Toward that end, I pledge our continued discussion of New Jersey's years of research, experience, failures and successes. I pledge New Jersey as a working laboratory for continued experimentation in reform and, finally, I pledge my personal commitment to work as tirelessly as you all have to see this through!

Thank you for the opportunity to be with you today.

Mr. PALLONE. And thank you for waiting, all of you, actually. I know you have been here since early this morning. So I appreciate it.

Next is Mr. Allen.

STATEMENT OF W. RON ALLEN

Mr. ALLEN. Thank you, Mr. Chairman. My name is Ron Allen. I am the Chair and CEO for the Jamestown S'Klallam Tribe located up in Northwest Washington. And I am also an officer at the National Congress of American Indians. And my testimony presented to you and the committee is on behalf of our organization that represents and advocates for all Indian Nations from Alaska to Florida, representing over 560 Indian Nations and communities and 4 million people.

As I listened to the dialogue all day today, we find it interesting. When we talk about the unmet needs of health care, no one knows that more than Indian Country. I was listening to some interesting comments this morning about how America is high represented in cancer recovery rates and diabetes recovery rates, et cetera. Well, in Indian Country we have the highest level of cancer rates and deaths and diabetes crisis, tuberculosis exposure, et cetera, than any other ethnic group or any other sector of our society. And it reflects the incredible unmet needs in our Indian communities.

But what we do believe is that this initiative that is being advanced by the Congress and by the administration is an important one. We agree that the idea of addressing and reducing costs and providing competent care and affordability and quality is something we all look forward to, and that the Indian tribes across America concur that that has to happen.

We want to remind the Congress, it seems like every time a key piece of legislation that emerges, that the tribal governments are a part of the American political family, and that we are governments, and that we are very unique in America as governments and as employers, as governments and our businesses that are important to the revenue generation for our essential services, including health care in our communities. And any legislation that is advanced to address a subject matter as this must include our government.

So we appreciate what is being advanced in all the different components of this proposed bill, but we do want to point out there is a number of issues that we are concerned about, and that we would urge you as the committee and as the Congress to consider these specific conditions that are essential for the services to be provided to the Indian communities because of our unique conditions and how services are provided to the American Indian, Alaskan Native peoples across the Nation.

We need the legislation to exempt American Indians and Alaskan Natives from mandates and penalties. We need this legislation to exempt tribal governments from the employee-employer penalties. It is essential that the American Indians, Alaskan Natives should be eligible for those insurance subsidies, and that the portability component is also essential for our people as well. It explicitly states that the Indian Health Service and the tribes are essential

community providers so that is clear that that is how the services are being provided.

And another key component that we are concerned about is making sure that it is clear that the health care services that are provided to the Indian people, that they are exempt as income. The IRS wants to identify these resources as taxable income, and for the Indian communities we have paid for it. They are reflected in our treaties and the commitments of this Nation. This Nation is great because of the commitment of the Indian communities across the Nation, and so, therefore, that as prepaid health care, they should not be taxed for services that have been long overdue from this Nation to our communities.

So these aren't just a wish list. They are critically important to make it effective to fulfill what we believe is the unmet need for our communities consistent with a lot of sectors of America.

The Health Care Improvement Act is important, and it does need to be passed and addressed, but it is not—this does not replace that bill, that legislation, that is fundamental for Indian Country and is so important for all of us.

There are many other points I could address, but I think that I have highlighted the main issues. Our testimony has identified a long list of issues and recommendations that we have made to you, and we look forward to working with you, the committee members, the staff, and the President, on making this happen to raise the level of health care for all people, including American Indians and Alaskan Natives.

Thank you, Mr. Chair.

Mr. PALLONE. Thank you, Mr. Allen.

[The information follows:]

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HOUSE COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH
Hearing on Health Care Reform Draft Proposal
June 24, 2009

Testimony of W. Ron Allen
On behalf of the Jamestown S'Klallam Tribe and the National Congress of American Indians

Good morning Chairman Pallone, Vice-Chairman Capps and members of the Subcommittee. My name is W. Ron Allen, and I am the Secretary and former President of the National Congress of American Indians (NCAI) and Tribal Chairman/CEO of the Jamestown S'Klallam Tribe in Washington State. Thank you for giving me the opportunity to testify today.

NCAI is the oldest and largest American Indian organization in the United States. I sit before you today representing over 250 tribal governments and hundreds of thousands of American Indian and Alaska Native people who are members of NCAI. NCAI was founded in 1944 in response to termination and assimilation policies. Since then, we have fought to preserve the treaty rights and sovereign status of Indian tribes and to ensure that Indian people may fully participate in the political system.

I and NCAI strongly support the Administrations and Congress's goals to reform health care. Perhaps nowhere in the country will the effects of this reform be more beneficial than in Indian Country. We share the commitment to reducing costs, protecting current coverage and access to culturally competent care, and ensuring affordability and quality. These goals, as well as investments in workforce, prevention and wellness and long term care are much needed in Indian Country.

We are, however, concerned with several aspects of the House draft bill that seem to diminish the trust responsibility of the federal government to provide health care for American Indian and Alaska Native people.

Basic core principles must be met in any reform legislation, including:

- Exclusion of penalties and mandates for Indian people and tribal governments;
- Eligibility of subsidies for Indian people; and
- Portability of care.

I will discuss each of these in greater length in my testimony below.

INDIAN HEALTH IS A FEDERAL RESPONSIBILITY

Although the Federal government created the Indian health system in use today, too often, Indian people and the Indian health system that serves them are only an afterthought in legislation. While we have many mutual goals, the vehicle for accomplishing them may need to be different in Indian Country. We must work together to be sure health reform legislation builds on the current Indian Health system and then extends the promise of health access to all Americans.

Health reform must accomplish two equally important objectives. First, the Indian health system must be protected from adverse consequences and fully supported as a critical component of the federal responsibility to provide health care to American Indian and Alaska Natives. Second, American Indian and Alaska Natives are also entitled to have the option to fully participate in health reform initiatives, by using their insurance or other health care coverage at Indian programs and have the Indian provider fully reimbursed for these services.

We must be clear: specifically addressing the needs of American Indians and Alaska Natives within health care reform legislation is not akin to providing requirements for reducing health disparities or considering the needs of ethnically diverse populations. While we may fall into those categories, the significant difference is that supplying health care to American Indians and Alaska Natives is a **federal obligation and being an Indian is a political status**. When Indian tribes ceded certain lands – lands which now constitute the United States – agreements were made by tribes with the United States government that established a "trust" responsibility for the safety and well-being of Indian peoples in perpetuity. In addition, a number of treaties specifically outlined the provision of education, nutrition, and health care. Therefore, the federal trust responsibility for American Indian and Alaska Natives health care must be woven into health reform policies.

At the same time, as United States citizens, American Indian and Alaska Natives should have equal opportunities as other citizens to participate in the benefits of health reform. While it may be tempting for Congressional members who are unfamiliar with the federal trust responsibility as it relates to health care to dismiss the complexity of tribal recommendations, especially in light of the complexity of health reform itself, I assure you they are needed. The Indian health system is invisible to most Americans, but it does, and it must, interface with local and regional health care systems. We understand on a conceptual basis what is needed to assure that health reform reaches and benefits, Indian Country. We ask that you take the time to understand how both the federal trust responsibility and mainstream health reform can work in tandem for Indian people. We are committed to work with you in any way we can. To that end, we offer the following more specific comments.

COMMENDABLE PROVISIONS IN THE DRAFT BILL

We sincerely appreciates that this Subcommittee has taken some initial steps to acknowledge the importance of including tribes and tribal communities in their discussion draft bill. For example, we strongly support the inclusion of these provisions:

- Consultation is key to fulfilling the trust responsibility of the federal government to American Indian and Alaska Native people. We would like to thank the Committee for

recognizing this by ensuring that the Health Choice Commissioner consults with tribes and tribal organizations.

- Children are sacred in Native communities. We would like to thank the Committee for expressly including tribes as eligible recipients in the home visitation program for families with young children. In light of American Indian and Alaska Native maternal infant health disparities, it is essential that there be an adequate "set aside" for tribal programs and that they are granted the flexibility to administer services in a culturally flexible manner.

- Providing culturally competent, community centered care has been recognized to improve health conditions in Native communities. We would like to thank the Committee for recognizing this and making tribal health departments eligible recipients of the community-based prevention and wellness service grants.

- Indian Country has been researching voluntary accreditation standards for public health. We would like to thank the committee for designating tribes as eligible participants of the core public health infrastructure grants program.

However, these provisions alone will not adequately address provisions needed to support the current system of Indian health coverage or ensure that American Indian and Alaska Natives can fully participate in new insurance options.

INDIAN HEALTH DISPARITIES

Here are some of the challenges that tribal leaders face every day. Many American Indian and Alaska Natives live in the poorest and most remote communities in the Unites States. Indian people have among the highest rates of disease and poorest health status of any other group in the United States. Over the past 50 years, the Native population diseases have transitioned, along with the U.S. general population, from infectious diseases pandemics to those of aging and lifestyle disease, such as diabetes and cardiovascular disease, cancer, and alcohol and drug abuse. Data for the Indian people is often incomplete. However, some of the comparisons with the non-Native population are quite disturbing:

- We die at higher rates than other Americans from: alcoholism (517%), tuberculosis (533%), motor vehicle crashes (203%), diabetes (210%), unintentional injuries (150%), homicide (87%) and suicide (60%);
- Our people have a life expectancy that is almost 4 years less than the U.S. all races population (72.9 years to 76.5 years, respectively; 1996-98 rates), and our infants die at a rate of 8.8 per every 1,000 live births, as compared to 6.9 per 1,000 for the U.S. all races population (1999-2001 rates);
- We suffer from higher rates of diabetes (15.3% compared to 7.3 percent among all U.S. adults);
- Heart disease is now the leading cause of death among Indian people;
- Suicide and homicide among Indians nationally are almost twice that of the U.S. population of all races;

- The death rate for all unintentional injuries was more than three times that of U.S. all races; and
- Alaska Natives and the Northern Plains Indians have a higher mortality rate from all cancers than the U.S. all race rate;

The Indian health delivery model is well positioned to address many of these health disparities in a comprehensive way. Unfortunately, it only receives about 50% of the funding needed. The Indian Health Service (IHS), an agency within the Department of Health and Human Services (HHS), provides comprehensive health care services – using a community-based, public health model – to 1.9 million American Indian and Alaska Natives residing in tribal communities located in 35 States.

The IHS directly operates 31 hospitals, 52 health centers, 2 school health centers, and 31 health stations. In addition, tribes and tribal organizations, through contracts and compacts under the Indian Self-Determination and Education Assistance Act (ISDEAA), operate almost 50% of the IHS system and provide health care in 15 hospitals, 256 health centers, 9 school health centers, and 282 health stations (including 166 Alaska Native village clinics). The IHS or tribes/tribal organizations also operate 11 regional youth substance abuse treatment centers and 2,241 units of staff quarters. The IHS also provides funding for Indian health centers located in 34 urban areas.

Over the years IHS has become more successful in assisting beneficiaries enroll in Medicaid, Medicare and CHIP, however in some communities with chronically high unemployment, few American Indian and Alaska Natives receive employer sponsored health insurance. Low insurance coverage rates coupled with health care as a treaty right, will require a significant long term effort to educate parts of Indian Country about the benefits of health insurance coverage.

Indian health providers have a long and unfortunate history with private health plans that will not contract with them. Access standards alone have proven unsuccessful. There are many disincentives for health insurance plans or networks to contract with Indian health programs. These include the adverse risk of American Indian and Alaska Native populations, limited administrative and patient capacity of some sites, restrictions on serving American Indian and Alaska Native only, unwillingness to modify boilerplate contracts. Because of the federal nature of the Indian health system, some insurance plans will not accept provider licensing, credentialing, FTCA or other contract terms that must be different from private providers. Because of these types of problems, Medicare Part D Plans are required to offer special tribal specific contracts to all Indian health pharmacies. These are the kinds of solutions that are needed to make health care reform work in Indian Country.

LEGISLATION MUST CONTAIN INDIAN-SPECIFIC PROVISIONS

The following Indian-specific provisions need to be included to make sure the promise of health reform reaches American Indian and Alaska Natives across the country:

1. Exempt American Indian and Alaska Natives from mandates and penalties. American Indian and Alaska Natives have already paid for their health care coverage. Failure to acknowledge that Native people are different from other groups needing health care coverage will result in either an abrogation of the federal trust responsibility or denial of

their right to fully participate in health reform. It is not appropriate to subject American Indian and Alaska Natives to the individual mandate, especially the penalty for failing to acquire or purchase health insurance. We recommend the House bill, like the Senate HELP Committee draft, expressly exempt Indians from individual mandate penalties.

2. Tribal government exemption from employer penalties. The employer mandate provisions must also exempt Indian tribes, as employers, from penalties. Indian tribes are sovereign nations and should not be subject to federal penalties in their roles as employers.

3. American Indians and Alaska Natives should be eligible for insurance subsidies. Permit American Indian and Alaska Natives to participate in subsidized insurance and explicitly permit tribes to pay premiums and cost sharing on their behalf. This concept is no different than how Medicare, Medicaid, CHIP, state subsidized insurance plans or employer based insurance work right now.

4. Portability of health care is essential. In order to guarantee portability between health insurance and the Indian health system, include express language which allows an individual American Indian or Alaska Native to enroll in an insurance plan at any time without assessment of late enrollment penalties or other negative consequences. Without this protection Indian people risk being forever locked into the Indian health system.

5. Explicitly state that the Indian Health Service is an essential community provider. Ensure that American Indian and Alaska Natives have access to culturally competent health care services and can use Indian health providers without penalty. Merely allowing an entity to designate Indian health providers 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.

6. Exclusion of Health Benefits as Income. Tribal governments have been trying to meet the challenge of addressing the health care needs in their communities. Some tribal governments have met this challenge by providing supplemental services above and beyond the limited IHS services while others are providing more comprehensive care through self insured funds or third-party plans. This type of universal health coverage for tribal citizens is similar to Medicare. However, some Internal Revenue Service field offices – in examining specific tribal governments for their compliance dating back to 2002 or 2003 – are asserting that this type of coverage, when provided by a tribal government, should be treated as a taxable benefit. In order to continue to encourage tribal governments to provide such benefits to their members on a non-discretionary basis, NCAI seeks a statutory exclusion to clarify that the health care benefits and coverage provided by tribal governments to their members are not subject to income taxation. Our proposal clarifies that the health services, benefits, or coverage received by Indians is excluded from gross income, in the same manner as Medicare - another government benefit health plan that is not viewed as taxable.

The provisions above are not a "wish list". I want to emphasize that they are **the fundamental components necessary for health reform to work in Indian Country**. Without them, the Indian health system will be severely damaged and the rights of Indian people will be trampled.

Support for Passage of the Indian Health Care Improvement Act

Finally, we strongly urge that health care reform not replace the Indian Health Care Improvement Act (IHCIA). We would like to thank Congressman Pallone for his leadership in introducing the bill this session. We urge you to support this important legislation that has been the lifeline for the delivery of health care for a nation of people that would otherwise be comprised or neglected. We would also ask that you introduce or support an amendment to the House health care reform bill to permanently reauthorize the IHCIA.

Conclusion

Included as part of my formal written testimony are several additional documents. They identify a range of recommendations that have come from tribes through NCAI, the National Indian Health Board, the National Council of Urban Indian Health, and the Northwest Portland Indian Health Board. All of these recommendations would significantly improve the availability of services to American Indian and Alaska Natives. Many would not have a federal financial impact. I urge you to consider these and consult with tribes about them on an ongoing basis throughout this entire process.

Thank you for inviting me to speak with you today. We look forward to having an ongoing dialogue about how our mutually shared goals of improving the health of Indian people can be fostered through health care reform.

APPENDIX A

FACTUAL INFORMATION ON THE INDIAN HEALTH DELIVERY SYSTEM:

The Federal Government has a trust responsibility to provide health care to s American Indian and Alaska Natives, based on the Indian Commerce Clause of the U.S. Constitution, and confirmed through treaties, federal law, and federal court decisions. In treaties negotiated during the 18th and 19th centuries, Indian Tribes ceded over 400 million acres of land in exchange for health care for their people. The Indian Health Care Improvement Act (Pub. L. 94-437), along with the Snyder Act of 1921 (25 U.S.C. 13), form the statutory basis for the delivery of federally-funded health care to American Indian and Alaska Natives

The Indian Health Service (IHS), an agency within the Department of Health and Human Services (HHS), provides comprehensive health care services – using a public health model – to 1.9 million American Indian and Alaska Natives residing in tribal communities located in 35 States. The IHS directly operates 31 hospitals, 52 health centers, 2 school health centers, and 31 health stations. In addition, Tribes and Tribal organizations, through contracts and compacts under the Indian Self-Determination and Education Assistance Act (ISDEAA), operate almost 50% of the IHS system and provide health care in 15 hospitals, 256 health centers, 9 school health centers, and 282 health stations (including 166 Alaska Native village clinics). The IHS or Tribes/Tribal organizations also operate 11 regional youth substance abuse treatment centers and 2,241 units of staff quarters. In addition, IHS provides funding for Indian health centers located in 34 urban areas.

The IHS and tribal programs are authorized to bill Medicare, Medicaid and State Children's Health Insurance Programs for services provided in their facilities. State Medicaid Programs are reimbursed at 100% Federal medical assistance percentage for services provided to American Indian and Alaska Natives in these facilities. To the extent that needed direct care cannot be provided by the IHS or Tribes, services are purchased from private and public sector providers under a contract health services (CHS) program. Private and public Medicare participating hospitals providing CHS services to American Indian and Alaska Natives are paid at reimbursement rates similar to Medicare payment rates. The IHS and tribal programs are residual payors to other federal health programs and private insurance.

The IHS is a discretionary funded program with annual appropriations of $3.3 billion (FY 2008) for health program operations, preventive health programs, facility construction, maintenance and improvement, and construction and operation of sanitation facilities. Some variable funding is supplied from Medicare and Medicaid collections estimated at $780 million/year and diabetes funding of $150 million/year. The IHS system has a total operating budget of $4.3 billion. Even with these additional funds, the IHS system is funded at only approximately 50% of the level of need in comparison to services available to the general population. In some parts of Indian Country, health care is limited to "life or death" emergencies. As a result, American Indian and Alaska Natives suffer lower life expectancies, disproportionate health disparities, and die at higher rates from alcoholism (550% higher), diabetes (190% higher), and suicide (70% higher) than the general U.S. population.

APPENDIX B

National Indian Health Board

HEALTH CARE REFORM
INDIAN COUNTRY RECOMMENDATIONS

EXECUTIVE SUMMARY

Tribal leaders concur with Chairman Baucus's proposal to augment funding for the Indian health system, and concur with his observation that "IHS desperately needs additional funding. It is impossible to keep America's promise to provide care to Native Americans and Alaska Natives with the current level of IHS funding."[1]

Indian Country strongly supports health care reform and seeks to ensure that the Indian health care delivery system is strengthened and improved so that Indian people and Indian health programs benefit from reformed systems.

Some key features of our recommendations include:

- Increasing the number of Indian people enrolled in Medicaid, CHIP and other publicly-funded insurance programs, including using fast track methodologies for Medicaid enrollment.
- Exempt Indian tribes from any employer mandate penalties and individual Indians from individual mandate penalties.
- Innovative ideas for addressing health care workforce shortages in the Indian health system such as pipeline incentive and utilizing alternative provider types.
- Expanding options for delivery of long term care services in Indian Country.
- Support targeted research and best practice benchmarking appropriate to American Indians and Alaska Natives.
- Achieve advancements for the Indian health system by incorporating provisions from legislative proposals to update and modernize the Indian Health Care Improvement Act.

Inquiries should be directed to Jennifer Cooper, Legislative Director, National Indian Health Board, 202.507.4070; jcooper@nihb.org

[1] Baucus, Senator Max, *Call to Action: Health Reform 2009* (Nov. 12, 2008), at 28.

INTRODUCTION

Foundation of Federal Obligation to Provide Health Care to Native Americans. When Indian tribes ceded certain lands – lands which now constitute the United States – agreements were made with the United States government. Among them was the establishment of a "trust" responsibility for the safety and well-being of Indian peoples in perpetuity. In addition, a number of the treaties specifically outlined the provision of education, nutrition, and health care. Since the creation of the Indian reservation system, and the subsequent federal policy of trying to move Indians to specific urban communities, the United States government has implemented that trust and treaty health care obligation through different forms of what is now the Indian Health Service.

Current Indian Heath Care Delivery Structure. The current system consists of services provided by: the Indian Health Service (IHS) (an agency of the Department of Health and Human Services); programs operated by Indian tribes and tribal organizations (through contractual agreements with IHS); and urban organizations that receive IHS grants and contracts (collectively the "Indian health system" or "I/T/U"). The I/T/U system serves approximately 1.9 million Native people and medical and dental care is delivered through more than 600 health care facilities.

Most beneficiaries served by the Indian health system live on very remote, sparsely-populated reservations and Alaska Native Villages. The Indian health system was designed in large part to reach these beneficiaries, who often have no other options. Even in more populated urban areas, where the Federal government moved Indian people during the 1950s and 60s, the Indian health system provides the most meaningful access as it is the only culturally competent provider and the only provider with a direct Federal-tribal relationship. The incentives in the Indian health system are not financial; its mission is the improvement of the health status of Indian people.

Inadequacies of Current System. Historical inadequate funding is the most substantial impediment to the current Indian health system's effectiveness. A 2008 CBO report on IHS stated that due to "staff shortages, limited facilities, and a capped budget, the IHS rarely provides benefits comparable with complete insurance coverage for the eligible population."[2] IHS expenditures per capita are roughly one-third the amount spent per capita for the general public and one-half the amount spent on federal prisoners.

RECOMMENDATIONS

Set out below are recommended systemic changes that, in concert with increased appropriations, will dramatically improve health care delivery for American Indians and Alaska Natives (AI/ANs).

Personal Responsibility Coverage Requirement (Individual Mandate)

Indian tribes do not object to the requirement that all Americans acquire a minimum level of health insurance, but would object to imposition of a penalty on an Indian individual who fails to obtain such insurance. The United States has a trust responsibility to provide health care to Indian people without cost, so assessment of any penalty for failing to acquire health insurance would violate this Federal responsibility.

[2] Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals*, at 127 (Dec. 2008).

Subsidies

1. IHS is not creditable coverage. Indian people should not be barred from qualifying for subsidies due to their eligibility for care from the Indian health delivery system. The Indian health system should not count as creditable coverage for two reasons: (i) it is not a health insurance program; and (ii) the Indian health system is unable to provide a consistent, comprehensive package of health benefits to its beneficiaries.

2. Insurance subsidies. To the extent tribal governments provide health insurance for their employees or members who would be eligible for premium subsidies, the subsidies should be made available to the tribal government to offset the cost of acquiring coverage that should be available to Indian people without cost.
   - This same support should also be extended to tribal organizations carrying out programs under the Indian Self-Determination and Education Assistance Act and the Tribally Controlled Schools Act, as well as urban Indian organizations.

3. Apply Federal law protections. The protections afforded to Indians regarding their participation in Medicaid should apply to their participation in any health insurance plan:
   - Indians should be exempted from all cost-sharing (including premiums, co-pays and deductibles), consistent with the recent amendment to the Social Security Act which exempts Indians from cost-sharing under Medicaid.
     - If the law nonetheless requires that Indians pay premiums, Indian health delivery system (I/T/Us) must have the authority to pay the premiums on behalf of their beneficiaries and administrative barriers to doing so must be removed.
   - Individual Indian income from Federally-protected sources must be excluded from the calculation of an individual AI/AN's income for purposes of determining eligibility for a subsidy. See, e.g., 25 USC §§1407, 1408; 43 USC §1626.
   - AI/ANs must not be subject to any restriction on selection of a provider. They must be permitted to obtain care from their IHS, tribal, or urban Indian organization program without any financial or other penalty. See recent amendment to Sec. 1932(h)(1) of the Social Security Act to permit an Indian enrolled in Medicaid to select an Indian health care provider as a primary care provider. Pub. L. 111-5, Sec. 5006(d) (Feb. 17, 2009).
   - A special enrollment period should apply to Indian beneficiaries in order to maximize opportunities for enrollment.

4. Allow integration of traditional health practices. Assure that prevention and wellness programs are covered services in all public programs (Medicare, Medicaid and CHIP). To the extent an Indian health program integrates traditional health care practices into its prevention/wellness programs, it should be permitted to do so with no adverse impact on its ability to receive federal support for prevention and wellness programs.

5. Outreach in Indian communities. Expressly designate Indian health delivery system as a location for outreach and enrollment activities for public programs.

Employer Mandate

Indian tribes, as employers, should be exempt from any requirement that an employer provide health insurance coverage to its employees or suffer a financial penalty. As sovereign governments, tribes must be permitted to determine for themselves the extent to

which they can/will provide health insurance coverage to their employees, and must not be subject to any penalty or tax for declining to do so.

Medicaid and CHIP Expansion

1. Medicaid income eligibility. Medicaid eligibility should be expanded to 150% of the Federal poverty level, and should be expanded to make childless adults eligible.

2. Cost-sharing exemption. All expansions of Medicaid and CHIP (including any waiver or demonstration programs) must expressly exempt AI/ANs served by the I/T/U system from any form of cost-sharing pursuant to the recent amendment to Title XIX made by Sec. 5006(a) of Pub.L. 111-5 (Feb. 17, 2009).

3. Out of state Medicaid applicability. Indian tribes support the proposal of the Finance Committee to require interstate coordination for child Medicaid beneficiaries to ensure that a child's home-state Medicaid program will cover the child's health care costs when he/she is out of state. Such a requirement would beneficially impact Indian children enrolled in Medicaid who leave their home states for such purposes as attending Bureau of Indian Affairs boarding schools.
   - This proposal should be expanded to require an adult Indian's home-state Medicaid program to cover the health care costs of such a patient who travels out of state in order to receive culturally competent care at an Indian health facility, including care related to behavioral health needs and substance abuse treatment.

4. Outreach and enrollment. Aggressive mechanisms are needed to increase enrollment of eligible Indians in Medicaid and CHIP. The AI/AN population suffers from disproportionately high poverty rates and thus has a high proportion of Medicaid and CHIP eligibility, but Indians are under-enrolled in these programs.
   - States should be authorized to rely on a finding of eligibility for Medicaid and CHIP made by an I/T/U to the same extent as they would rely on such a finding by an Express Lane agency (as defined in Sec. 203 of CHIPRA).
   - Indian health providers should be permitted to apply fast-track enrollment methods and to participate as Express Lane or other Medicaid enrollment simplification network entities.
   - States must be required to demonstrate they have employed effective outreach and enrollment activities on/near Indian reservations and in off-reservation Indian communities, with penalties attaching for failure to do so.
   - Tribal governments should be authorized as portals for accepting Medicaid applications.

Health Insurance Exchange

1. All insurance plans admitted to a health insurance exchange (including any public option) should be subject to the protections for Indian beneficiaries and Indian health system providers recently applied to Medicaid managed care programs by Sec. 5006 of Pub.L. 111-5 (Feb. 19, 2009). These include:
   - Assurance that an Indian enrolled in a plan in the exchange is permitted to obtain care from his/her Indian health program without any financial or other penalty.
   - A requirement that provider networks includes sufficient Indian health care providers to assure access for Indians.
   - A requirement that I/T/U providers be paid (whether or not enrolled in the network) at a rate negotiated with the I/T/U, or if no rate is negotiated, at the rate paid to a non-Indian network provider.
   - A requirement for prompt payment to an I/T/U provider.

2. The legislation should include a requirement that the Secretary establish terms for I/T/U participation in provider networks that take into account their unique treatment under Federal laws that apply to the Indian health delivery system such as the Federal Tort Claims Act.
   - This recommendation builds on lessons learned during implementation of the Medicare Part D drug program where it was necessary for CMS to require specific terms for pharmacy contracts in order to assure participation opportunities for I/T/U pharmacies.

3. Outreach and enrollment. Aggressive mechanisms are needed to assure that Indians eligible for insurance subsidies can quickly obtain subsidy determinations. The AI/AN population suffers from disproportionately high poverty rates and thus has a high proportion of people who will be eligible for a subsidy. Experience demonstrates that Indians are under-enrolled in Medicaid and CHIP; thus it is expected that aggressive outreach and enrollment efforts will be needed to encourage Indian people to avail themselves of premium subsidies for which they are eligible.
   - Insurance plans for which subsidies are available should be authorized to rely on a finding of subsidy eligibility made by an I/T/U to the same extent as means-tested programs rely on eligibility findings by Express Lane agencies (as defined in Sec. 203 of CHIPRA).
   - Indian health providers should be permitted to apply expedited mechanisms (similar to fast track processes in Medicaid) to subsidy determination
   - Authorize Tribal governments to serve as portals for accepting insurance subsidy applications.

Other Safeguards Needed for Indian Health System

1. Health care workforce. Indian health programs already have difficulty recruiting and retaining needed health care professionals, and competition for health care workforce personnel will intensify as millions of individuals enter the ranks of the insured. The Indian Health Service budget must be enhanced to assure that Indian programs can attract and retain health care personnel.
   - The legislation should enhance funding for scholarship and loan programs to encourage Indian people to enter the health professions and serve in Indian health programs.
   - Mechanisms for assignment of National Health Service Corps personnel should be revised to facilitate participation by Indian health programs and enable these programs to access NHSC personnel on the basis of their Indian service population.
   - Expand funding to train and support alternative provider types who have proven records of providing quality care, such as community health representatives, community health aides, behavioral health aides, and dental health aide therapists.
   - Include the Indian health delivery system as a key focus area in the coordinated national strategy to address health care workforce shortages.

2. Medicare amendments.
   - The Medicare law should be amended to provide 100% payment to Indian health programs for covered Medicare services. At present, the system for making Medicare reimbursements to IHS and tribally-operated facilities provides payment at only 80%, as Medicare presumes a 20% patient co-pay, and expects patients to satisfy deductibles before qualifying for benefits. Because of the trust responsibility for Indian health, the IHS does not charge patient co-pays; thus, the IHS budget subsidizes Medicare by paying the remaining 20%, as well as applicable deductibles. According to 2008 data, reimbursing Indian facilities for Medicare services at 100% would infuse over $40 million more into the Indian health system annually, funds that would be used to reduce health status disparities.

- Remove from Section 1880 of the Social Security Act the sunset date (December 31, 2009) applicable to IHS and tribal program authority to receive payment for certain Medicare covered items and services.

3. Research. Reform legislation must support targeted research and best practice benchmarking appropriate to AI/ANs. Best practices in prevention and treatment must be grounded in evidence-informed study on the actual population involved.
   - Any Federally-funded population survey or collection of data to establish best practices, or benchmarking must ensure that AI/ANs are over-sampled to be able to generate statistically reliable estimates.
   - Conduct a comprehensive national health needs assessment for off-reservation Indian communities to measure undocumented need.
   - Funding should be provided to I/T/Us to create and maintain comprehensive data collection systems.

4. Health information technology. HIT improvements must reach all Indian health providers. The remote location of many I/T/U facilities and complex relationships with IHS lead to wide disparities in health technology capabilities. Explicit policies are needed to assure that all Indian health providers receive an equitable distribution of resources for improving health information technology and that Indian health providers are not penalized for lack of information technology.
   - Supply funding to develop and implement a system for monitoring and measuring the needs of the Indian health system to assure that budgetary resources are sufficient to support the level of need throughout the system.
   - The Secretary of HHS should be required to conduct a feasibility study to determine how the Indian health system can efficiently integrate smart card technology through which a patient's medical history can be stored on a portable microchip pocket card.

5. Payor of Last Resort. Include coordination of benefits policies which assure that, consistent with existing Federal regulations, the I/T/U program is the payor of last resort.

6. Facilities. The quality and capacity of facilities throughout the Indian health system differ widely as the IHS construction budget has never kept up with the level of need. Thus, tribes need the authority to explore innovative ideas for addressing facility needs and the flexibility to utilize existing facilities fully and efficiently. Proposals follow:
   - Establish a loan program through which Indian tribes can borrow funds to construct health care facilities.
   - Enact incentives to facilitate opportunities for IHS and tribes to develop cost-effective cooperative arrangements for sharing of facilities and staff with local non-Indian communities.
   - Facilitate tribal authority to decide whether to serve non-Indians at their health facilities. The demand for health services will greatly increase in a reformed health care environment and tribes are likely to be asked to open their doors to serve non-Indian patients and receive payment for such services. This is a challenging decision that requires consideration of capacity and resources and whether adding users will improve the breadth of services that can be offered or would diminish an already limited capacity. To support tribes who are willing to expand accessibility to health care by serving non-Indians, the legislation must –
     - Extend the Federal Tort Claims Act coverage now provided to ISDEAA contractors to include coverage for services to non-Indians. (This is consistent with the FTCA coverage extended to community health centers which receive funding from HRSA under Sec. 330 of the Public Health Service Act.)

- Revise as necessary Sec. 813 of the Indian Health Care Improvement Act to facilitate a tribal decision to serve non-Indians.

Long-Term Care Services and Support in Indian Country

1. Federal support. Grant funding and federal support should be made available to assist tribes and tribal organizations to develop the full range of long-term care services needed to meet their community needs, with an emphasis on culturally appropriate home and community based services, including care management services that will delay or prevent the need for nursing home care. Specifically, Indian tribes must be expressly included as entities eligible for long-term care grant programs, including: the Community Choice Act Demonstration Project, Real Choice Systems Change Grant Initiative, Aging and Disability Resource Centers (ADRC), Informal Caregivers and Green House Model.

2. State support. State Medicaid programs should be required to enter into agreements with IHS and tribal health programs under which reimbursement would be made for the range of long term care services tribal programs are able to offer, and assure covered services include care management and home health care.

Other Matters

1. Tribal involvement. Include Tribal representation on key commissions, boards and other groups created by health reform legislation, and direct the Secretary of HHS to consult with Tribes on health reform policies and regulations. Only by engaging knowledgeable Tribal leaders before policy approaches are evaluated, refined and implemented can health reform promise to improve the Indian health system and the health status of AI/ANs.
   - Tribal organizations (as defined in the ISDEAA) which operate health programs should be included in the consultation, as they are created by tribal governments expressly to perform health care delivery.
   - Consultation should occur throughout Indian Country, as Indian cultures, tribal resources and health system structures differ greatly.
   - The views of Federally-funded programs serving Indian people in urban communities should also be sought.

2. Exclusion of health benefits as income. Indian tribes, as sovereign governments, and the tribal organizations that serve them by providing health services, should have the express authority to pay the costs of providing health insurance coverage to their members and beneficiaries and the value of such coverage should not be considered to be taxable income to the AI/AN. (See Appendix A.)

Indian Health Care Improvement Act Amendments

Legislation to amend and reauthorize the Indian Health Care Improvement Act contains many provisions that would improve the Indian health delivery system and enable it to better perform its mission. Since the IHCIA legislation has not yet achieved enactment, Congress should consider including in Health Care Reform legislation some provision from IHCIA bills, and should make the IHCIA a permanent law of the United States. Recommendations follow.

Provisions from 110th Congress IHCIA reauthorization legislation *(S. 1200 section numbers)*

1. **Sec. 123 – HEALTH PROFESSIONAL CHRONIC SHORTAGE DEMONSTRATION PROGRAMS.** This demonstration program is intended to address the chronic shortages of health care professionals in the Indian health system.
2. **Sec. 205 – SHARED SERVICES FOR LONG-TERM CARE.** This would authorize IHS and ISDEAA tribes/tribal organizations to operate long-term care programs, and to share staff and facilities.
3. **Sec. 213 – AUTHORITY FOR PROVISION OF OTHER SERVICE.** This provision would expressly authorize IHS and tribes to offer hospice, assisted living, long-term care and home- and community-based care.
4. **Sec. 207 – MAMMOGRAPHY AND OTHER CANCER SCREENING.** This provision updates current law standards for cancer screenings.
5. **Sec. 209 – EPIDEMIOLOGY CENTERS.** This revision to current law would give epi centers access to IHS health data which they need to do their jobs. NOTE: revise text to combine Sec. (e) of S. 1200 and H.R. 1328 (110th Congress bills).
6. **Sec. 222 – LICENSING.** This provision would enable tribal health programs to employ health care professionals licensed in other states just as the IHS is currently able to do. This authority is needed to aid in recruitment and retention of needed professionals.
7. **Sec. 403 – THIRD PARTY COLLECTIONS.** This revised provision would strengthen IHS and tribal program authority to collect reimbursements from 3rd party insurers, and would make the Federal Medical Care Recovery Act applicable to tribal programs.
8. **Sec. 405 – PURCHASING HEALTH CARE COVERAGE.** This would authorize tribes and tribal organizations to use appropriated funds and Medicare/Medicaid revenue to purchase health benefits coverage for beneficiaries.
9. **Sec. 407 – PAYOR OF LAST RESORT.** This provision would codify in law the existing IHS regulation which makes IHS payor of last resort, meaning that all other available sources (e.g., Medicare, Medicaid, private insurance, other) pay for care before IHS appropriated funds are used.
    - To assure such policies are properly implemented, require the involvement of the CMS Tribal Technical Advisory Group in development of regulations, and provide funding to support the TTAG's work. (NOTE: Federal law formally recognizes the TTAG and directs the Secretary to maintain this panel within CMS. See Pub.L. 111-5, §5006(e) (Feb. 17, 2009)).
10. **Sec. 509 – FACILITIES PROGRAM FOR URBAN INDIAN ORGANIZATIONS.** Authorize funding for acquisition and construction of facilities for urban Indian organizations, and authorize feasibility study for creation of a loan fund for construction of urban Indian organization facilities.
11. **Sec. 514 – CONFERRING WITH URBAN INDIAN ORGANIZATIONS.** – Authorize the IHS to confer with urban Indian organizations.

12. **Sec. 517 – COMMUNITY HEALTH REPRESENTATIVES.** Authorize grants/contracts to urban Indian organizations to operate Community Health Representatives programs authorized by Sec. 109 of current IHCIA.
13. **Sec. 601 – ELEVATION OF IHS DIRECTOR TO ASSISTANT SECRETARY FOR INDIAN HEALTH.** This provision would revise current law to elevate the position of IHS Director to an Assistant Secretary of HHS.
14. **Sec. 814 – CONFIDENTIALITY OF MEDICAL QUALITY ASSURANCE RECORDS.** This provision would facilitate quality assurance program reviews for IHS, tribal and urban Indian organization programs. [NOTE: The National Tribal Steering Committee recommends minor revisions to the S. 1200 text.]
15. **New Title VII on BEHAVIORAL HEALTH.** This new title broadens the existing law's title VII which focuses only on substance abuse programs. [NOTE: The National Tribal Steering Committee recommends revisions to recognize systems of care treatment for youth and families.]
16. **Bill title II, Sec. 201 – EXPANSION OF MEDICARE, MEDICAID AND CHIP FOR ALL COVERED SERVICES FURNISHED BY INDIAN HEALTH PROGRAMS AND URBAN INDIAN PROGRAMS.** This provision would amend the Social Security Act to facilitate access to payments from Medicare, Medicaid and CHIP by IHS, tribal and urban Indian organization programs.
17. **Bill title II, Sec. 209 – ANNUAL REPORT ON INDIANS SERVED BY SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.** This provision would require HHS to collect on an on-going basis much needed data on Indian enrollment in Medicare, Medicaid and CHIP. Congress and tribal health advocates need such data to design policies to assure proper access to these programs. HHS does not now have a mechanism in place to collect this information.

Other recommendations not contained in 110th Congress IHCIA reauthorization bills:

1. **TAX EXEMPTION FOR IHS SCHOLARSHIPS AND LOANS.** [Sec. 124 from S. 211, 107th Cong.]. Make health profession scholarships and loans from IHS non-taxable to recipients.
2. **ACCESS TO FEDERAL FACILITIES AND FEDERAL SOURCES OF SUPPLY FOR URBAN INDIAN ORGANIZATIONS.** [Sec. 517 from S. 212, 107th Cong.) Authorize the Secretary to permit urban Indian Organizations to access FSS, and to acquire excess and surplus Federal property.
3. **ADDITIONAL PROGRAM AUTHORITY FOR URBAN INDIAN ORGANIZATIONS.** Authorize urban Indian organizations to operate the following types of programs authorized by IHCIA current law: mental health training (per Sec. 209); school health education (per Sec. 215); prevention of tuberculosis (per Sec. 218); and behavioral programs in proposed new IHCIA Title VII (see above): Sec. 701 (behavioral health prevention and treatment services); and Sec. 707(g) (multi-drug abuse program).

APPENDIX A

PROPOSAL TO CLARIFY THE EXCLUSION OF HEALTH BENEFITS PROVIDED BY INDIAN TRIBES FROM INCOME

Current Law

Internal Revenue Code ("Code") Section 61 provides that, except as otherwise provided, gross income includes all income from whatever source derived. The U.S. Supreme Court has ruled that Code Section 61 generally includes in-kind benefits and payments to third parties satisfying the obligations of the taxpayer.[3] Treasury Regulation Section 1.61-1(a) states that "gross income" means all income from whatever source derived unless excluded by law.

The Internal Revenue Service ("IRS") and federal courts have consistently held that payments made under legislatively provided social benefit programs for the promotion of general welfare are not includable in the recipient's gross income.[4] Revenue Ruling 76-131, 1976-1 C.B. 16 explicitly lists health as a need that promotes the general welfare. Consistent with this position, in Revenue Ruling 70-341, 1971-2 C.B. 31, the IRS ruled that government provided health care benefits for the elderly, commonly known as Medicare benefits, were nontaxable to recipients. However, in recent non-binding guidance, the IRS has required individuals participating in state-sponsored health-related assistance programs to satisfy a financial means test.[5]

Reasons for Change

A statutory exclusion is needed to clarify that health benefits and health care coverage provided by Indian tribes to their members are not subject to income taxation. The Federal government has a longstanding policy of providing tax-free medical care to Indians. To effect this policy, federal statutes have been enacted stating that a major "goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level"[6] and providing specific authorization for the Indian Health Service, a federal agency that administers funds provided by Congress for the promotion of Indian health care services.[7] However, the federal funds appropriated for Indian Health Service programs have been consistently inadequate to meet even basic health care needs,[8] and Indian tribal governments have been encouraged to use gaming revenues to provide for the health care needs of their members, including through universal coverage programs.[9]

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[3] See Old Colony Trust Co. v. Commissioner, 279 U.S. 429 (1929).

[4] See, e.g., Rev. Rul. 57-102, 1957-1 C.B. 26 (payments to the blind); Private Letter Ruling 200845025 (November 7, 2008) (ruling that payments made by an Indian tribe to elderly tribal members who were displaced by a flood were general welfare payments); Bailey v. Commissioner, 88 T.C. 1293 (1987) (considering whether grants to restore a building façade were excludable from income as general welfare payments).

[5] See e.g., Chief Counsel Advice 200648027 (July 25, 2006).

[6] 25 U.S.C. §1601(b).

[7] 25 U.S.C. §13.

[8] See Overview of Federal Tax Provisions Relating to Native American Tribes and Their Members (JCX-61-08) (stating that "the average funding of an IHS site was found to be 40 percent less than an equivalent average health insurance plan").

[9] See NIGC Bulletin No. 05-1 (Subject: Use of Net Gaming Revenue) (January 18, 2005) (available at http://www.nigc.gov under the "Reading Room" tab and "Bulletins" sub-tab).

Consistent with the Federal government's policy of providing health care services to Indians, the proposal would clarify that health care benefits provided to Indians are not subject to income taxation. It would also encourage Indian tribes to provide such benefits to their members on a non-discriminatory basis.

Description of Proposal

The proposal clarifies that the value of "health services," "health benefits" or "health coverage" received by Indians, whether provided or purchased by the Indian Health Service, either directly or indirectly through grants to or a contract or compact with an Indian tribe or tribal organization, or grants to or other programs of third parties funded by the Indian Health Service; or by an Indian tribe or tribal organization to an Indian either directly, through purchased services, or through accident or health insurance (or through an arrangement having the effect of accident or health insurance) is excluded from gross income. It also provides for the exclusion from gross income any other benefit or service provided by an Indian tribe that supplements the programs and services provided by the federal government to Indian tribes, or other general welfare benefits or services provided by Indian tribes to their members.

The terms "accident or health insurance" and "personal injuries and sickness" have the same meaning as such terms do in Code Section 104 and, as such, are intended to include preventative health care services.

The term "Indian tribe" is defined in the proposal as any Indian tribe, band, nation, pueblo, or other organized group or community, including any Alaska Native village, or regional or village corporation, as defined in, or established pursuant to, the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.) which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

The term "tribal organization" follows the definition in the Indian Self-Determination and Education Assistance Act and means the recognized governing body of any Indian tribe (or consortium of Indian tribes) or any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization (see 25 U.S.C. 450(*l*)).

The term "Indians" or "Indian" is based on the definition of the term "Indians" or "Indian" under the Indian Health Care Improvement Act (25 U.S.C. 1603(c)). The proposal states that "Indians" or "Indian" means any person who (A) is a member of an Indian tribe, as defined in subsection (b)(2) of this section, (B) (i) irrespective of whether the individual lives on or near a reservation, is a member of tribe, band, or other organized group terminated since 1940 and those recognized now or in the future by the State in which they reside, (ii) is a descendant, in the first or second degree, of any such member, (C) is an Eskimo, Aleut or other Alaska Native, or (D) is considered by the Secretary of the Interior to be an Indian for any purpose.

No inference is intended as to the tax treatment of governmental benefits (including, but not limited to health care benefits not covered under this proposal) provided by Indian tribes to Indians before, on, or after the date of enactment of this section.

Health Benefit Exclusion Language (Internal Revenue Code Section 61)

(a) Gross income does not include

(1) health services or benefits provided or purchased by the Indian Health Service, either directly or indirectly, through a grant to or a contract or compact with an Indian tribe or tribal organization, or grants to or other programs of third parties funded by the Indian Health Service;

(2) health services, health benefits or other amounts for health care services, including preventive care and treatment of personal injuries or sickness and other health conditions, provided by an Indian tribe or tribal organization to an Indian either directly, through purchased services, or through accident or health insurance (or through an arrangement having the effect of accident or health insurance);

(3) the value of health coverage provided or premiums paid by an Indian tribe or tribal organization to or on behalf of an Indian under an accident or health plan (or through an arrangement having the effect of accident or health insurance); or

(4) any other benefit or service provided by an Indian tribe that supplements the programs and services provided by the federal government to Indian tribes or Indians, or other general welfare benefits or services provided by Indian tribes.

(b) Definitions.

(1) The terms "accident or health insurance" and "personal injuries and sickness" shall have the same use and meaning as 26 U.S.C. 104.

(2) The term "Indian tribe" means any Indian tribe, band, nation, pueblo, or other organized group or community, including any Alaska Native village, or regional or village corporation, as defined in, or established pursuant to, the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.) which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(3) The term "Indians" or "Indian" means any person who

(A) is a member of an Indian tribe, as defined in subsection (b)(2) of this section,

(B) (i) irrespective of whether the individual lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, (ii) is a descendant, in the first or second degree, of any such member,

(C) is an Eskimo or Aleut or other Alaska Native,

(D) is otherwise eligible for services provided or funded by the Indian Health Service under applicable law, or

(E) is considered by the Secretary of the Interior to be an Indian for any purpose.

(4) The term "tribal organization" means the recognized governing body of any Indian tribe (or consortium of Indian tribes) or any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization (see 25 U.S.C. 450b(*l*)).

(c) No inference is intended as to the tax treatment of governmental benefits (including, but not limited to health care benefits not covered under this section) provided by Indian tribes to Indians before, on, or after the date of enactment of this section.

Mr. PALLONE. Next is Assemblyman Webber. Thank you for being here as well.

STATEMENT OF JAY WEBBER

Mr. WEBBER. Thank you, Chairman. And I would like to thank the committee for the invitation.

My name is Jay Webber. I represent the 26th legislative district in the New Jersey State Assembly. I am here actually like Senator Vitale; I think we both take great pride in our State, but we have different views of the state of health care in our State. And one of the reasons that we are in such desperate need of reform in New Jersey is some of the things that we have done in the past.

My message to the committee, if I can leave one, is please don't do to the Nation what New Jersey has done to itself. We embarked on a series of reforms in 1992 with the intent of improving access to health care and health care insurance for our citizens. Many of the policies we put in place have been discussed already in the committee today, things like guaranteed issue, community rating. There were a series of mandated coverages that have continued to be piled on. And even as recently as this year, the legislature and the Governor raised the minimum loss ratios for insurance companies in our small-employer and individual markets.

These reforms, so-called, have created what I would call a toxic mix for destroying the health insurance market in the State. Actually, one commentator called New Jersey the poster child for how to destroy the health insurance market. And the results have been rather predictable: Costs for health insurance in New Jersey have skyrocketed to the point where today the average premium for families on the individual market is as much as twice the national average. Small employers find themselves not being able to afford to provide insurance to their employees anymore. And consumers have fewer choices as fewer insurance companies write policies in the State.

The reforms in 1992 did not result in a reduction in the number of uninsured. Quite the contrary. Whereas in 1992 we had 13.9 percent of our population uninsured, after these reforms the uninsured population stands today at about 15.8 percent.

I have a lot more statistics in my written testimony to the subcommittee, but there is one story I would like to relate to you. A constituent wrote in to me just after the bill that Senator Vitale discussed earlier—just after that bill was passed. A man named Fred, he is a CPA, his wife is quite ill with a lot of doctors bills. Very content with his coverage that his employer was able to provide him, but after the bill that the senator discussed was passed, and the minimum loss ratios were put into place, the insurance company stopped writing insurance in New Jersey, and Fred lost his insurance coverage. His employer could no longer afford to purchase it.

There are stories like that being played out across the State as our attempts to reform the system wind up doing more harm than good. There are solutions that I advocate vigorously and many members of the legislature do advocate in New Jersey, the most prominent of which would be to allow New Jerseyans to purchase health insurance across State lines. Increasing competition and

consumer choice will provide less expensive and higher quality health care to New Jerseyans. It will lower their premiums. And one study by University of Minnesota economists estimated that as many as 700,000 New Jerseyans would be able to afford to buy health insurance if they simply were allowed to purchase health insurance across State lines. That is 700,000 or almost 50 percent of the uninsured population in the State wiped off the uninsured rolls without spending a taxpayer dime. I think that is a significant reform that we should try.

There is great enthusiasm for that measure; and I have gotten unsolicited letters, e-mails all across the State, not just from constituents in my district, urging the legislature to go forward with it. I just think it is no longer acceptable to trap New Jerseyans in a State and in a system that they want to leave. We have New Jerseyans who are looking to purchase health insurance out of State, would do it if they could, and insurers who would sell them insurance if they were allowed to come in and sell policies free of the underwriting rules and the coverage mandates that New Jersey puts on them, but we stand in their way with regulations and laws that block those transactions.

I discussed with a colleague of mine on the floor of the assembly why they opposed the Health Care Choice Act that I have sponsored in New Jersey, and the answer was quite simple, and it was rather disturbing. And the answer that I got was, we need their lives. We can't have New Jerseyans who would buy cheaper health insurance across State lines who might be uninsured today. We can't have them leaving the State because we want to do single payer, and we need their lives to subsidize the sicker and the older in the State.

I disagree with that approach; and it is disturbing to me that after—you know, more than 20 years after Ronald Reagan went to the Brandenburg Gate and told the Soviet Union to tear down that wall in Berlin, that New Jersey continues to put up walls to trap its citizens in a system that is failing them and that they want to leave.

So if that is the enduring lesson that I can bring to you today, that is what I am trying to do. Again, I would respectfully request that the members of the committee and Congress not repeat the mistakes that New Jersey has made on a national level.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you, Assemblyman.

[The prepared statement of Mr. Webber follows:]

Testimony to the U.S. Committee on Energy and Commerce, Subcommittee on Health

By Assemblyman Jay Webber, 26th District, New Jersey General Assembly

Wednesday, June 24, 2009, 2123 Rayburn House Office Building

Good afternoon Mr. Chairman and Members of the Subcommittee. My name is Jay Webber, and I represent the citizens of New Jersey's 26th Legislative District in the State General Assembly. I thank the Chairman and the Members of the Subcommittee for inviting me to testify about healthcare reform from the perspective of the states.

A newspaper article recently referred to New Jersey economic policies in this decade as "the perfect bad example." That title applies equally to New Jersey healthcare laws — another "perfect bad example."

Why has New Jersey performed so poorly in healthcare insurance compared to other states?

The answer is simple —bad government policies. In fact, New Jersey has been called the "poster child" for how a state government can destroy a health insurance market. New Jersey's laws and regulations have limited our selection of healthcare policies, driven insurers out of the market, skyrocketed premiums, and significantly increased the number of uninsureds in the state.

In 1992, New Jersey embarked upon an effort to reduce the number of uninsureds and improve the quality of insurance coverage in our state by passing several laws. The results of that effort proved to be a toxic mix of mandated coverages and underwriting rules that force insurance sales to any applicant ("guaranteed issue") at the same price, regardless of health, age, or other risk factors ("community rating"). Those policies have disrupted the efficient working of the state's health insurance market and artificially increased the cost of health insurance on all New Jerseyans. Increased costs, in turn, have relegated hundreds of thousands of citizens to the ranks of the uninsured. In short, New Jersey's overregulation of its insurance market has failed. About 2 years ago, even the Commissioner of New Jersey's Department of Banking and Insurance admitted as much before this Subcommittee.

New Jersey's so-called reforms badly damaged our individual health insurance market. Today, New Jersey has the highest rates in the country for individuals buying coverage for themselves. If they can afford it at all, New Jersey families pay exorbitant rates for healthcare coverage — an average annual health insurance premium of $10,398, or nearly twice the national average. One commentator noted that the typical family policy in New Jersey now costs more, per month, than the lease of a Ferrari. Not surprisingly, 40 percent fewer people buy their health insurance on New Jersey's individual health insurance market than in 1992.

Our small group market has fared no better. According to the New Jersey Association of Health Plans, during the two-year period from January 1, 2007 to January 1, 2009, enrollment decreased in the small group market from 920,000 covered lives to about 850,000 covered lives. The climb of healthcare coverage costs has hit New Jersey small employers (those with fewer than 50 employees) the hardest, with the average cost of providing health insurance doubling in the last six years. In 2007 alone, the average cost of an insurance policy for small companies rose by an average of 9.8 percent, to $7,251 per employee. And as costs climb relentlessly, growing numbers of small companies are dropping coverage for employees because insurance becomes unaffordable. Even if they maintain coverage, the small companies have reported scaling back hiring plans or limiting pay increases in order to afford that health insurance. For New Jersey's smallest companies (under 20 employees), 75 percent now provide health coverage to their employees, down from 92 percent just four years ago.

The artificially inflated costs of healthcare insurance and their predictable impact on New Jerseyans' economic behavior are reflected in the utter failure of our state to reduce the number of uninsured persons since the early 1990s. Whereas 13.9 percent of our population was uninsured in 1992, today our uninsured population stands at 15.8 percent, which exceeds the national uninsured rate. Last year, a record 1.4 million residents —1 of 6 people —had no health coverage in New Jersey.

The 1990s laws not only increased costs and the number of uninsureds, but they also decreased consumer choice. In 1992, 28 insurance carriers populated the individual health insurance market. Today, only 7 insurance carriers operate in the individual market, and only 5 of those added new insureds in the last quarter.

Rather than learn our lessons on this issue, state government continues to compound our problems. While there recently was a positive policy change toward modified community rating, other government interference in the health insurance market has done more damage still. New Jersey continues to mandate that insurance policies provide certain mandated coverages for every insured, to the point where now fully 45 separate coverages must be offered in every New Jersey policy. Those coverages include mammograms and cervical cancer coverage for every male New Jersey resident, and prostate cancer coverage for every female. Individuals who do not drink alcohol must buy coverage for alcoholism treatment, and every couple in the state must buy coverage for fertility treatments, even if they have no intention of ever using such therapies. And those are not the only absurdities the system yields. Since 2002, New Jersey has implemented 15 new health insurance mandates, the cost of which have resulted in about 110,000 more uninsured New Jersey residents.

Another recent policy change imposed an 80 percent loss ratio on insurance companies and a requirement that those companies sell insurance on the individual market. Just one call from a constituent shows the result of those misguided statutes. My legislative office received a call from a CPA named Fred who had just received a letter from his small group health insurance provider that indicated the company would be pulling up and leaving New Jersey in one year. The company specifically cited the new requirements (80 percent loss ratio and individual market mandate) as the reasons for discontinuing coverage in New Jersey. Fred has an ill wife with many medical bills, and his insurance provider always pays claims in full with no squabbles. Fred does not want to change providers, but the flight of yet-another health insurance provider because of more bad laws gives him and his wife no choice.

And the beat in New Jersey goes on. Tomorrow, it is expected that the State Legislature will debate a new tax increase on health insurance premiums, with universal agreement that it will increase even more the number of New Jerseyans without health insurance.

Despite the arguments of its proponents, there is no compassion in New Jersey's present regulation of the healthcare market. The state has "compassioned" its people right out of healthcare coverage or into the poorhouse. I agree with The Wall Street Journal's statement about New Jersey's backward and misguided regime: "It is simply immoral that millions should be exposed to the possibility of financial ruin because of the all-or-notbing choice offered hy the insurance regulations of states like New York and New Jersey."

One simple solution to this problem is to expand the choices New Jerseyans have in obtaining healthcare coverage. That is what my bill, the New Jersey Healthcare Choice Act (NJHCA), does. Much like the bill authored by Representative John Shadegg of Arizona, my bill would allow New Jerseyans to purchase regulated health insurance policies from other states and empower us to seek out and buy health insurance policies that best fit our needs and budgets. At the same time, the bill maintains New Jersey's core consumer protections to make sure that insurance companies keep the promises they make to our citizens.

New Jerseyans would benefit from this reform immediately. In other states, like Pennsylvania, better regulations have resulted in more affordable policies. For example, Pennsylvania residents can purchase health insurance policies for as little as 40 percent of the cost of comparable policies in New Jersey, primarily because of Pennsylvania's better regulations. Permitting New Jersey's citizens to access those policies, and others from around the country, would open the door to lower prices and policies suiting their needs and budgets.

More importantly, according to a recent study by University of Minnesota economists Stephen Parente and Roger Feldman, simply lowering government-created barriers that stand between New Jerseyans and the policies that fit them best would reduce the number of uninsureds in New Jersey by as much as 50 percent. That amounts to about 700,000 people, a number too large for any serious policymaker to ignore. And the proposal, a mere change in statutory language that provides no subsidies, does not cost a taxpayer dime.

But the case for healthcare choice goes beyond the numbers. Perhaps the best evidence that we need this law has been the dozens of unsolicited, compelling stories I have received from residents across our state. Soon after I introduced the legislation, New Jersey citizens reached out to me to emphasize the impact the bill would have on their lives. I received e-mails and letters from small business people, the self-employed, and single moms. One particularly moving note ended with the following: "For my sake and the sake of all who want to have a choice or at least an affordable alternative to health insurance, I pray for your proposal's success."

As Congress discusses healthcare reform, I respectfully suggest that the answer is *not* to nationalize the failed New Jersey experience in healthcare regulation. Individual mandates, guaranteed issue, community rating — those are the failed hallmarks of a failed regulatory regime that has done real damage to a state and its citizens. I encourage Congress to avoid doing to the nation what New Jersey has done to itself.

Mr. PALLONE. Dr. Scheppach—I had to ask how to pronounce it.

STATEMENT OF RAYMOND C. SCHEPPACH, PH.D.

Mr. SCHEPPACH. Thank you, Mr. Chairman. I appreciate the opportunity to appear before you today on behalf of the Nation's Governors.

I will very quickly focus on six issues, the first with respect to the insurance reforms.

Although we agree that the Federal Government probably should set the market rules with respect to guaranteed issue and renewability, we think the rate bands in the bill are too narrow. They should be broader so that States have the ability to go above those particular minimums.

We are also very concerned that a lot of the State insurance reform is being preempted essentially by the Health Choices Administration in the bill. We think that States do a relatively good job of protecting consumers, but we think that the bill is going to add a lot of confusion with respect to who does regulation and who does enforcement. Is it the State, is it the Department of Labor, is it the independent agency or the Department of Human Services?

Finally, I think there is going to be a real challenge in setting of market rules outside the exchange to be consistent with the ones in the exchange, because different rules would likely perpetuate the risk selection and fragmentation that exists in the marketplace today. With respect to the health insurance exchanges, it seems that the draft bill creates a super independent agency, the Health Choices Administration, to make just about every decision with respect to exchanges. There does not seem to be any clear advantage for States to design and administer the exchanges, and yet they have the expertise and capability and I think it is very important that the other subsidized population needs to be well coordinated with Medicaid.

The bottom line is, given the rigidity of the administrative rules here, I question at this time whether a substantial number of States would actually opt in to the system.

With respect to the Medicaid expansion, while governors differ somewhat on the Medicaid expansion, my sense is that they would question the necessity of increasing the eligibility of childless adults and parents over 100 percent of poverty. It seems that these individuals could be made directly eligible for the other subsidy and receive their benefits through the exchange.

Governors do, however, very much appreciate the fact that the committee is willing to have the Federal Government pay 100 percent of the expansion. The phased-in mandate to increase reimbursement rates for primary care physicians give States pause, but we do realize that it is a very, very small percentage of the total reimbursement rate.

Governors do support the choice for individuals to move out of Medicaid into the exchange. However, we would not support requiring States to provide the wraparound benefit. This would also include the CHIP population. The problem is that the wraparound benefit is administratively difficult, and maintaining the additional benefits may weaken the negotiating power of the exchange in receiving the most competitive prices.

With respect to the dual eligibles, there is a number of provisions in the bill that we do think strengthen the integration of the dual eligibles, so governors are generally supportive of those provisions. And, also, with respect to the drug benefit rebates and a number of the provisions there, governors support that as well.

Just one final comment on the transition, that if and when this bill passes it is going to be a huge implementation role for States and others; and, therefore, I think that the bill should include specific provisions about some up-front money for States to build capacity to implement as well as certain certifications when the insurance reforms are done and what other components are willing to be administered.

Clearly, you have got to coordinate the individual mandate, the other subsidized population, as well as the employer mandate in the bill.

Thank you for the opportunity to testify. I look forward to working with the committee as you move the bill forward.

Mr. PALLONE. Thank you.

[The prepared statement of Mr. Scheppach follows:]

Written Testimony for the House Subcommittee on Health of the Energy and Commerce Committee

Presented by the National Governors Association Executive Director Raymond C. Scheppach, Ph.D.

June 24, 2009

Mr. Chairman and members of the subcommittee, my name is Ray Scheppach, and I am the Executive Director of the National Governors Association. I appreciate the opportunity to be a part of this panel on behalf of the nation's Governors to discuss health reform and specifically the important issues involving health care coverage. We are prepared to work with federal policymakers to ensure that reforms are workable, cost-efficient, and sustainable over the long-term.

Need for Comprehensive Reform

Governors understand the vital role that health plays in productivity, competitiveness and quality of life and have made providing cost effective health care to their citizens a top priority. Given its unsustainable course, significant reforms of the health care system are necessary.

More than 45 million Americans are currently uninsured, and millions more are underinsured. Achieving greater access to affordable, quality health care is a critically important goal. However, health reform proposals must recognize that changing any one component will have direct and indirect impacts on other aspects of the health care system, and therefore, reform must move on parallel tracks to expand coverage, improve quality, and contain costs.

Governors' Views on Health Care Reform

Within the discussion on health care coverage, we wish to share the views of governors in five basic areas:

1. Insurance Regulation
2. Medicaid
3. Exchange Mechanisms
4. Long Term care and the Dual Eligibles
5. Transition Timelines

1. Insurance Regulation

While states are supportive of having the federal government establish certain insurance market reforms on such issues as guaranteed issue, health care reform should not diminish or impede the long standing establishment of state regulation of health insurance.

States strongly encourage federal policymakers to avoid measures that would preempt stronger state laws and regulations, and urge that any federal standards operate as floors rather than ceilings. Among the many regulatory authorities that should remain under state determination are to ensure the solvency of health insurance plans, and the enforcement of marketing requirements on those plans; the proper licensure of providers; and the protection of consumer rights and benefits.

2. Medicaid

Governors recognize Medicaid's important role in meeting the needs of our most vulnerable populations and they are committed to modernizing the program so that it better responds to their needs. There are several aspects of this transformation that I wish to highlight.

Governors understand that proposals under consideration would eliminate the categorical nature of the Medicaid program for individuals under a certain income threshold. While there is a reasonable case for streamlining eligibility policies, proposals to mandate a significant expansion of the Medicaid program raise important questions and some concerns.

Medicaid (Costs) — First of all is the cost. Governors oppose changes to the Medicaid program that will result in an unfunded mandate imposed on the states. Any increase in the mandatory minimum eligibility threshold will cost states tens of billions of dollars per year. States must take into consideration not only the actual cost of including additional individuals on the rolls, but also the complex interaction of reimbursement rates and access.

With any coverage expansion, states must consider the direct and indirect impact on provider reimbursement rates as well as health care workforce capacity, particularly primary care providers. There simply are not enough providers willing to treat additional Medicaid enrollees with complex conditions and situations at current reimbursement rates. Currently, Medicaid reimbursement rates average 72 percent of Medicare rates nationwide, and Medicare rates are often significantly lower than rates paid by private insurance. Those states that have already experimented with expanding Medicaid coverage broadly have demonstrated that Medicaid reimbursement rates must be increased to approximately Medicare rates to ensure access.

Combining the existing program expenditures with those required to meet new requirements and needs, without other changes to the program or adequate federal funding, could overwhelm states' budgets. Our initial estimate of the state impact of the Medicaid expansion as described in the Senate Finance Committee's proposal, including the reimbursement rates increases that would be necessary to ensure access would cost tens of billions of dollars per year in state funds alone. This would represent a significant percentage of total state general revenues.

Finally, Medicaid has become the nation's de facto source of long-term care coverage as well as a critical source of coverage for individuals eligible for both the Medicare and Medicaid program –

known as the dual eligibles. I will discuss those two issues later, but it is critical to remember that Medicaid's continued coverage of these responsibilities may be fiscally incompatible with an increased role in coverage of all low-income Americans.

States are in dire financial straits now and any additional costs in the short run must be 100 percent federally financed. Furthermore, future projections of state fiscal capacity show a slow recovery and weak growth in the long run. This will necessitate permanently increasing the federal share of the program to account for not only the increased eligibility and reimbursement rates, but also the demographic trends for long term care, which alone could bankrupt the states.

Medicaid (reforms) — States would also like to work with federal policymakers to do more to streamline the Medicaid program and eliminate cumbersome requirements which make the program difficult to administer and sometimes work against the interests of both beneficiaries and taxpayers. For example, some of the proposals being considered by federal policymakers seek to limit the use of categorical eligibility determinations, but still leave in place a patchwork system for determining eligibility for the program and for specific services.

Should federal policymakers approve mandatory income eligibility changes, these must be balanced by the pressing need to modernize the Medicaid program as well as establish a path to incorporate state innovations as permanent parts of the state Medicaid plan. States require new flexibilities to administer a more efficient Medicaid program that better meets today's needs of low-income and vulnerable populations and reduces costs for both states and the federal government.

Specifically, states support providing new flexibility to develop evidence-based benefit packages. This could minimize complexity in determining which services are medically necessary. States need flexibility to determine which services are purchased and how they are delivered. This would help ensure that expansion populations have access to the Medicaid services they need while providing states flexibility to improve the value of services offered to beneficiaries and manage costs. In addition, if the exchange is used to connect any low-income population to Medicaid coverage, new state flexibility will be needed to break down barriers to building systems of care and supporting care coordination.

3. Health Insurance Exchanges

A properly designed health insurance exchange can help correct inefficiencies in the existing health insurance markets and should be considered in the context of other proposed reforms. If federal policymakers adopt the exchange concept, states support the following approaches for developing the exchange framework:

- Exchange mechanisms should be established, operated, and regulated at the state-level. States also should retain the right to establish and participate in no more than one multi-state based exchange. Enhancing the ability of states to establish such mechanisms could help realize efficiencies in the health insurance marketplace as well as coordination between Medicaid and other subsidized populations.
- The number of exchanges in a state should be limited to one and no other exchange should preempt, compete, or interfere with state and multi-state based exchanges. The presence of multiple exchanges in a state is likely to perpetuate competition based on risk minimization.

- State flexibility is needed to design the structure, specify the functions, and determine how insurance products operate within a marketplace that has an exchange. This state-based approach can minimize disruption in the marketplace, ease the transition of market reforms for all stakeholders, leverage existing state infrastructure and public-private partnerships, and avoid disruption of the reforms already underway in some states.
- Provide federal support for start-up costs for state and multi-state based exchanges.
- Preserve the right of states to collect health insurance premium taxes on insurance businesses offered through the exchange.

4. Long Term Care and the Dual Eligibles

It is clear that Medicaid can no longer be the financing mechanism for the nation's long-term care costs and other costs for individuals eligible for Medicare and Medicaid – known as the dual eligibles. The demographic changes and escalating costs for services and new technologies make it critical for states to begin to transition to the federal government much of their current financial responsibility in Medicaid for financing of long-term care. Postponing the discussion on long-term care services and supports perpetuates the fragmented system of care that exists today. Efforts to improve the financing mechanisms, care coordination and quality of long-term care services and supports can be complementary and very important in the efforts related to strengthening the rest of our health care system.

Additionally, more than seven million Americans are dually eligible for full Medicare and Medicaid benefits, and nearly two million others receive financial assistance to cover out-of-pocket costs, such as co-payments and deductibles. These individuals represent just 18 percent of Medicaid's caseload, and despite the fact that they are fully insured by Medicare, a disproportionate percent of all Medicaid expenditures is consumed by filling in the gaps in Medicare services. In fact, they are responsible for over 42 percent of all Medicaid expenditures and 24 percent of Medicare expenditures ($250 billion in FY2008).

Health care reform must include a streamlining of the current dysfunctional silos that dual eligibles currently access. There are at least two options for approaching this challenge. Full federalization of financing the care for this population would serve many policy goals, including creating enormous efficiencies and savings for both states and the federal government and treating the most medically fragile citizens in a holistic manner that dramatically improves the quality of their health care.

Alternatively, if the federal government does not provide the financing to improve the care of these beneficiaries, provide states with the tools to do so. Despite recent state and federal efforts to address structural problems, the existing system for dual eligibles is predominantly a fragmented, uncoordinated, and inefficient system of care. Misaligned benefit structures, opportunities for cost-shifting, and unresolved tensions between the federal and state governments as well as an uncoordinated system of care for beneficiaries remain. Specifically, states must be credited for generating savings to Medicare when making Medicaid investments for this population. States also should have a certain level of influence over the coverage and financial decisions being made for the duals. And certain administrative rules and policies between Medicare and Medicaid must be streamlined to improve care for the dual eligibles.

In addition to specific reforms to improve care for the dual eligibles, a stronger, more equitable partnership between Medicare and states is essential to the success of health reform efforts. Medicare has significant influence in shaping cost and coverage decisions in the public and private domain and thus has a tremendous impact on health care trends. Yet Medicare largely is not engaged in state specific health reform initiatives which involve both public and private stakeholders.

5. Transition Timetable

Federal policymakers should work with states and the territories to determine an appropriate transition and implementation timeline for all health care reform changes. This includes changes both to state administered programs such as Medicaid and the Children's Health Insurance Program (CHIP), as well as any national reforms to the health insurance marketplace. It also may be helpful to have early planning grants to states while the federal government promulgates rules. It also would involve general certifications by governors at given benchmarks.

Significant health care reforms will require a lengthy process of state, federal, and market changes. This includes sufficient transition time for any coverage expansions, the proposed removal of income disregards, changes to benefit package requirements and services, new requirements which may involve a health insurance exchange entity, and other changes being considered.

States also urge federal policymakers to consider the health care workforce capacity, particularly with regard to the implementation of any coverage expansions that may be approved. Proposed coverage and delivery system reforms must be coupled with federal support for developing and retaining health care workers who are prepared to deliver quality care across the health care spectrum.

Conclusion

Any reforms approved at the federal level must allow states flexibility to adapt to local conditions and retain the primary state roles of administration, regulation, and consumer protection. It is also important that this framework support the role that states play in innovations around delivery system reform and value-based purchasing.

If a federal framework is developed it should include sustainable, sufficient financing mechanisms (through a combination of public programs and private sector incentives) to ensure that coverage and delivery system reform goals can be met. On their own, states are not well-positioned to sustain increases in their health care budgets.

Governors look forward to working with our federal partners on a bipartisan basis to address these important issues.

Mr. PALLONE. Mr. Freeman.

STATEMENT OF ROBERT S. FREEMAN

Mr. FREEMAN. Mr. Chairman, members of the committee, my name is Robert Freeman; and I am here to represent five publicly run health plans that administer the Medicaid, SCHIP, and other programs for low-income individuals. We currently serve 9 and soon to be 11 California counties, and our group is the California Association of Health Insuring Organizations.

Today, I hope to provide a local perspective of what is currently being accomplished by our publicly sponsored health plans in California. I do so in the hopes that it may serve this committee as it addresses the massive task of national health care reform.

I would like to briefly describe how our health plans operate. I hope that it will further discussion by policy makers in relation to the health care delivery administration at the local level as opposed—I mean, in addition to the State and national level.

County organized health systems are one of two public plan models in California, and we have been in existence for over 25 years. My plan, CenCal Health, was the first, beginning operations in 1983. Since that time, four other county organized health systems have been established in California and one in Minnesota. These five plans have built on their success and will soon be effectively providing access to high-quality health care to over 880,000 individuals. That is larger than 25 State Medicaid programs.

Our governing boards consist of local government officials, physicians, hospital administrators, plan members and other health providers. We are independent of county government and function as a business. Although we are public entities, we have no guarantee of perpetuity so, like a business, if we don't do our jobs well, we can go away. We also operate full-risk contracts with the State of California, necessitating efficiency and innovation.

We are cost-effective. In relation to CenCal Health, 92 cents out of every dollar goes to the direct provision of health care services.

Further, the California legislative analysts, which is similar to the Congressional Budget Office, has stated that county organized health systems annually save the State of California $150 million over what it was would otherwise spend on its Medicaid program. As public entities, all governing board meetings are public, and board decisions are made in an open and transparent environment.

Our plans also have broad-based provider networks. We found the policy of broad-based provider networks to be very effective in both providing member choice and building community support.

Speaking of my own plan, we have approximately 90,000 members and have 289 primary care physicians, 1,200 specialists, 9 hospitals, and 113 pharmacies who serve our population in two counties.

We also believe that our broad-based provider policies have contributed to the high quality of care we provide to our members. The State of California has a series of indicators that annually measures to assess access to care and quality of care levels, mostly preventive. County organized health systems are consistently high performers in relation to these measures. We also score well in biannual consumer satisfaction surveys.

With this in mind, we believe that the public health plan concept currently works at the local level in relation to our plans. Further, in relation to the SCHIP program in California, public plans compete with private plans effectively and fairly, with neither private nor public model working from a disadvantage.

In the areas of Medicaid expansion and creating vehicles who serve currently uninsured, we are in favor of both concepts. Expanding the Medicaid programs is an existing means to provide health coverage to currently uninsured individuals. The infrastructure to provide the care already exists, as do significant State and Federal standards, requirements, and regulations to protect members, providers, and others.

The health insurance exchange concept outlined in the draft legislation seeks to create a fair and reasonable means of providing access to care and quality of care and choice. We do suggest that extra care be given to ensure the development of a health exchange will do no harm to existing health care programs and safety nets in our communities that currently work well. Our association believes the transparency provisions in the draft legislation are essential to build and maintain public trust in the delivery system.

I will conclude my remarks by requesting the committee to take a good look at local delivery of health care options in relation to national health care reform. We believe including such a local component would promote community involvement, investment, and enthusiasm in national health care delivery as all health care delivery is local.

Thank you for your time.

Mr. PALLONE. Thank you, Mr. Freeman.

[The prepared statement of Mr. Freeman follows:]

WRITTEN TESTIMONY OF ROBERT FREEMAN
HOUSE ENERGY AND COMMERCE COMMITTEE
SUBCOMMITTEE ON HEALTH
WEDNESDAY, JUNE 24, 2009

Thank you for this opportunity to provide testimony on the Draft Health Care Reform Legislation, released by the House Energy & Commerce Committee on June 19, 2009. I am Robert Freeman, Deputy CEO of CenCal Health, a County Organized Health System (COHS) that administers the Medicaid, Children's Health Insurance Program (CHIP), and other publicly-sponsored health care programs in Santa Barbara and San Luis Obispo Counties, California. I also represent the California Association of Health Insuring Organizations (CAHIO), the association of California's five (5) COHS plans.[i]

California operates the largest Medicaid program in the nation.[ii] Public plans[iii], including COHS plans, serve 20% of this Medicaid program. In fact, California's public plans serve more beneficiaries than the Medicaid programs of 46 other states. COHS plans serve more beneficiaries than the Medicaid programs of 25 other states.[iv] The success of COHS plans over 25 years in creating cost-effective delivery systems for vulnerable populations can inform this Committee. Moreover, our record of ensuring transparency to our communities can help Congress address the demands of American taxpayers for accountability from publicly funded programs.

My written testimony is divided into three (3) sections: (1) CAHIO's support for health care reform; (2) key accomplishments of the COHS plans that can guide the Committee; and (3) specific comments on the Draft Legislation.

I. CAHIO strongly supports health care reform.

CAHIO supports meaningful health care reform. Now is the time for health care reform. Health insurance premiums continue to rise at alarming rates; more and more individuals and businesses find health insurance too costly to afford; and the number of uninsured Americans continues to grow. As a result of these conditions, increasing health care costs represent a growing risk to American businesses and families. Further, local health care safety nets are under increased stress as they attempt to address the needs of American families.

CAHIO supports efforts to stabilize the Medicaid Program. California's public plans cover more Medicaid beneficiaries than the Medicaid programs of 46 states. As part of that system, COHS plans can serve as a model to expand coverage for new populations. Secondly, CAHIO applauds this Committee for recognizing the need to increase federal funding to expand and improve provider participation in the Medicaid program.

CAHIO believes the experience of existing public plans have had a positive impact in the delivery of health care in their communities. COHS plans have earned the trust of their communities by ensuring transparency in the delivery of health care services. COHS plans promote the accountability that Americans deserve and demand from publicly funded programs and institutions.

II. COHS accomplishments can guide this Committee.

COHS plans are critical to the nation's largest Medicaid program. COHS plans cover more Medicaid beneficiaries than the Medicaid programs of 25 states. As part of California's Medicaid managed care system, COHS plans:

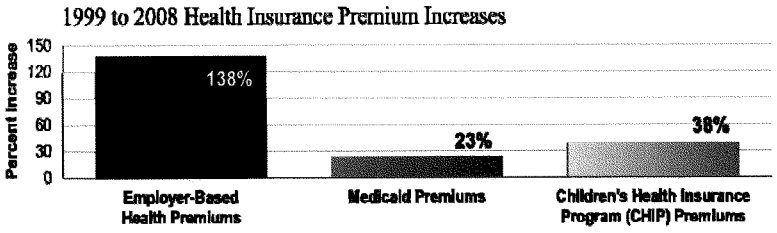
- Serve all populations, including dual eligibles (Medicaid and Medicare) and persons with disabilities
- Create meaningful provider networks that
  - Include traditional and safety net providers
  - Support creation of a 'medical home'
- Offer programs that their communities need
  - 4 COHS plans that offer CHIP:
    - Serve more CHIP beneficiaries than 33 states[v]
    - Successfully compete with commercial insurance plans
    - Serve as the designated Community Provider Plans in their counties
    - Rated among the highest performing plans in quality
  - 3 COHS plans that offer Medicare Advantage Special Needs Plans (MA SNPs):
    - Serve 20,000 or 17% of the state's beneficiaries in MA SNPs
    - Serve more dual eligibles in MA SNPs than are served in MA SNPs in 34 States[vi]

COHS plans promote transparency and accountability. Specifically:

- County Supervisors appoint COHS plan governing boards
- COHS Board meetings are open to the public
- COHS keep administrative costs low, the lowest in California[vii]

COHS Plans are cost-effective:

- COHS plans save $150 million in State General Fund Medicaid costs annually when compared to Medicaid fee-for-service (FFS).[viii]
- Along with California's other public plans, they demonstrably restrain spending in public programs.[ix] The following chart shows the dramatic impact of California's public plans in restraining health care spending



III. CAHIO offers the following preliminary comments on the Draft Legislation:

A. CAHIO supports the Committee's approach. CAHIO applauds the Committee for its commitment to build on what works in the health care system and fix what is not working. CAHIO represents a proven model of delivering publicly funded health care programs that are responsive and accountable to local communities. We urge the Committee to build on this model.

B. CAHIO supports the Committee's expansion and support for the Medicaid program. CAHIO supports the Committee's recommendation that the federal government fund increases in Medicaid payments for primary care physicians to 80% of Medicare rates in 2010, to 90% in 2011, and 100% in 2012 and thereafter. CAHIO strongly supports such increased support for the Medicaid program. CAHIO believes that the Medicaid program can serve as the basis for serving expanded populations effectively and efficiently and applauds Congress for appropriately funding this critical program.

C. CAHIO supports vehicles to enhance clarity in the healthcare marketplace. CAHIO supports the concept of creating a vehicle to allow plans to serve expanded populations of Americans currently without health insurance. CAHIO believes that a health insurance exchange could promote clarity in the health care marketplace so that American families can better make informed choices. We applaud the Committee for requiring participating plans to explain their coverage in plain language so that American families can make better understand the benefits their plan covers, as well as the costs of such a plan. CAHIO plans have a long history of ensuring that our plan services are delivered in a culturally and linguistically accessible manner to our members.

   Further, CAHIO recognizes the Committee's rationale for creating a public plan option that would compete with private insurers within a health insurance exchange. As a critical component of California's managed care delivery system, COHS plans can offer the Committee examples of how California's public plans have enhanced the delivery of publicly funded health care programs, including Medicaid, CHIP, and MA SNPs. For example, California's CHIP program allows for competition among all plans to deliver CHIP benefits to eligible families. Public and private plans compete on a level playing field for membership. They also compete for the "Community Provider Plan" designation, which the state awards to the plan that utilizes safety net providers to the greatest extent, and allows that plan to charge a reduced premium. This system has proven very effective over the last decade in promoting fair and effective competition between public and private health plans, giving the member a clear choice of health plans, and protecting the safety net.

D. CAHIO supports the Committee's focus on ensuring the delivery of quality heath care services to all Americans. Specifically, CAHIO supports payment mechanisms to promote better coordinated care by rewarding physicians that provide high quality care at reasonable costs to their patients. CAHIO strongly supports the creation of a medical home for members by promoting the role of primary care physicians and ensuring access to primary care providers. We have a long history of promoting coordinated care for vulnerable populations, and support mechanisms that will enhance such coordination.

For more information regarding this testimony, please contact:
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(805) 562-1011

CAHIO Contact:
Jack Horn, CEO, Partnership HealthPlan of California and CAHIO Chair
(707) 863-4241 www.cahio.org

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[i] Attachment A, COHS Plan Summary, as of April 2009
[ii] Attachment B, COHS Summary of California's Medicaid Managed Care Plans
[iii] Public Plan is defined as a managed care program contracting in areas specified by the director for expansion of the Medi-Cal managed care program under California Welfare & Institutions Code, Section 14087.3(d)(1):, or Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, or 14087.96.
[iv] Kaiser Family Foundation, State Health Facts, 2006 data for individual states (www.statehealthfacts.org)
[v] Kaiser Family Foundation, Monthly CHIP Enrollment, June 2007, (http://www.statehealthfacts.org/comparemaptable.jsp?ind=236&cat=4), and Managed Risk Medical Insurance Board, HFP Monthly Enrollment by County by Health Plan, April 2009
[vi] CMS SNP Comprehensive Report – May 2009,
(http://www.cms.hhs.gov/MCRAdvPartDEnrolData/SNP/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=descending&itemID=CMS1222662&intNumPerPage=10)
[vii] CMA 15th Annual Knox-Keene Health Plan Expenditures Report, June 2008 for Fiscal Year 2006-07
[viii] An SOS for the COHS: Preserving County Organized Health Systems, Pacific Health Consulting Group, funded by the David Lucille Packard Foundation, 2004, (http://www.pachealth.org/does/PackardReport0504Final.pdf)
[ix] Kronick, Richard, Understanding the Slow Growth in Medi-Cal and Healthy Families Premiums, 1999-2009,
(http://www.ucop.edu/cpac/documents/cpacfindings_kronick.pdf)

ATTACHMENT A:

WRITTEN TESTIMONY OF ROBERT FREEMAN
HOUSE ENERGY AND COMMERCE COMMITTEE
SUBCOMMITTEE ON HEALTH
WEDNESDAY, JUNE 24, 2009

COHS Plan Summary

as of April 2009

COHS Plan	Established	Counties	Medicaid Members	CHIP Members	MA SNP Members	Other Members
CalOptima	1995	Orange	329,000	33,000	8,800	1,100
CenCal Health	1983	Santa Barbara, San Luis Obispo	85,000	7,000	.....	2,300
Central California Alliance for Health[1]	1996	Santa Cruz, Monterey, Merced*	160,000**	20,000	.....	2,600
Health Plan of San Mateo	1987	San Mateo	49,500	6,300	7,400	21,900
Partnership HealthPlan of California	1994	Solano, Napa, Yolo, Sonoma*	142,000**	N/A	3,500	1,800
Totals	**NA**	**11 Counties**	**765,500**	**66,300**	**19,700**	**29,700**
Percent of State[2]	**NA**	**19%**	**21%**	**7%**	**17%**	**NA**

*Beginning 10/1/09

**Includes new membership expected 10/1/09

Totals membership served: 881,200

[1] Previously Central Coast Alliance for Health

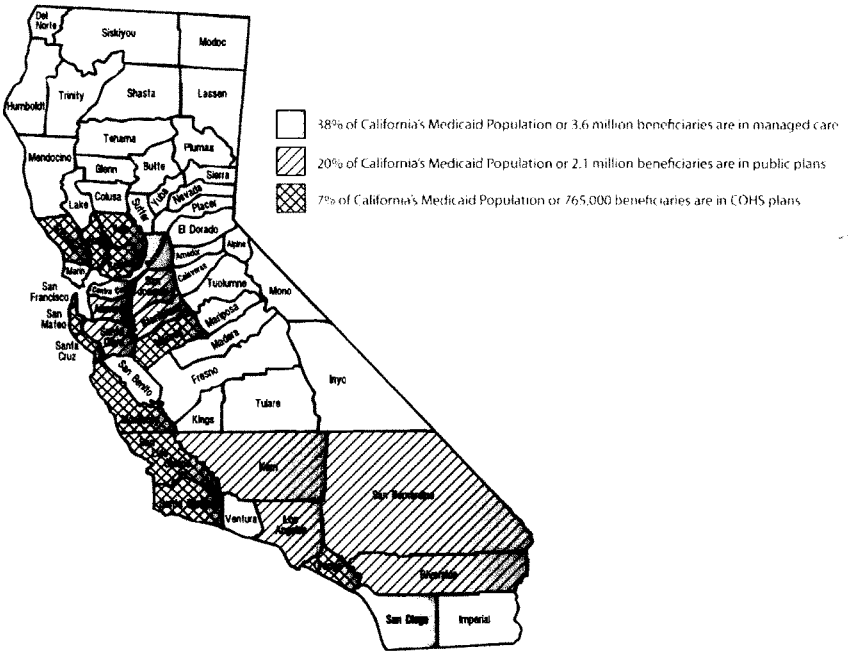
[2] DHCS Managed Care Capitation Report - April 2009, (http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Fin_Rpts/APR2009CapReport.pdf)

ATTACHMENT B:

WRITTEN TESTIMONY OF ROBERT FREEMAN
HOUSE ENERGY AND COMMERCE COMMITTEE
SUBCOMMITTEE ON HEALTH
WEDNESDAY, JUNE 24, 2009

COHS Summary of

California's Medicaid Managed Care Plans



* As of 10/01/09, Merced County will join Central California Alliance for Health and Sonoma County will join Partnership HealthPlan of California

Mr. PALLONE. Mr. Pollack.

STATEMENT OF RON POLLACK

Mr. POLLACK. Thank you, Mr. Chairman. Thank you and members of the committee for your prodigious patience. Very much appreciated.

I want to thank you for the draft bill that has been offered. We think it goes in the right direction for a number of reasons. I was asked by the staff to focus my remarks on the changes with respect to the Medicaid program, and so I will focus my comments on that.

As you know, Medicaid provides coverage today for almost 60 million low-income people, approximately half of whom are children; and we think that Medicaid is the right vehicle to provide coverage for the poor. Medicaid provides certain things that simply don't exist today in the private marketplace that I think are absolutely critical for low-income populations.

A recent article in Health Affairs pinpointed how important it is to provide cost-sharing protections for low-income people; and if they don't have those cost-sharing protections, it means they are unlikely to get the services that they need.

Well, Medicaid rises to that challenge. Medicaid does not require premiums or enrollment fees. Copayments for individual services are limited normally to nominal amounts. Certain kinds of services are exempt from cost sharing, things like preventive care for children, emergency services, pregnancy related services; and certain populations also are exempted from cost sharing: foster children, hospice patients, women in Medicaid, breast or cervical programs. These are very important protections that simply do not exist in the private sector.

But, over and above that, Medicaid provides certain kinds of services. For example, for children, early and periodic screening, diagnosis, and treatment was very important so that children get preventive care and any diagnosis that shows that something needs to be taken care of does get treated. Transportation is provided to doctors' offices for appointments and to community health centers. There are appeals rights that are very important that do not exist in any similar robust fashion in the private sector.

There aren't insurance market problems like you have in the private sector, kinds of problems that would be corrected over time with the bill that you have introduced.

Medicaid provides good health outcomes. As the Kaiser Commission on Medicaid and the Uninsured reported in May of this year, those in Medicaid are less likely to lack a usual source of care. Obviously, that is true, compared to the uninsured, but it is also true compared to those with private insurance. They are more likely to have a doctor's appointment in the last year. They do not have an unmet health need with the same frequency as those who are uninsured and those that have private insurance. Low-income women are more likely to have a pap test in the past 2 years.

So Medicaid does provide very significant services for this important population, and it does so while costing approximately 20 percent less to cover people in Medicaid than it would cost if they purchased coverage in the private market.

Now, building on Medicaid and strengthening the eligibility standards is something that I believe is close to consensus agreement. There was huge support for this from the various stakeholders: American health insurance plans, Blue Cross/Blue Shield, American Medical Association, American Hospital Association, AARP, NFIB, Chamber of Commerce, Business Roundtable. We all reached agreement about the importance of doing this.

And one of your favored colleagues of the past, Billy Tauzin, and we at Families USA have agreed that it is very important to extend eligibility, as this draft bill does, to 133 percent of the Federal poverty level.

So I want to concentrate on why I think that measure is so important. We have huge differences today between different populations, children, their parents, and other adults who do not have dependent children. For children, due to the confluence of the Children's Health Insurance Program and Medicaid, in almost every State children are eligible for coverage if their income standards are below, family standard is below 200 percent of poverty. And in some States, as you know, Mr. Chairman, some States have exceeded that.

However, for parents, in only 16 States and the District of Columbia does the eligibility standard even reach the Federal poverty level, which, mind you, for a family of three is only $18,310. Indeed, the median income eligibility standard among the 50 States, as you will see in the chart at the end of my testimony, is only 67 percent of the Federal poverty level, roughly $12,300 for a family of three.

Mr. PALLONE. Mr. Pollack, you are a minute over. If you could summarize.

Mr. POLLACK. I apologize. I would just say I think this would be very helpful if we did extend eligibility, irrespective of family status; and I am glad that the committee appears to want to go in that direction and pay for those costs. Thank you.

Mr. PALLONE. Thank you.

[The prepared statement of Mr. Pollack follows:]

Written Statement for the Record by
Ron Pollack, Executive Director, Families USA

For the U.S. House of Representatives
Energy and Commerce Committee
Health Subcommittee

Hearing on Health Care Reform

June 24, 2009

Mr. Chairman, Members of the Subcommittee,

Thank you for inviting Families USA to participate in today's hearing on health care reform. Families USA is the national organization for health care consumers. Our analysis of the House bill, grounded in our consumer perspective, finds that the House bill will provide significant help to *both* uninsured and *insured* Americans. We applaud the three House Committees that worked cooperatively to draft this proposal. It will end discrimination and unfair practices by insurance companies, make high-quality health insurance coverage truly affordable for hard-working families, give Americans the choice to keep the coverage they have now or choose from new options, and make sure that all Americans have access to health insurance coverage we can count on to protect our families.

From our perspective, the House bill achieves the two most important core goals for health care reform: that everyone who currently has satisfactory health care coverage can keep that coverage, and that those who do not currently have health care coverage can get it. We believe that the most effective and efficient way to achieve both of those goals is to build upon the existing health care system. The House bill does just that in the following ways:

- It strengthens employer-based health coverage by improving regulation of the market,
- It subsidizes coverage for those workers with low and moderate incomes to enable them to obtain and keep health coverage, and

- It expands the Medicaid program to fill in the gaps for low-income people whose needs are not met by private health insurance.

Today, I would like to focus my comments on why expanding the Medicaid program is the best approach to expanding coverage for low-income people. There is no question that moderate-income individuals will benefit greatly from the subsidized coverage available in a reformed private insurance market as contained in the House bill. But for the lowest-income Americans, the most appropriate coverage vehicle is undoubtedly the Medicaid program. Medicaid is specifically designed to meet the unique needs of low-income people with complex health care needs, while the private insurance market is not.

That Medicaid is the best way to provide coverage for people with low incomes is widely acknowledged by health care stakeholders. In fact, virtually all major health care stakeholders—including the American Medical Association, the American College of Physicians, the Federation of American Hospitals, the U.S. Chamber of Commerce, the National Federation of Independent Businesses, the Business Roundtable, the AARP, the Pharmaceutical Researchers and Manufacturers of America, and America's Health Insurance Plans, to name only a few—are on record expressing support for serving the lowest-income populations through Medicaid. These diverse groups recognize that the Medicaid program provides unique services and protections for our most vulnerable Americans.

The public also supports expanding Medicaid. An April 2009 Kaiser Health Tracking Poll found that 77 percent of the public support or strongly support expanding government health insurance programs for low-income people.[1]

Medicaid Meets the Unique Needs of Low-Income People

Medicaid is already the backbone of the health care system for the most vulnerable Americans. It covers approximately 60 million low-income people: 29.4 million children, 15.2 million adults, 6.1 million seniors, and 8.3 million people with disabilities. What's more, it is specially designed to meet the unique needs of these populations, who tend to be sicker and have more intensive health care needs than the general population.[2]

Medicaid is the most efficient and effective way to cover more low-income Americans who cannot obtain coverage in the private market. Every state already has a Medicaid program with an existing provider network and administrative infrastructure. It makes sense to build on this foundation, particularly since it has a proven track record of effectively serving low-income individuals.

A few people have claimed that the Medicaid program suffers from inefficiencies due to waste, fraud and abuse by providers and consumers. This is simply not true. Medicaid, in fact, is actually *more efficient* at covering low-income people than private coverage. After controlling for health status (since Medicaid enrollees tend to have greater health care needs), it costs at least 20 percent *less* to cover low-income people in Medicaid than it does to cover them in private health insurance.[3] In this cost-conscious climate, it only makes sense to expand coverage in the most cost-effective ways possible. The most cost-effective way to expand coverage for low-income uninsured people is Medicaid.

Both the federal government and states have taken steps in the last several years to improve oversight and enhance Medicaid program integrity to ensure that all of the resources supporting the Medicaid program are used to provide high-quality, comprehensive health care. The House bill includes additional funding to improve even further on these efforts and requires that Medicaid providers adopt programs to reduce waste, fraud and abuse.

Cost-sharing protections

Medicaid includes very important protections against out-of-pocket costs to ensure that these costs do not prevent people from getting the health care services they need. Unlike private health insurance, Medicaid typically does not require premiums or enrollment fees, and there are limits concerning how high other forms of cost-sharing can be. Certain services (preventive care services for children, emergency services, pregnancy-related services, and family planning services) and certain populations (children of certain ages and incomes, foster children, hospice patients, institutionalized patients, and women in the Medicaid breast or cervical cancer programs) are exempt from any kind of cost-sharing, and copayments on individual services are limited to so-called "nominal" amounts of a few dollars or less.

These protections are absolutely imperative to the success of the Medicaid program for low-income people. Low-income adults with private insurance pay more than six times as much on out-of-pocket costs as do low-income adults with Medicaid.[4] Research abounds demonstrating the serious burden these out-of-pocket health care costs can pose for low-income people. A study published in *Health Affairs* in early June found that even minimal cost-sharing requirements would greatly increase the financial burden low-income families face.[5] When people cannot afford these costs, they often delay or forgo care, which can result in more costly complications later on. Because Medicaid incorporates such strong cost-sharing protections, people enrolled in Medicaid are more likely to get the care they need, when they need it.

Comprehensive benefits

Medicaid's comprehensive benefits package ensures that the program provides appropriate coverage to people with diverse health care needs. For example, Medicaid has specific protections that are designed to ensure that children get both preventive care and treatments for any health complications they may have (referred to as Early and Periodic Screening, Diagnosis, and Treatment, or EPSDT, services). Medicaid also covers services that low-income people need that are not usually covered in private health insurance. For example, Medicaid covers transportation to doctors' appointments, services that help people with disabilities live independently, and services provided at rural and community health centers. It is unlikely that a private health insurance plan would ever cover these services.

Medicaid is also a key source of coverage for people who are very sick or who have disabilities. While most private health plans have annual or lifetime maximums that people with intensive health care needs can quickly exceed, Medicaid has no such limits. It provides coverage to all those who need it, even people with serious health care problems, whom the private market is simply not interested in serving. Similarly, while private coverage often excludes coverage for pre-existing health conditions, people enrolled in Medicaid are guaranteed to receive the health care services they need, regardless of any past or current health care problems. The Medicaid benefits package is specifically designed to meet the health care needs of low-income individuals, and, as a result, people enrolled in Medicaid are less likely than both the uninsured

and those with private coverage to lack a usual source of health care or to have an unmet health care need.

Medicaid appeal rights and protections

Because low-income people cannot afford health care services that are not covered by their insurance, Medicaid's appeal rights are particularly important. These rights ensure that low-income people who are sick can appeal coverage denials without jeopardizing ongoing treatment. They can also appeal enrollment or eligibility decisions, and have the right to a fair hearing. Also, unlike the private health insurance market, there are no pre-existing condition exclusions in Medicaid, nor are there waiting periods before an otherwise eligible person can enroll. Medicaid is guaranteed to be available to all who are eligible; people cannot be turned away because they are sick or have experienced health problems in the past, and they can begin receiving services as soon as they are determined to be eligible. In addition to the cost-sharing protections and the comprehensive benefits package, these design features make Medicaid particularly well-suited to providing coverage to low-income people.

People in Medicaid Have Better Health Outcomes

People enrolled in Medicaid are less likely than both the uninsured *and those with private coverage* to lack a usual source of health care or to have an unmet health care need.[6] A study published by the Kaiser Commission on Medicaid and the Uninsured in May this year found that people enrolled in Medicaid were less likely than people who were uninsured and people with private insurance to lack a usual source of care, not to have had a doctor's appointment in the last year, and to have had an unmet health care need due to costs. It also found that low-income women in Medicaid are more likely to have had a Pap test in the previous two years than low-income women with private coverage or low-income women who are uninsured (16% had NOT had a Pap in the past two years compared to 20% of those w/private coverage and 41% of the uninsured).[7]

The Importance of a National Medicaid Eligibility Floor

But under current federal and state laws, there are significant gaps in eligibility for Medicaid. To be eligible for Medicaid, a person must not only have a low income; he or she must also belong to one of the following Medicaid eligibility categories: children, pregnant women, parents with

dependent children, people with disabilities, and seniors. If a person does not fall into one of these categories, he or she can literally be penniless and still be ineligible for Medicaid. Also, because the Medicaid program is a state-federal partnership, states set their own eligibility levels. There are federal minimums, but eligibility levels vary widely from state to state. See the chart at the end of this testimony for state-by-state eligibility levels for children, parents, and childless adults.

Only 16 states and the District of Columbia cover working parents at least up to the federal poverty level ($18,310 for a family of three), and the national median eligibility level for parents is a mere 67 percent of poverty ($12,268 for a family of three). The picture is even grimmer for low-income adults who do not have dependent children: In 43 states, these individuals are ineligible for Medicaid no matter how low their income. An estimated 45.1 percent of non-elderly Americans with income below the poverty level were uninsured in 2007.

Let me give you a few examples of specific states. In Texas, a state that has traditionally had very low eligibility levels for Medicaid, a parent with two children who earns more than $4,944 in a year makes too much to be eligible for Medicaid (based on the 2009 poverty guidelines for a family of three), and adults who do no have dependent children are ineligible, even if they are literally penniless. In Michigan, a somewhat more generous state, eligibility levels are still dismal: Parents are only covered up to an annual income of $12,085 a year (for a family of three), and while Michigan provides coverage to adults without dependent children through a Section 1115 waiver, it only covers these individuals if they earn less than $3,790 a year (based on the 2009 poverty guidelines for a single adult).

Further, a study in *Health Affairs* released yesterday highlighted the importance of having the same Medicaid eligibility levels for parents and all children.[8] The study found that families with two or more children with different income eligibility levels for public health insurance programs are more likely to have an uninsured child, even if all the children are eligible for coverage. In other words, arbitrary differences in eligibility levels based on categories are as confusing and illogical to families as they are to all of us. If we want to make sure that currently eligible children are enrolled, we need to make sure that everyone in the family is also eligible

and enrolled. Families often function as family units so the Medicaid program should not arbitrarily split up families in to different eligibility units.

The House bill addresses the illogical and often gaping holes in the health care safety net by making sure that all low-income Americans are covered in all states—all Americans below 133 1/3 percent of poverty ($24,413 for a family of three). Families USA applauds the House bill for establishing a national Medicaid income eligibility floor, below which any individual is guaranteed to be eligible for Medicaid, regardless of age, parental, or health status. This will allow families with incomes below the floor to all enroll in the same coverage, which will make it easier for families to enroll in coverage, get the services they need, and stay enrolled. Moreover, it will mean that individuals who need Medicaid's protections the most will be able to get Medicaid coverage. More than one in three uninsured Americans has an income below the poverty level. This federal floor for Medicaid would significantly reduce the rate and number of uninsured Americans.

While an expansion of the Medicaid program is the best way to provide effective, efficient health coverage to these low-income uninsured people, there is no question that such a significant expansion would put significant strain on state budgets. The current Medicaid program is a state-federal financial partnership; the rising costs of health care, an aging population, and turbulent economic times have challenged states' abilities to balance the costs of Medicaid with other state funding priorities. Health reform will help improve that dynamic by lowering the rate of health care cost growth, but states will still not be able to take on the additional costs of covering such a large number of newly eligible people without significant federal assistance. The House bill strikes an important balance that will help fulfill the goals of health reform by providing full federal funding for new Medicaid coverage requirements while requiring states to maintain coverage that they are already providing.

Why Wait Five Years to Allow Low-Income People to Choose the Exchange?

The House bill includes provisions that will some allow states to choose whether to allow individuals to enroll in the exchange rather than directly in Medicaid, but not until year five after health reform is enacted. This is a critically necessary timeline. Here are some reasons why.

First, moving this additional large number of Americans into the Exchange all at once would create enormous challenges for the Exchange (or exchanges, if some states opt to create their own). It makes sense to move some populations into the Exchange (including larger employers and their workers) using a phased-in timeline. Even for the initial eligible populations, it will be extremely difficult and time-consuming to put into place all of the necessary components of an effective Exchange. We can meet the challenges, but let us not be naïve about the time it will take to do it right. There will be time needed to complete the bidding and contracting process with insurers, to establish effective education and outreach to the public, to create on-line and other screening and enrollment procedures, and to establish the tiers of benefits packages with the overlay of cost-sharing protections. We can *immediately* provide coverage through the existing Medicaid program to the most vulnerable low-income people. Lives are at stake—let's not wait.

Second, it is unclear at this point in time how the Exchange benefits packages, cost-sharing protections and other elements will look like from the perspective of low-income people. Will the needs of people at the very lowest income levels be served by the plans available in the Exchange as well as they are Medicaid? We need to be sure that coverage that does meet the needs of this very vulnerable and often sicker population is offered. The House bill requires the Commissioner to approve Exchange coverage suitable for low-income, Medicaid-eligible people before they can be given the choice to enroll in it, and if they do enroll in coverage through the Exchange, the state must provide a benefits wrap-around. These protections are critically important, but may not go far enough in guaranteeing that low-income people get the same level of coverage through the Exchange as they would through Medicaid. People with very low incomes cannot afford to pay for a service out-of-pocket; if a service isn't covered, they won't receive it. Likewise, cost-sharing requirements that are too high pose a real barrier to care for these individuals.

Third, we need to make sure that we have in place an effective outreach campaign and enrollment materials that are specifically targeted to Medicaid eligible populations. Choice is only real if we first educate low-income people about the differences—positive and negative—

between Medicaid coverage and coverage through the Exchange. For a low-income individual or family, the source of coverage can literally be a life-and-death decision, and we want to be sure that low-income people are given accurate, well-designed tools to make informed, appropriate decisions.

Improving Access to Care

As in any coverage expansion, special attention will need to be paid to ensuring that the Medicaid delivery system is retooled to handle an increase in the number of Medicaid enrollees without compromising access to care. As mentioned previously, research shows that people enrolled in Medicaid have better outcomes than low-income people with private health coverage. The House bill makes it better by including provisions that will increase the availability of primary care by increasing the payment rates for primary care providers and supporting a new pilot program for medical homes. These provisions will be important for ensuring that everyone in Medicaid has access to necessary, high-quality health care.

Conclusion

Strengthening the Medicaid safety net, improving employer-based health coverage, and bending the cost-growth curve are key components of health care reform. The House bill achieves these objectives. As a result, the bill takes important strides towards ensuring access to high-quality, affordable health coverage for all Americans. We commend the drafters of this bill, and we will work tirelessly with you to achieve its enactment.

Upper Public Program Eligibility Levels for Children and Adults (2009)

	Children (age 0-18)[9]	Parents/ Caretakers[10, 11]		Childless Adults[3]
		Non-Working	Working	
Alabama[12]	200%	11%	25%	
Alaska	175%	80%	85%	
Arizona	200%	200%	200%	100%
Arkansas[13]	200%	14%	17%	
California[14]	250%	100%	106%	
Colorado[15]	205%	60%	66%	
Connecticut	300%	185%	191%	
Delaware	200%	100%	106%	100%
District of Columbia	300%	200%	207%	
Florida	200%	21%	55%	
Georgia	235%	29%	52%	
Hawaii	300%	100%	100%	
Idaho	185%	22%	28%	
Illinois[16]	200%	185%	185%	
Indiana	250%	20%	26%	
Iowa[17]	200%	30%	86%	
Kansas[18]	200%	27%	34%	
Kentucky	200%	36%	62%	
Louisiana	250%	12%	26%	
Maine	200%	200%	206%	100%
Maryland	300%	116%	116%	
Massachusetts[19]	300%	300%	300%	300%
Michigan	200%	39%	66%	35%
Minnesota[20]	275%	275%	275%	
Mississippi	200%	25%	46%	
Missouri	300%	20%	26%	
Montana[21]	175%	33%	58%	
Nebraska[22]	185%	46%	58%	
Nevada	200%	26%	91%	
New Hampshire	300%	41%	51%	
New Jersey	350%	200%	200%	
New Mexico	235%	30%	69%	
New York[23]	400%	150%	150%	100%
North Carolina	200%	37%	51%	
North Dakota[24]	150%	45%	62%	
Ohio[25]	200%	90%	90%	
Oklahoma	185%	32%	48%	

	Children (age 0-18)[1]	Parents/ Caretakers[2, 3]		Childless Adults[3]
		Non-Working	Working	
Oregon[26]	185%	42%	67%	
Pennsylvania	300%	27%	36%	
Rhode Island	250%	175%	181%	
South Carolina	200%	49%	90%	
South Dakota	200%	54%	54%	
Tennessee	250%	73%	134%	
Texas	200%	13%	27%	
Utah	200%	40%	68%	
Vermont	300%	185%	191%	150%
Virginia	200%	24%	30%	
Washington	300%	38%	77%	
West Virginia	250%	17%	34%	
Wisconsin[27]	250%	200%	200%	*
Wyoming	200%	40%	54%	

[1] Kaiser Family Foundation, "April 2009 Health Tracking Poll," (http://www.kff.org/kaiserpolls/upload/7891.pdf).
[2] Teresa A. Coughlin, Sharon K. Long, and Yu-Chu Shen, "Assessing Access to Care under Medicaid: Evidence for the Nation and Thirteen States," *Health Affairs* 24, no. 4 (July/August 2005): 1073-1083.
[3] Jack Hadley and John Holahan, "Is Health Care Spending Higher under Medicaid or Private Insurance?" *Inquiry* 40, no. 4 (Winter 2003/2004): 323-342; Leighton Ku and Matt Broaddus, "Public and Private Insurance: Stacking Up the Costs," *Health Affairs* 27, no. 4 (July/August, 2008): w318-w327.
[4] Leighton Ku and Matt Broaddus, "Public and Private Insurance: Stacking Up the Costs," *Health Affairs* 27, no. 4 (July/August, 2008): w318-w327.
[5] Thomas M. Selden, Genevieve M. Kenney, Matthew S. Pantell, and Joel Ruhter, Cost Sharing In Medicaid And CHIP: How Does It Affect Out-Of-Pocket Spending?, *Health Affairs* 28, no. 4 (2009): w607–w619 (published online 2 June 2009; 10.1377/hlthaff.28.4.w607).
[6] Kaiser Commission on Medicaid and the Uninsured analysis of 2007 National Health Interview data
[7] *Medicaid As A Platform For Broader Health Reform: Supporting High-Need and Low-Income Populations*, Kaiser Commission on Medicaid and the Uninsured, May 2009
[8] Julie L. Hudson, "Families with Mixed Eligibility For Public Coverage: Navigating Medicaid, CHIP, and Uninsurance" *Health Affairs* 28, no. 4 (2009): w697-w709 (published online 23 June 2009; 10.1377/hlthaff.28.4.w697).
[9] The eligibility levels for children reflect the upper eligibility level for Medicaid and/or CHIP.
[10] This chart reflects different income eligibility levels for non-working and working parents because many states disregard a certain amount of earned income when determining eligibility for Medicaid.
[11] Parent and childless adult eligibility levels reflect Medicaid programs that are currently open to new enrollment, provide comprehensive benefits and cost-sharing protections, offer an adequate provider network, and allow individuals to enroll regardless of an employer decision to participate.
[12] Alabama enacted legislation in June 2009 expanding CHIP eligibility to 300 percent of the federal poverty level (FPL). Implementation is scheduled to begin in October 2009.
[13] Arkansas enacted legislation in February 2009 increasing CHIP eligibility to 250 percent of FPL. Implementation is expected to begin July 1, 2009.

[14] Infants in California (age two and under) are eligible for CHIP up to 300 percent of FPL if they are born to women on the Access for Infants and Mothers (AIM) program, unless the child is enrolled in employer-sponsored insurance or no-cost full scope Medi-Cal.

[15] Colorado enacted legislation in April 2009 increasing CHIP eligibility for children to 250 percent of FPL, and eligibility for parents in Medicaid to 100 percent of FPL. No implementation date had been set as of April 28, 2009.

[16] Illinois covers children regardless of income, but subsidies for children with family incomes over 200 percent of FPL are paid for with state-only funds.

[17] Iowa passed legislation in 2008 increasing CHIP eligibility to 300 percent of FPL in July 2009.

[18] Kansas enacted legislation in 2008 increasing CHIP eligibility to 225 percent of FPL in fiscal year 2009 and to 250 percent of FPL in fiscal year 2010; however, funding for the expansion was not approved until 2009. The expansion to 250 percent of FPL is scheduled to begin January 1, 2010.

[19] Massachusetts provides premium assistance to children with family incomes up to 400 percent of FPL, but receives no federal funding for that assistance.

[20] Infants (age two and under) in Minnesota are eligible for coverage up to 280 percent of FPL.

[21] Montana voters passed a ballot initiative in 2008 to increase CHIP eligibility to 250 percent of FPL, and the legislature approved funding for the expansion in March 2009. The expansion is scheduled to begin in October 2009.

[22] Nebraska enacted legislation to expand CHIP (Kids Connection) to 200 percent of FPL. As of June 23, 2009, an implementation date had not been set.

[23] In addition to the coverage listed above, New York also provides coverage for 19-21 year olds to 150 percent of FPL. It enacted legislation in April 2009 increasing eligibility for all adults with incomes up to 200 percent of FPL if funding is approved.

[24] North Dakota enacted legislation to expand CHIP eligibility to 160 percent of FPL. As of June 23, 2009, an implementation date had not been set.

[25] Ohio received federal permission to expand children's coverage to 300 percent of FPL in December 2008, but has not yet implemented the expansion.

[26] Oregon enacted legislation in June 2009 expanding CHIP eligibility to 200 pereent of FPL and increasing funding for the Oregon Health Plan (OHP) for adult coverage. OHP provides coverage to all adults up to 100 percent of FPL, but is currently closed to new enrollees. "Categorically eligible" parents (those who qualify as a "mandatory eligibles") can still enroll. Implementation of the CHIP expansion will begin July 1, 2009, but it is unclear when enrollment will reopen for OHP.

[27] Wisconsin subsidizes coverage for children in families with incomes up to 300 pereent of FPL with state-only funds. It also received a Medicaid waiver to provide a more limited benefit package to childless adults with income up to 200 percent of FPL.

Mr. PALLONE. I want to thank all of the panelists.

Now we are going to go to questions, and we are going to start with Ms. Schakowsky.

Ms. SCHAKOWSKY. I appreciate your beginning with me, Mr. Chairman. I really have just one question.

Mr. Freeman, I wanted to, first of all, thank you for flying from California to testify this evening. And I really want to thank all of you. I was in the State legislature in 1993 and testified at a very similar panel about what the State of Illinois was doing. So it is a little bit deja vu for me too.

I want to congratulate your county and the other California counties that operate health plans and for providing a public option for families enrolled in Medicaid and the CHIP program.

I wanted to ask you about a provision in the discussion draft that is intended to reduce waste and increase value for Medicaid taxpayers, for the taxpayer dollars that your State and the Federal Government is paying. The provision would require that all Medicaid-managed care plans have a medical loss ratio of at least 85 percent. You have already testified that your plan's medical loss ratio is a pretty remarkable 92 percent. So I think everybody understands that that means—85 percent, it would mean that of every Medicaid dollar that is paid to the plan, at least 85 cents are used to pay for health care services furnished by hospitals and doctors and other providers. No more than 15 cents on the dollar could be used for marketing administration or, in the case of private, for-profit plans, payouts to shareholders.

So do you believe that it is reasonable for taxpayers to expect that any well-managed plan, whether public or private, have a medical loss ratio of at least 85 percent? We have heard from some that that is somehow unreasonable, so I would like to hear what you say about that.

Mr. FREEMAN. Well, I will just respond from our own experience.

First of all, the California CHIP program has that requirement. So every plan——

Ms. SCHAKOWSKY. Same requirement?

Mr. FREEMAN. Yes, same requirement. And as for our plan and our sister plans, none of our plans have had an issue of meeting that requirement on a consolidated basis. It has never been an issue for us.

Ms. SCHAKOWSKY. You looked like you wanted to say something. Do you have that at all? Do you have a requirement on loss ratio?

Mr. VITALE. Yes, thank you, Congresswoman. We just changed our medical loss ratio in New Jersey from 75/25 to 80/20, which means that more money will be directed toward providers and the care that they provide to reimbursement with regard to doctors and hospitals.

It is something that works in our State. It hadn't been changed in years. So we took an incremental step. We had discussed 85/15, but we settled at 80/20, which literally puts millions of dollars more into the providers' side of the equation and a little less money into the profit side of the insurance industry.

It did not cause any disruption in the insurance industry market. A couple of small companies closed and moved out, but that was

unrelated to the 80/20 change. It is just that more money is now spent on the provider side, then less in the pockets.

Ms. SCHAKOWSKY. Does anyone else want to comment on that? Yes.

Mr. WEBBER. I just take a very different view from Senator Vitale on the issue. And in fact, Guardian, which is a not a small provider, the representative was in my office last week saying the 80 percent loss ratio made us leave the State. They simply couldn't be profitable in New Jersey after the loss ratio went to 80 percent.

And that is actually what caused the constituent that I referred to during my testimony to lose his coverage. The insurance company told him flat out that because New Jersey is going to impose an 80 percent loss ratio and because they are going to make us write in the individual market, which is not profitable for insurers in the State, we are going to pull out of New Jersey and you are going to lose your coverage.

So there is a difference of opinion from the legislators in New Jersey as to whether this 80 percent loss ratio is a good thing.

Mr. SCHEPPACH. The only comment I would make is that we are dealing with three separate populations in Medicaid. You have got the women and children, you have got the disabled, and you have got the long-term care. I am just saying that the mix there, because the disabled and long-term care are more intensive in terms of managing, if it is done correctly, integrating the services. So States that have an unusual percentage of that might have more difficulty meeting that than other States.

Mr. VITALE. I just wanted to follow up on my colleague's response to you. I appreciate your years in the State legislature and understanding the nuances of that business.

When I spoke with the Department of Banking and Insurance and I learned that Guardian and a small company left, their letter to the Department had nothing to do with the MLR, with the medical loss ratio. In fact, it had to do with other reasons.

You know, there are—most every—well, actually, every insurance company who writes in New Jersey already has a higher MLR by practice. We put it—we codified it into law. They don't.

There isn't one company that is going to leave that State. They are profitable. Some of it is difficult, just like any other business. But for those who are in that State, whether it is Horizon or it is Blue or it is anyone else, they are doing just fine. They would always like more.

And when a lobbyist or a representative from an insurance company will come to my office and complain to me that they are going to make less this year, well, that is just what they do. They will want to put the fear into any legislator that, if something changes, if the dynamic in the insurance industry changes, if they are made to pay more to providers and put less in their pocket, then the sky is going to fall and the world will end for them; and none of that has happened.

Ms. SCHAKOWSKY. Thank you very much.

Mr. PALLONE. The gentleman from Georgia, Mr. Gingrey.

Dr. GINGREY. Mr. Chairman, I am not quite ready. If you could come back to me, or if I am the only one I will get ready.

Mr. PALLONE. Sure.

Mr. Shadegg, do you have questions?

Mr. SHADEGG. I do, Mr. Chairman. Thank you very much. I would like to ask each of the witnesses a set of three brief questions. I would like just a quick answer to them, if I could.

First would be, do you have a copy of the tri-committee discussion draft? Yes or no. When did you receive it, and have you had a chance to read the entire bill?

Mr. Allen, do you have a copy?

Mr. ALLEN. Yes, we do have a copy. We received it Friday. We have reviewed it as best we can over the weekend.

Mr. SHADEGG. I understand the "we". I like the pronoun. Have you read the bill personally?

Mr. ALLEN. No, I have not.

Mr. SHADEGG. Mr. Vitale?

Mr. VITALE. We have received a copy in our office, and we have not reviewed it yet. Thank you.

Mr. WEBBER. I have got an answer to only one of your questions, the first one. No.

Mr. SHADEGG. You don't have a copy of the bill? You were not provided a copy of the bill?

Mr. WEBBER. No.

Mr. SHADEGG. OK. Doctor.

Mr. SCHEPPACH. Yes, I have a copy of the bill. I received it Friday; and, yes, I have read the entire bill.

Mr. SHADEGG. Thank you. You are the first.

Mr. Freeman.

Mr. FREEMAN. Yes, we received the bill. We received it Friday around noon California time. And I have read—I think I am on Page 115.

Mr. SHADEGG. Out of?

Mr. FREEMAN. 852.

Mr. SHADEGG. Thank you.

Mr. Pollack.

Mr. POLLACK. I did receive the bill on Friday. I have read portions of the bill. Our staff has read the entire bill.

Mr. SHADEGG. Thank you very much.

Assemblyman Webber, I appreciate your testimony. I was able to watch it from my office. I do appreciate your efforts on behalf of consumers; and I, as you know, share your interest in allowing the across State purchase of health insurance so that we could bring some competition to the market and bring down cost.

But I guess we are looking at a broader debate here. We are looking at the government becoming vastly more involved in the insurance sector and, quite frankly, getting the government or giving the government a much larger role kind of between patients and their doctors.

You made a plea in your testimony for not—for the Congress not to do what has been done in New Jersey. I presume that is a reference to the 1992 legislation in New Jersey and also to guaranteed issue and community rating. Can you expand on that?

Mr. WEBBER. Well, again, the health insurance market is not healthy in New Jersey. In fact, it is very sick. We had at many as 28 insurers writing policies in the State back in the early '90s; and due to these reforms undercutting their ability to underwrite effec-

tively and efficiently, mandating coverages, putting in minimum loss ratios that are not profitable, we are down to about only five companies that really write policies on the individual market to any great degree. So consumer choice has been virtually eliminated, certainly diminished in the State.

And, Congressman, I am eager to take on the challenge of health care reform at the State level; and we have talked about this many times, actually. If we had the opportunity to get at it and allow New Jerseyans to get out of State and create a system in which they could really shop for policies that suit them, instead of the policies that the politicians in Trenton think are suitable for them, I think we would go a long way to making health care and the delivery of health care better in New Jersey, and then we can get at the rest of the uninsureds.

Mr. SHADEGG. Mr. Pollack seems to be concerned, and I think justifiably so, about uninsured Americans, about those people who do not have health insurance coverage at all. If we provided everyone in New Jersey and indeed everyone in America who does not have insurance right now and who cannot afford to buy health insurance right now with a refundable tax credit, that is, cash from the Federal Government to go buy a health insurance policy of their own, do you believe that would take care of, number one, their health insurance needs? And, number two, would it benefit them to let them make those choices? Or is it better to put them in some form of, I guess, a Medicare program or a program like the tri-committee draft?

Mr. WEBBER. No, I think there is broad consensus that people want more control over their health care decisions. Certainly the refundable tax credit would help. But I have to tell you that, as I understand it, the range for a family would be around $5,000; and in New Jersey that is not even going to buy half of the average premium for a family. So New Jersey would need a little more reform.

If we had the opportunity, for example, to buy health insurance policies across State lines and got a tax credit to purchase that, then we could really start to eliminate the uninsureds from the rolls.

Mr. SHADEGG. Many of us have advocated not only a refundable tax credit but the creation of more insurance pools, allowing more pooling mechanisms so people would have more choices and obviously creating a level playing field in terms of taxes so people could buy health insurance on the same tax basis that a company can. Would you support those reforms? And do you think those would help the people of New Jersey?

Mr. WEBBER. Well, absolutely; and that is why I am eager for the States to get a shot at this and really take our cut, not in the way that New Jersey has tried it but in the way New Jersey can try it going forward. And association group plans like you are talking about, certainly, after health care choice and interstate purchase of health insurance, would be one of the top things we would want to do.

Mr. SHADEGG. Thank you very much for your work in this area. And I think Mr. Chairman, I concluded my last question within the 5 minutes.

Mr. PALLONE. And I certainly appreciate that.

Mrs. Capps, our Vice Chair.

Mrs. CAPPS. Thank you, Mr. Chairman; and I thank you all for your patience and your testimony today.

I particularly want to thank and welcome my constituent, Mr. Robert Freeman. The program that he described, CenCal, and the counties that I represent in Congress, I can attest to the fact that you, since its beginning, which I was a part of as a community member and also one who worked in public health nursing in the school districts, that it is very successful, very effective, and now has grown to include two counties and is part of, as you describe, the alternative ways of delivering Medicaid, which we know as MediCal, and Healthy Families in California.

Now, I want to give you a chance to expand further but ask you some—two or three questions. One of the complaints that we are hearing from many who oppose a public plan option is that it would we weed out unfairly, they say, private competitors. Can you elaborate on how CenCal competes and does business alongside of private entities for the Healthy Families Program, which is how we term the SCHIP in California? Are there still private plans offering coverage? And how do you get along with one another?

Mr. FREEMAN. Thank you, Mrs. Capps.

Sure, in the California SCHIP program it is called Healthy Families. It is set up as a competitive model where they have the States divided into regions and in those regions counties where you would have multiple plans compete for the Healthy Families business, usually three or four health plans in a designated area. And in those areas where, like in Santa Barbara and San Luis Obispo counties where we are from, we are a public plan and we compete with private insurers, as well as those other areas of the State that have public plans.

And in the 10 years that the Healthy Families Program has been going, the competition between the public and private models has been, we think, effective. It has been friendly. It has been, I think, successful in providing choice and in giving options for those subscribers as to which health plan they would like to join.

Recently, actually, we have had a couple of the private plans pull out of our area because—I don't know their reasons. I am assuming the business situation changed. But—so now we are one of only—instead of four plans, we are one of two plans in both Santa Barbara and San Luis Obispo counties. And we do think one of the advantages of our plan is because we are created by—of the community, we can't exit the market place. We wouldn't. Our mission is to serve our service area.

But, in general, I think the competition has—it has done as it was intended to do at the time.

Mrs. CAPPS. Actually, I described San Luis Obispo County where the number of private providers has dwindled in large part because of the lack of providers. It is a very rural area, and the reimbursement rate being so low, and that there really is a monopoly in the private sector. So this really is the only choice that families eligible for Healthy Families can choose.

My second question, does the county organized health system, as you have experienced it, have bipartisan support both within our

county and the State? It is not particularly seen as a partisan program, is it? Does it enjoy broad-based support; I am asking.

Mr. FREEMAN. It does. All of our plans enjoy, I think, bipartisan support at both the local and State level. I think anytime you have a public program that delivers what the policymakers intend it to do and is very watchful and efficient with taxpayer monies, I think that is something that either—no matter what your party affiliation, that is good public policy. And our assemblymen and State senators and county supervisors of both parties and over time have been supportive, because they do see it is a community run plan where the community actually—the health care community gets together to solve problems.

Mrs. CAPPS. And I know the State appreciates it, because you have saved a great deal of money and provide also very individualized services to your constituents.

Mr. FREEMAN. We do our best, and we think we have been successful.

Mrs. CAPPS. And you do have representation on your board, all of those sectors. I have talked with many of them.

Finally, can you tell us how you contract with providers, and especially with safety net providers in the community?

Mr. FREEMAN. Sure. Safety net providers make up—first of all, we contract with all the safety net providers in our community; and we consider that county clinics, community health clinics, all the hospitals. We have all the hospitals. And we also, which is fairly unique for a Medicaid plan, we do cover long-term care. So we contract with all the skilled nursing facilities. And we think that it has been—it is very effective.

We know that—it is important to us that these safety net providers stay healthy, because they do see a large portion of our membership. They are open at times when our members can get to them.

And we have also been very mindful that some of these, especially some of these skilled nursing facilities, really are watching every penny. So we do our best to make sure they get paid as quickly as possible; and at times in the past we have literally cut checks early so they can meet payroll and so forth, because it is in our interest for them to survive. They are part of our community, they are partners with us, and it is certainly in our interest to make sure they are as viable as possible.

Mrs. CAPPS. Thank you. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you.

Mr. Pitts.

Mr. PITTS. Thank you, Mr. Chairman.

I would like to thank the panel for your testimony, especially thank Assemblyman Webber for your comments.

I would like to ask you, Assemblyman, why does health care in New Jersey cost so much? Is it because of the mandates?

Mr. WEBBER. There is a lot of things that drive the cost of insurance in New Jersey. Certainly, the underwriting rules, notice guaranteed issue, that is, the insurance companies have to take all comers, regardless of their health condition, and then the community rating that has been modified recently, that also drives up the cost of insurance for many.

There are other New Jersey specific reasons. I mean, it is an expensive place to live and work and provide the medical care as well.

But, in addition to those factors, we do have as many as 45 mandated coverages for everything from mammograms to cervical cancer to Wilms tumor and infertility treatments, and there is a series of mandated coverages that also drive up the cost.

Mr. PITTS. How has the price of health insurance increased since New Jersey enacted these mandates? Can you give us examples of the amounts of increases?

Mr. WEBBER. Well, it is difficult to pin down how much each mandate costs and increased the cost of insurance. But the estimate is that for every 1 percent of increase in the health insurance premium that mandates cause as many as 8,000 people in the State lose their health coverage because their employers can no longer afford to provide it for them or because they can no longer afford to purchase it themselves. So just in the last, I believe, 7 years we have had over 110,000 people in the State join the uninsured rolls.

At the same time, we are putting in rules and mandates. We have mandated over 15 coverages in the last 7 or 8 years in the State. So we can continue to increase the costs even as people find it more and more unaffordable to purchase health insurance in New Jersey. And I just think that is backwards. We need to start looking for ways we can provide more efficiently health insurance to our constituents.

Mr. PITTS. In your testimony, you mention that your legislation maintains your State's core consumer protections. What are those protections?

Mr. WEBBER. The legislation would require out-of-State insurance companies to come in and be certified by the State Department of Banking and Insurance, the New Jersey DOBI. In order to do that, they would submit themselves to jurisdiction to be sued in the State of New Jersey; and if there were complaints or appeals, they would have to submit themselves to the jurisdiction of the Department of Banking and Insurance to rectify those problems.

So a New Jerseyan who would purchase, say, a policy from Colorado wouldn't be going to Boulder to fight with the insurance company. They could go to Trenton or the local Department of Banking and Insurance representative.

I think that strikes the right balance. It gives New Jerseyans the opportunity to purchase health insurance that meets their needs in terms of the mandated coverages and the underwriting rules that might be written in another State, but it maintains protection for New Jersey consumers and allows them to deal with their insurance companies in their home State.

Mr. PITTS. And do you think that a public plan like the one in the discussion draft before us will lead to crowding out of the private insurance market?

Mr. WEBBER. Well, again, I haven't seen the bill. But I think, just intuitively, when there is a government plan available, subsidized by the taxpayers, without any real profit motive or incentive, there are going to be private companies who will dump their

employees into what we call New Jersey Family Care, or whatever alternative government program is available, especially as those income levels rise for eligibility in New Jersey.

Now we have 350 percent of poverty. There are going to be employers who recognize that they can still have their employees covered by insurance and not have to pay for it themselves. I think intuitively, yes, they will start to crowd out private health insurance.

Mr. PALLONE. The gentleman's time has expired.

I know the clock is a little weird there. I apologize for that. I am going to recognize myself for 5 minutes.

This discussion about the protections, if you will, it really goes to the heart of a lot of what we are dealing with in this bill. I mean, I have to be honest with you. When I—you know, Members from other States are constantly telling me that they want to make sure that, you know, that individuals can get insurance regardless of pre-existing conditions.

I mean, the proposal before us says that insurance companies can no longer be able to engage in discriminatory practices that enable them to refuse to sell or renew policies due to an individual's health status. They can no longer exclude coverage or treatments for pre-existing conditions. It limits the ability of insurance companies to charge higher rates due to health status, gender, or other factors, I mean. It is a very important part of the discussion draft. And frankly, when I—you know, I am proud of the fact that in New Jersey those kinds of discriminations are not allowed. OK?

So the other thing you have to understand is that, you know, the Insurance Trade Association, AHIP I guess it is called, they have told us that they are willing to accept new regulations at the Federal level with limitations on their underwriting rating practices, no more pre-existing condition exclusion.

How is it—and I have to get to three questions, so I am going to ask you first, Assemblyman Webber. How is it that the trade association thinks that we should include these provisions and you don't? What is the theory?

I mean, obviously, they think they can sell insurance nationally. They are suggesting that these New Jersey provisions be put into the Federal legislation. Why are they advocating that?

Mr. WEBBER. Well, I can't speak for the insurance industry, for sure. And when there is a big hammer hanging over your head, I think insurance companies might be willing to compromise more than they otherwise would.

Let's say this. There are better ways to deal with people with pre-existing conditions and those we call the chronically uninsured or chronically uninsurable than to require guaranteed issue of all insurance policies.

Mr. PALLONE. And I just don't have a lot of time, and I want to ask Senator Vitale. I mean, my fear is just the opposite, that if we don't include these provisions or, as you suggest in New Jersey, that we simply deregulate, it would have major consequences. I mean, I would ask Senator Vitale to respond that. I mean, this is a cornerstone of what we are trying to do is to not allow, you know, to have these protections at a Federal level. You have them at the State level. What happens if we don't have them?

Mr. VITALE. Well, it has been very meaningful for the consumers in New Jersey to have guaranteed issue, one of the few States that enjoys that provision. It guarantees that insurance companies shall write a policy and can't exclude someone because of pre-existing conditions. So, essentially, it is take all comers.

Imagine an environment in New Jersey, as bad as it is in our State for those who are uninsured and every other State, for an insurance company to cherry-pick who it is that they would like to insure. Will they decide not to insure women of child-bearing years because they are higher risk and they are going to be expensive?

Mr. PALLONE. And gender is one of the things that has been used. Exactly.

Mr. VITALE. That is right. And will they decide not to insure an older New Jerseyan, a pre-Medicare New Jerseyan because he or she is at higher risk of anything, heart disease, kidney disease, cancer? The older you get, the sicker you get. It is a fact of life. Will they only want to insure children?

When you purchase insurance out of State without the safeguards provided in our State, they will only take those who are in good condition who are considered to be a good risk, leaving those in New Jersey who are considered to be a higher risk, women of child-bearing years, older men and women, out of the mix. And the way the insurance business works—and I don't need to give you this lesson—is it is about pooling risk with healthy lives and sick lives together and risky lives and less risky lives together and you come up with an average price.

Mr. PALLONE. I don't mean—I know I am going to have to cut you off. Regardless of the debate—and I am going to move on to Mr. Allen and just make a comment here. Regardless of the debate, though, about whether you think we should deregulate in New Jersey and people should go to other States—I mean, the bottom line is that what the discussion draft would do would be to basically say that insurance companies would have to apply these rules federally across the country. And I mean, if the Insurance Trade Association says it is OK, I frankly don't understand why it wouldn't be.

But let me just go to Mr. Allen, very quickly, because I am concerned—you know, I want you to comment, if you will. The discussion draft raises Medicaid eligibility levels to 133 percent of Federal poverty in every State. In addition, it makes available income-based subsidies for persons obtaining insurance coverage in the new health insurance exchange. I think these provisions are very important for Native Americans; and I just wanted you to comment on them, if you could.

Mr. ALLEN. Well, without a doubt. I spend a lot of energy on the Travel Advisory Council for CMS with regard to Medicaid rates. I can't tell you specifically, you know, because I am not the one who actually administers it with my tribe. But we can get back to you in terms of, is it enough? Is it going in the right direction? And I think it is. Off the top of my head, knowing what we have been trying to do with regard to the recovery rates for the tribes, that it will help us immensely.

Accessing Medicare and Medicaid has been real challenging for the tribes in terms of the policies they administer over there. So it has been difficult for us, and we are looking forward to our new

opportunities. I can say that if this bill incorporates some language in there that strengthens it and puts provisions in there that it improves our ability to, as providers, whether it is through the Indian Health Service or the tribal clinics and hospitals, then it is definitely going to improve our ability to raise the level of services to all of our people.

Mr. PALLONE. I mean, we are trying. I mean, you probably know that the Indian Health Care Improvement Act, which you know is my bill, that I am the prime sponsor, is coming up in Resources tomorrow. We have been trying since the beginning of the year to incorporate a lot of the provisions of that, you know, in SCHIP and the stimulus and also protections in this health care reform or in Native Americans. And we will still try to move the other bill. But we do want to and we are really trying, as much as possible, to address some of the disparities that we know exist with Native Americans. I just wanted you to know that.

Mr. ALLEN. I would also like to inform you, Mr. Chair, that, you know, times are changing for tribes in terms of how we provide services. So our clinics and hospitals provide services to both Indian and nonIndian alike now. It has changed. Where in the old days where we just provided services to the tribal citizens; and now, because of the diversity of our communities and the communities around us where, like my community, the providers actually bailed out in the community, so we basically took on that role. So we have a clinic right now where 95 percent of our patients are nonIndian.

Mr. PALLONE. I appreciate that, and I know I went over. But I am just concerned that—I want to make sure that the Native American concerns come out.

Mr. Gingrey.

Dr. GINGREY. Mr. Chairman, thank you for doing that.

Mr. Chairman, you were just, I think, asking Representative Vitale in regard to why, in the State of New Jersey, this situation where there would be guaranteed access, community rating, all of these mandates that make it untenable for many insurance companies to continue to do business in the State of New Jersey. And the chairman said, well, gee, you know, AHIP says it is OK, and they are buying into that across the country.

But I would suggest that they, as soon as we—if we did this—and I hope we do—pull out the mandate that everybody has to have health insurance, the mandate that they have to do it, and employers also have to provide it, that would be at the point at which AHIP would say all of a sudden no longer are we going to accept community rating and universal mandated coverage.

So I will just throw that out there.

Let me ask a question of Representative Webber. Your State, as you said in your testimony, has had massive decrease in insurance carriers, I think from 28 in 1992 down to seven insurance carriers now in the individual health insurance market. Do you think that a public plan like the one we are discussing in this draft before us, do you think it will lead to maybe some of these private carriers coming back into New Jersey or, rather, a further crowding out and lesser numbers participating?

Mr. WEBBER. Well, I can't see any of the private insurers coming back just because there is a public plan now being made available. You know, there will be fewer lives on the private insurance market. I would assume—you know, bear in mind we might have seven companies writing policies, but if you are writing policies and charge $18,000 a year in premiums, you are really not intending to cover anyone. So we really have fewer than seven who are still writing policies seriously in the State. I don't think it is going to get any better anytime soon.

Dr. GINGREY. Let me ask your colleague from New Jersey, the Honorable—is it Vitale? And I heard that—in fact, it is right here in this document—that New Jersey has in fact enrolled people earning as much as $295,000 a year in public coverage. Yet 23 percent of children below 200 percent the Federal poverty level are uninsured. How can that happen in the State of New Jersey?

Mr. VITALE. Well, let me—I appreciate that question, but it is a question that has been asked and answered during budget hearings in New Jersey, of which I am a member, also. But it is a question that has a very simple answer, and the answer is that there were as many as three or four individuals who applied for coverage in New Jersey who lied on their forms when they applied for New Jersey family care. And it was through the process of an audit that we discovered that lie. And it was corrected. In fact, I wrote additional legislation that required not only that people fill out more information on their form in terms of their income but that Treasury do a back check against their wages and the filing so we know exactly what they are earning in the year that they are claiming they want to be a member of the program.

So it was a matter of fraud on behalf of the three or four individuals that made big headlines. But—and, unfortunately, tried to give a black eye to the hundreds of thousands of honest New Jerseyans and parents and children who are doing the right thing.

Dr. GINGREY. Reclaiming my time. I mean, I have got a sheet here of all the States and the average annual premiums in the individual market. In New Jersey, it is $5,300. And you go down to Wisconsin, it is $1,200. And I think we are getting some answers in regard to what the problem is in New Jersey.

Mr. Pollack, in the limited amount of time I have left, let me just ask you this. I know you have been involved in health care reform for a long time. You had a lot of things to say about Medicare Part D and government controlling prices and setting prices of drugs and things like that. But your organization is, you know, well respected, of course, and has a lot of opinions on all this.

Let me just ask you a quick question, though. Shouldn't we require States to ensure that low-income children are covered, let's say in the CHIP program, before opening up coverage to middle- and high-income families?

Now, I ask that question really in a way for my colleague, Representative Nathan Deal, who is the ranking member, as you know, on the Subcommittee on Health that has a bill to that effect, that had an amendment when we were working on the CHIP program to say that if we are going to expand it, let's at least assure that 95 percent of those who are intended in the original bill between

100 and 200 percent of the Federal poverty level that we cover them before going up to 300 and 350 percent. Your response.

Mr. POLLACK. Well, Congressman, I don't think it is one or the other. The CHIP legislation, which the President signed in February, is designed to accomplish what you just described, namely, making sure that more children who have been eligible for CHIP actually enroll in the program, and the States are actually provided financial incentives in order to do that work.

Now, when you are talking about 200 percent of the Federal poverty level, remember, for a family of three, that is approximately 36, $37,000. The average cost of family health coverage today is approximately $13,000. So that is more than one-third of their income. And so if you go above 200 percent of poverty, you are helping people who otherwise could not afford to provide coverage for their children.

And I don't think those two goals that you described are antithetical to one another. I think we can do and should do a much better job of getting kids enrolled who have been eligible and who are not in the program; and, at the same time, we should make coverage more affordable for those people who simply can't afford it, even though their incomes are above 200 percent of poverty.

Dr. GINGREY. I thank you.

Mr. Chairman, I know that my time has expired. I appreciate your patience on that. Thank you, Mr. Pollack.

Mr. PALLONE. Thank you.

The gentlewoman from Florida, Ms. Castor.

Ms. CASTOR. Thank you very much, Mr. Chairman.

Since we have some experts on local and State initiatives, I would like you all to address a concern I have. You know, all across America, local communities have stepped up to fill the void because they don't have anywhere else to turn.

For example, in my hometown in Tampa, Hillsborough County, we have, for the past 15 years, provided an initiative where if you do not have health insurance from any other place, if you don't qualify for Medicaid or Medicare, and you are a working family below about 200 percent of poverty, the county has created a partnership with local hospitals and community health centers so that these folks don't end up in the emergency room and county government doesn't pay those very high costs out of property taxes, which everyone hates.

It is very successful, and it has created a robust primary care system of 12 clinics, and hospitals are reimbursed and the doctors there are reimbursed. And now, with our health reform initiative, it looks like we, the Feds, now will come in and we will cover the cost for the people that my community were covering. And that is great. That is going to be great for my taxpayers. But I hate the thought of losing this award-winning local clinic system of primary care system that we have.

And there are other communities across the country, I think—Oakland, California, maybe, San Antonio, Texas, others, plenty of others—that have these. How do we, in transition, ensure that these terrific initiatives on the local level survive?

Mr. VITALE. Well, I think the program in Tampa is wonderful, and it is programs like that in New Jersey that we are trying to

emulate. We have called them collaborative care models. We are working with local hospitals who are in close proximity to federally qualified health centers and other clinics to transition the uninsured, or even the insured, who present in an emergency department with what is really non-emergent illnesses or injuries.

We are required, of course, to take all comers, but those who present at an emergency department really don't need to be there. So we are working with our local hospitals. So it is a great model.

I think the question, I hope, I think is, how are those providers, those caregivers, doctors and nurse practitioners and nurses reimbursed for the care they would provide?

Ms. CASTOR. So is it—Dr. Scheppach, is it State leadership that needs to step in, because the States will have so much of the responsibility when we are talking about the 133 percent of poverty? It is going to be through Medicaid that they will be covered.

Mr. SCHEPPACH. Yes. I mean, there is a lot of programs now. Some States do programs with State-only dollars and a lot of the locals do. So there are those sort of tiered effects. This is probably going to be—if this bill were to pass, it is going to be a transition, I suspect, of 4 to 5 years before you transition. And I think to some extent what States would do would be to work with communities to ensure that they are doing part of the eligibility. That is feeding in. Because all the problems in Medicaid and SCHIP, oddly enough, is finding these kids and getting them, in fact, enrolled. And I think we are going to have the same problem with the other subsidized populations.

What worries me very much about this bill, however, is that the entire sort of gateway or alliance is Federal. So now you are going to have the Federal Government in the middle of this doing insurance regulation for those qualified plans, and then you have got States outside that doing nonqualified plans. So I think the coordination problem is going to be greater going forward. I would worry about that.

Mr. POLLACK. Congresswoman, your community is well known as doing something that is exceptional. Obviously so many communities across the country don't do that. And it is one thing to provide primary care as community health centers do. Often people who get primary care may have difficulty getting access to a specialist.

But your question and what Ray was just talking about, I think, tells us that, yes, there is going to be a transition, but it makes a whole lot more sense to put that lower-income population into Medicaid that exists rather than create the exchanges and overburden those exchanges which are going to have significant difficulty reaching out to larger portions of the population. Let us keep that lower-income population, at least for the time being, in Medicaid. Let us see how the exchanges function. But also, let us make sure that the protections that now exist uniquely in Medicaid continue to be provided to that low-income population.

Mr. FREEMAN. If I could finish up and briefly add that, again, we think that all health delivery is local. And I think we also believe that the ability of local communities to address their own needs is very effective, and what has happened in your community is a perfect example.

And also, when you have the local delivery, you really do—you do encourage physicians and hospitals and other health care providers to really talk to each other and work towards this common goal of how can we make the community that we all live in a better place for all of their citizens.

So we are big believers in really having whatever comes out of the Federal health care reform take a look at what is working at the local level and hopefully maintaining that.

Ms. CASTOR. Good. I look forward to working with you all on that.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you.

Mr. Shimkus.

Mr. SHIMKUS. Thank you, Mr. Chairman. And I have got a couple points I want to try to drive, but I will try to be quick and pretty efficient.

Senator Vitale and Assemblyman Webber, when constituents have problems with the New Jersey program, do they call your offices? So you have—and that is probably not part of the calculations of the costs. We do the same thing. We have Medicare, Medicaid. We have, I have at least, one person full time to address those constituent concerns, and they are not easy, and they are bureaucratic. And I was just wondering, if we take on this as a national health care plan, guess what? We get it all, gang. We are going to get all the caseload calls. And that is why you guys support it, because then they won't be calling your offices. No.

Let me—and just for the record, Medicare D is very successful. Medicare and Medicaid for the 60 years that it was here, still here, did not do what the private sector did, which was provide prescription drugs to people who had private insurance. You can't have modern medicine without prescription drugs. Although we have carried a system that didn't have it, and we fixed it, and we are under budget, provide better service, and the quality of service is high. And I think we can do that in this private sector debate, I really do, if we would just give it a chance.

Let me—I want to go to Mr. Allen real quick. The Indian Health Service—I don't have any Indian tribes, so I am not as familiar—isn't it a one-payer system?

Mr. ALLEN. It is referred to as a payer of last resort, so it requires that the tribes tap the insurance system or the Medicare or Medicaid, and then if there is still a gap in providing services to the tribal citizen, then we access the IHS monies.

Mr. SHIMKUS. OK. Let me go to your encouragement to move people, I think, from the Indian Health Service to this insurance plan. I guess a better way to ask this is in your testimony, you do—you want to exempt the mandates and penalties from the Indian tribes; is that correct?

Mr. ALLEN. Yes.

Mr. SHIMKUS. Why would you want to—and we will have problems with that. I know there is tribal issues and sovereignty issues and stuff, but if we are going to do a one-size-fits-all arena, we are going to have to do a one-size-fits-all arena. I am not sure how we start exempting.

One of the—and you want—in your testimony you also talk about you want exemption from employer mandates that should be exempt even for the Indian tribes that have the benefit of the casinos and golf courses and tourism issues; is that correct?

Mr. ALLEN. Yes.

Mr. SHIMKUS. And you want that exemption also to employees of that facility that may not be American Indians?

Mr. ALLEN. Say again?

Mr. SHIMKUS. Say you have an employee at a casino that is not an American Indian.

Mr. ALLEN. Yes.

Mr. SHIMKUS. And you are pushing for some exemptions of the mandates for the insurance provided to them.

Mr. ALLEN. Yes. Our argument is that the tribal government, those businesses are under the umbrella of the tribal government, and as a tribal government, that it should be exempt.

Mr. SHIMKUS. I got it.

I have got one last question, and I want to try to be respectful of the time.

Senator Vitale, Assemblyman Webber, what is your FMAP percentage? Do you know? Do you know what FMAP is? Do you know what your percentage is?

Mr. VITALE. For those who are Medicaid and those childless adults covered in Medicaid are 33 percent of the Federal poverty level.

Mr. SHIMKUS. But what is our share? What is the Federal payment?

Mr. VITALE. Now, what is it——

Mr. SHIMKUS. I think you are 50 percent. Who is California? Freeman?

Mr. FREEMAN. I believe it is 50 percent.

Mr. SHIMKUS. What would you say if there are States that have higher FMAP rates? Would you say that is intrinsically unfair and un-American that this Federal Government would allow some States to get a higher Federal reimbursement for Medicaid versus others? Senator Vitale?

Mr. VITALE. Well, we are for——

Mr. SHIMKUS. I am just talking about fairness. We are all citizens of the United States. The Medicaid is a Federal program, shared with the State. We do—we have a ratio of what we are going to compensate. Would you say it is fair that some States pay less than other States?

Mr. VITALE. I would say that it is unfair that some States get less, and New Jersey is one of those States.

Mr. SHIMKUS. So I will take that as yes.

And I am going to end up with Assemblyman Webber.

Mr. PALLONE. This will have to be the last question.

Mr. WEBBER. The same question. You are talking to a guy from a State who gets pennies back on the dollar that we send down to Washington. So I am not going to advocate for New Jersey to give money away, if that is the question.

Mr. SHIMKUS. No. Should every State be given the same ratio?

Mr. WEBBER. I don't think I am an expert.

Mr. SHIMKUS. Say yes.

Mr. PALLONE. You can't tell him what to say.

Mr. SHIMKUS. Let me tell you, if the bottom line is if Mississippi gets 76 percent return, and you are getting 50 percent, should we change the law?

Mr. PALLONE. Don't answer the question, because he is a minute over. We have to try to stick to the time.

All right. Mrs. Christensen.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman. I think just a few brief questions.

Mr. Allen, like Chairman Pallone, I am a member of Natural Resources, and there are several others of us on this Health Subcommittee and on the big committee, so we definitely have an interest in addressing the issues of the Native Americans in our country, and the tri-caucus, I will tell you, has taken a position of equity for American Indians as well as territories. But we haven't really addressed some of those exemptions that you have put in your testimony, so that is very helpful to us.

But the urban Indians, the Indians who are not on the reservations, we generally have had problems in coverage and reaching that population. Do the recommendations in your testimony address the unique issues of that population, or are there other recommendations that you might want to add?

Mr. ALLEN. The answer is, yes, we have additional recommendations. The provisions in the bill go a long way to helping fill the gap. There is a lot of very positive conditions in there, including access to subsidies.

The issue for us will be that over half of our citizens of each of the tribes in general are outside what we call the service area, and they are in urban communities, et cetera. And if we are able to access the resources to serve them if they are underserved, then we can fill that gap. We can close that gap. That has been an historical gap for the tribes.

This testimony is in collaboration with the National Indian Urban Centers, and they work very closely with us trying to fill that gap. But there are service centers who have been severely underfunded historically and don't even come close to providing the quality care that this bill is intended to address.

Mrs. CHRISTENSEN. Thank you.

Dr. Scheppach, my Governor and Governor deJongh of the U.S. Virgin Islands is an active member of NGA and has signed on to the policy statements on health care reform, energy, and many of the other ones. We have a particular issue with Medicaid and wanting to get the cap lifted, at least begin to move in that direction. Does the NGA have a position on the territories if you support it? Are you supporting my Governor in his attempt to move the cap?

Mr. SCHEPPACH. I sure am. We do have a policy position to support all the territories in raising the cap. Yes.

Mrs. CHRISTENSEN. Thank you.

Mr. Pollack, it is good to see you here. You have told us about some of the reports on Medicaid that show—that are positive, but there are also some other reports that, while, yes, there is increased access to services and to care, there is still some reports that show that the outcomes are not as good as they need to be.

And you didn't really have a chance to talk about where we may need to go to improve on Medicaid, which I feel we definitely need to do. Medicaid patients are often in another line if they are not in the back of the line because they are Medicaid patients. The cost, as you said, of providing that service is lower than the private insurance market, but part of that is because they don't pay, and so the providers do not locate or they move out of poor areas. So we have access issues.

You know that I have proposed that we put the Medicaid patients into the public plan. I am not going to necessarily ask you to comment on that, but do you have some suggestions as to how we can improve Medicaid outcomes? How can we improve Medicaid and make it not only just so that patients can get to a physician, which is often a problem, but that we can ensure that they have better outcomes?

Mr. POLLACK. I think one of the biggest problems that exists for those people on Medicaid is sometimes they have difficulty getting a doctor, and that is largely a function of the payments that are provided, that are given to providers.

I am happy to see that in this draft bill there are some improvements made with respect to payments to primary care doctors. I think there is also, I think, hope for improvements because there is an experiment proposed here, a pilot program for medical homes. So I think those kinds of things will lead us in a much better direction in making care actually much more accessible for people on the program.

Mrs. CHRISTENSEN. My time is up, so I don't get to go back to the public plan issue. We will talk about that again.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you.

Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman. I just have one question.

Dr. Scheppach, in your testimony, you mentioned you would oppose changes to Medicaid that were drawn in an unfunded mandate. And having served 20 years as a State legislator, I can relate to that. And you say States must take into consideration not only actual costs of including individuals on their roles. I understand why you oppose a Medicaid expansion if it is unfunded, but what about a mandate to cover the population the States are already supposed to be covering under Medicare? And I will give you an example.

In Texas, we have approximately 900,000 uninsured children; 600,000 are Medicaid-eligible but unenrolled, and 300,000 are SCHIP-eligible but unenrolled. And I would like Texas to cover those children, and I would like to mandate 12 months of continuing eligibility under both programs to do so. Texas has that responsibility to cover these children, but has repeatedly allowed these kids to drop off the SCHIP and Medicaid roles in order to avoid paying the State match. We cannot continue to allow children to remain uninsured so States can avoid paying their match.

Short of federalizing Medicaid, what can we do to ensure States cover the individuals under Medicaid that they are responsible for covering? And I can understand what my colleague Mr. Shimkus—although as a lawyer probably the worst case I have ever seen of

leading the witness when you say, "Please answer yes." I don't quite go that far.

But what can we do short of federalizing Medicaid to get States like Texas and maybe Florida from my colleague Ms. Castor to cover more of the children particularly, since we have had SCHIP since 1997, and Medicaid for 30 years?

Mr. SCHEPPACH. In all seriousness, one of the problems with Medicaid is it is three sort of programs in one. It is women and kids, it is the disabled, and it is long-term care. And it is the long-term care that we think is the biggest problem because the demographics are changing and so on, and a lot of the dollars really go there. The women and children are relatively inexpensive and a good investment.

And so the problem is, is that Medicaid now is 22, 23 percent of the average State budget, about what all elementary and secondary education is. And right now, from a State perspective, we are looking at about 180 billion in terms of shortfalls over the next 3 years. So what you are seeing, and I think you are beginning to—Texas is a little bit better off than a lot of States, but it also has a problem of basically raising the State's share to cover those.

I think at some point Medicaid needs to be restructured so that the long-term care portion of the population goes into a separate trust fund or so on. States, I think, understand it is sort of their responsibility, women and children, because it is also a population they have to work with in terms of welfare and other things. So I don't think the women and kids are a huge problem.

Mr. POLLACK. Mr. Green, I would say there are two things in response to your question. First, we obviously can do a whole lot better in terms of the enrollment process. It is rather cumbersome, and particularly the reenrollment process. After the year is up, and a child has been eligible, they have to reenroll. If they fail to do that for whatever reason, they are off the rolls. And there is a lot of churning in the program.

So we can do a lot more in terms of outreach and better enrollment. And the CHIP legislation that passed in February actually, I think, provides some opportunities to make that happen.

But with respect to Texas, there is a very important thing. One of the things we know is that children are less likely to enroll if their parents can't enroll with them. And in Texas the eligibility standard for parents is a meager 27 percent of the Federal poverty level. So if you have got a parent and two kids or two parents and one child, if that family has income in excess of $5,000 a year, they are ineligible. The parents are ineligible.

So I think one of the things this bill does is it allows the parents to enroll with the children, and I think that will help solve the problem you are talking about.

Mr. GREEN. Well, I have a concern again about the churning, because I know in 2003 when some tough budget decisions like our legislators have to make, they cut a bunch of children off of CHIPS. And they knew how to do it; they made them reenroll every 6 months. And you can quantify it very quickly to say you know how many kids are going to drop off because the parents just can't go down and stand in line at the Health and Human Services office. So that is the concern.

Thank you, Mr. Chairman, for your patience.

Mr. PALLONE. Thank you. And I think that concludes the questions for this panel. But I want to thank you. I know it is late, and I know you had to wait a long time, but we really appreciate your input, because what you are saying at the State, local, and tribal level is very important in terms of what we are doing with this health care reform.

Mr. ALLEN. Mr. Chair, could I correct one point that I said that was not right in the record? The Congressman from Illinois asked were we asking the tribal government and our casino, our businesses to be exempt? We are asking that our governments are exempt, not our businesses. So that is a distinction that I think he was asking for with that question, and I wasn't quite clear.

Mr. PALLONE. All right. Thank you for that clarification.

And thank you all, really, for being here. Thank you.

Mr. PALLONE. And we will ask the next panel to come forward, and this is our panel on drug and device manufacturer views.

I want to welcome all of you. I know the hour is late. It is already 6:00, and we may end up having votes, too, to interrupt us, but hopefully not. And I am changing the order a little bit because Mr. Gottlieb, I know, does have to leave.

So let me first introduce Dr. Scott Gottlieb, who is a resident fellow at the American Enterprise Institute.

And then to his left, I guess my right, is Thomas Miller, who is chief executive officer, workflow and solutions division, for Siemens Medical Solutions, USA.

And then we have Kathleen Buto, who is vice president for health policy at Johnson & Johnson. Thank you for being here.

And William Vaughan, senior health policy analyst for Consumers Union. He is no stranger to this committee.

And finally is my friend Paul Kelly, who is vice president of government affairs and public policy of the National Association of Chain Drug Stores.

And you know the drill: Five minutes, but your written testimony in complete becomes part of the record.

And we will start with Dr. Gottlieb.

STATEMENTS OF SCOTT GOTTLIEB, M.D., RESIDENT FELLOW, AMERICAN ENTERPRISE INSTITUTE; THOMAS MILLER, CEO, WORKFLOW AND SOLUTIONS DIVISION, SIEMENS MEDICAL SOLUTIONS, USA; KATHLEEN BUTO, VICE PRESIDENT FOR HEALTH POLICY, JOHNSON & JOHNSON; WILLIAM VAUGHAN, SENIOR HEALTH POLICY ANALYST, CONSUMERS UNION; AND PAUL KELLY, SENIOR VICE PRESIDENT, GOVERNMENT AFFAIRS AND PUBLIC POLICY, NATIONAL ASSOCIATION OF CHAIN DRUG STORES

STATEMENT OF SCOTT GOTTLIEB

Dr. GOTTLIEB. Thank you, Mr. Chairman. I would like to submit my oral statement for the record.

I just want to pick up on some themes that were discussed in some of the earlier statements. It is a pleasure to be here, by the way. I am from the 12th Congressional District of New Jersey, and my parents still live there, so it is a pleasure to be here with you.

There was a lot of discussion around Medicare's efficiency in some of the earlier testimony, and the issue of rationing also came up tangentially in Medicare.

With respect to Medicare's efficiency—and I worked at the agency for a period of time under Dr. McClellan—one of the things that Medicare lacks is clinical expertise on the staff, and I think it has become quite apparent in recent years. If you look at the structure of Medicare, they have about 20 physicians in the entire organization. If you look at private plans, by comparison they will have literally hundreds. And I think this gets to an important consideration when you talk about why Medicare is able to operate with less overhead. It is in part because they are not doing a lot of clinical review, for better or worse, in the context of the kinds of reimbursement decisions they have made and even the kinds of coverage decisions they make.

Just anecdotally, they made about 165 different decisions with respect to cancer products since 2000 without a single oncologist on the staff of the organization. And why this is important, I think, with respect to the intersection of talking about Medicare's efficiency and the low overhead that they operate with, and then you get into discussions around rationing, is because it is without a doubt that we already engage in issues of rationing with respect to the Medicare program. We are doing it right now in the context of coverage decisions and reimbursement decisions and how we go about coding. And my fear is that if we expand government control over health care, we are going to have to do those things much more.

If you look at the kinds of proposals that have been put forward in front of this committee, as well as the proposals in the Senate, and you look at some of the cost containment measures in those proposals, they are really not very robust. Comparative effectiveness, product medical records, paying for prevention, all those individual proposals might have merit on their own, but there is a reason why the Congressional Budget Office hasn't assigned meaningful savings to them.

And so the fear is, of people who talk about the potential for rationing inside a government program, is that in the absence of being able to control costs with policy prescriptions that are embedded in these bills, ultimately the default case 2, 3, 4 years from now will be to have to engage in more robust rationing decisions inside the Medicare program or whatever other government scheme we come up with. And if you look at the draft legislation in the Senate and the House, you see multiple references to quasi-independent advisory committees that we could certainly contemplate could become vehicles for that sort of rationing.

So why is this important in the context of thinking about Medicare structure and its efficiency and its overhead? Well, if one of the reasons why Medicare is efficient and operates with a low overhead is because they don't have a lot of clinical expertise, the intersection between an organization that is going to be called upon to engage in more decisions to deny access on the basis of their own clinical judgment and their reading of the clinical literature with an organization that doesn't have a lot of clinical expertise is, quite

frankly, frightening. And it was frightening in certain instances, anecdotally, when I was at the organization.

And so in my written testimony today I tried to lay out a couple suggestions for how we could improve that process, because if we are to go down a road where we will have a system that has to make more clinical judgments in the context of what they decide to reimburse people for and give people access to, the least we should expect is that organization is clinically proficient, it is rigorous, it is based on good science, it is a transparent process. And we have none of those things today.

And so some of the proposals I laid out in my written testimony was the creation of an advisory committee structure on Medicare where you subject decisionmaking of that body to external therapeutically focused advisory committees. Certainly if we contemplate a public insurance plan that will be making similar kinds of decisions either initially or eventually, we should create a similar structure. I think we also need to contemplate what the structure is for making coverage process decisions, reimbursement decisions, coding decisions, and making clinical considerations in the context of these programs.

If you look at the structure right now of Medicare, if you were to ask anyone in a company, or if someone in a company, CEO, asked one of the subordinates who works on Medicare coverage processes what is the process, they would be hard-pressed to delineate that process in a clear and coherent fashion, certainly not with the same clarity that you would be able to explain the FDA review process, which is very clear, very structured.

Finally, in the proposals before this committee, there is a proposal for the creation of a comparative effectiveness center agency, if you will. I think before we step into that, once again we need to think about the structure for how that information will be used. And in many contexts of government decisionmaking, when scientific information is being created by a government entity, there is very clearly delineated in legislation regulation what the threshold is for an actionable piece of data. When will a piece of data reach sufficient scientific rigor to be deemed actionable for a regulatory body? Certainly this is a case at FDA where you have a clear threshold for actual information in the context of the paradigm around P equals .05. There is no contemplation of what the threshold will be for actionable information on the part of any government organization with respect to comparative effectiveness information. And I think marrying the criteria inside CMS and any other government plan with the criteria used by FDA for consideration of comparative information, it certainly would be a step in the right direction, and I recently wrote a long paper on this and put it out for the American Enterprise Institute.

But in summation, Mr. Chairman, I don't see a lot of elements in the proposal before this committee that we could have confidence are truly going to bend the cost curve in a way where we are realigning reimbursement with the kinds of outcomes we want to see these programs achieve. And in the absence of that kind of reimbursement scheme, I fear we are just going to have more of the kind of wasteful spending that we have seen under Medicare; that the marketplace for health care is inefficient not in spite of Medi-

care, but, frankly, because of the way Medicare pays for things. And so if we go down the route where an organization like Medicare——

Mr. PALLONE. I know you said you are summarizing, but you are a minute and a half over.

Dr. GOTTLIEB. I am finishing right now—make more decisions, I think the least we can do is make sure it is a clinically rigorous process.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you.

[The information follows:]

Testimony before the House Energy and Commerce Committee

Hearing on Comprehensive Health Reform

June 24, 2008

Scott Gottlieb, MD

The American Enterprise Institute

Mr. Chairman, Mr. Ranking Member, thank you for the opportunity to testify this afternoon before the Committee. Proposals for health reform are built on a premise that only by expanding government control of healthcare can we bring down its cost. But so far, the ideas that have been offered for how to lower costs, and make medical care more efficient, seem anemic.

For example, there is no question that Medicare's payment system leads to wasteful spending. But plans to fix it – and better align pay with improved outcomes -- are, at best, incremental.

The wider adoption of electronic medical records can improve the delivery of care. But there is little independent evidence it will bend the cost curve.

Generating more comparative research on important medical questions has merit. But there is a reason the Congressional Budget Office doesn't score these proposals as saving much money.

This is why many people – including myself – worry that the end result will be greater intervention by government agencies to regulate which drugs, devices, and medical services patients can access. It seems to be the default option. The fearful case goes something like this: If we cannot adopt policies and incentives that make the individual decisions of doctors and patients more conscious of cost, then it will turn to government agencies to start making these cost considerations for all of us.

But worse still, government agencies that regulate health programs – principally the Centers for Medicare and Medicaid Services – are ill equipped to incorporate these kinds of clinical considerations into their decisions. I don't advance this in a pejorative way. The bottom line is that CMS was not conceived as an agency that would makes these sorts of decisions. Their mandate was to process claims. Only incrementally, have they been tasked with making nuanced coverage decisions based on their reading of medical literature. When they have, they've often done so poorly.

I believe that there are better policy solutions than those put forward by this Committee that don't force us to have to embrace a system where the government makes these kinds of "rationing" decisions. But the bottom line is that these assessments are already being made with increasing frequency inside Medicare. If this Chamber's healthcare proposal becomes law, I believe it will become far more pervasive under a new government-run insurance plan. At the least, we owe it to ourselves to make sure decisions to regulate access to medical care are based on sound science, and a fair and transparent process. It is toward these ends that I want to briefly offer suggestions.

First, if Medicare and a new government health plan are going to take on clinical considerations in reimbursement decisions, the process for developing these clinical positions should be more highly structured and transparent. In comparison to CMS, the process used by the Food and Drug Administration is highly prescriptive, with many opportunities for submission of, and consideration of, data generated by sponsors as well as third parties. Meanwhile, the current coverage process at CMS is often opaque, with no discreet points at which the agency is required to disclose its evolving opinion and to solicit and incorporate outside data into its considerations.

Congress could direct Medicare, as well as a new government-run insurance program, to develop a much more rigorous, transparent, and structured coverage process.

Second, Medicare – and a new government insurance option – should be required to bring reimbursement policy decisions before independent, therapeutically focused advisory committees. This would again mirror the process at FDA. Right now, CMS is required to consult outside experts, but this is a largely unstructured process. Expert panels would provide discipline and expert input to the process and help to ensure that decisions reflect the practical considerations of clinical practice.

Third, if we develop a center for creating government-financed studies that evaluate competing medical treatments, under current legislative proposals, it seems inevitable that the questions that are studied will turn on economic and policy considerations, rather than purely clinical hypotheses. It seems equally likely that this information will used to support coverage policies aimed at steering patients to lower cost alternatives. If that is the end, then we should make sure that we interpret this government-sponsored, comparative data in a consistent, transparent, and rigorous fashion. To these ends, we should develop in legislation a standard that guides when this information is actionable for decisions by government insurance programs. In many other contexts, government has clear criteria for when scientific information is sufficiently rigorous to support policy decisions.

There are other considerations that we can make in legislation to create a more rigorous and transparent process for making coverage decisions. I remain fearful that if the proposals before this Committee prevail, we will end up with a system where government health entities make an increasing number of one-sized restrictions that don't respect variation in preferences and disease.

Decisions on which medical products and services to use should be kept as close as possible to the locus where care is actually provided. The more remote these decisions become, the more we undermine the kinds of choice that allows clinicians to tailor care to patients' needs. There will also always remain an element of clumsiness when federal agencies assume these kinds of choices for us.

But if we do end up centralizing more of these clinical considerations in the context of government-directed reimbursement rules, we need to make sure that the process for making these decisions is fair and meticulous. We don't have such a system today, and it is not a consideration that, I believe, has been made in the current legislation. It is one that ought to be made before we go forward.

Mr. PALLONE. Mr. Miller.

STATEMENT OF THOMAS MILLER

Mr. MILLER. Thank you, Mr. Chairman. It is an honor to be here. I represent Siemens Health Care. It is one of the largest medical technology companies on the planet. And I can only say to you, when I was a young medical physics student at MIT studying quantum electrodynamics, I thought that was hard, but the task in front of you folks seems to be a lot more difficult than that.

In the written testimony, we talked about four what I would call myths surrounding medical-imaging technology, and we tried to dispel those myths. And the myths were, first, that medical-imaging technology increases the cost of care. We would actually argue just the opposite.

It is amazing that the phrase "exploratory surgery" has vanished from our vocabulary. It is because of imaging. It used to be 30 percent of appendectomies were unnecessary; we were cutting open healthy kids. We don't do that anymore. It used to be the patient coming into an ED with stroke symptoms would be observed, and now we use a CT scanner with clot-busting drugs to take care of them with potentially millions in cost savings for care later. And CT angiography is now being used to intervene in intermediate-risk chest pain patients, avoiding healthy patients going for angiography.

One thing in common with all these examples. We introduced something that seems to be expensive, that raises costs, but the total cost of care actually goes down.

The second myth that I wanted to address was that the financial self-interest of physicians has led to technology overuse: The evil physicians are just lining their pockets by ordering unnecessary exams. That is not true. Over 90 percent of imaging tests are ordered by nonradiologists, read by radiologists who have no financial link. In fact, medical imaging increases have happened also in Canada, a nation we have talked about a lot today, and there is no financial incentive to do so.

Imaging is being used more. It is being used more because of the diagnostic confidence. You know, I am a physician, I want to know what is going on with my patients, I will order an image.

Further reductions in reimbursements are the best means to reduce costs. We would actually argue just the opposite. Demand and supply in medical imaging are decoupled. By reducing reimbursement, you reduce supply. You do nothing to affect demand. And the DRA, which was implemented a couple of years ago, resulted in dramatic cuts, saving up to three times what the CBO estimated. Our business was affected by it by a 30 percent reduction, and we ended up laying off a bunch of people. I hate laying off people. That wasn't pleasant.

But last but not least, anyone that even attempts to argue that the use of advanced medical technology does not produce health care outcomes will have a fight with me. And breast cancer is the best example. It has been cited here before. It used to be a death sentence. It is not anymore. We find it earlier.

So what are our suggestions and recommendations to the committees? First, we wish to applaud the committee on four things:

First of all, the attempt to permanently fix the Medicare physician fee schedule sustainable growth rate formula; second, the abandonment of the Ways and Means Committee formula fix that would have created a separate expense target for radiology; the lack of a recommendation for radiology benefits managers. Personally, I like physicians to manage my care. I also wish to thank the House committees for not increasing utilization calculation on equipment in the draft from 50 to 95 percent, as some people estimate.

Let me make one point clear. A 95 percent utilization assumption would result in rationing care. We finance many of our customers. We know what their P&Ls look like, and medical imaging centers will close. Access will plummet, especially in rural areas. Wait times will result possibly for time-critical care, and hospitals in their current capital constraints state they can't pick up the slack.

Now, 75 percent, your recommendation, is better than 95 percent, but there has no credible data for either number. I think we had better study it and figure out what the access impact is before we do either.

So how do you get costs under control? What would we recommend? Well, you could do what Massachusetts General Hospital did and have physicians develop appropriateness guidelines. They reduced diet patient CT growth from 12 percent per year to 1 percent per year, despite of the fact their outpatient visits went up. We could get behind that.

We have been a strong advocate for accreditation requirements, containing the Medicare improvements for patient providers back to 2008, which assures that if you don't meet the accreditation, you don't get paid.

We support comparative effectiveness research. It might surprise you, but we do. We are a fan of our technology. We think it does good. But we support it only if it looks at the entire longitude of care, because as we have said, we believe in some cases the cost for imaging will go up, but the resulting expenses longitudinally will go down.

And, finally, we commend other legislative efforts to fund medical-imaging research. Specifically, we need to find a diagnostic imaging test for prostate cancer to benefit men like mammography has benefited women. The PRIME Act in House Resolution 353 does exactly this.

To conclude, medical imaging not only improves health care, it saves lives, and it also contributes to cost reductions in health care. So we should be careful of any policy that could reduce access.

I thank you for the privilege of representing Siemens Health Care in this national dialogue and your patience.

Mr. PALLONE. Thank you, Mr. Miller.

[The information follows:]

Health Care Reform Draft Proposal, Day 2
Testimony of Siemens Healthcare
Submitted by Thomas J. Miller, CEO,
Workflow and Solutions Division, Siemens Healthcare

Thank you, Subcommittee Chairman Pallone and Ranking Member Deal, for the opportunity to testify, on behalf of Siemens Healthcare, on the committee's healthcare reform proposal. It is an honor to be invited to testify before Congress on a topic of such national priority.

My name is Tom Miller, representing Siemens Healthcare, a global medical and healthcare information technology company. In the USA, we employ over 18,000 employees in our healthcare business and over 69,000 across all of our businesses. On behalf of Siemens Healthcare, we fully support you and our President in the task of making changes to our healthcare system to ensure affordable, quality healthcare.

We appreciate that significant players in the healthcare marketplace/delivery system are appropriately expected to generate savings and efficiencies to extend coverage to all Americans. Our industry, in coalition, is also doing so, including developing physician-driven appropriateness guidelines that will assure appropriate and effective use of diagnostic technologies to generate savings, while assuring every patient has access.

Additionally, Siemens Healthcare, as a pioneer in the healthcare information technology industry, is a strong advocate of Congress and the Administration's commitment to the use of Electronic Health Records. We know the true potential of well-executed HIT systems to generate efficiencies, support clinical decision-making, reduce errors, and improve workflow across the care process.

Personally, my entire career has been dedicated to developing and bringing to market medical imaging technologies and healthcare information systems. When I first began my career as a young physicist and engineer, I was passionate about the transformational benefits of advanced medical technologies. And this passion has not diminished now that we have the ability to see inside the human body in exquisite detail – without resorting to the scalpel.

The evidence that medical imaging finds disease earlier, renders some invasive procedures obsolete, and saves lives, is irrefutable. Therefore, I am sometimes disappointed that myths about these life-saving technologies have crept into some segment of public opinion and healthcare reform discourse. I am concerned when these same myths could result in policy decisions that are contrary to our mutual goals. I will therefore take the opportunity to enumerate and dispel four of these myths as they apply to the committee's healthcare reform proposal.

Myth 1: Expensive Diagnostic Technologies Increase the Cost of Care

Every quantum leap in productivity in history has been associated with a new technology and medicine is no exception. And the most wasteful acts in medicine are associated with treatments that are inappropriate or even totally unnecessary for the individual patient. Therefore, technology that permits greater knowledge of a patient's specific disease process, location, and extent must ultimately reduce subsequent costs.

Coronary CT angiography (CCTA) in the emergency room is a precise, rapid, and clinically effective technique to rule out/diagnose cardiovascular disease in patients presenting with chest pain. Costs for an ED-administered CCTA averaged $1,500, while patients admitted for further observation, stress testing and telemetry monitoring incur in excess of $4,000. Additionally, a patient receiving immediate CCTA is discharged, on average, after eight hours, while those who did not receive CCTA and were admitted for testing/monitoring have in-hospital stays exceeding 24 hours[1].

The diagnosis of abdominal pain was once approached with exploratory surgery and the accompanying expense of a hospital stay, risk of infection and complications, and loss of income during recovery. Now, MR and CT have rendered this surgery obsolete: CT scans have been found to significantly reduce the negative appendectomy rate and the number of unnecessary hospital admissions, saving $447 per patient[2].

The American Heart Association estimates that the long term cost for stroke care is expected to rise to $68.9 billion in 2009. Today, we have the imaging technologies to diagnose and categorize a stroke in the emergency room and administer, upon diagnosis, therapies that greatly diminish the likelihood of long-term disability, and, therefore, the medical and societal cost. It is estimated increased imaging could save up to $1.2 billion annually in stroke costs.[3]

All of these examples, and there are many more, share one common attribute: the introduction of a diagnostic imaging procedure, some would say expensive diagnostic imaging procedure, up front, to avoid much more expensive care later in the treatment process. Unfortunately, to date, most studies of diagnostic procedure costs focus on this cost category alone and are not in-depth studies that take a longitudinal accounting approach to evaluate downstream costs and quality of care. We have not yet accounted for imaging as a replacement for once-common invasive techniques and the accompanying costs and risks. Therefore, we support comparative effectiveness research and we urge that this research be conducted with open and transparent methods that focus on holistic patient and societal outcomes and not simply payer outcomes.

Reducing healthcare cost is a national priority, one which our industry fully supports. . And our industry, our customers and their patients has already been subject to very large reductions through the Deficit Reduction Act (DRA). However, we caution against looking narrowly at diagnostic imaging as a cost reduction strategy.

Medical imaging contributes to lower total healthcare costs, as supported by numerous independent studies. Researchers have found that every $1 spent on inpatient imaging correlates to approximately $3 in total savings[4]. And, according to a Harvard Medical School study, every $385 spent on imaging decreases a patient's hospital stay by one day, saving approximately $3,000 per patient[5]. Therefore, further cuts may result in the unintended consequence of ballooning costs of unnecessary treatments. Fifty-seven of Congress stated as much in their June 11 letter to President Obama urging him not to restrict access to medical imaging technologies. The bipartisan letter notes that that medical imaging can reduce health care costs and ensure better outcomes for patients.

However, we expect that, like other industries in the healthcare sector, we must continue to participate in cost reduction efforts and will continue to support efforts to achieve this aim.

Myth 2: The Financial Self-Interest of Physicians has led to Technology Overuse

The use of advanced imaging technology is increasing not due to the financial self-interest of physicians, but rather because it has transformed the practice of medicine for almost every disease. In fact, there is nothing else that would account for the fact that similar patterns of increase are occurring in every industrialized nation in the world, even in those nations in which there is a clear financial disincentive to do so.

The overwhelming majority (>90%) of imaging tests are ordered by non-radiologists and read by radiologists. Therefore, the vast majority of ordering physicians have no financial incentive to order these studies[6]. Furthermore, studies critical of the rise in medical imaging, typically document the increase and then attribute it to financial incentives without evidence[7]. Rather, the volume increase in imaging studies in the USA (as in the 25% increase in a two-year period in Canada[8] where there are absolutely no financial incentives driving this increase) is more likely due to the clear clinical benefit resulting from the diagnostic confidence thus gained.

As imaging continues to be increasingly integral to best clinical practice, physician-developed appropriateness guidelines, with IT-based clinical decision support tools, may provide an answer. In fact, leading private health systems, such as Massachusetts General Hospital (MGH), are currently using or piloting appropriateness criteria - and it is working. As just one example, the use of appropriateness guidelines at MGH reduced the outpatient CT growth from 12% annually to 1%. This decrease occurred even as the growth of outpatient visits to the same facility increased steadily at a compound annual growth rate of nearly 5%.

By advocating for both appropriateness and accreditation criteria – both of which were included in last year's Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) – the imaging community is gratified to have worked with members of Congress to produce solutions that benefit patients, providers and the Medicare program.

Therefore, we support the implementation of appropriate use guidelines as essential to healthcare reform. And we have worked within our industry coalition, the Access to Medical Imaging Coalition (AMIC), to develop such policies that ensure 'the right scan, for the right patient, at the right time.' Through such policies we can achieve the active elimination of unnecessary imaging services, defensive medicine behavior, and self-referrals, to both generate savings while preserving the quality of care. Our goal, like yours, is to achieve the optimal balance between minimizing costs and protecting patient access.

We have also been a strong advocate for the accreditation requirements contained in the Medicare Improvements for Patients and Providers Act (MIPPA) which will ensure that all imaging practices are subject to accreditation standards or will be prevented from participating in the Medicare program.

Myth 3: The Best Means to Reduce Costs and Overuse is to Reduce Reimbursements

Healthcare costs have continued to climb – the anticipated rate for 2010 is 9% (slightly lower than previous rates)[9] -- even with greater than expected savings generated by reduced reimbursements and even as spending on advanced imaging services has slowed significantly. This suggests that reducing imaging only results in an increase in the cost of care elsewhere. In fact, a study by the Government Accountability Office (GAO) reported the slowdown in imaging services, suggesting that any further cuts could endanger the availability of imaging to patients[10]. This would lead to the application of expensive therapies based upon incomplete diagnostic knowledge, or worse, waiting to apply therapy at a later stage of disease when it becomes much more expensive to treat or turns into a chronic condition generating costs associated with long-term care.

As is well known, the DRA proposed reductions in the reimbursement to medical imaging that were estimated by the Congressional Budget Office (CBO) to produce $500 million in 2007, the first year of implementation. However, the reality is that, according to the GAO, the DRA resulted in $1.64 billion in Medicare cuts to imaging services in 2007 alone. This is more than three times the $500 million estimate by the CBO.

This GAO analysis is supported by a Moran Company study that found that Medicare spending on advanced imaging was reduced by 19.2% from 2006 to 2007 and that the volume of these services grew by a modest 1.9% in that period. This analysis additionally shows that the rate of imaging volume growth has been declining since 2005. The slow 1.9% growth rate for advanced imaging is less than the overall growth rate for Medicare physician payments in general.

During the time period in which imaging reimbursements have been dramatically cut, overall healthcare cost continued to climb at two to three times the rate of inflation, exceeding $2.4 trillion in 2007[11]. As stated previously, demand for imaging is not created by the suppliers of imaging. Cutting supply by reducing reimbursement is equivalent to rationing healthcare availability, contrary to one of the primary goals of healthcare reform.

The solutions to controlling costs are not an easy fix. Many inefficiencies in healthcare can be addressed through sophisticated healthcare information technology systems: the right information at the right time to the right person. We commend you and the Administration for ensuring that HIT is an integral component of healthcare reform.

Siemens Healthcare also wishes to applaud the committees in their goal to permanently fix the Medicare Physician Fee Schedule Sustainable Growth Rate (SGR) formula, a critical policy which may be omitted from the Senate committee drafts.

We were pleased to see the Committees have abandoned previous policy, in which the Ways and Means Committee approved a formula fix that would have created six separate expenditure targets, including one for radiology. To apply a volume cap on payments to radiologists for services ordered by other specialties could have resulted in inequitable payments. Siemens Healthcare strongly believes that the SGR problem should be remedied permanently for predictability in payment for our customer healthcare providers and for their patients.

We also wish to thank the House Committees for not ceding to recommendations to increase the assumption on utilization of equipment from 50% to 95%. Although 75% is more reasonable than a 95% increase, which could cut payments for CT and MR alone by over 40%, there is no credible data based on machine usage to validate either number. Therefore, our strong recommendation is that, before such a deep cut is applied to all advanced imaging services nationwide, a study be conducted to determine actual use rates and the effects of such increases on patient access to care.

The current MedPAC recommendations to change the reimbursement rate formula are based on isolated survey data. AMIC identified several problems with the survey on which MedPAC based its recommendations:

- The sample size of six urban diagnostic imaging centers excluded rural imaging centers, and was, therefore, not indicative of the actual national environment.
- The MedPAC survey only included CT and MR but the recommendation encompasses all imaging modalities. This may again result in unintended consequences such as the reduction of breast cancer screening availability reversing the gains enabled by imaging in the fight against this disease.
- The methodology used to determine the utilization assumptions did not account for current health status or age of the patient and the corresponding impact on patient preparation time, a significant factor affecting the length of an appointment, and ultimately, the utilization rates. Older and ill patients – the growing Medicare population -- simply require more time to be prepared for an imaging exam.

Increasing utilization rates will effectively change how imaging service are delivered. Today, many tests are conducted in outpatient diagnostic imaging centers which, if cuts are enacted as proposed, will not be able to survive. This forces the patient in need of imaging to go to a hospital, which may mean traveling a greater distance and long wait times. Hopefully, Americans will not see the same appointment wait times as are common in Great Britain where patients wait five weeks for a CT and up to 14 weeks for an MRI[12].

Forcing patients to hospitals for imaging will over-tax hospital capacity. And, in the current financial crisis, hospitals increasingly lack the financial capital to expand capacity. Shifting the imaging burden to hospitals will therefore result in care rationing and associated long wait times for possibly time-critical medical studies.

Finally, we will, as scientists and engineers, continue to do our part to reduce the costs and increase the clinical performance of the technology we produce. As an example, the capital and operating costs of a typical 1.5T MR scanner of today cost less than one half of what it did five years after introduction, and yet offers dramatically increased diagnostic performance.

We acknowledge the tremendous scrutiny and pressure to enact healthcare reform and to find the means to fund the cost. We appreciate that you will not allow the pressure and demand for speed to displace an informed and cautious approach to developing a system that ensures continued access and quality for all.

Myth 4: The Use of Advanced Diagnostic Technology does not Improve Health Outcomes

Imaging has enabled screening, earlier detection, and greater accuracy and speed in diagnosing many of the most serious of diseases facing our population, including cardiovascular and neurological conditions and cancers. Earlier detection of disease has a direct relation to medicine's ability to treat and cure. Diagnostic imaging doesn't just improve health, it saves lives.

To dispute this myth, one only has to consider the effectiveness of our breast cancer imaging devices and the effect on the decrease in breast cancer deaths. A full 46% of the breast cancer mortality rate decline is directly attributable such screenings[13]. In patients with recently diagnosed breast cancer using mammograms, MRI is effective in detecting additional, unsuspected malignant tumors in approximately 20% of patients[14]. These are tumors that were previously undetected, and, therefore, were not considered in determining disease staging and appropriate treatment protocols.

New PET (positron emission tomography) scanners can allow precise discovery and localization of very small clusters of malignant cells that have metastasized. We know that for the major cancers, physicians have reported that PET scanning allowed them to avoid additional tests or procedures in 77% of patients. Moreover, in over 36% of patients, the results of the PET test led the physician to alter the course of the patient's treatment[15].

The USA also has demonstrably better outcomes for many diseases, including cancer, when compared to those in European countries, with five-year survival rates of at least

90% for skin melanoma, breast, prostate, thyroid, and testicular cancer. In Europe, only one type reaches 90% survival: testicular. These outcomes are most likely due to regular and early screenings – in the USA, even the uninsured, are more likely to have regular screenings and have the fastest access to treatment. Consider that, in the USA, 84% of women (ages 50-64) have regular mammograms compared to 63% in Great Britain.[16] This may be directly attributable to greater access to the technology.

Furthermore, a study conducted by Professor Frank Lichtenberg of Columbia University using statistically controlled state by state variation data showed advanced imaging techniques extended life expectancy in the USA by 0.62 - 0.71 years over the time period 1991-2004[17].

We have, quite simply, the most innovative medical technologies and advanced treatments, the best clinical research facilities, and the finest healthcare providers in the world. In the commitment to create an affordable, national healthcare system, we must take great caution not to continue the trend to make advanced diagnostic technologies a target for further cuts.

We commend other legislative efforts to fund medical imaging, specifically, the PRIME Act and House Resolution 353, which call for research into utilizing medical imaging to develop more effective diagnostic and treatment tools for prostate cancer. For while, one in six men will diagnosed with prostate cancer, we currently, we do not have any truly effective diagnostic means. And many men undergo unnecessary biopsies and surgery, with current treatments leaving 50-80% of men impotent, incontinent or both[18]. In the future, the protocol for prostate cancer will be image-guided diagnosis and treatment that is far more accurate and far less invasive saving lives as well as costs.

Concluding Statement

In conclusion, allow me to present to you four facts about medical imaging:

1. Diagnostic technologies support more cost-effective care by enabling earlier, faster and more accurate diagnosis, eliminating the need for expensive and invasive surgeries and inappropriate therapies, reducing hospital admissions, and, in many cases, avoiding costs of long-term chronic conditions.

2. The growth in medical imaging can be attributed to its transformational effect on medicine for almost every facet of every disease. Physicians know that medical imaging is simply the best tool they have to diagnose disease with confidence. And, the great majority of physicians have one overriding interest: to achieve the best possible outcomes for their patients.

3. The best means to reduce costs and overuse is by creating a more efficient healthcare system through Healthcare Information Technology and to manage medical imaging utilization through physician-driven appropriateness guidelines.

4. Advanced diagnostic imaging technologies don't just improve health – they save lives. Simply ask any woman whose mammogram detected breast cancer in its earliest stages to make her a survivor. Ask anyone whose Coronary CT Angiography found blocked arteries before he/she suffered a catastrophic – or fatal – heart attack. Or ask my father, who, after suffering a stroke, can now still converse with his grandchildren due to immediate access to critical diagnostic imaging technology.

Understanding disease – finding it sooner, intervening earlier and with better outcomes is the true solution to our healthcare crisis. And, diagnostic imaging –with its insight into the human body – is the key.

Thank you for the privilege of representing Siemens Healthcare in the national dialogue of healthcare reform. As the legislative process progresses, we look forward to working with you and with our President and all involved institutions and organizations to build policies that ensure appropriate use of imaging and access to these technologies to prevent, detect, and treat disease – and to build a healthier America.

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[1] **Society of Academic Emergency Medicine Proceedings**, Study presented by Judd E. Hollander, MD, University of Pennsylvania, May 2009. Goldstein, James A. et al. **A Randomized Controlled Trial of Multi-Slice Coronary Computed Tomography for Evaluation of Acute Chest Pain.** *Journal of the American College of Cardiology.* 2007: 9(8)

[2] Rao, Patrick M., et al. **Effect of Computed Tomography of the Appendix on Treatment of Patients and Use of Hospital Resources.** *N Engl J Med* 1998 338: 141-146

[3] Gleason, et al. **Potential Influence of Acute CT on Inpatient Costs in Patients with Ischemic Stroke,** *Academic Radiology,* 2001 Oct: 8(10): 955-64

[4] Beinfeld, Molly, MPH and Gazelle, Scott. **Diagnostic Imaging Costs: Are They Driving Up the Costs of Hospital Care?** Radiology, June 2005

[5] **Medical Expenditures Panel Survey 2004**, (Average expense per night for a hospitalization in 2004 was about $3,000 while median per diem was about $1,800) (http://medps.ahrq.gov/mepswebdata_files/publicationsst164/stat164/stat164.pdf on 1/07/09)

[6] Smith-Bindman et al. **Rising Use of Diagnostic Imaging in a Large Integrated Health System**, *Health Affairs*, Volume 27, Number 6, DOI: 10.1377/hlthaff.27.6.1491
[7] Baker, et al. **Expanded Use of Imaging Technology and the Challenge of Measuring Value**, *Health Affairs*, Vol. 27 Number 26 doi: 10.1377/hlthaff.276.1467
[8] **Canadian Institute for Health Information,**
(http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_13jan2005)
[9] **Behind the Numbers: Medical Cost Trends in 2010,** Price Waterhouse Coopers, pwchealth.com, June 2009
[10] **Medicare:** Trends in Fees, Utilization, and Expenditures for *Imaging* Services before and after Implementation of the Deficit Reduction Act of 2005 , GAO-08-1102R, September 26, 2008, p.8
[11] **Facts on Healthcare Costs,** National Coalition on Healthcare, (http://www.nchc.org/facts/cost.shtml)
[12] An Improving Picture. Healthcare Commission UK
[13] Berry, et all **Effect of Screening and Adjuvant Therapy on Mortality from Breast Cancer,** *N Eng J Med*, Volume 353:1784-1792
[14] Schell, et al. **Role of Breast MRI in the Pre-operative Evaluation of Patients with Newly Diagnosed Breast Cancer**. *American Journal of Roentgenology*, 2009, 192 (5): 1438 DOI: 10:.2214/AJR.08.1551
[15] Hillner, et al. **Relationship between Cancer Type and Impact of PET and PET/CT on Intended Management: Findings of the National Oncologic PET Registry**, *Journal of Nuclear Medicine*, 2008, 49 (12) 1928-1935 DOI: 10:2967/jnumed.108.056713
[16] **National Center for Policy Analysis**. October 2007
[17] Litchenberg. **The Quality of Medical Care, Behavioral Risk Factors, and Longevity Growth,** National Bureau of Economic Research, Working Paper
[18] The AdmeTech Foundation (www.admetech.org/TakeAction/index.php

Mr. PALLONE. Ms. Buto.

STATEMENT OF KATHLEEN BUTO

Ms. BUTO. Thank you, Mr. Chairman. My name is Kathy Buto. I am vice president of health policy for Johnson & Johnson, and we really appreciate the opportunity to be here to comment on the discussion draft. We very much support enacting legislation this year to provide coverage for all Americans, and we look forward to working with the committee toward that end.

By way of introduction, I want to just say that I focus on a broad array of health policy issues for Johnson & Johnson worldwide in many countries, including China and India as well as the United States, and I have spent much of my career on these issues, including 18 years with the Health Care Financing Administration where I was involved with implementing changes in Medicare and Medicaid and in efforts to pass earlier health care reform legislation.

I am going to focus on really four things, and leave to you my written testimony on a number of other provisions that we support in the bill: wellness and prevention, comparative effectiveness research, part D of Medicare, and the public plan. So first wellness and prevention.

As an employer that has focused for more than 30 years on improving the total health of our employees, we strongly support the inclusion of prevention benefits and zero cost sharing to promote greater wellness in the population. Our CEO, Bill Weldon, was invited recently to meet with President Obama along with other executives to describe their experiences in reducing risk factors in the workforce. And I will just give you one example. At Johnson & Johnson over a 10-year period beginning 1995–1999 and measuring a difference in 2007, we reduced smoking from 12 percent in the workforce to 4.3 percent. And we had many results like that, which are in the written testimony. So we believe that this is critical. We at J&J have saved about $250 million over 10 years through these efforts.

Now, comparative effectiveness research. We are very pleased that the bill includes an enterprise that will focus on improving the evidence physicians and patients can use to make treatment and care decisions. And while we have great respect for the Agency For Healthcare Research and Quality under Carolyn Clancy's leadership, we actually believe a public-private entity provides a stronger long-term framework with transparency of methods and processes, inclusion of stakeholders, and a focus on clinical comparative effectiveness research. We think a public-private entity can build trust and collaboration, which is critical in this important area; leverage additional research dollars of physician and academic groups as well as industry; and create a broader-based constituency for sustainable funding resources for this enterprise.

Rather than provide a single assessment of cost effectiveness, we believe the entity should provide information that allows the market to determine the relationship between clinical value and costs for different patients of varying plans. And I would include, for example, minorities and women who have particular issues in this kind of research.

Now, switching to Medicare Part D. We want to commend the committee for taking on this difficult issue of closing the coverage gap or doughnut hole over time. The pharmaceutical industry's recent proposal to provide discounts of 50 percent for the majority of beneficiaries in that gap we think is going to complement your approach by providing immediate relief in reducing those costs.

We also want to applaud the committee for allowing payments to be made through AIDS drug assistance programs and the Indian Health Service to count toward meeting the out-of-pocket threshold as well.

Let me conclude by talking a bit about the public plan. We certainly support having a health insurance exchange that can provide information for the public on different options, and we support a number of the other changes proposed, such as administrative simplification and insurance reforms. We think these changes are going to actually make the government plan unnecessary, and we believe concerns about a public plan takes the focus off sort of job number one, which is achieving coverage of all Americans and identifying sustainable financing approaches as well as making fundamental changes in the system of care.

Providers like the Mayo Clinic—and they were recently cited in an Atul Gawande article in the New Yorker as providing highest quality care at the lowest cost—have been very vocal about their concern that the public plan is going to use Medicare rates and therefore not cover actual provider costs. Cost shifting will ultimately lead to higher-cost private plans and ultimately a dominant public plan that underpays. We are concerned, and our industry is concerned, because systematic underpayment of providers will undermine the market base system that allows incentives to find cures for cancers, Alzheimer's, and other dread diseases.

We also are concerned about government negotiation of pharmaceutical prices reducing the willingness of our industry to undertake risky and long-term investment needed to produce important treatments. And we also think this threatens American leadership in medical innovation in ways that we don't fully understand and would be hard to anticipate.

The last point on this is that biologics promise to be a major avenue for breakthrough medicines and one we know the committee is considering. We have been at the forefront in the U.S. And other countries of supporting a regulatory pathway for biosimilars that assures patients safety and preserves incentives for life-changing and life-saving medicines. We have strongly supported H.R. 1548, introduced by Representative Anna Eshoo, which has over 100 cosponsors.

I will leave to you the written testimony which enumerates a number of other provisions in the discussion draft, such as the Medicaid eligibility; expansion of funding for community health centers, which we have recently supported in a bill introduced by Representative Clyburn and others; as well as a focus on health disparities and health literacy; and a process to make payments between two physicians from industry more transparent.

So thank you again for the opportunity, and we look forward to working with you.

Mr. PALLONE. Thank you.

[The information follows:]

Statement of Kathleen Buto

Vice President, Health Policy

Johnson & Johnson

Before the Subcommittee on Health

Committee on Energy and Commerce

House of Representatives

On the Tri-Committee Health Reform Bill

June 24, 2009

Good afternoon, Mr. Chairman and members of the Committee. My name is Kathy Buto, Vice President, Health Policy, Johnson & Johnson, and I am pleased to come before you today to offer comments on the Tri-Committee Health Reform bill. Johnson & Johnson supports enacting legislation this year to provide coverage to all Americans, and we look forward to working with your committees to achieve this critical objective. Johnson & Johnson is the most comprehensive health care company in the U.S., with businesses spanning pharmaceuticals, medical devices, diagnostics, health and wellness, and consumer products, such as over-the-counter medicines, baby products, and cosmetics. The corporation employs approximately 119,000 individuals worldwide and had over $63 billion in sales in 2008. The major business segments comprise pharmaceuticals (39% of sales), medical devices and diagnostics (36%) and consumer products (25%).

By way of introduction, I focus on a broad array of health policy areas for Johnson & Johnson worldwide, including Medicare, Medicaid, access to care both in the U.S. and in other countries, and public policies to improve evidence-based practice, achieve greater value in health care, and to maintain incentives for innovation to address unmet medical needs. I have spent much of my career on these issues, including 18 years with the Department of Health and Human Services, where I was involved in implementing changes in the Medicare and Medicaid programs and participating in efforts to enact health reform legislation.

The draft bill is comprehensive, so I will focus on a few topics where our perspective as a company might be helpful to the Committee: these are wellness and prevention, comparative effectiveness research, Medicare Part D, and options available through the health insurance exchange.

Wellness and Prevention

As an employer that has focused for more than 30 years on improving the total health of our employees, we were especially pleased that the bill would include prevention benefits and set cost sharing at zero in Medicare and the

essential benefits package to promote the use of approaches to encourage greater wellness in the population. Recently, our CEO, Bill Weldon, was invited to meet with President Obama and other executives, to discuss what can be learned from successful employer-based wellness and prevention that might be incorporated into health reform. We were able to share the fact that, in the past 10 years, Johnson & Johnson has used incentives and outreach to reduce risk factors in our employees through these programs. For example, smoking was reduced from 12% in 1995-1999 to 4.3% in 2007. High blood pressure reduced from 14% to 6.2%. Elevated cholesterol levels were reduced from 19% to 7%. Johnson & Johnson saved $250 million over 10 years. Last year, we decided that we need to develop a business that will help other employers achieve these results as well. We believe the bill's focus on promoting use of clinical preventive services, tobacco cessation, and vaccines will make a difference in improving the health of the nation.

Comparative Effectiveness Research

We are pleased that the bill includes having a comparative effectiveness enterprise that will focus on improving the evidence physicians and patients can use to make treatment and care decisions and reduce the geographic variation in treatment that has been documented by the Dartmouth group. We have great respect for the Agency for Healthcare Research and Quality under the leadership of Carolyn Clancy. But having worked in government, I know the yearly uncertainty about funding and staff resources that can sometimes hinder a single agency within the broader federal government. We believe the overall effort will be better served if the entity is a public-private partnership, with transparency of methods and processes, inclusion of stakeholders, and a focus on clinical comparative effectiveness research. Such an entity will provide information that will allow the market to determine the relationship between clinical value and cost. There are benefits of having a public-private entity, including leveraging additional research dollars of physician and academic organizations and industry, creating a strong and broad-based constituency for sustainable funding, and building the trust and collaboration needed for the entity to succeed.

Medicare Part D

We commend the Committee for the proposal in the bill that would develop a path for closing the Medicare drug benefit coverage gap or "donut hole" over time. The pharmaceutical industry's recent proposal, to provide discounts of 50% for the majority of beneficiaries in the coverage gap, will provide immediate relief in reducing the cost burden to beneficiaries during this transition. Rather than provide rebates to the federal government as mentioned in the bill, we believe our proposal will help the sickest beneficiaries by providing financial help directly to them. We do applaud the committees for including in the bill an important change for patients receiving pharmaceuticals through AIDS Drug Assistance Programs and Indian Health Service by allowing those costs to count toward meeting the threshold for out-of-pocket costs.

Health Insurance Exchange

We support having a health insurance exchange that can provide information to the public on different options, including covered benefits and costs of coverage. We believe it is important to address administrative simplification and support reforms to make insurance more accessible and affordable. We understand that, in order for these reforms to work, individuals have a responsibility to get coverage. We believe that these reforms will make a public or government plan option unnecessary. You may wonder why there is such concern about a public plan. From our perspective, health reform must be first and foremost about making coverage available and accessible to everyone and to make changes in how we use health care resources – focus on preventing disease and early detection, using better evidence to guide care options, and improving reimbursement incentives so integrating care is made easier not harder.

We know there are concerns from providers like the Mayo Clinic and others about Medicare's administrative pricing systems, which usually do not cover actual provider costs. Medicare already shift costs to employers and private payers, and an expansion of these payment rates to a potentially large public plan

and many more enrollees will make matters worse. From our industry, there's concern that a public plan could undermine a market-based system that provides incentives for the long-term research we will need if we are to find cures for cancers, Alzheimers disease, and other debilitating and costly conditions. A government plan that negotiates prices of pharmaceuticals would be more likely to use price controls that would undermine risky and long-term research in important new treatments. We won't know what hasn't been developed until we look back and wonder why we aren't seeing the breakthroughs we've seen in the past.

On the topic of incentives for innovation to address unmet medical needs, biologics are considered by many researchers to be the most promising avenue for some of these cures. We know the Committee is looking at a pathway for follow-on biologics. Johnson & Johnson has been in been in the forefront in the U.S. and many other countries of supporting a regulatory pathway for biosimilars that assures patient safety and preserves incentives for the discovery and development of life-changing and life-saving medicines. We would be happy to make our experts available to work with you. We strongly support the Pathway for Biosimilars Act (H.R. 1548) introduced by Rep. Anna Eshoo (D-CA), which at last count has over 100 co-sponsors.

Other Important Provisions

The bill would make important changes to providing coverage quickly to some of the lowest income individuals. PhRMA recently joined Families USA in endorsing a balanced approach to health care reform, including increasing Medicaid eligibility to 133% of the poverty level. Johnson & Johnson also supports the expansion of funding for federally-supported Community Health Centers (CHCs) and has endorsed the Community Health Center Funding Expansions Access for All Americans Act (H.R. 1296), introduced by Rep. Clyburn (D-SC) and others . Particularly, as broader reform will require a transition period, both of these changes would improve access for uninsured individuals immediately.

We also believe that a focus on health disparities, based on race and ethnicity are important. Medicare and private insurers have found that, even with equitable coverage on paper, disparities exist in the use of services and in the outcomes of care by race and ethnicity. At Johnson & Johnson, we are working on health literacy initiatives worldwide, as we believe health literacy initiatives, such as those included in this bill, are needed to address language and cultural barriers but also to make complex health care information more understandable.

Another important provision relates to establishing a process to make payments to physicians from pharmaceutical, medical device, and diagnostic companies transparent. We are in favor of greater transparency regarding the relationships between healthcare companies and physicians. We continue to believe such transparency is in the best interest of patients, payers, other stakeholders in healthcare, and the industry itself. Earlier this year, Johnson & Johnson endorsed the Physician Payments Sunshine Act of 2009 (S. 301) introduced by Senators Kohl and Grassley.

Further, please be aware of what we are doing voluntarily in this area. The U.S. pharmaceutical companies of Johnson & Johnson will begin voluntarily providing information about the payments that they make to physicians on their respective web sites beginning in the first half of 2010. Reporting will be expanded to include Johnson & Johnson's medical devices and diagnostics companies and will reflect the general provisions of S. 301 by June 30, 2011.

We support the inclusion of transparency language in health care reform legislation. We do, however, have some concerns with the differences between S. 301 and the discussion draft. While further adjustments may be made to the bill as it moves through your Committee, we are hopeful that Congress will see the wisdom of focusing on a single, well-designed and nationwide approach to the reporting of physician payments. Properly designed and comprehensive, this will be more useful to patients than a patchwork of disparate information resources

based on different requirements across state and localities, all covering the same types of disclosures.

We want to commend the Committee for including a focus on the primary care workforce to meet the needs of reform. Johnson & Johnson has undertaken for many years, a Campaign for Nursing's Future, to highlight the critical role of nurses in our health system. Yet, reimbursement, medical education policies, and scope of practice rules can slow the availability of nurses to meet these needs – we believe this bill will help advance the availability of nurses and other important practitioners of primary care.

In conclusion, I would like to thank the Committee again for this opportunity to testify on this important issue. We would like to work with you to enact reform this year. We believe there is broad support to expand access to all Americans and a sincere commitment to find ways to finance it.

Mr. PALLONE. Mr. Vaughan.

STATEMENT OF WILLIAM VAUGHAN

Mr. VAUGHAN. Thank you, Mr. Chairman and Members, for inviting us.

Consumers Union is the publisher of Consumer Reports, and we don't just test tires and toasters; we try to help people with medical products. And we do strongly endorse the approach taken in the tri-committee draft, assuming that additional savings are found or progressive financing to make sure that it is budget-neutral and sustainable over time.

We believe the draft is a plan that can give all Americans that peace of mind of health security and an affordable quality system. The draft bill has done an excellent job of identifying a number of savings, both large and small, but we hope you can dig deeper for some more savings to stop that Pacman that is gobbling up our GDP. Gotta try.

As for PhRMA's pledge for $80 billion in savings, wow, that is great. Congratulations to PhRMA, but I think it was Ronald Reagan used to say, trust but verify. We hope that you can get this in legislative language in a way that CBO would score it for $80 billion in savings.

We like the drafts bill trying to close the doughnut hole, and we really like the provisions on helping low-income people in Part D. We would like to see that doughnut hole closed faster, but that would take more money, and we suspect that PhRMA is likely to say, hey, we have given at the office, go away. But we hope you will keep pushing on that door a little bit.

There should be no excuse whatsoever to reduce the pressure for the maximum use of generics in Part D. In fact, you might want to consider an amendment to get a rebate from Part D plans that are poor in doing generic substitution.

There are a lot of other sources of money on the table. H.R. 1706, by Mr. Rush and seven others of this committee, would ban reverse payments from brand companies to generics to keep the generic off the market. Yesterday the FTC Commissioner said: Gee, that would save the government about $1.2 billion a year and consumers $3.5 billion a year. Hope you guys can do that one.

We have supported Mr. Waxman's follow-on biologics, but we have got to find a solution. Last June—as of last June, Europe had approved over 10 of these, and I am assuming they have gone higher, and we are sitting here paralyzed. And so we hope you can come together and work something out, because that is essential.

The June MedPac report that has just come out in talking about FOBs also suggested maybe take a look at reference pricing. Why pay more for something that doesn't bring more to the table than what you are already paying?

We urge you to also support giving Medicare negotiating authority in Part D. Once you get a good food and drug safety program in place on imports, let us have reimportation or free trade in pharmaceuticals. And, a new idea, require rebates to Medicare for drug inflation in excess of population growth and CPI, except—except—no rebate on a new kind of drug, a new molecular entity that the FDA would identify. This would get you a handle on spending, but

move the industry more towards really breakthrough research. If my wife sees an ad on TV for a fourth type of ED, she is going to throw something at the TV. I mean, we need lifesaving breakthrough research, and not just more of some of these "me too's."

The other areas, we love comparative effectiveness research provisions in your bill. Save the consumers a ton of money. If you want to see how it works for consumers, the last page of my testimony takes a look at heartburn medicine and proton pump inhibitor stuff. And if you look at the science that the comparative effectiveness research brings, there is no particular difference between a $20 pill and that purple pill. And working with your doctor, check it out. We always say check with your doctor first, but why in the world would you start with a $200-a-month medicine when you can get a $20-a-month one that is just about as good?

Finally, we endorse the physicians' payment sunshine provision in this bill. That is the one that would disclose how much drug and device companies are giving to doctors and med schools. We think those gifts aren't totally free. They come with some strings of influence, and we need to stop that.

Thank you so much for your time.

Mr. PALLONE. Thank you, Mr. Vaughan.

[The information follows:]

Testimony of William Vaughan
Senior Health Policy Analyst
Consumers Union
before the
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
June 24, 2009

on

The Tri-Committee Draft Proposal for Health Care Reform: Pharmaceutical Provisions

Mr. Chairman, Members of the Committee:

Thank you for inviting Consumers Union to testify on the pharmaceutical aspects of the Tri-Committee Draft health care reform proposal.

Consumers Union is the independent, non-profit publisher of *Consumer Reports.*[1] We not only test consumer products like cars and toasters, we evaluate various health products, and we apply comparative effectiveness research that can save consumers hundreds and even thousands of dollars in purchasing the safest, most effective brand and generic drugs.[2]

> --Since 1939 we have been advocating for an affordable, secure, quality health insurance system for everyone. That year, Congressman Dingell, we endorsed your father's bill, the Wagner-Dingell Act.
>
> --Our May 2009 issue features an article on "hazardous health plans," and points out that many policies are "junk insurance" with coverage gaps that leave you with a financial disaster. One of the most prevalent stories we have heard from our readers is that they thought they had good insurance—until they had a major health problem, and then it was too late.
>
> --Our about-to-be-released August issue includes a 10-page special editorial feature, using examples of families across the country, on why American

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[1] Consumers Union, the nonprofit publisher of *Consumer Reports*, is an expert, independent organization whose mission is to work for a fair, just, and safe marketplace for all consumers and to empower consumers to protect themselves. To achieve this mission, we test, inform, and protect. To maintain our independence and impartiality, Consumers Union accepts no outside advertising, no free test samples, and has no agenda other than the interests of consumers. Consumers Union supports itself through the sale of our information products and services, individual contributions, and a few noncommercial grants.

[2] See www.ConsumerReportsHealth.org/BBD

consumers so desperately need comprehensive reform. We've attached a copy of this special issue.

Tri-Committee Draft

Therefore, we strongly endorse the approach taken in the Tri-Committee draft, assuming that additional cost containment or progressive financing will be added to ensure that it is budget neutral.

We believe the Draft is a plan that would at long last ensure access to affordable, quality, "peace of mind" health insurance for every American.

The Draft has too many major improvements to list separately. In Attachment I, we provide a table that lays out our health reform principles from our August magazine issue, and how the Draft would dramatically advance these key consumer issues. Attachment II includes a few suggestions to make the Draft even better, but these are minor suggestions compared to the important reforms proposed in the bill.

The Need for More Savings

The American people are desperately worried about the high—and rapidly inflating—cost of health care. Our national polls have frequently shown that the high cost of health care is one of the greatest concerns for consumers, and many fear they would be bankrupted if a major medical problem hit their family. Climbing health costs threaten our national future. Last week The Economist (June 13-19) editorialized the issue well:

> "America has the most wasteful [health] system on the planet. [America's] fiscal future would be transformed if Congress passed reforms that emphasized control of costs as much as the expansion of coverage that Barack Obama rightly wants."

The Draft bill has done an excellent job in identifying big and small savings, but more needs to be done in this bill.

Why?

--The Draft includes the vital reform of requiring private insurance to be guaranteed issue with no pre-existing conditions;

--These needed reforms will only work for private insurers if everyone has to buy health insurance (and can't just wait till they are sick, and then buy it);

--We can't mandate that people buy insurance unless it is a good product and is affordable;

--Many unemployed, lower-income, and working Americans will need subsidies at least to the 400% level for the mandated insurance to be affordable;

--The subsidies cost money, and in a budget neutral bill, that means finding savings or finding taxes.

--The documentation is overwhelming that our health care 'system' is very inefficient and that enormous savings are possible. Thus we hope you will make savings a priority.

Pharmaceuticals in the Draft

We endorse the pharmaceutical changes you have proposed, but many additional savings have been left on the table and should be re-considered. We especially urge you to consider reforms that will answer the industry's favorite lobbying technique—that if you question our profits, we won't do any more research. The fact is that the drug industry is not doing enough efficient, effective research on breakthrough life-saving medicines.[3] Congress can achieve savings that also focus more resources on important breakthroughs.

PhRMA's Pledge

We note the recent reports that PhRMA has agreed to find $80 billion in savings over the next decade in drug discounts, largely to fill in the Medicare Part D donut hole. If true, that is good news. It is a major step forward and we congratulate PhRMA.

But as Ronald Reagan said so often, 'trust but verify.'

Some of the Members were here for the Carter-era fights over hospital cost containment. The hospitals defeated containment legislation by pledging to hold costs down. Congress trusted them. The public was betrayed.[4] The thought of trusting a savings pledge from a for-profit trade association (assuming that PhRMA can get past the anti-trust issues) is like watching Lucy holding the football--you know what's going to happen.

Therefore we hope you will legislate the policies on which the pledge is based in a CBO-score-able way. If the savings off baseline are not achieved, company-specific rebates to Medicare, Medicaid, and the Health Insurance Exchange could be legislated. For companies that fail to meet the savings for ERISA/private sector plans, various tax breaks could be reduced (and the savings placed in a compensation fund for the health plans).

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[3] FDA data shows that only about 15 percent of new drug approvals are for breakthrough or new molecular entities. The rest are 'me-too' type drugs that bring some competition to the marketplace, but generally little or no medical advance.

[4] Karen Davis, Commonwealth Fund, May 26, 2009, "Bending the Health Care Cost Curve: Lessons from the Past": "The [hospital] coalition set a 1978 goal of reducing the rate of increase by 2 percentage points below the 1977 rate of increase; that goal of 13.6 percent increase in 1978 was met. All subsequent goals, as well as goals related to holding down increases in the number of beds and employees, as well as increases in capital investment were substantially exceeded...."

Pharmaceutical Provisions in the Draft

Comparative Effectiveness Research (CER)(page 423ff):

We strongly endorse the AHRQ-based CER Trust Fund that, when fully operational, will provide $375 million a year for this key safety and efficiency research.

Attachment III is a sample of our Best Buy Drug work on proton pump inhibitors (anti-heartburn medicines). The CER data is from the Oregon Health and Science University. As you can see, several of the medicines are very similar. But one is 1/10 the cost of the heavily advertised brand drug. As a consumer, why not prefer the $20 a month drug rather than the $200 a month product? If it doesn't work, after talking to your doctor, try one of the others. This is what CER can do to help hold down costs. Clearly, in this example, most of us could save $180 a month.

Many are worrying that comparative effectiveness research (CER) may lead to limits of what is covered. We believe CER will help us all get the best and safest care. It makes sense to give preference to those items which objective, hard science says are the best, especially if the research takes into consideration relevant differences such as gender, ethnicity, or age. But if a drug, device, or service does not work for an individual, then that individual must be able to try another drug, device, or service without hassle or delay. The key to this is ensuring that the nation's insurers have honest, usable exceptions processes in place. A "model exceptions and appeals"-type legislative effort is where we should be putting our energy to address the otherwise legitimate concern of many people about CER.

Physicians Payments Sunshine Provisions (page 560ff)

Including this anti-fraud type provision in the bill should score for savings and reduce the level of unsavory 'gifting' that is flooding the medical world. In recent years, there has been phenomenal growth in various forms of financial transfers to those doctors and hospitals who are responsible for ordering drugs, devices, and supplies. These financial incentives are given many names and justified in many ways, but we all know 'there is no such thing as a free lunch.' These financial 'gifts' are designed to encourage, subtly and not so subtly, the increased use of the givers' products.

When disc jockeys were given gifts by record companies, it was called payola—and it was a scandal. It should be equally disturbing to patients and health policymakers to see so much money transferred to physicians and hospitals, because it can distort medical judgment and increases utilization of the most expensive products which are not necessarily the best products.

Closing the Doughnut Hole Division B, Section 1182, p. 307):

We strongly support closing the Medicare Part D donut hole. Congress took a major step by enacting a prescription drug benefit. But it can be made better. Beneficiaries in the donut hole—this year a gapping hole of over $3400—frequently stop taking their medicines or cutback on doses. The health of some of our most vulnerable beneficiaries could be improved by closing this gap. The Draft takes about a decade to achieve this, and with additional resources (ideas described below), we hope you could end this insurance anomaly sooner.

Improving low income access to medications: Division B, Title II, Subtitle A (pages 316ff). These sections which raise asset tests and make it easier to enroll in the low-income subsidy programs will make a major difference in the ability of the most vulnerable to take advantage of the promise of Part D and actually obtain their medications.

Protecting Medicare Part D beneficiaries from mid-year formulary changes (Division B, section 1185, pages 312-313): We support this section permitting beneficiaries to switch plans if the plan makes formulary changes that impact the enrollee. In our monitoring of the program, we have found that a much more serious problem is year-long price increases in various drugs that can badly disrupt a senior's budgeting plans. These often dramatic price increases appear to be a form of bait-and-switch. We urge you to consider an amendment that if the price of a drug increases by more than X percent of the advertised price during the open enrollment period, then the beneficiary may switch plans.

Drug rebate reforms in Medicaid and Medicare (Division B, Sections 1842, 1843, and 1181; pages 708ff): These sections achieve major savings of about $20 billion over ten years in Medicaid and in the Medicare dual eligible programs.[5] These changes seem very appropriate, particularly closing the loophole whereby a minor change in a drug can cause it to be treated as a new formulation that is exempt from rebates owed because of excessive inflation. Rebates on Medicaid and dual eligibles in Medicare managed care plans will also correct for the fact that Medicaid plans do not seem to be obtaining the same level of savings as the Medicaid program previously obtained directly from the companies.[6]

Additional Savings to Consider

Stop Brand Company payments to Generic Companies to delay entry of generic drugs (reverse payments); Eliminate other Brand-Generic abuses such as 'authorized generics.' CBO should score Congress with billions in savings if the current Hatch-Waxman Act abuses identified by the FTC and independent researchers are stopped. HR 1706 (by Rep. Rush and 7 others on this Committee) should be included in the reform package.

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[5] CBO, Budget Options, Volume I,: Health Care, pages 138-143.

[6] Center for Health Strategies, Inc., "Comparison of Medicaid Pharmacy Costs and Usage Between the Fee-for-Service and Capitated Settings," January 2003. Also, the Lewin Group, "Extending the Federal Drug Rebate Program to Medicaid MCOs: An Analysis of Impacts," May, 2003.

Create a pathway for follow-on biologics (FOBs). A way must be found to end the endless monopoly that now exists for biologics. They are an increasingly costly and inflationary part of the health care economy. We have endorsed Chairman Waxman's bill (HR 1427). CBO clearly shows that huge savings are possible in this field.

If agreement cannot be reached on the period of exclusivity, then other ways should be found to help consumers and taxpayers obtain savings. The June 2009 MedPAC report discusses the idea of reference pricing[7] or payment for results, where a drug's payment is linked to beneficiaries' outcomes through risk-sharing agreements with manufacturers.

We note that the MedPAC report says that the EU's FDA had approved as of last June more than ten FOBs[8]. Medicare could achieve billion dollar-a-year savings if the U.S. FDA certified that these EU biologics were safe and were not causing adverse events and if their importation were permitted.

Promote research while controlling costs: Require drug rebates to Medicare for drug inflation in excess of population and CPI growth, except no rebates would be required on new breakthrough drugs (as defined in the FDA approval process), thus controlling costs while encouraging drug innovation. Under this proposal there would be a cap on growth in spending on pharmaceuticals, but it would reward companies that had the most truly innovative products.

Help consumers and advance comparative effectiveness research: Amend the FDA laws to require that new drugs be tested against the best practice in the field, not just against a placebo;

Re-importation: After ensuring safety, permit the importation of drugs (Berry, et al, HR 1298), including biosimilars;

Permit Medicare to negotiate on drug prices (Berry, et al., HR 684)[9]; special attention should be given to negotiating prices on selected biologics;

For safety and savings, enact a two or three year moratorium on the direct-to-consumer advertising of newly approved prescription drugs (proposals by DeLauro and others); require rebates for the increased high-cost drug utilization caused by such advertising.

Encourage savings for consumers and taxpayers through mail-order pharmacy use of maintenance drugs. There may be data that mail-order pharmacy is safer (fewer errors in

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[7] MedPAC, June, 2009, p. 106. "Set a drug's payment rate no higher than the cost of currently available treatments unless evidence shows that the drug improves beneficiaries' outcomes."

[8] MedPAC, June, 2009. Page 114.

[9] This provision receives an amazing 86 percent support in the Kaiser Family Foundation Health Tracking Poll of April, 2009.

refills) and our own data shows savings of up to several hundred dollars on a common package of five drugs through Part D plans.

Encourage generics: Require rebates from the 20 percent of Part D plans that have the lowest generic drug substitutions rates, in cases where a generic is exchangeable with a brand;

Conclusion

We thank you again for this opportunity to testify.

The American health care system must and can be fixed.

The Tri-Committee proposal will bring us to the goal of affordable, quality, dependable health care for all, and we hope you give consumers even more tools to help drive the system toward quality and cost savings. The proposals in the pharmaceutical sector make important improvements and savings. Even more savings are possible and can be directed toward spurring breakthrough research.

Appendix I

Consumer Union Goals in Health Reform	**Tri-Committee Draft**
Ensure health access to every American: Make insurance simple by creating a national health insurance exchange where one can always go—regardless of one's health or situation in life-- to choose a private or public plan, with sliding scale subsidies based on income to make it affordable.	The Health Insurance Exchange, with reformed private policies (guaranteed issue, no pre-existing conditions) and a public plan option, with premium and cost-sharing subsidies phasing out at 400% of poverty, achieve this goal. Those who have good plans today can keep what they have.
The insurance offered should be comprehensive, bringing financial security and peace of mind.	The minimum standard benefit package (and at least 2 distinct, more valuable options), with no yearly or life-time limits and with out-of-pocket catastrophic protection at $5,000 for an individual and $10,000 for a couple, would achieve this goal. The low-income get even more protection.
Coverage should be especially good for preventive care.	The packages all include comprehensive preventive services; Medicare is improved to make preventive care more affordable; and a new Wellness and Prevention Trust Fund would help spur community wellness.
Eliminating pre-existing conditions and guaranteeing issue can't work for insurers, unless everyone has to have insurance. But we can't force people to buy policies they can't afford or that are inadequate, so subsidies are needed. And a public plan option working on a level playing field can use competition to minimize the need for subsidies by holding costs down and driving quality up.	The individual mandate to have at least the 'Essential' benefit plan, coupled with subsidies, and efforts to control cost, achieve this goal. Cost containment includes the public plan option, medical loss ratio requirements, comparative effectiveness research, form simplification, stepped up anti-fraud, stopping drug and device company 'gifts' to providers, new ways for doctors to deliver quality coordinated care, and implementation of MedPAC recommendations. Consumers Union urges even more be done to control costs.

Increase quality and help consumers choose quality, by making error rates public, particularly infection rates (largely preventable infections kill 100,000 Americans per year).	Division B's Section 1151 reduces payments for hospital readmissions due to poor quality and section 1441 establishes a new center to set priorities for quality improvement. State Medicaid plans are rewarded for not paying for poor care such as infections. We hope it is clearer that infection rates are to be public on a facility specific basis, and that more is done to report 'never events,' and require periodic quality recertification of providers, per the recommendations of the IOM.
Encourage care based on quality, not just quantity, and help spread the use of electronic medical records.	Efforts to develop accountable care organizations and medical homes will help ensure better care coordination. The Stimulus package HIT monies should help productivity over time and improve quality.
Encourage more primary care doctors.	The Draft's major sections on the workforce, graduate medical education, and increased payments to primary care doctors should all help.
Help small businessmen get affordable health insurance for themselves and their employees.	The Health Insurance Exchange will make policies more affordable; subsidies to small and lower wage firms will make it affordable.

Attachment II

On quality

We urge that you more clearly help consumers encourage quality, by increasing the public reporting of infections and other medical errors. Consumer pressure can inspire providers to focus more on preventing infections and other errors—but first, consumers need to be informed.

Ten years ago, the Institute of Medicine issued its report, To Err is Human, noting that medical errors were killing up to 98,000 people a year and costing the health system tens of billions in unnecessary costs. The CDC now says that 100,000 are dying just from largely preventable infections, which add an extra $35.7 to $45 billion per year in treatment costs. No one can say whether anything has really improved over the last decade: the IOM's recommendations have been largely ignored.

We urge you, in addition to the 7 hospital re-admission conditions discussed on page 222 of the Draft, to include public reporting of healthcare-acquired infections such as MRSA and other deadly conditions. We also hope you will take another look at the IOM report, and move to require public reporting of 'never events' (like surgery on the wrong part of the body) the way Minnesota has done. It is way past time to adopt the IOM's proposals for periodic quality re-certification of providers. We retest pilots and others for competency—we should retest providers on a periodic basis. Finally, we urge you to consider some of the excellent language in the Senate HELP bill to improve our nation's failing Emergency Medical Systems.

Do More to Help the Consumer in the Health Insurance Exchange

The honest, sad truth is that most of us consumers are terrible shoppers when it comes to insurance. The proof is all around you.

> --In FEHBP, hundreds of thousands of educated Federal workers spend much more than they should on plans that have no actuarial value over lower-cost plans.[10]
>
> --In Medicare Part D, only 9 percent of seniors at most are making the best economic choice (based on their past use of drugs being likely to continue into a new plan year), and most are spending $360-$520 or more than the lowest cost plan available covering the same drugs.[11]
>
> --In Part C, Medicare has reported that 27% of plans have less than 10 enrollees, thus providing nothing but clutter and confusion to the shopping place.[12]

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[10] Washington Consumers' Checkbook Guide to Health Plans, 2008 edition, p. 5.
[11] Jonathan Gruber, "Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?" (prepared for the Henry J. Kaiser Foundation) March, 2009.
[12] SeniorJournal.com, March 29, 2009.

The Institute of Medicine reports that 30 percent of us are health illiterate. That is about 90 million people who have a terrible time understanding 6th grade or 8th grade level descriptions of health terms. Only 12 percent of us, using a table, can calculate an employee's share of health insurance costs for a year.[13] Yet consumers are expected to understand "actuarial value," "co-insurance" versus "co-payment," etc.

If Congress wants an efficient marketplace that can help hold down costs, you need to provide more consumer tools in that marketplace. The Health Choices Administration and Insurance Ombudsman are a good start. We hope you can flesh out their powers and duties as follows:

We believe standard benefit packages (and definitions) are the key to facilitating meaningful competition. The Draft bill provides 3 broad categories of policies, and we appreciate the fact that these broad groupings will be helpful to consumers. But like Medigap policies A-L, we urge you to make the policies sold in each of these broad categories identical, so that consumers can shop on the basis of price and quality, and not on tiny, confusing differences (10 rehab visits v. a plan with 12, etc.). If someone wants to buy extra bells and whistles, they can do that outside of the exchange. To only require these broad groupings to be 'actuarially equivalent' is to invite a Tower of Babel of tiny plan differences, designed by the insurers to attract the healthy and avoid the most expensive—and with the end result of confusing the consumer.

Consumers want choice of doctor and hospital. We do not believe that they are excited by an unlimited choice of middlemen insurers.[14] Fewer offerings of meaningful choices would be appreciated. There are empirical studies showing that there is such a thing as too much choice, and dozens and dozens of choices can paralyze decision-making.[15]. The insurance market can be so bewildering and overwhelming that people avoid it. We think that is a major reason so many people having picked a Part D plan, do not review their plan and fail to make rational, advantageous economic changes during the open enrollment period.

√ Require standardization of insurance definitions so consumers can easily compare policies on an "apples-to-apples' basis. This is key. Hospitalization should mean hospitalization. Drug coverage should mean drug coverage, etc. Attached on the last page of this testimony is an article from our May magazine which demonstrates what radically different coverage two similar sounding policies can provide. It is not clear that the

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[13] HHS Office of Disease Prevention and Health Promotion

[14] "Nearly three-fourths (73 percent) of people ages 65 and older felt that the Medicare Prescription drug benefit was too complicated, along with 91 percent of pharmacists and 92 percent of doctors. When asked if they agreed with the statement: "Medicare should select a handful of plans that meet certain standards so seniors have an easier time choosing," 60 percent of seniors answered in the affirmative." Jonathan Gruber, "Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?" (prepared for the Henry J. Kaiser Foundation) March, 2009. Page 2.

[15] Mechanic, David. Commentary, Health Affairs, "Consumer Choice Among Health Insurance Options," Health Affairs, Spring, 1989, p. 138.

"benefit standards defined" (p. 29, line 11) will guarantee comparability of terms among plans.

√ Require insurers to clearly state (in standardized formats) what's covered and what's not in every plan offering, and to estimate out-of-pocket costs under typical treatment scenarios. The Washington Consumers' Checkbook's "Guide to Health Plans for Federal Employees (FEHBP)" does a nice job showing what consumers can expect, but even in FEHB policies they find it impossible to provide clear data on all plans.[16] HR 2427 by Rep. DeLauro and Rep. Courtney and 23 others is excellent language on how to design such scenarios.

√ Maintain an insurance information and complaint hotline, and compile federal and state data on insurance complaints and report this data publicly on a Web site. The States would continue to regulate and supervise insurers operating in their state, but with the continual merger and growing concentration of insurers, consumers need a simple place where complaints can be lodged and data collected, analyzed, and reported nationally concerning the quality of service offered by insurers. This type of central complaint office may have allowed quicker detection of the UnitedHealth-Ingenix abuse of underpaying 'out-of-network' claims.

√ Institute and operate quality rating programs of insurance products and services. This would be similar to the Medicare Part D website, with its '5 star' system.

√ Manage a greatly expanded State Health Insurance Assistance Program that would provide technical and financial support (through federal grants) to community-based non-profit organizations providing one-on-one insurance counseling to consumers. These programs need to be greatly expanded if you want the HIE connector to work. The SHIPs should be further professionalized, with increased training and testing of the quality of their responses to the public.

√ Require plans to provide year-long benefit, price, and provider network stability. In Medicare Part D, we saw plans advertise certain drug costs during the autumn open enrollment period, and then by February or March increase prices on various drugs so much that the consumer's effort to pick the most economical plan for their drugs was totally defeated. This type of price change—where the consumer has to sign up for the year and the insurer can change prices anytime—is a type of bait and switch that should be outlawed.

√ Make consumers fully aware of their rights to register complaints about health plan service, coverage denials, balance-billing and co-pay problems, and to appeal coverage denials. We appreciate the requirement in Sec. 132 for 'fair grievance and appeals mechanisms,' but urge that the Commissioner, perhaps with the help of the NAIC, develop a **model** system that all participating insurers have to use.

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[16]Op. cit., p. 68.

Attachment III—Comparative Effectiveness Research Example

Proton pump inhibitors (PPIs) are a class of drugs used to treat heartburn, gastroesophageal reflux disease (GERD), and ulcers. Heartburn and GERD are quite common. Between a quarter and a third of adults in the U.S. will have GERD at some point in their lives. There are five medicines in this class. One is available as a relatively inexpensive nonprescription drug.

To help you and your doctor choose a PPI if you need one, *Consumer Reports* has evaluated the drugs in this category based on their effectiveness, safety and cost. This two-page brief is a summary of a 14-page report you can access on the Internet at www.CRBestBuyDrugs.org. You can also learn about other drugs we've analyzed on this *free* Web site. Our independent evaluations are based on scientific reviews conducted by the Oregon Health and Science University-based Drug Effectiveness Review Project. Grants from the Engelberg Foundation and National Library of Medicine help fund *Consumer Reports Best Buy Drugs.*

DO YOU NEED A PPI?

If you have heartburn only occasionally and have not been diagnosed with GERD, you probably do *not* need a PPI. Over-the-counter antacids and generic prescription drugs will very likely provide relief. See the Our Recommendations box on this page for mention of several such medicines. If you have chronic heartburn or get diagnosed with GERD, your doctor is highly likely to prescribe a PPI.

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Not everyone with heartburn needs a PPI drug. Several of the PPIs have been widely advertised to consumers and heavily promoted to physicians, and this has led to overuse of the drugs in the treatment of "garden variety" heartburn.

If you suffer from only occasional heartburn and have not been diagnosed with GERD, nonprescription antacids such as Maalox, Mylanta, Rolaids, and Tums, or acid-reducing drugs such as cimetidine (Tagamet), famotidine (Pepcid), nizatidine (Axid), and ranitidine (Zantac) will very likely provide relief.

Talk with your doctor about the role that dietary and lifestyle changes can play in alleviating heartburn, too – such as eating smaller meals, weight loss, and avoiding alcohol.

If, however, you experience heartburn twice a week or more for weeks or months on end, have frequent regurgitation of food into your throat or mouth (with or without heartburn), or if your heartburn is not relieved by the drugs mentioned above, you may have GERD and need a PPI. GERD is a condition that makes you prone to acid reflux and can, over time, cause damage to your esophagus.

The five available PPI medicines are roughly equal in effectiveness and safety, but differ in cost. One – omeprazole (Prilosec OTC) – is available as both a prescription and nonprescription generic drug.

Taking the evidence for effectiveness, safety, cost, and

other factors into account, **Prilosec OTC** is our choice as a *Consumer Reports Best Buy Drug* if you need a PPI. You could save $100 to $200 a month by choosing this medicine over more expensive prescription PPIs.
If you have health insurance, find out if your plan helps pay for Prilosec OTC. If not, talk to your doctor about taking the PPI with the lowest out-of-pocket cost to you.
Safety note: A few studies have linked PPIs to a higher risk of pneumonia and infection with a bacterium called *C. difficile*, and in December 2006 a study found that long-term use of PPIs may be associated with an increased risk of hip fractures. Talk with your doctor about these risks, especially if you must take a PPI over a long period of time. People aged 65 and over, and people with chronic medical conditions, who take a PPI should get vaccinated against pneumonia and get a flu shot every year.
This summary was last updated in January 2007.

Esomeprazole
20mg Nexium NA₁87%
(84%-91%) 87%
Esomeprazole
40mg Nexium 73%
(65%-82%)
90%
(88%-92%) 93%
Lansoprazole
30mg Prevacid 70%
(61%-80%)

86%
(83%-90%) 91%
Omeprazole
20mg Prilosec 65%
(54%-76%)
85%
(81%-88%) 86%-92%
Pantoprazole
20mg Protonix 77%
(70%-84%)
77%
(65%-88%) 55%-86%
Pantoprazole
40mg Protonix 72%
(62%-83%)
89%
(86% to 92%) 78%
Rabeprazole
20mg Aciphex 69%
(52%-86%)
82%
(76%-89%) 89%
1. Effectiveness data presented for PPI dosage strengths that have been studied to date.
2. Data from individual studies. Ranges given reflect multiple studies.
3. NA= Data Not Available

PPI W2 0207
1. "Generic" indicates drug sold by generic name.
2. Monthly cost reflects nationwide retail average prices for September 2006 (except where noted), rounded to nearest dollar.
Information derived by *Consumer Reports Best Buy Drugs* from data provided by Wolters Kluwer Health, Pharmaceutical Audit
Suite.
3. This is a nonprescription (over-the-counter) version of omeprazole available at any drug store. The shelf price of this medicine
varies widely. It may be least expensive at large discount stores and at Internet pharmacies. The cost for a month's supply
given in this table ($19-$26) is based on a spot check of prices at Internet online pharmacies on October 30, 2006.
4. Generic omeprazole is generally available at a lower price at large discount stores. In some cases the price may be half of
that reflected in this table, which presents nationwide average prices.
UNDERSTANDING GENERICS: A generic drug is a copy of a brand drug whose patent has expired. In
this table, only omeprazole is available as a generic. It is also sold under its brand name, Prilosec. A nonprescription
version, Prilosec OTC, is also available. The remaining PPIs are sold only as brand name
drugs.

Esomeprazole 20mg tablets Nexium No $193
Esomeprazole 40mg tablets Nexium No $181
Lansoprazole 15mg delayed-release tablets Prevacid No $145
Lansoprazole 30mg delayed-release tablets Prevacid No $131
Lansoprazole 15mg delayed-release capsules Prevacid No $184
Lansoprazole 30mg delayed-release capsules Prevacid No $186
Omeprazole 20mg[3] tablets Prilosec OTC[3] Yes $19-$26[3]

Omeprazole 10mg sustained-release tablets Prilosec No $125
Omeprazole 20mg sustained-release tablets Prilosec No $153
Omeprazole 40mg sustained-release tablets Prilosec No $265
Omeprazole 10mg, sustained-release tablets Generic Yes $116,
Omeprazole 20mg, sustained-release tablets Generic Yes $89,
Omeprazole/sodium bicarbonate 20mg/1100mg Zegerid No $138
Omeprazole/sodium bicarbonate 40mg/1100mg Zegerid No $146
Omeprazole/sodium bicarbonate 20mg/1680mg Zegerid No $170
Omeprazole/sodium bicarbonate 40mg/1680mg Zegerid No $176
Pantoprazole 20mg delayed-release tablets Protonix No $159
Pantoprazole 40mg delayed-release tablets Protonix No $146
Rabeprazole 20mg tablets Aciphex No $189

Consumer Reports
BEST BUY DRUGS
PROVEN • EFFECTIVE • AFFORDABLE
www.CRBestBuyDrugs.org

Treating Heartburn, Ulcers, and Stomach Acid Reflux

The Proton Pump Inhibitors

Consumer Effectiveness, Safety and Price

Proton pump inhibitors (PPIs) are a class of drugs used to treat heartburn, gastroesophageal reflux disease (GERD), and ulcers. Heartburn and GERD are quite common. Between a quarter and a third of adults in the U.S. will have GERD at some point in their lives. There are five medicines in this class. One is available as a relatively inexpensive nonprescription drug.

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DO YOU NEED A PPI?

If you have heartburn only occasionally and have not been diagnosed with GERD, you probably do *not* need a PPI. Over-the-counter antacids and generic prescription drugs will very likely provide relief. See the Our Recommendations box on this page for mention of several such medicines. If you have chronic heartburn or get diagnosed with GERD, your doctor is highly likely to prescribe a PPI.

Table 1. Comparative Effectiveness of PPIs

Generic Name And Dose Per Day	Brand Name	Complete Symptom Relief at 4 to 8 Weeks, Average Percent of Patients (Range)	Esophageal Healing at 8 Weeks, Average Percent of Patients (Range)	Relapse Prevention[2]
Esomeprazole 20mg	Nexium	NA[3]	87% (84%-91%)	87%
Esomeprazole 40mg	Nexium	73% (65%-82%)	90% (88%-92%)	93%
Lansoprazole 30mg	Prevacid	70% (61%-80%)	86% (83%-90%)	91%
Omeprazole 20mg	Prilosec	65% (54%-76%)	85% (81%-88%)	86%-92%
Pantoprazole 20mg	Protonix	77% (70%-84%)	77% (65%-88%)	55%-86%
Pantoprazole 40mg	Protonix	72% (62%-83%)	89% (86% to 92%)	78%
Rabeprazole 20mg	Aciphex	69% (52%-86%)	82% (76%-89%)	89%

1. Effectiveness data presented for PPI dosage strengths that have been studied to date.
2. Data from individual studies. Ranges given reflect multiple studies.
3. NA= Data Not Available

Our Recommendations

Not everyone with heartburn needs a PPI drug. Several of the PPIs have been widely advertised to consumers and heavily promoted to physicians, and this has led to overuse of the drugs in the treatment of "garden variety" heartburn.

If you suffer from only occasional heartburn and have not been diagnosed with GERD, nonprescription antacids such as Maalox, Mylanta, Rolaids, and Tums, or acid-reducing drugs such as cimetidine (Tagamet), famotidine (Pepcid), nizatidine (Axid), and ranitidine (Zantac) will very likely provide relief.

Talk with your doctor about the role that dietary and lifestyle changes can play in alleviating heartburn, too – such as eating smaller meals, weight loss, and avoiding alcohol.

If, however, you experience heartburn twice a week or more for weeks or months on end, have frequent regurgitation of food into your throat or mouth (with or without heartburn), or if your heartburn is not relieved by the drugs mentioned above, you may have GERD and need a PPI. GERD is a condition that makes you prone to acid reflux and can, over time, cause damage to your esophagus.

The five available PPI medicines are roughly equal in effectiveness and safety, but differ in cost. One – omeprazole (Prilosec OTC) – is available as both a prescription and nonprescription generic drug.

Taking the evidence for effectiveness, safety, cost, and other factors into account, **Prilosec OTC** is our choice as a *Consumer Reports Best Buy Drug* if you need a PPI. You could save $100 to $200 a month by choosing this medicine over more expensive prescription PPIs.

If you have health insurance, find out if your plan helps pay for Prilosec OTC. If not, talk to your doctor about taking the PPI with the lowest out-of-pocket cost to you.

Safety note: A few studies have linked PPIs to a higher risk of pneumonia and infection with a bacterium called *C. difficile*, and in December 2006 a study found that long-term use of PPIs may be associated with an increased risk of hip fractures. Talk with your doctor about these risks, especially if you must take a PPI over a long period of time. People aged 65 and over, and people with chronic medical conditions, who take a PPI should get vaccinated against pneumonia and get a flu shot every year.

This summary was last updated in January 2007.

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PPI cost comparison

Generic Name and Dose per Day[1]	Brand Name	Available as a Generic?	Average Monthly Cost[2]
Esomeprazole 20mg tablets	Nexium	No	$193
Esomeprazole 40mg tablets	Nexium	No	$181
Lansoprazole 15mg delayed-release tablets	Prevacid	No	$145
Lansoprazole 30mg delayed-release tablets	Prevacid	No	$131
Lansoprazole 15mg delayed-release capsules	Prevacid	No	$184
Lansoprazole 30mg delayed-release capsules	Prevacid	No	$186
BEST BUY Omeprazole 20mg[3] tablets	Prilosec OTC[3]	Yes	$19-$26[3]
Omeprazole 10mg sustained-release tablets	Prilosec	No	$125
Omeprazole 20mg sustained-release tablets	Prilosec	No	$153
Omeprazole 40mg sustained-release tablets	Prilosec	No	$265
Omeprazole 10mg[4] sustained-release tablets	Generic	Yes	$116[4]
Omeprazole 20mg[4] sustained-release tablets	Generic	Yes	$89[4]
Omeprazole/sodium bicarbonate 20mg/1100mg	Zegerid	No	$138
Omeprazole/sodium bicarbonate 40mg/1100mg	Zegerid	No	$146
Omeprazole/sodium bicarbonate 20mg/1680mg	Zegerid	No	$170
Omeprazole/sodium bicarbonate 40mg/1680mg	Zegerid	No	$176
Pantoprazole 20mg delayed-release tablets	Protonix	No	$159
Pantoprazole 40mg delayed-release tablets	Protonix	No	$146
Rabeprazole 20mg tablets	Aciphex	No	$189

UNDERSTANDING GENERICS: A generic drug is a copy of a brand drug whose patent has expired. In this table, only omeprazole is available as a generic. It is also sold under its brand name, Prilosec. A non-prescription version, Prilosec OTC, is also available. The remaining PPIs are sold only as brand name drugs.

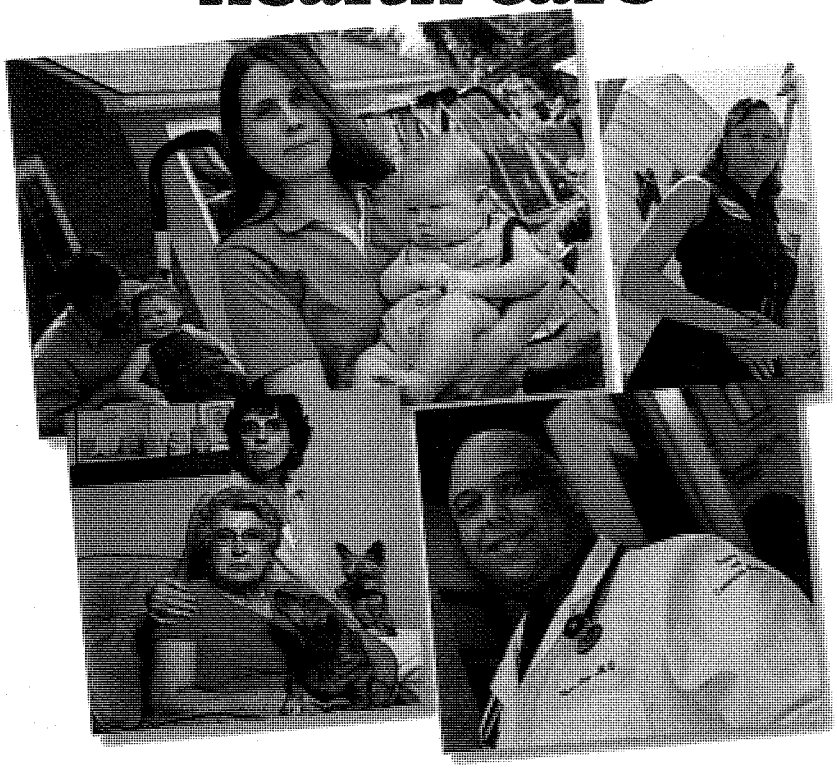
1. "Generic" indicates drug sold by generic name.
2. Monthly cost reflects nationwide retail average prices for September 2006 (except where noted), rounded to nearest dollar. Information derived by *Consumer Reports Best Buy Drugs* from data provided by Wolters Kluwer Health, Pharmaceutical Audit Suite.
3. This is a nonprescription (over-the-counter) version of omeprazole available at any drug store. The shelf price of this medicine varies widely. It may be least expensive at large discount stores and at Internet pharmacies. The cost for a month's supply given in this table ($19-$26) is based on a spot check of prices at Internet online pharmacies on October 30, 2006.
4. Generic omeprazole is generally available at a lower price at large discount stores. In some cases the price may be half of that reflected in this table, which presents nationwide average prices.

SPECIAL VIEWPOINT ON HEALTH REFORM

An excerpt from the August 2009 issue of CONSUMER REPORTS

ConsumersUnion

A prescription for health care



VIEWPOINT

A prescription for health care

Almost all agree the health system is broken. Here's how Consumers Union would fix it.

This summer, for the first time in 16 years, Washington seems poised to address the problems plaguing American health care. Take the fact that your medical costs are soaring at about twice the rate of inflation, for starters. Even if you don't pay the bills directly, you see the increase in higher insurance premiums, deductibles, and copays. And what are you getting for your money? A system that often limits your choice of doctors and hospitals, forces you to satisfy a complex web of rules to get reimbursed, locks you into a job for fear of losing coverage, and strands you without affordable protection if you lose insurance while suffering a chronic condition. No wonder that in recent years, medical bills or illness have contributed to 62 percent of all U.S. bankruptcies, and 46 million people go without any coverage at all.

If the problems are self-evident, the solutions are less so. On the political right, you'll find conservatives for whom "reform" is just the first step toward European-style socialism. You've seen their ads pop up on TV, sponsored by groups you've never heard of, full of scary warnings about faceless bureaucrats standing between you and needed care (as if you didn't have that now from insurance companies).

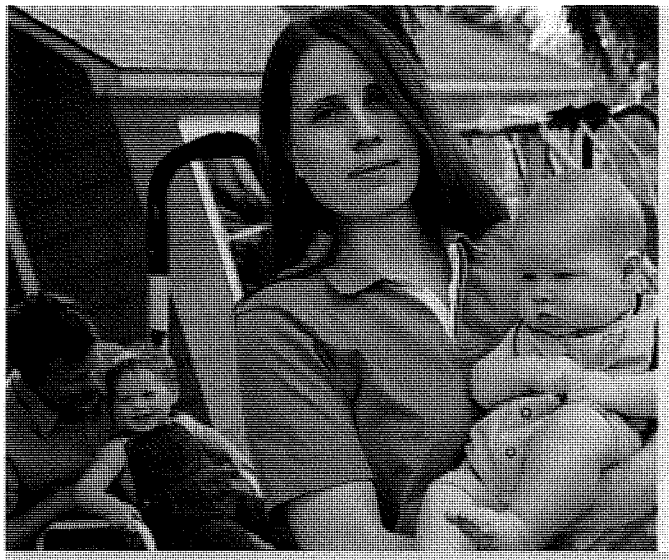
On the flip side, you'll hear some left-leaning commentators claim that the only solution is to nationalize health care as the British and Canadians have done. Consumers Union, the nonprofit publisher of CONSUMER REPORTS, has long argued for stronger government protection for consumers. But that doesn't mean we'd favor creating a huge new federal bureaucracy to manage an industry that constitutes a whopping 18 percent of the economy.

The right solution in today's environment lies somewhere between those poles. And it must be a truly American solution, one that takes advantage of our traditional ingenuity and entrepreneurship while preserving freedom, fairness, and choice.

In this special expanded Viewpoint column, we present Consumers Union's views on health reform. Rather than offering up a dense policy treatise, we divide the article into seven sections like the one at right. Each section opens with a person talking about his or her health-care experience. They're a diverse group—a waitress, a retired Air Force captain, a doctor, a business owner, and others—who, together, have seen the best and worst of today's care. And each section closes with one of our key goals for change, along with details about how we think a reformed system should work. (For a complete report on our policy positions, go to PrescriptionForChange.org.) We also lay out the facts behind some common fears about reform (see page 18). And we follow two women who beat breast cancer, but with very different financial consequences.

Not every reader will agree with each position here, of course, and we respect those differences of opinion. Regardless of your views, we urge you to contact your legislator, talk to family and friends, and volunteer to help the reform group of your choice. For more about our reform efforts or to share your story, go to Consumers Union.org and click on Health Care.

Fixing health care will take hard work by many and some degree of sacrifice by all. But Americans have faced, and conquered, bigger challenges in the past. Consumers Union thinks the effort is well worth it. And we support reform as an essential investment in our country's future, one that will result in lower costs and better health for you, your family, and the generations to come.



"Some people would think I'm being irresponsible not having insurance, but don't pay monthly for health care I really can't afford or take that money and use it for my family? It would be great for us all to be on one plan and not have to worry about it if something goes wrong."
— Amanda Buchanan, 32, of Weiser, Idaho, with her husband, Jason Vlcek, 33, and sons, 3-year-old Kwei and Merin, 5 months

Health reform should make insurance simple

Parents like Amanda Buchanan and Jason Vlcek have plenty to keep them busy without worrying about health insurance for their children.

Yet the couple, from Weiser, Idaho, were trapped by one of the Catch-22s that abound in the current system. To get coverage for their first child, Kwei, now 2, they chose a so-called catastrophic plan with a steep $3,000 deductible and 30 percent copay. It was all they could afford on Vlcek's $34,600 salary as a second-grade teacher. So when their next child was on the way, they checked into the federal/state CHIP program that is supposed to cover children who lack other protection.

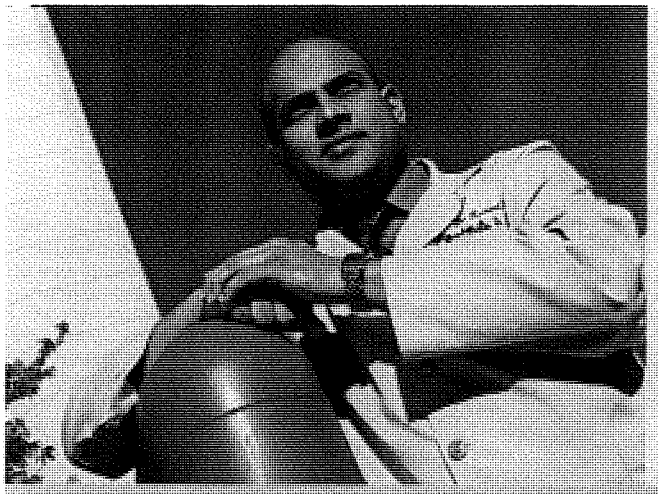
Problem was, Buchanan and Vlcek fell through a crack. "We totally qualified financially," Buchanan says, "but would never be accepted because Kwei was already insured, which somehow meant we could afford it even though we really couldn't." So in March, the couple canceled Buchanan's coverage so that they could continue to insure new son Merin. That saves $280 a month—but leaves Buchanan without protection.

CU recommends

Consumers Union supports health reform that would end those headaches. We favor the creation of a National Health Insurance Exchange, for example, that would function something like a big insurance store. Couples like Buchanan and Vlcek who either couldn't get or couldn't afford insurance from their employers could buy it directly from a private or public insurer through the exchange, with sliding-scale subsidies based on their income to help make it affordable.

Every policy sold through the exchange would provide at least a standard set of comprehensive protections. That means it would cover all major expenses, including immunizations, checkups, and screenings. And each new baby would be automatically included.

Best of all, there wouldn't be the tangle of bureaucracies and rules that forced this couple into a no-win situation. A reformed system would give them, and everyone, the peace of mind of having good coverage that couldn't be taken away. And it would put simple, affordable coverage within reach of every family.



"The insurance companies are getting away with murder. If a patient develops some condition, he's either dropped for some excuse or other, or the premiums go higher."
—Ajit Kesani, M.D., 58, of Chicago

Health reform should cover everyone—even the sick

It sounds like a joke—pleading for insurance to cover those who are ill. But insurers today typically refuse individual insurance to anyone with a chronic condition or serious past illness, even if the person is a doctor, like kidney specialist Ajit Kesani of Chicago.

Kesani's crime? He developed type 2 diabetes while at his first job after medical training. That was fine as long as he stayed put. But when he changed practices a year later, no private insurer would touch him. The only coverage he found was a state-mandated "conversion" policy at a steep $18,000 a year.

Like many, Kesani decided to roll the dice. He went without coverage for three years until he could join a group plan for hospital affiliates, earlier this year, at $320 a month. Now if he sees an uninsured patient, he may suggest that the person seek coverage before getting a diagnostic workup. "If they get labeled as having kidney disease," he says, "they may not ever be able to get insurance."

CU recommends

We think it's an outrage that those who are sick have the hardest time getting and keeping insurance. Even well-intentioned previous "reforms," like the conversion policy Kesani was offered, turn out to be mirages. If a young doctor balks at paying $18,000 for insurance, how many others will be able to afford it in a country where the median household earns $50,000 a year?

Solving this problem would be a step forward, but the fix can't be one-sided. If insurers had to accept everyone, but individuals could decide whether or not to buy, people would wait until they got sick before joining. That would send the price of coverage through the roof and drive insurers out of business.

A fair solution would be to couple the above reform with a rule requiring everyone to have coverage. Those with good employer-based insurance could keep it. Others could buy it at an affordable price through the insurance exchange described on page 13. Besides private plans, the exchange would also include a public insurance option offered by the government. The public plan would get no special favors or funding. But its administrative costs would presumably be lower because it would operate on a nonprofit basis, and its presence in the market would help keep overall premiums down. Then physicians like Kesani wouldn't have to ask about your health coverage before determining what care you need.

"I lay in my hospital bed watching my stomach turn black and purple and red. It looked as if I had been snapped in half by a shark." — Alicia Cole, 46, of Sherman Oaks, Calif.

Reform should make it easy to get information on quality

When Alicia Cole learned she needed surgery for benign fibroids, she did her homework on the surgeon and the hospital. "I looked at HealthGrades, Leapfrog, Hospital Compare, and other Web sites," says Cole, a 46-year-old actress from Sherman Oaks, Calif. "But one thing I didn't check was the hospital's infection rate."

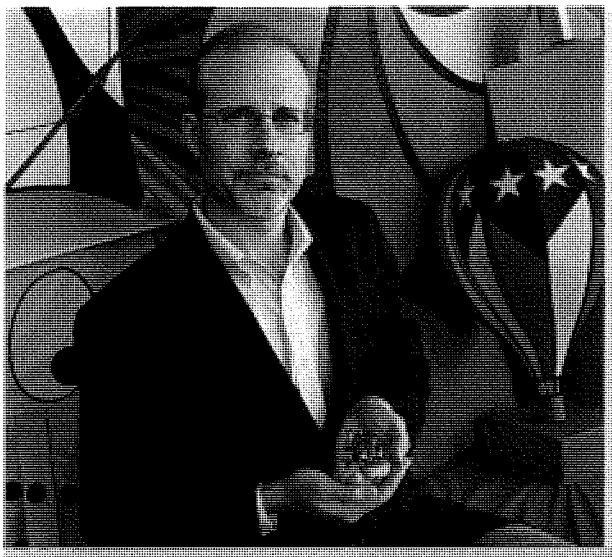
Even if she had tried to check, California hospitals didn't have to make such data public, and hers didn't. Cole had the operation there anyway. During her hospital stay, she came down with a post-surgical flesh-eating infection that turned her entire midsection into something worthy of a horror movie. After two months in the hospital and two years of painful rehabilitation, she still can't work. "The skin and scar tissue is so delicate that the least pressure will tear or scratch it," she says. Federal inspectors subsequently found unsterile conditions in the hospital's operating area.

Enraged by her experience, Cole joined the fight against hospital infections and helped persuade the California legislature to pass a law requiring public reporting; she now sits on the advisory board for the law. Did she ever learn the hospital's infection rate? Sadly, no. The law has not yet been implemented. "What we really need is a national law," Cole says, noting that hospital-acquired infections are a leading cause of death in this country. "It's the elephant in the room," she says.

CU recommends

Health reform should make it simple to get good information on health-care quality. You should be able to find data not only on infection rates, a reform we've backed for years, but also on doctors, drugs, treatments, and errors. Yet most states still allow doctors to shield a history of malpractice settlements. And infection rates, if reported at all, are often kept secret, which doesn't provide enough incentive for improvement.

What does work is disclosure. Pennsylvania, which passed the first statewide reporting law, remains the only state to require disclosure of all major types of hospital infections. And infections there have dropped 8 percent in the last two years.



"When I started offering health benefits in 1994, the cost was low enough that I paid 100 percent of the premium for a good plan. Now the cost has tripled, we only pay 50 percent, and still we have had to switch to a high-deductible plan. We're seeing employees put off preventive care that's going to cost them money."
— Michael Brey, 45, of Annapolis, Md., owner of Hobby Works stores

Reform should help employers offer better protection for workers

The proportion of small-business employees who have health insurance at work dropped from 58 percent in 2001 to 52 percent last year, according to the Kaiser Family Foundation.

If you're wondering why, just ask Michael Brey. He is president and CEO of Hobby Works, a chain of four hobby-supply shops in Maryland and Virginia. Like most business owners, Brey, 45, wants to give his employees good coverage. But his health premiums have gone up 31 percent in the past three years, despite his switch to a high-deductible plan. He says the burden on the company and employees has grown, and many employees are dropping out of the plan.

"At one time, I believed that having more skin in the game"— paying a larger share of costs out-of-pocket—"would force people to be smarter health consumers," Brey says. "But in practice, that's not what happens. Cost-shifting drives them to put off preventive care in favor of urgent care." So they get help in the most-expensive, least-effective way—after they're sick, rather than while the illness might be avoided.

CU recommends

Small-business owners remain the job-growth engine of the economy. Brey, for example, wants to expand his chain of stores. But health-care costs make it more expensive to add employees. And in today's economy, that could mean little or no growth.

Under the health-care reform that we support, small firms that couldn't otherwise afford coverage could buy it—with a subsidy, if needed—through the same National Health Insurance Exchange available to individuals. The price they would pay wouldn't depend on the health of their workers, as it does today. And insurers couldn't jack up the cost if an employee or family member got sick.

The results? Better care for employees and fewer obstacles for entrepreneurs who want to build a business.

"The whole process was incoherent. ... I didn't understand why she was being admitted to the hospital, but we just went along. They didn't have any history on her, and a nurse blew one of my mother's veins while trying to insert an IV."
— Eloise Kay, 57, of Gainesville, Fla., and her mother, Mirium Kay, 87

Reform should reward great care, not 'procedures'

The episode began, Eloise Kay recalls, when her mother's doctor ran a test to check on her rectal ulcer. The results suggested possible Crohn's disease, and a gastroenterologist prescribed drugs. Soon after, Mirium Kay began having abdominal pain and another doctor put her on a different drug. But when the pain worsened, both doctors suggested she go to the emergency room, where a hospitalist, a physician who practices only inside a hospital, took over.

"The hospitalist was great," Eloise Kay says, "but I don't think she had records on my mother. I'm a psychiatric nurse practitioner, so I could give a history. But with somebody who didn't know anything about health care, the history would have been sketchy."

After three days of interrupted sleep, hospital food, and diagnostic tests, it turned out that Mirium Kay had a duodenal ulcer that was easily treatable with inexpensive oral antibiotics. "But they also found a bacterium that is often associated with hospitals," her daughter says, so Mirium Kay got another antibiotic that cost $400. Total tab: over $11,000.

"I still don't understand why hospital resources were needed for the diagnosis," Eloise Kay says, "to say nothing of the cost and delays."

CU recommends

Today, insurers pay a fee for every test, pill, consultation, and procedure—which means that the more care given, the more providers get paid. Even without questioning anyone's motives, it's easy to see how such a system is biased toward overtreatment. And indeed, studies show that those who get more care don't necessarily do better, and often do worse, as a result.

Under patient-centered reform, doctors, hospitals, and labs would earn a combined flat fee for managing an "episode of illness." They'd be rewarded for quality of outcome, not quantity of care, so their main incentive would be to work together to make you well. Electronic records would ensure that with your permission, any doctor could access your history. Together, those reforms would help improve care and reduce costs.

Reform must let doctors be doctors

As a family doctor in a 70-person practice affiliated with Thomas Jefferson University Hospital in Philadelphia, Victor A. Diaz Jr. grapples daily with irrational insurance coverage rules. For example, many insurers will cover only 15 minutes of a doctor's time for follow-up visits, he says. "We're doing such a great job of helping patients live longer that they get to be older and develop co-morbidities like arthritis, high cholesterol, diabetes, depression," Diaz points out. "If you're going to address those issues, plus things like cancer screening, you'll never get everything done in 15 minutes."

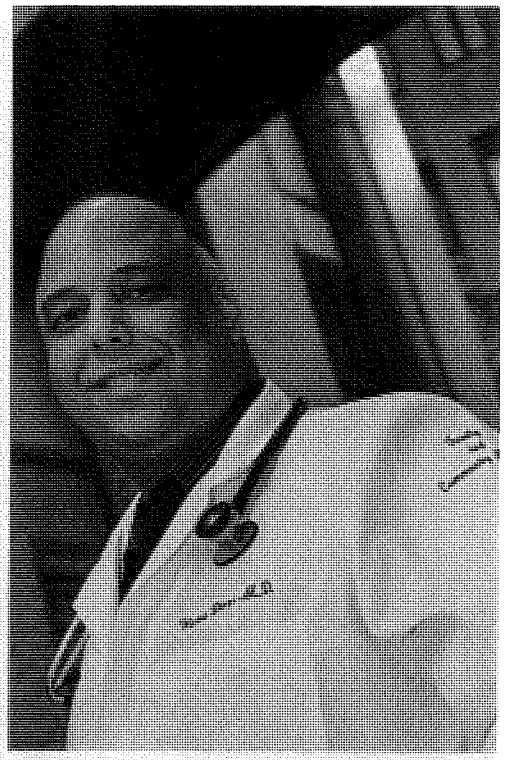
Then there's the question of group- visit therapy. Diaz and his colleagues find it's an excellent way to encourage people to lose weight, eat smarter, and take up exercise—all things that could really help improve their health. But "the insurance billing code for group visits is ill-defined," he says. "To get reimbursed, we see each patient individually first, and then we gather them together in a group."

Diaz adds that as a salaried faculty physician, he can leave the billing and collection headaches to others. His colleagues in private practice can't always do that. The cumulative effect, he says, is to drive medical students away from primary-care medicine and into higher-fee specialties just to pay off their medical school debt.

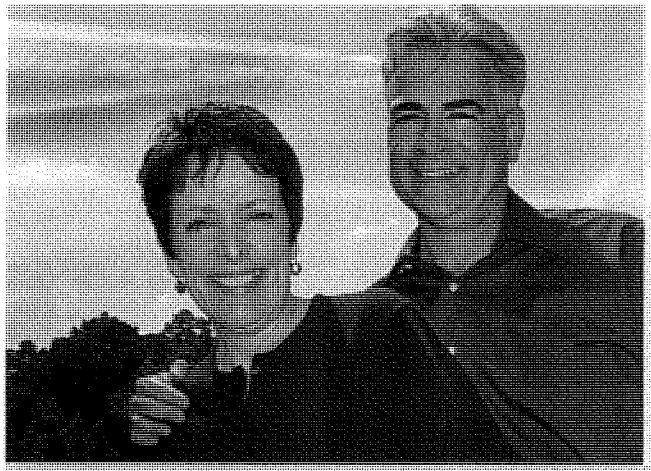
CU recommends

Many people's idea of good care is a super-specialist using the latest high-tech equipment. But what most people truly need is a dedicated family physician like Diaz. Such a doctor would keep you healthy as long as possible and manage any chronic conditions. Just as important, he or she could coordinate any specialist care you might need—which would help the "episode of illness" payment system described in the previous section.

Not that we have anything against specialists. They're essential. But as CONSUMER REPORTS noted in its July 2008 report "Too Much Treatment," patients in areas with a lot of specialty care actually fare worse than those where primary care is more common. In fact, if the focus were on primary care throughout the U.S., costs would drop an estimated 20 to 30 percent.



"We've had to struggle to get diabetic patients covered when they see a nutritionist to learn to manage their diet, even though it's certainly cheaper than having to go on dialysis or having a toe removed. Our system is disease-oriented, not patient-oriented."
—Victor A. Diaz Jr., M.D., M.S., of Philadelphia



"Every American deserves a health plan like mine. If we all had health care that nobody could take away, it would open up a flood of creativity in this country."
— Mike Marks, 48, of Huntington, W. Va., and his wife, Mary, 48

Health reform should give you the freedom to choose

The number of people with generous workplace coverage is dwindling. Out-of-control costs are forcing employers to trim or scrap coverage. And in this recession, millions are confronting a grim side effect of job loss: By 2010, one in five people under age 65 will be uninsured.

That's no worry for Mike and Mary Marks of Huntington, W. Va. Thanks to his 20 years of service, Marks, a retired Air Force captain, and his wife are covered under Tricare, a system for active and retired military personnel. They pay just $460 a year (that's not a misprint) and love its flexibility. "If we lived near a base, we'd get treated there for free," he says. "But we don't, so we use community facilities in the network."

As a result, Mike Marks, now a licensed physical therapist, can choose jobs without health benefits. "Right now, I'm working full time as a replacement for a woman who's on maternity leave," he says. "I didn't have to ask about health care." Compare that with the situation of Marks' brother, "a wizard with wood. He's been a general contractor and a boat collier, but some of his family have medical issues, so he's working at a factory to stay insured."

With truly portable coverage, Marks believes, Americans would feel freer to pursue their talents. "You could start a business without being afraid of not being able to provide health care for yourself or your employees," he says. Economists say job mobility would increase by as much as 25 percent if people didn't have to worry about coverage.

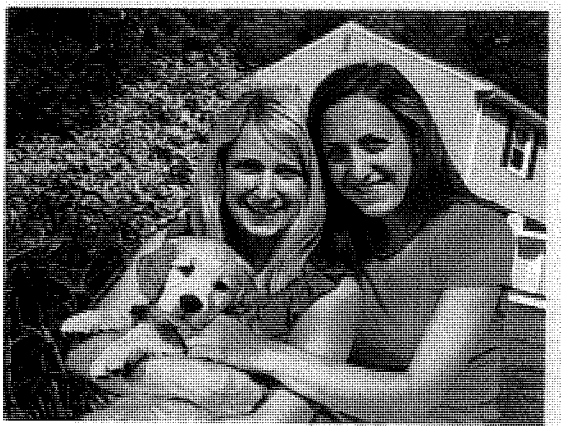
CU recommends

Under health reform, Americans would enjoy not only a wider choice of careers but also a wider array of health plans to choose from, including the public insurance plan described on page 14. Opponents of reform like to vilify the public plan as "government takeover" of health care. We disagree. It's simply another insurer that uses the same private providers to deliver care. It would bring competition to the many markets now dominated by just one or two private carriers. And though the plan could never be as inexpensive as Tricare (provided in return for military service), programs like it demonstrate that public insurance can work. So we think a public plan would be an important element in comprehensive reform that gives every American the peace of mind of affordable, portable, quality coverage.

A tale of two breast cancers

Getting breast cancer at age 27 was certainly unfortunate for Jaclyn Michalos, but the fact that it was diagnosed just after Massachusetts changed its health-care system in 2007 turned out to be fortunate indeed. Michalos was working as a waitress in Randolph, Mass., and had no health policy. But the new law required everyone to have coverage, and those like Michalos who couldn't afford it could join the statewide Commonwealth Care plan. That plan eventually paid the $125,000 cost of her treatment. "If I hadn't had that insurance, I never would have made the doctor's appointment that turned up my cancer, and I might not be alive today," Michalos says.

Catherine Howard of San Francisco also had insurance when she learned she had breast cancer. But as a freelance film producer, she couldn't afford a good comprehensive policy. Instead she had chosen a plan with low premiums but a high $2,500 deductible and 30 percent copay. It promised to limit her out-of-pocket costs to $7,500 yearly. But that figure didn't include all charges. "I remember staring at the needle of one shot that cost $2,000 and thinking, 'I owe $600 for this,'" says Howard, 36. She still owes $40,000 for her $160,000 of treatment.



CURED Jaclyn Michalos, 29, (far left, with sister Julie) and Catherine Howard, 36, (above) were treated successfully for breast cancer and are cancer-free today. But because they lived in different states, Howard is still paying medical bills, while Michalos emerged debt-free.

5 common fears about health reform

Now that health-care reform is a possibility, the forces of opposition are gearing up. Anti-reform campaigns with names like Patients United Now, Partnership to Improve Patient Care, and Conservatives for Patients' Rights are trying to make meaningful reform sound dangerous. Here are five of the worst fears you might hear—and the facts as we see them under the reforms we recommend.

FEAR Health reform will let faceless government bureaucrats come between you and your doctor.

FACT Private health insurance already comes between you and your doctor. And because each company sets its own rules, it's hard to imagine a more bureaucratic system. Some insurers decide which doctors you can see, which hospitals you can visit, and what drugs you can take and still be covered. And they may require copious paperwork before approving a treatment you and your doctor want. Health-care reform would standardize claim procedures to cut down on all of that. And it would protect you from other abuses, like being rejected for coverage or paying exorbitant premiums if you get sick.

FEAR Health reform will take away the good coverage from your job.

FACT If you're satisfied with your job-based coverage, you would be able to keep it. Employers who don't offer insurance would either start to provide it or contribute to a fund that helps employees buy it on their own. Some small businesses would be eligible for subsidies to offset the cost. And every policy would offer at least a standard, easy-to-understand, comprehensive set of benefits like those your congressperson now enjoys.

FEAR Comparing the relative effectiveness of treatments and drugs will lead to rationing.

FACT This issue flared up because Congress recently approved more funding for "comparative-effectiveness research." The term refers to studies to evaluate which drugs or treatments work best for different medical conditions and different patients. That's one more piece of information—based on science, not drug-company advertising or sales reps pushing pills—to help your doctor and you decide what's right. Consumers Union has long argued for better health-care information. For an example of our work, go to ConsumerReportsHealth.org and click on Best Buy Drugs. You'll find free advice based on comparative-effectiveness research into which drugs work best for some two dozen conditions, ranging from heartburn to heart disease. That's not rationing. It's just being smart. And if you suffer from one of those conditions, you may find you could choose a better medicine with fewer side effects and save thousands of dollars a year.

FEAR Health reform means a government takeover of medicine as in England and Canada.

FACT The system we support would look nothing like those in England and Canada. Both of those countries finance health care out of general tax revenues. England goes even further. The government owns and operates most of the hospitals. We support a specifically American reform that would build on the current employer-based insurance while ensuring affordable comprehensive coverage for those who lack it.

FEAR Health reform will be too costly; it will raise your taxes and could even bankrupt the country.

FACT The real threat to your finances is the health system the U.S. has now. A recent study concluded that today's $2.4 trillion annual health-care tab would jump to $4.4 trillion by 2018 if nothing is done to rein in expenses. Consumers Union thinks reform is the best hope for getting costs under control. It would cut down on waste, overhead, and price gouging, and reduce inappropriate care and preventable errors. We fully understand why some people are apprehensive about reform: Any change is scary. But we also see the shameful damage caused by the current system. Americans deserve better than this, and can have it.

Mr. PALLONE. Mr. Kelly.

STATEMENT OF PAUL KELLY

Mr. KELLY. Thank you, Chairman Pallone and Ranking Member Deal. National Association of Chain Drug Stores appreciates the opportunity to testify today.

I am Paul Kelly, vice president of Federal Government affairs, and I am substituting today for Carol Kelly, our senior vice president, who was ill and sends her regrets. But I really appreciate your indulgence in allowing me to pinch hit.

NACDS represents the Nation's chain pharmacies, whose 40,000 pharmacies and 118,000 pharmacists fill 2.5 billion prescriptions a year. That is 72 percent of all prescriptions nationwide. Pharmacies are the face of neighborhood health care. There is a community pharmacy, on average, within about 2 miles of every American.

One of pharmacy's major contributions is helping with medication adherence. Simply put, adherence is taking medications correctly. It has major implications for patient health and for health costs. Nonadherence leads to long-term health complications that diminish the quality of life, and nonadherence has been estimated to cost $177 billion annually. I am here to make recommendations that will help prevent this problem from getting worse.

Preventing it from getting worse involves preserving access to pharmacies. Essential to this is reforming the pharmacy-Medicaid reimbursement system. As you know, the Deficit Reduction Act of 2005 would set pharmacy reimbursement for some generic drugs at 36 percent below cost. The issue is complex, but it boils down to a basic principle. This is unworkable for pharmacies, as it would be for any health provider. Unless Congress intervenes, current policies would put 20 percent of pharmacies at risk, most of which serve low-income individuals.

Last year Congress blocked implementation of these severe Medicaid cuts until October 1, which we appreciate. We also appreciate that members of this subcommittee, including you, Chairman Pallone and Mr. Deal, remain highly cognizant of this issue, and we really appreciate your leadership, Mr. Pallone, in keeping this issue on the radar screen. We are also grateful that the committee draft recognizes the need to address this problem, and there is an AMP provision in that legislation. But as this legislation unfolds, we would emphasize there are several essential reforms that we think are needed to ensure a patient-centered Medicaid AMP policy.

First, average manufacturer price, or AMP, which will be used as a basis for reimbursement to pharmacies, must be defined correctly.

Second, AMP-based Federal upper limits should be determined using weighted average AMPs rather than the lower AMP. And we sincerely appreciate that the draft includes this provision.

Third, Federal upper limits should be set when there are three sources of supply, the brand and two generics. Setting limits prior to that when there are two sources of supply is premature.

Fourth, there is a concern that the multiplier of 130 percent that is proposed in the draft is not sufficient to ensure pharmacies are reimbursed fairly.

And, fifth, we deeply appreciate the provision in the draft to strike the requirement to post brand and generic AMPs on a public Web site until AMPs are based on an accurate definition.

Now, regarding the cost of nonadherence and increasing the quality of care. We appreciate the recognition of medication therapy management as part of the medical home concept in the committee's draft. MTM, medication therapy management, is preventative care and includes services designed to help ensure drugs are used appropriately to maximize health and reduce adverse medication events. Pharmacist-provided MTM services have been shown in one study to reduce overall health care costs—overall costs by $12 for every dollar invested.

Our recommendation is to enhance and expand the medication therapy management program in Medicare Part D, and we thank Congressman Ross and Congressman Murphy of this subcommittee for their leadership on this issue.

We have other recommendations, including the need to maintain patients' access to diabetes management tools through their neighborhood pharmacies. Two current rules related to the treatment of durable medical equipment and Medicare jeopardize access to diabetes care and jeopardize patient health. We recommend that health reform legislation address this misapplication of these rules to pharmacies, which pharmacies are already licensed and highly regulated by the States. We are the good actors when it comes to Medicare durable medical equipment, and additional hurdles and costs are simply counterproductive. We thank Congressman Space for his leadership on this issue.

In closing, part of the value of pharmacy is its ability to help patients stay on medication therapy. The improvement of lives and reduction of long-term costs is worth fighting for, and we look forward to working with this committee in pursuit of those goals.

Thank you again for your support, Chairman Pallone, and look forward to answering any questions.

Mr. PALLONE. Thank you.

[The information follows:]

NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

Statement of:

National Association of Chain Drug Stores

On:

Comprehensive Health Reform Discussion Draft

To:

U.S. House of Representatives
Committee on Energy & Commerce
Subcommittee on Health

June 24, 2009

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Introduction

Chairman Pallone, Ranking Member Deal and members of the Subcommittee, the National Association of Chain Drug Stores (NACDS) is pleased to have this opportunity to testify on the House Health Reform Discussion Draft. I am Carol Kelly, Senior Vice President, Government Affairs and Public Policy.

The National Association of Chain Drug Stores represents the nation's chain pharmacies, advocating for pro-patient and pro-pharmacy public policy. Chain pharmacies operate more than 39,000 pharmacies, employ 118,000 pharmacists and a total of more than 2.6 million employees, and fill nearly 2.5 billion prescriptions yearly – about 72 percent of U.S. prescriptions.

Pharmacies are the face of neighborhood healthcare. Millions of Americans rely on their local pharmacy every day for prescription drugs and pharmacy services. In addition, pharmacies provide patients with convenient access to preventive services such as immunizations. Legislation has passed in all fifty states to allow pharmacists to administer immunizations such as flu and pneumococcal.

NACDS shares in the common goal of providing accessible, affordable and high quality healthcare coverage to as many Americans as possible. There is a community pharmacy, on average, within about two miles of every American, making pharmacies among the most accessible healthcare resources. We believe patients should have access to the most cost-effective medications to appropriately treat their particular medical conditions. In addition, patients should have the freedom to choose where to obtain their pharmacy services and prescription medications. Pharmacists play a key role in helping patients take their medications as prescribed and offer a variety of pharmacist-delivered services, such as medication therapy management (MTM), to improve quality and outcomes. When patients take their medication as prescribed, it is possible to reduce utilization of costly medical services, such as emergency department visits and unnecessary physician visits, and enhance their quality of life. Failure to take medications as prescribed – which is known as "non-adherence," has been estimated to impose $177 billion annually in direct and indirect healthcare costs.[1]

Maintaining Access to Local Pharmacies

Fair and accurate reimbursement to providers is key to maintaining access to healthcare services. NACDS appreciates the recognition of the Subcommittee of this important link. In particular, we are grateful for the leadership of Chairman Pallone on this issue. As the primary sponsor of H.R. 3700, the Fair Medicaid Drug Payment Act, legislation from the 110th Congress to reform pharmacy reimbursement for generic drugs in the Medicaid program, Chairman Pallone understands the importance of maintaining patient access to their local pharmacy. We also appreciate the many members of this Subcommittee who co-sponsored this critical legislation, and we applaud the inclusion of several critical provisions in the House Health Reform Discussion Draft.

[1] Ernst FR and Grizzle AJ, "Drug-Related Morbidity and Mortality: Updating the Cost of Illness Model." *J Am Pharm Assoc. 2001;41(2):192-9.*

While we are appreciative of the Subcommittee's efforts, we do believe that additional improvements are needed in House health reform legislation in order to create a fair and accurate reimbursement system for generic drugs in the Medicaid program.

The Deficit Reduction Act of 2005 (DRA) required the use of average manufacturer price (AMP) to set federal upper limits (FULs) to determine maximum pharmacy reimbursement for generic drugs in the Medicaid program. Because AMP was created to determine manufacturer rebates, and was never intended to be used as a benchmark for pharmacy reimbursement, several policy changes are needed to ensure it will result in payment to pharmacies that cover their costs to acquire and dispense medications, and make a reasonable return. Several government studies have revealed that the reimbursement policy created by the DRA would result in reimbursement to pharmacies that is on average below their costs to obtain prescription medications.[2]

We believe the most important component of a reformed average manufacturer price-based reimbursement system is an accurately defined AMP. The AMPs currently reported to CMS by drug manufacturers do not reflect the AMP definition, which is the average price paid by wholesalers for drugs distributed to the retail class of trade. If AMP is to be used for pharmacy reimbursement, it should not include rebates, discounts and sales that are not part of the retail class of trade. For example, pharmacy benefit manager (PBM) rebates should not be included in the AMP definition, as they are used to drive formulary placement and are not available to retail pharmacies. In addition, sales to entities that are not part of the retail class of trade, such as physicians, surgical centers, and mental health centers, should not be included in the AMP definition. These entities obtain discounts and rebates not available to retail pharmacies. We urge Congress to include an accurately defined AMP in its health reform legislation.

Furthermore, NACDS believes AMP-based federal upper limits should be determined by using the weighted average AMP rather than the lowest AMP. Use of the lowest AMP, required by DRA, fails to take into account the wide range of market prices for generic drugs. Moving to weighted average prevents reliance on the prices of small generic suppliers. Use of these AMPs would obviously result in market prices that are not widely and generally available to retail pharmacies. NACDS applauds the provision in the House Health Reform Discussion Draft to move from lowest to weighted average AMP to set federal upper limits.

The Deficit Reduction Act required FULs to be set when there are two sources of supply – the brand and one generic – for a prescription medication. Previously, FULs were created when there were three sources of supply – the brand and two generics. Setting FULs when there are only two sources of supply is premature. FULs should not be established until there is a steady and consistent supply of generic drugs available to all retail pharmacies nationwide. Drug shortages are relatively common. When the first generic enters the market, particularly in cases when it is brought to the market by a small manufacturer, there may not be a sufficient supply for all retail pharmacies. We believe setting FULs when there are three sources of supply ensures all retail pharmacies have access to a generic, while still providing CMS with the ability to establish federal upper limits appropriately. We urge final healthcare reform legislation to include a provision moving back to the original policy of waiting until there are three sources of supply.

[2] GAO-07-239R Medicaid Federal Upper Limits

One of the most difficult aspects of creating a fair and accurate AMP-based reimbursement system is determining an appropriate multiplier – that is, an appropriate "mark up" above the cost of a product to cover pharmacies' costs and make a reasonable return. Determining the correct multiplier is challenging since average manufacturer price data is not publicly available, and because an AMP that accurately reflects the average price paid by wholesalers for drugs distributed to the retail class of trade is not currently being reported to CMS. Because of these uncertainties, NACDS believes that multiplier proposed in the House Health Reform Discussion Draft – 130% - may not be sufficient to ensure that pharmacies are being reimbursed fairly.

While a "mark up" of 30% may appear to be generous, it is important to keep in mind the low cost of generic medications. For example, a generic drug with a per unit AMP of 3.67¢ would yield a markup of 1.1¢. Calculating this on a per prescription basis, an AMP of $5.75 would yield a "mark up" of $1.72.

There are two components of pharmacy reimbursement – product reimbursement as well as a dispensing fee - to cover the costs of dispensing a medication. While the federal government determines maximum reimbursement for drug product through federal upper limits, states make determinations about an appropriate dispensing fee – although proposed increases and decreases to pharmacy reimbursement must be approved at the federal level by CMS. Currently, the average dispensing fee in the Medicaid program is a wholly insufficient $4.40. A national study conducted by the accounting firm Grant Thornton found that the actual cost to dispense is approximately $10.50, more than twice the average dispensing fee. When determining reimbursement for pharmacies, it is critical to consider both of these components.

NACDS understands the desire by policymakers to create a system where reimbursement for drug product closely reflects pharmacy's cost to acquire prescription medications. However, we urge the Subcommittee to keep in mind the importance of fair and accurate reimbursement for *both* product and dispensing fee. During consideration of the Deficit Reduction Act, Congress was clear that if pharmacy reimbursement for product was reduced, dispensing fees would need to be increased. Despite clear guidance by Congress, CMS has not acted on any state plan amendments (SPAs) to increase pharmacy dispensing fees. Just yesterday, the Federal Register published a notice of a denial by CMS of a state plan amendment to implement a 4 to 6 cent increase in retail pharmacy dispensing fees in Washington State. Rejection by CMS of even the most minimal increases to pharmacy dispensing fees – which are already below the average cost to dispense – prevents comprehensive reform of pharmacy reimbursement in the Medicaid program.

NACDS appreciates the provision in the House Health Reform Discussion Draft to strike the requirement of the DRA to post brand and generic AMPs on a public website. The House rightfully recognized that this provision of DRA does not meet the goal of greater transparency in prescription drug pricing. Instead, it would only result in the posting of flawed and inaccurate data. Before any AMP data are publicly posted, it is critical that AMP is defined accurately. When AMPs are collected based on an accurate definition, NACDS supports the public posting of a weighted average AMP.

We are committed to continuing to work with this Subcommittee and all Members of Congress to create a pharmacy reimbursement system that results in fair and accurate reimbursement to pharmacies, assists in controlling prescription drug costs, and encourages generic utilization in the Medicaid program.

Value of Medication Therapy Management in Improving Health and Reducing Costs
As Congress has debated healthcare reform, we have been pleased that policymakers have realized the importance of addressing the problem of poor medication adherence. The failure of patients to adhere to medication therapy has been associated with an estimated $47 billion each year for drug-related hospitalizations[3], as many as 40 percent of admissions to nursing homes and an additional $2,000 a year per patient in medical costs for visits to physician offices.[4]

As highly accessible medication experts, community pharmacists, working in partnership with physicians and other health providers, can greatly improve patient adherence to medication therapy. NACDS thanks the Subcommittee for highlighting the importance of medication therapy management (MTM) and the role of non-physician practitioners, such as pharmacists, in the Medical Home Pilot Program.

In addition, we think there are other opportunities to expand access to medication therapy management, thereby improving health outcomes and reducing costs. For example, although medication therapy management (MTM) programs are currently in operation in Medicare Part D, they remain limited. Part D requires MTM for certain Medicare beneficiaries using multiple and costly medications. We believe that the MTM requirements in Part D should be strengthened and expanded in order to improve health outcomes for Medicare beneficiaries and reduce costs for the program. The Medicare MTM benefit should include services such as an annual comprehensive medication review for eligible beneficiaries, and eligibility standards should be broadened to include dual eligible beneficiaries enrolling in Medicare for the first time, and beneficiaries in transition, such as those recently discharged from a hospital or other institutional setting. These beneficiaries are likely to have had new medications introduced, and would benefit from a targeted intervention by a pharmacist.

Studies have clearly demonstrated that community-based MTM provided by pharmacists to senior populations improves healthcare outcomes and reduces spending. In North Carolina, the ChecKmeds NC program, which offers eligible seniors one-on-one MTM consultations with pharmacists, saved an estimated $10 million in healthcare costs and avoided numerous health problems in the first year of the program for the more than 15,000 seniors receiving MTM.[5]

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[3] Johnson JA, Bootman JL. Drug-Related Morbidity and Mortality. A Cost-of-Illness Model. Arch Intern Med. 1995 Oct 9;155(18):1949-56.
[4] Medication Compliance-Adherence-Persistence Digest. American Pharmacists Association. 2003.
[5] North Carolina Health and Wellness Trust Fund. NC Health and Wellness Trust Fund's ChecKmeds NC Program Serviced Over 15,000 Seniors in First Year news release. Accessed at http://www.healthwellnc.com/hwtfc/pdffiles/PressChecKmedsNC10-30-08.pdf, March 25, 2009.

Results from MTM programs and related interventions that were not limited to seniors have been equally promising. For example, five-year outcomes of the Asheville Project – a diabetes program designed for city employees in Asheville, North Carolina, and delivered by community pharmacists – revealed a decrease in total direct medical costs ranging from $1,622 to $3,356 per patient per year, a 50 percent decrease in the use of sick days, and an increase in productivity accounting for an estimated savings of $18,000 annually.[6]

Similar results have been achieved in numerous demonstrations of community pharmacist-delivered interventions and services. The Minnesota Medication Therapy Management Care Program – a program designed for low-income residents who are taking four or more prescription medications to treat or prevent two or more chronic medical conditions – generated total savings of approximately $2.11 million, with the state share estimated at $1.05 million, in 2006-2007. Approximately 62.2 percent of the total savings were the result of overall decreases in the number of hospitalizations, clinical office visits, emergency department visits, and urgent care visits.

Ensuring Access to Durable Medical Equipment

The Centers for Medicare and Medicaid Services (CMS) is requiring suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) to obtain accreditation and a $50,000 surety bond per location to serve Medicare beneficiaries. While NACDS supports the efforts to curb fraud and abuse in Medicare, these requirements will reduce beneficiaries' access to prescribed drugs and supplies and could cause disruptions in their healthcare.

DMEPOS includes such items as diabetic testing supplies and monitors, walkers, hospital beds, wheel chairs and oxygen tents. Many beneficiaries rely on their local pharmacies for their DMEPOS, particularly diabetes testing supplies. In fact, nearly two-thirds of older diabetic patients obtain their diabetes test strips from community pharmacies where they have readily available access to these products and counseling from their trusted pharmacists. These relationships help patients better manage their diseases and save Medicare resources.

These requirements are unnecessary for pharmacies as they are heavily regulated by state boards of pharmacy and numerous state and federal laws. In addition, each pharmacist employed by a community pharmacy must graduate from an accredited school of pharmacy and be licensed in the state where they practice. These assurances obviate the need to require accreditation and surety bonds from licensed pharmacies.

These rules also place Medicare beneficiaries' health at risk by reducing access to medications, supplies and pharmacists' counseling if pharmacies are unable to continue providing services as a result of accreditation and surety bond. The costs of obtaining accreditation and a surety bond add to the expenses pharmacies already face to participate in Medicare Part B, making it exceedingly difficult for many pharmacies to continue to serve Medicare beneficiaries. According to CMS' own estimate, over 25,000 suppliers will exit the Medicare program due to these requirements, reducing access to drugs and supplies for many Medicare patients.

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[6] Cranor, CW, Bunting BA, Christensen DB. The Asheville project: long-term clinical and economic outcomes of a community pharmacy diabetes care program. *J Am Pharm Assoc. 2003;43(2):173-84.*

These requirements will also have a spill-over effect on Medicaid patients. Several state Medicaid programs require DMEPOS suppliers to be enrolled in Medicare in order to provide DMEPOS to Medicaid patients. If pharmacies in these states are unable to withstand the costs of accreditation and surety bond requirements, they will be forced to turn away vulnerable Medicaid patients in addition to Medicare beneficiaries.

Pharmacies need to be in compliance with accreditation by September 30, 2009, and must obtain bonds before October 2, 2009. Therefore we strongly urge Congress to immediately provide an exemption to state-licensed pharmacies from these unnecessary and disruptive requirements. NACDS has endorsed H.R. 616, sponsored by Rep. Marion Berry, which provides conditional exemptions to pharmacies and pharmacists from Medicare accreditation requirements in the same manner as the exemption applies to other professionals. We have also endorsed H.R. 1970, introduced by Rep. Zack Space, which exempts pharmacies with positive histories with the Medicare program from surety bond requirements. We urge these bills to be incorporated in health reform legislation.

Conclusion

Chairman Pallone, Ranking Member Deal, and Members of the Subcommittee, thank you for this opportunity to testify today. NACDS is grateful for the opportunity to share our views on how to reform our nation's healthcare system. We commend you for your leadership and look forward to working with you to advance healthcare legislation that protects patient access, improves health outcomes, and reduces costs.

Mr. PALLONE. And we are going to go to questions, and start with the gentlewoman from the Virgin Islands Mrs. Christensen.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman. And I know the hour is late. I am not going to have a zillion questions. But I want to start with Mr. Miller.

And, first of all, let me say that no one supports—I don't support, and I know you don't support—unnecessary or duplicative tests. That being said, though, I really appreciate as a physician your defense of physicians in your testimony and your defense of the diagnostic technologies. As you said, and I had made note of this before you said it, I think we have forgotten how far we have come from the days when you had to undergo anesthesia, one risk; laparotomy, another risk, to make these diagnoses. But my question—you said that your experience is really in HIT. Is that correct? Did I read that in your testimony?

Mr. MILLER. I have actually experience in both diagnostic imaging, HIT, as well as therapies.

Mrs. CHRISTENSEN. Sure. But I wanted to ask about HIT. I think you were very clear in your defense of the technologies. We have been told by many that the projected savings from HIT are grossly exaggerated. And I wondered if, based on your long-time experience on HIT, if you had any thoughts on whether that was the case, or whether we would be realizing the savings that we think we are.

Mr. MILLER. The answer to the question is, unfortunately, it depends. If we simply say that what we will do is digitize all information for all patients at all times and think that will lead to productivity, I think we are misguided. I don't know about you, when I get an e-mail with a huge attachment to it, I still print it out. And I used to run with the largest health care information technology businesses in the world.

The fact of the matter is, just like pharmaceuticals, to get efficiency out of health care information technology, you need the right information about the right patient and the right context of care going to the right provider at the right time. It is a lot different than just a big file full of data. If a patient is coming to me with severe chest pain, I don't want to know about the mole that was removed last week as the first thing I see in the file. I want to know whether they are taking medication. I want to know what contraindications for medications there may be. This requires a little more intelligence.

So I think the potential is there. We certainly have customers who have realized a lot of potential. But the devil is in the details, and an inexpensive HIT system which simply takes all data, logs it, and makes it available will not change productivity. Productivity rhymes with activity, not with information.

Mrs. CHRISTENSEN. Thank you.

Ms. Buto, we applauded J&J's wellness and prevention programs and also the recent proposal by PhRMA to cut the cost of medication during the doughnut hole by 50 percent. We also appreciate your support for elimination of health disparities in the community health centers that you stated in your testimony. We do have a point of departure on the public plan which the tri-caucus is fully supporting, and which I think this committee is bending over back-

wards to ensure that it does not undermine our market-based system.

But I wanted to ask about the CER issue. I have joined with other Members in legislation that goes so far as defining the committee that will oversee it and ensuring that the membership on that committee, representative of all of the stakeholders, important to the tri-caucus as well. We directed that research must be done on women and racial and ethnic minorities so that we will really have the best science for everyone. And, further, we direct that the outcome of that research would only be used to provide clinical guidance.

Does this address some of the concerns that you raised, or are there others that remain?

Ms. BUTO. It sounds like your approach really does address many of the concerns I have raised. And I think the other issue that once you dig below the surface on minorities and women and other subpopulations is as we get closer to personalized medicine, I think we are beginning to realize we need a different approach doing the clinical trials that actually helps us sort so that we can provide and be more targeted in the treatments we develop. And we are trying to figure out how to do that in a way that gets those targeted treatments that, again, will be better value for money in the system, but also will get to subpopulations, minorities, women, and others who will benefit. And we are still sorting through that. But I think that is part of the equation as well, and it sounds like your approach would allow for that kind of research to go on.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. GREEN [presiding]. Congressman Deal for 5 minutes.

Mr. DEAL. Thank you.

Mr. Kelly, you are familiar, I think, with H.R. 3700 from last Congress that was introduced by Chairman Pallone. I believe you have generally been supportive of the language that was in that piece of legislation. What is missing from this draft that was in the bill Chairman Pallone introduced last year, 3700?

Mr. KELLY. There are some differences. We certainly appreciate that the committee in its draft bill has recognized the importance of this issue and included improvements to the existing law in the bill. We also appreciate your leadership over the years in trying to be helpful in this issue as well.

As I understand it, H.R. 3700 defines AMP in a way that reflected pharmacies' acquisition costs, which is our top priority and really central to this debate. The committee's draft currently does not include that, and that is an important priority of ours, and we look forward to continuing to talk to the committee about that. That is reflected in our written statement. That is one of the major issues.

Mr. DEAL. You mentioned that States should consider both components of reimbursement when determining what they are going to pay pharmacists for. What are those two components? And would you explain why it is important to consider both components?

Mr. KELLY. Certainly. Thank you.

Historically, pharmacies have been paid for the drug product itself and for dispensing the product; so reimbursement here and

then a dispensing fee here. In Medicaid, the States on average reimburse the pharmacy $4.40 to dispense the products. All the evidence indicates that it costs the pharmacy about $10.50 to actually dispense a prescription drug when you consider all the overhead that is involved with running a modern pharmacy today. So it is important to make sure that reimbursement for the drug product is right, which is why getting the AMP definition is so important when it comes to Medicaid product reimbursement, which the Federal Government has sole jurisdiction over. The States control the dispensing fees in the Medicaid program.

And I tell you, this committee and Congress could really help us quite a bit with CMS on this issue of dispensing fees. When DRA was passed, there was a ton of legislative history which indicated the expectation was and the encouragement was that States would allow for increased dispensing fees for pharmacies. Well, about a half a dozen States have submitted State plan amendments requesting just that, and CMS has shut down every single one of them. In fact, just this week the State of Washington submitted a State plan amendment that would have increased fees by a nickel, and CMS shot it down. So to the extent folks on the committee can be helpful in that regard, CMS, we would sure appreciate it.

Mr. DEAL. So the two products. One is control at the Federal level, that being the payment for the drug itself, which is the AMP issue that you alluded to, and you don't think this draft addresses that issue as clearly as the Pallone legislation did. And then the second component being the dispensing fee, which is a State issue by and large, is still left that way under this draft legislation. Is that correct?

Mr. KELLY. There is nothing in this draft that we have seen that indicates any policy changes on dispensing fee. And you are right, there is product reimbursement, and that relates directly to how you define AMP and how you reimburse and calculate the AMP.

Mr. DEAL. I believe when we were dealing with the MMA, we tried to make sure that seniors had a pharmacy that was going to be close enough and accessible enough for them to handle their pharmacy needs. I don't think there is any language of a similar nature in this draft. Did you find anything that would address that issue? And, if not, is that something we should be concerned about?

Mr. KELLY. We have not seen that in this draft. And you are right, that is a part of the Medicare drug benefit. They actually use the TriCare health care program access standards for community pharmacies, access to community pharmacies.

Look, seniors want access to pharmacies. Most citizens want access to pharmacies. They want it to be convenient. That is very important. As I said in my testimony, there is a pharmacy within a couple miles of everybody, on average, in the country.

You know, I am not sure how those access standards would fit into the context of this bill. It made sense for the drug benefit when you were creating that, but I am just not sure at this moment whether it would fit into the context of this particular bill. It came up very recently, as you know, and we are still kind of combing through it, quite honestly, to get a sense for that.

Mr. DEAL. Thank you.

Mr. GREEN. Congresswoman Schakowsky for 5 minutes.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

I would like to start with Mr. Vaughan, and I welcome you. And I don't know if I have seen you in this role before, but you have been on the Hill for a long time, too.

In your written testimony, you identified as a cost-saver legislation that I introduced with Representative Berry, H.R. 684, the Medicare Prescription Drug Savings and Choice Act, which allows Medicare to negotiate for lower drug prices.

I am wondering if you could talk a little bit about how that would reduce costs.

Mr. VAUGHAN. Yes, and thank you for that cosponsorship. And it would probably be—you know, we have got good competition in generics and stuff—this would be a place where in a biologic that came in at one of those very, very, very high prices, if the Secretary could work with it a little bit, bring the price down—and I know it works.

I happened to work for the Chairman of the Ways and Means Health Subcommittee in 1989 when the first big blockbuster biologic came in, EPO for folks with kidney disease. And as I recall, the company wanted a launch price, and the Chairman was saying, whoa, we are the monopoly buyer, everybody in the kidney program is in Medicare. And you have got a monopoly company. Let's negotiate. The then-Secretary didn't particularly want to do that, and it took a lot of press releases and screaming and hollering and threats of hearings and stuff.

But I do really believe that that jawboning by just one, not just, by a subcommittee chairman on the Hill pushed the Secretary enough that we got that price down $3, $4 a unit. We should have gotten it down, 8 or 9, you know, if the Secretary had been a little more gung ho on it. But that company recovered its entire investment in that drug in 9 months, and is making over a billion dollars a year in profit from Medicare from that drug now. And we didn't do a very good job negotiating, but we saved billions. But it can work.

Ms. SCHAKOWSKY. So we don't have to imagine it.

Yes, Ms. Buto.

Ms. BUTO. Bill, I have to kind of disagree with your memory on this. I was at HCFA at the time. I actually did negotiate that price. And it was done way before the chairman got involved, because the company came to us saying, this is an ESRD drug. ESRD is a Medicare population. And we decided that—I decided I couldn't do this alone. So I got the Inspector General's Office and the Office of Management and Budget to sit down with us, and we went through SEC filings. This was a company with one drug and one drug in the pipeline, and we did the best we could around the table to do that. I think you all came along; and I think rightfully so, said, you know, can't we maybe take another dollar off? You did that legislatively.

Ms. SCHAKOWSKY. So you can fight that out later. But the point is it worked.

Ms. BUTO. My point was this: In spite of the fact that it was one company with one drug, we had a very difficult time actually doing the negotiation. That was actually my point.

Mr. VAUGHAN. It is difficult, but you did get some money out of it. And I stand corrected. Congratulations to you for having started it all.

Ms. BUTO. It wasn't about money. Can I just make the point? It was about making sure that ESRD beneficiaries had it at the moment that FDA approved it. We wanted to make sure because there was no other market that there wasn't a huge delay before they could get access, and that was the reason we needed to set a rate. Because otherwise, Medicare waits for a year or so, and the rates are set in the marketplace, right?

Mr. VAUGHAN. Yes.

Ms. BUTO. It was about access.

Ms. SCHAKOWSKY. It is about access. But I think if we institutionalize this notion of Medicare being a negotiator, with the huge network that it represents, that we can do better than we do right now.

Ms. BUTO. I disagree that.

Ms. SCHAKOWSKY. You don't agree with that?

Mr. VAUGHAN. I do agree.

Ms. SCHAKOWSKY. Well, don't insurance companies regularly negotiate for their subscribers?

Ms. BUTO. They do, and they set formularies, and my experience with Medicare is that it has been reluctant, shall we say, to set formulary restrictions on what Medicare will cover, because the notion is that—and we always had this underlying our coverage policy—is that the beneficiary population is very diverse and usually fairly chronically ill. And so to exclude certain things just to get price down——

Ms. SCHAKOWSKY. Well, in our bill, in the bill actually that we are talking about, we do set a formulary in the draft for the public option, right?

Oh, in my bill we actually talk about a formulary so that we can negotiate. I guess my time is up.

Mr. GREEN [presiding]. Out of time, thank you. Congressman Pitts, 5 minutes.

Mr. PITTS. Thank you, Mr. Chairman. Thank you, panel, for your wonderful testimony.

Mr. Miller, you said that a large part of imaging is done without any association to the financial self-interest of the ordering physician. You also said that the increases in use of imaging are perhaps too often attributed to a financial incentive in ordering the test.

Do you believe that one possible reason for the rise in imaging could be the practice of defensive medicine? Do physicians order tests to protect themselves from potential medical liability?

Mr. MILLER. I can only speculate that that could be the case, in some cases. I can also state that if, when we speak to our customers and ask them, because it is important when we design machines we ask them, you know, why do you order tests? What are you trying to look for, what are you trying to discover? The great majority of time they are really telling us we want to be able to see this disease process. We are having difficulty because we don't know if the patient has X versus Y.

Now, in knowing if a patient has X versus Y before they treat, if that is defensive, then I can only agree with you. It is probably also good medicine.

Mr. PITTS. MedPac has given us clear indication that it feels there is a tremendous overuse of medical imaging and that we should rein in the use and reimbursement of such use.

Do you feel that there is overuse, and what do you feel is the appropriate way to get at that issue?

Mr. MILLER. I don't think that there is overuse, by and large. Are there cases of overuse that might crop up in someplace or another? Yes, probably. However, as I stated in my testimony, what we really believe and support as an industry is appropriate in this criteria. I do believe that we should have guidelines which are physician-created and physician-administered that guide people to say, for this type of symptoms, this test is appropriate. For patients with this background of illnesses, this test is appropriate.

Doing so may have, however, two consequences. There are times when a test won't be ordered because it is inappropriate. There are other times—and we see this just as often—that a patient will be subjected to a slowly increasing series of tests. They will come in with chronic headaches and then something has been going on for a long time, and an X-ray of the head will be ordered. An X-ray of the head will show you the skull. Not many headaches caused by the skull.

So sometimes it could lead to actually an increase in the type of imaging that is ordered, a temporary increase in cost. But our argument has been and what I have tried to put forward is that, knowing the patient's condition precisely, characterizing the disease in detail before you start to treat, is probably the best way to save cost in health care; because there is nothing more expensive, more wasteful or more unethical than treating a patient with the wrong treatment for their disease or, even worse, starting the treatment for a disease they don't have.

Mr. PITTS. I have just a couple of questions on the DRA. You mentioned in your testimony the large reductions that the DRA imposed to medical imaging, and that during the first year of implementation, that growth in imaging was reduced to only 1.9 percent.

What do you think the reasons were for growth in previous years? And do you feel that the DRA was the only factor in this slowing of the growth? And what was the impact of the DRA and the dissemination of new updated technologies to patients? What would be the impact on future cuts to advanced imaging technology, such as CT, MRI, PET, nuclear imaging, do you think this would—what impact?

Mr. MILLER. Well, we have an advantage that we do business in about 180 countries of the world, so we can look at use patterns not only in the United States, but in many other countries and see trends and see changes. The DRA had a sudden drop in imaging growth, which we didn't see in any other countries at the same time. So, in other words, it must have been the DRA. We didn't see it happen in Canada, we didn't see it happen in China. We didn't see it happen in South Africa, any country in Europe, et cetera. DRA happened, growth was reduced.

In other countries where there has been no DRA and no financial linkage that would cause overuse, we have seen medical imaging increase year over year in almost every other market we are in. It is increasing in China, it is increasing in Australia, it is increasing in Germany. It is increasing everywhere, because, as I said, we are substituting more expensive physical and invasive tests with things that are noninvasive, more comfortable for the patient and, frankly, looked at as whole as cheaper.

I think the DRA did cause in some parts of the country, some of our customers to, frankly, go out of business. I don't think that it resulted in a sea change in care, but we start to get it to limit. And therefore, what I would argue is in some ways—I hate to phrase it this way—we gave once at the office. We took a large cut in our industry and we are now at the point where more reimbursement cuts to the supplies of a service will definitely cause reduction in access.

Mr. PITTS. Thank you. Thank you, Mr. Chairman.

Mr. PALLONE [presiding]. Thank you. Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman. The Chair got back. Otherwise I was going to recognize myself for 2 hours to answer—ask questions, because I know we were all having so much fun today. But I appreciate it, Mr. Chairman.

Let me first ask, Mr. Miller, you mentioned in your testimony the large reduction that the Deficit and Reduction Act imposed on medical imaging, and that during the first year of implementation that growth in imaging was reduced by only 1.9 percent.

What do you think the reasons were for the growth in previous years, and do you feel like that the DRA was the only factor in slowing that growth?

Mr. MILLER. The growth was starting to slow somewhat in previous years. There were years in which the growth was faster. It started to slow even before the DRA. But the DRA was a quantum-step change in the growth of imaging. As I have stated before, I believe the growth in imaging has simply to do with its utility.

One of the best examples I can give is that we will probably see a growth in the use of computer tomography in the management of chest pain. That is going to grow. And it is going to grow and, frankly, if it were my family members or me, I would want it to grow, because right now the standard of care in many places for chest pain is, you either sit for a long time to get blood tests, the blood tests determine whether your myocardium is dying. Or you get put in a cath lab for a very invasive exam. A CT-scan for chest pain has an almost 100 percent negative predictive rate. In other words, if it doesn't show you have disease, you can go home.

You are therefore avoiding two things. You are avoiding either sitting around the ED, or if it is late at night, getting checked into the hospital. Or you are avoiding a $10,000 catheterization. Forget about the ethical issues. And I believe, if people have informed me correctly, you have some experience with this.

Mr. GREEN. I do. And I have to admit I joked a few years ago that I got belt and suspenders when I was diagnosed for having a heart problem. And it turned out, I did the catheter, and then they said, well, why don't we see if we can do the scan? And I sat there

and watched it, and I felt like I was getting lobbied with a hospital gown on, and paying for it at the same time.

But I appreciate that because I know in this bill we are concerned about that. I just don't want, and I don't think members want to cut off some of the newer technologies we can get that are less invasive and that actually can be cheaper than, for example, a catheter.

Mr. MILLER. I think that the point I want to make I can best make by one also very personal experience, my father; 18 months ago my dad had a stroke. Amazingly, I was in the neighborhood when it happened. I showed up at the emergency room when he had it. The emergency room was outfitted with a state-of-the-art CT-scanner, from us. And they were able to rule out hemorrhage. He was a candidate for a clot-busting drug. When he came to the ED he could barely speak. Part of his face was paralyzed. After the drug, some hours later, he now speaks perfectly with his grandchildren.

Now, I would ask you, was that expensive? Yes. But what would be the cost of the rehabilitative care over the rest of his life had that not been available? The real issue in looking at these costs is we must look longitudinally over the entire not only episode of care, but the entire sequence of care.

Mr. GREEN. Let me go on, because I have questions and only limited time.

Ms. Buto, I have been working on a piece of legislation, H.R. 1392, which removes the prompt-pay discount to extend it to wholesalers from the average sales price of Medicare Part B drugs. Most of these drugs are oncology therapies, including chemotherapy, and are administered in physicians' offices or in outpatient settings. As you know, many oncology practices have been reimbursed for these Part B drugs at 2 percent under the price they purchase the drugs because of the prompt-payment discount.

One point of opposition to the bill is that some believe the passage of this legislation and the removal of the prompt-pay discount will result in higher costs to the government if manufacturers raise drug prices, because the physicians will be reimbursed at the proper rate of the drugs.

I believe the price increases in the Part B drug market are largely a function of the level of competition for these drugs rather than a result of the terms included or excluded from methodology. Would you agree with that? And do you believe that the removal of the prompt-pay discount will directly result in drug manufacturers raising their prices?

Ms. BUTO. I do agree with your position, and the prompt-pay discount is really a factor in the average sales price that recognizes the cost of doing business. So we really don't think it is a legitimate factor that should go into the average sales price.

I agree with you as well that it is the competition among the different drugs in a class that are going to drive the average sales price, not removal or adding of this factor to the ASP.

Mr. PALLONE. Mr. Green, as you can see, the time—the electronic timing devices have ceased to exist.

Mr. GREEN. I promise not to take my 2 hours, Mr. Chairman

Mr. PALLONE. You are almost at a minute over. From now on, I am going to have to tell you manually what the time is.

Mr. GREEN. Oh. Can I just get one more question?

Mr. PALLONE. Sure. Go ahead.

Mr. GREEN. Again, Ms. Buto, as a strong supporter of H.R. 1548, the pathway to biosimilars is sponsored by Representatives Eshoo, Inslee and Barto, and I saw your testimony in support of the bill as well.

I am particularly concerned with the patient safety, and this bill allows for clinical trials and the approval of biosimilars.

Could you elaborate for the committee on why clinical trials for biosimilars are an important part of the approval process for biosimilars? And I believe it is important to allow innovator companies to have adequate time to make a return on their investment. There is no incentive for these innovator companies to develop these lifesaving treatments, if you don't allow that. Can you discuss the data exclusivity provision of H.R. 1548?

Mr. PALLONE. Quickly, please.

Ms. BUTO. Very quickly. And I can just say I am not an expert on this, but I will tell you that our clinical experts are available to the committee. And one of them was an official in the Biologic Division at the FDA.

But briefly, the reason clinicals are so important is that biologics are generally protein-based compounds and they are not chemicals. So they are not, they can't easily be, in fact, they cannot be replicated. And that is why the clinical studies are so important.

Our own experience is, even when we changed the bottle stopper on our biologic, it created an immunogenicity problem that created some real adverse effects. So you can make a small change. If you are not careful in doing the studies, you won't know between the innovator and the biosimilar. So it is important.

Mr. GREEN. Thank you for your time.

Mr. PALLONE. Thank you. From now on I am going to have to—oh, it is back up. All right. Here we go. Great. All right. Next is Mr. Shadegg.

Mr. SHADEGG. Thank you, Mr. Chairman. And I trust I will get the same indulgence.

Mr. Miller, I want to begin with you. I have my own experience. I had bypass surgery, I think 7 years ago now, and I am a huge fan of the work that you and Ms. Buto do. I think it is vitally important that we fund that kind of research and that we fund both the development of drugs, cutting-edge drugs and of cutting-edge biologics.

I believe I heard you, Mr. Miller, say that you like a physician to manage your health care. Was that—is that what you said?

Mr. MILLER. Yes, that is.

Mr. SHADEGG. And I take it you would agree with me that some of us who have concerns that physicians won't be able to manage health care if we have government-controlled single payer, whatever you want to call it, health care—at least if it put a bureaucrat between you and your physician, you would be concerned about that, would you not?

Mr. MILLER. I would be more than concerned.

Mr. SHADEGG. OK. Great. I believe at one point you said that something would cause access to plummet and especially in rural areas. I take it that is any limitation on technology or on the availability of analytic devices such as the type you are advocating—imaging?

Mr. MILLER. Here is the point I was trying to make. In many rural areas if the reimbursement rates were driven by a formula that insisted on a 95 percent—which is not in this draft—but a 95 percent utilization rate, there will be rural medical imaging centers that will just go out of business. I mean, we know this. They will go out of business. You might say, well, that is oK. They can just drive a little further to a hospital, get imaged there.

Hospitals these days have capital constraints. They are not ordering extra capacity because they can't afford it. And even worse than that, I mean, populations are getting older. Imaging exams are being dominated not by the technology, but getting the person into the room, calmed down, on the table, comfortable with the exam and getting back off. There is a limitation to what you can do.

And frankly, one last point. The high-tech stuff supports some low-tech stuff. Mammography, for example, gets supported by some high-tech stuff. That will also go away.

Mr. SHADEGG. I think your point is exactly right on; that imaging has, in fact, in the long run brought down the cost of health care, and I think restraints placed on imaging have been a mistake.

You said that you support, and your company supports, comparative effectiveness research so long as it is looked at in the entire—I think you said longitude of care. I would agree with that. But my concern is if that longitude of care is looked at by a government bureaucrat only looking at dollars and cents, as opposed to a physician or a group of physicians looking at both cost and benefit, I am deeply concerned that comparative effectiveness research could, quite frankly, put the government in the position of devastating both drug development or pharmaceutical development and device development. If somebody is sitting in there kind of second-guessing you guys, I don't know how it doesn't restrain your capital.

Mr. MILLER. We have the same fear. We have the fear that if it is not done right, it can simply be a way to restrain technology development, which would be horrible for the United States. We are are a net exporter of health care technology. That would be a huge mistake.

However, we look at all technology we develop and ask ourselves a single question: Does it change the care of the patient in cost, quality and time? All three factors must be simultaneously considered. And if so, comparative effectiveness research can be a good thing. If not, as you imply, and in the way in which you imply it, I would be dead-set against it.

Mr. SHADEGG. Ms. Buto, I believe you testified very similarly. I believe in very carefully selected language you said, in the hands of physicians, in the hands of people using it for valuable purposes, comparative effectiveness research can be very good; but that if it is, in fact, used to ration care, as it perhaps has been done in other countries, that would not be good. Am I correct?

Ms. BUTO. You are correct. We have had the experience where treatments for which there is no alternative have been denied based on the application of a cost-effectiveness threshold that most people would admit is kind of arbitrarily set. So I do think it is valuable. I think in this country, people will use it; physicians will use it and patients will use it. So I have no doubt that it will—the value proposition will enter in, but at the right level, rather than being set at a national level by a national entity.

Mr. SHADEGG. You also expressed concern about government negotiation of drug prices. Do you fear that if we had a single-payer system or if we get a public plan that has the power of the government behind that?

Ms. BUTO. Yes. I was reading the discussion draft and there was government negotiation within the public plan section. That has great concern for us, as I say. I think our concern really comes from the cascade of public plan dominating, and then a public plan really becoming more commodity-based in its approach, trying to squeeze down cost by setting prices. That will definitely inhibit innovation.

And again, we think this country has been a leader in innovation, and we want to maintain that leadership as well as the strong position in the economy that these biologic and pharmaceutical and device companies play in making our economy strong.

So there are a lot of reasons, but the real fear is that you have a cascading effect that results in really a commoditization and lack of incentive for the research to go on to develop new treatments.

Mr. SHADEGG. I want to thank all the witnesses for their testimony. I want to thank the Chair for his indulgence. And I just want to conclude by saying, for me, the single greatest fear I have of either a public plan which would compete with and, I believe, ultimately undermine and destroy private health care insurance, or a single-payer insurance, is that it will end innovation.

And I mean, right now we have clinical effectiveness research done by the government. If you put forward either a pharmaceutical, saying it will reduce John Shadegg's blood pressure, or a device that will perform a prostate cancer operation on him, you have got to prove that it is clinically effective.

And I am all in favor of doctors or insurance companies being able to use comparative effectiveness to look at the cost effectiveness of my care. I want somebody to say look, Congressman, this drug will be financially much better now for you than that drug.

But putting comparative effectiveness authority in the hands of a bureaucrat whose job it is to meet numbers criteria rather than to assure, first and foremost, patients' care, I believe is very dangerous and, I believe, for the world.

I mean, it seems to me—I happened to just drive down here from New Jersey yesterday and passed Johnson and Johnson's headquarters. And I know that that is a central part of the economy of New Jersey. And I just pray that we don't do something that will drive capital away from the cutting-edge research that we have, because I am sitting here alive today because of the work you all have done, and I would like America to stay out front. And I fear that under any publicly government-run program, we are going to inhibit that capital, and we are not going to have the kind of cut-

ting-edge medicine that you get when free markets invest and explore for those drugs or those biologics.

Mr. PALLONE. Thank you. The gentleman from Ohio, Mr. Space.

Mr. SPACE. Thank you, Mr. Chairman. And I would like to thank the witnesses for their indulgence. I know it has been a very long day. And I may be the last member to question you. I am sure you are happy to here that.

I come from Ohio's 18th Congressional District. It is a very rural district. It is, for the most part, within Appalachian proper. And one of the things that we suffer from is a lack of access.

Mr. Kelly, I want to thank you for referencing my bill in your testimony, which I have had a chance to review. This bill is designed to exempt those pharmacists who have, in good faith, practiced without fraud or abuse from the surety bond requirements imposed by the last administration as a part of the Medicare DME system.

And in our district, we have got—I have got one county that has one pharmacist in the entire county. We have a significantly higher-than-average incidence of diabetes, and the diabetes we do have is not being properly managed. Many of the people that I represent don't have the insurance to purchase test strips, for example, which is a very critical component of the management process for those who suffer from diabetes, Type 1 diabetes in particular.

And I am interested in your thoughts on H.R. 1970—that we dropped, concerning the exemption of those pharmacists—and as to how it will affect those pharmacies that are really serving as the primary interface with much of the health consumption community, as well as how it may affect the ability of people who are either uninsured or have policies that don't provide significant coverage and their abilities to purchase things like test strips or other DMEs.

Mr. KELLY. Certainly. I thank you, Mr. Space. And as to your bill, H.R. 1970, we fully endorse it and support it and appreciate your introducing it.

The cost of chronic care has been chronicled a lot in this debate on health care reform, and it is very important to get a handle on chronic care. Only 50 percent of the folks with chronic conditions take their medications as they are prescribed. And that is a problem. The people who can help them with that are pharmacists in communities like yours and across the country, in every community, low income and upper income, across the country.

As it relates specifically to these new requirements, the surety bond requirement that the last administration imposed, CMS actually predicted—projected, I should say—that 25,000 DME suppliers would probably drop out of the program as a result of this new surety bond requirement. And this surety bond would apply to each and every pharmacy in a chain of pharmacies. And that is a big deal, not just to members of mine who have 6,000 pharmacies across the country, but half of our members have 20 or fewer stores in their chain. So we have a lot of small business people operating pharmacies across the country. That is going to be a huge expense and a huge hassle to them to obtain a surety bond just to continue to provide diabetes testing supplies and testing strips and glucose monitors to diabetic patients.

In Medicare, seniors overwhelmingly obtain their diabetes testing supplies from their local neighborhood pharmacies. And they are going in there to get their insulin already.

Mr. SPACE. All right. And many of these DMEs, glucose monitors and test strips, for example, are over-the-counter products. These are not prescriptive products, correct?

Mr. KELLY. That is absolutely right. The patient is able to walk in and obtain that equipment from the local pharmacist. Our concern, as you have articulated, is that this new requirement and others would really hassle pharmacies out of this program. And that destroys continuity of care. And we are talking a lot in the health care reform debate about the importance of continuity of care. It is especially true with chronic conditions like diabetes. If a patient can't get their diabetes testing equipment at the same place where they are already getting their insulin, it doesn't make a lot of sense to us, and you are going to break that bond that is so important right now for good care.

Mr. SPACE. Thank you, Mr. Kelly. And I yield back the balance of my time, all 12 seconds.

Mr. PALLONE. Thank you Mr. Space. Unfortunately for the panel, I still have questions to ask. Hopefully, I will be the last one, unless someone else shows up.

I wanted to start with—I wanted to ask Ms. Buto a question; then I wanted to ask Mr. Miller. I will try to get both of these in in the 5 minutes or so.

Ms. Buto, the President reported 2 days ago that the White House had reached a deal with pharmaceutical manufacturers to cut costs for seniors, with incomes up to $85,000, in the donut hole by 50 percent for brand-name drugs. AARP CEO Barry Rand, along with Senators Baucus and Dodd and representatives of the pharmaceutical community were involved in reaching the deal.

We agree with the importance of rectifying this major flaw in the prescription drug bill that left seniors with no coverage between $2,700 and $4,350. And the discussion draft fills about $500 of this cost immediately and then phases out the donut hole for all Medicare beneficiaries over time. And the discussion draft reinstates the ability of the Federal Government to get the best price for prescription drugs for the most vulnerable low-income Medicare beneficiaries. Those savings are used to fill the donut hole for all Medicare beneficiaries.

And my question is—and I asked AARP the same question yesterday—can you clarify for me, do you see this proposed provision in the draft as working together with the commitment by the pharmaceutical manufacturers, thereby filling the donut hole for seniors; or do you view your agreement with the White House in lieu of that discussion draft provision?

Ms. BUTO. First let me just clarify something and make sure that I have your question correct. You know, we feel that the 50 percent discount will provide immediate relief, obviously. A provision that we like in the discussion draft is closing the donut hole over time. A provision that we don't like is applying Medicaid rebates to Medicare. So I don't know if that answered your question.

But I want to be really clear that we do think that closing the donut hole over time in the immediate term, being able to provide

these 50 percent discounts, will help a lot in making that more possible. We are hoping it will reduce the cost for the committee of getting to that closure. But we don't support the transfer of Medicaid rebates to Medicare.

Mr. PALLONE. OK. Well, I understand where you are coming from. I just wanted to make sure, because of course AARP said that they would like to see us go all the way in the way that the discussion draft proposes. And obviously I agree with the discussion draft. I just wanted to get your opinion on that.

Let me get to Mr. Miller. And I am going back to the point that Mr. Shadegg touched on about the comparative effectiveness research, you know, in the context of the health reform effort. The discussion draft would create a permanent center for comparative effective research. And the purpose of the center is to support research to determine, and I quote, the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated and managed clinically.

In my opinion, it is simply about arming doctors with the best info possible to help them make decisions with their patients. It says nothing about insurance or cost effectiveness. In fact, the draft would prohibit the center from mandating coverage policies.

But even with all that, you know, we get the attacks from—that this research somehow is going to ration care or reduce access to new technology.

So I have two questions. Do you believe that thoughtful, methodologically appropriate comparative effective on this research focused on patient outcomes will help or hurt patients? And secondly, Siemens, I know, is on the cutting edge of medical imaging technology because it is, you know, it is basically a revolutionary company. Won't this research simply validate the quality of your products?

Mr. MILLER. In both my written and oral testimony, I said I am for comparative effectiveness research, with a caveat. And the caveat was that it looks longitudinally across care, and it looks to validate which technologies result in ultimately, as I mentioned before, the lowest cost, lowest time, and the best quality for the entire episode of patient care.

We engage in competitive effectiveness research all the time in the company. We will have people come to us and say, every year we have budget time, and our engineers all want to spend all of the money on everything. And we are big, but we still have limited budgets like everyone does. So we have to decide do we invest in this new MR, do we invest in this new CT, or this new ultrasound, or this new thing that no one's ever thought of yet?

To do this we engage in our own form of comparative effectiveness research. It may be done more or less well, but these are exactly the same kind of questions that we actually ask when we decide where we invest our innovation dollars. So therefore, we can't be against it in truth. And plus, if all of the statements I made in both written and oral testimony are true, if I truly believe them, I have nothing to fear. In fact, what should happen, if I am right, is that you will end up spending more money on my technology because it improves patient outcomes. So I support it. It must be

done the right way. The devil is in the details, but the concept is absolutely supportable.

Mr. PALLONE. All right. That is what I wanted to find out. And I appreciate it. And I think that——

Ms. BUTO. Mr. Chairman, if I could just add just one other point to what Mr. Miller said.

Mr. MILLER. You are not going to fight with me.

Ms. BUTO. No, no. I am not going to fight with you.

I think the other thing, too, to talk a little bit about is the fact that I think the appropriate comparisons are really across—in dealing with the condition across the different modalities. One might be a device, one might be a drug, one might be watchful waiting. So I think people tend to think drug to drug, device to device.

And the other thing that has recently come in is the geographic variation in the costs are actually being driven by variation around process of care. So more visits, more testing around a treatment can make a big difference. So I think, you know, as the committee considers this, just the complexity of the issues and going beyond just the notion of drug-to-drug, device-to-device, to get that bigger picture of what comparisons were really after.

Mr. PALLONE. I understand. And that certainly makes sense to me. I think we are done with the questions and done with the whole hearing. But really, thank you again. Because I think, again, your panel as well as the others were very helpful in terms of what we are trying to achieve here with health care reform and so we certainly appreciate it.

You may get written questions within the next 10 days. We would ask you to respond to them and get back to us as quickly as possible.

Now, again, as yesterday, the committee is going to recess—the subcommittee, I should say, is going to recess and reconvene tomorrow morning at 9:30 to continue our review of the discussion draft. So the committee stands in recess. Thank you.

[Whereupon, at 7:24 p.m., the subcommittee recessed, to reconvene at 9:30 a.m. Thursday, June 25, 2009.]

[Material submitted for inclusion in the record follows:]

NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

August 4, 2009

The Honorable Henry Waxman
Chairman, House Committee on Energy and Commerce
2125 Rayburn Building
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Waxman:

Thank you for your letter requesting written answers regarding my testimony before the Committee on June 24, 2009 at the hearing on the "Comprehensive Health Reform Discussion Draft." As requested, I have enclosed answers to the written questions submitted by committee members pertaining to my testimony.

I want to thank you for inviting the National Association of Chain Drug Stores (NACDS) to testify. We appreciate the chance to share our views with the committee and look forward to working with you and other members to help craft health reform legislation that benefits all Americans, including the millions who receive care at neighborhood pharmacies each day.

Please feel free to contact me if you have any questions.

Sincerely,

Paul T. Kelly
Vice President, Government Affairs

CC: The Honorable Frank Pallone, Chairman, Health Subcommittee, Committee on Energy and Commerce
The Honorable Nathan Deal, Ranking Member, Health Subcommittee, Committee on Energy and Commerce

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The Honorable Nathan Deal

1. Mr. Kelly, you mentioned that in order for states to increase their dispensing fee they must receive approval from CMS. What states have made efforts to increase their dispensing fee and what is the status of those efforts?

Mr. Deal, several states have submitted state plan amendments (SPA) to CMS for increases in dispensing fee. To date, Arkansas, Louisiana, South Carolina, Texas and Washington have all submitted SPAs for increases in dispensing fees. CMS rejected Louisiana's proposed increase, while the South Carolina and Texas SPAs are still pending. In August 2008, CMS disapproved the Arkansas SPA. Arkansas is appealing the decision. A hearing is scheduled for September 15, 2009 for reconsideration. Other CMS actions include the May 6, 2009 disapproval of the Washington SPA to implement a 4 to 6 cent increase in retail pharmacy dispensing fees.

2. Mr. Kelly, you mentioned that states are paying pharmacies dispensing fees that are well below the national average. Can you explain?

Mr. Deal, the current national average for dispensing Medicaid prescriptions is $4.40. This rate is about 42 percent of what a 2006 Grant Thornton Cost of Dispensing national survey found to be the average cost of dispensing a medication ($10.51) to Medicaid beneficiaries. In some cases, state dispensing fees are below the national average and in all cases state dispensing fees are below the average determined by the Grant Thornton Survey.

3. What is the generic dispensing rate and overall pricing difference for generic drugs when compared to brands that dispensed by retail pharmacies?

Mr. Deal, in 2008, branded drugs constituted only 34.9 percent of prescriptions dispensed by Medicaid, which accounted for 84.9 percent of Medicaid prescription drug expenditures in that year.

The average cost of a generic dispensed to Medicaid enrollees in calendar year 2008 was about $22.28, which is just 10.8 percent of the $204.54 average cost for a single-source (patented) brand name medication, and an average difference of about $182.26 per prescription.

4. Mr. Kelly, can you please explain what medication therapy management is and how it improves healthcare outcomes and saves money. In addition, I understand that CMS recently made some changes to enhance and strengthen the program under Medicare Part D. Can you please briefly summarize those changes and why Congress should consider codifying them into law?

Mr. Deal, Medication Therapy Management (MTM) is a service or group of services that optimize therapeutic outcomes for individual patients. MTM includes a broad range of activities designed to improve patient care and outcomes, increase medication adherence, prevent medication errors, enhance communication between providers and patients, improve communication among providers, and enable patients to be more actively involved in medication self-management. In the pharmacy setting, MTM includes services such as review of the patient's prescription and over-the-counter medications, development of a personal medication record for a patient to share with his/her physicians(s) and a medication-related action plan to achieve specific health goals in cooperation with his/her pharmacist.

One of the primary ways in which MTM can improve patient health is through increased adherence. According to a World Health Organization report, only 50% of patients with chronic diseases in developed countries adhere to medication therapies. In the United States, only 51% of patients taking blood pressure medications are adherent while only 40-70% of patients taking anti-depressants adhere to prescribed therapies. Medication non-adherence imposes approximately $177 billion annually in direct and indirect costs. These costs come in the form of adverse events, hospital readmissions and the need for higher cost medical attention. With increased adherence and reduced adverse events, it is possible to avoid other higher cost medical services.

While the Medicare Modernization Act provided the framework for MTM services under Part D, the availability and utilization of this critical benefit remains low. In 2007, only 10 percent of Part D beneficiaries were eligible for MTM services in 2007. Of those who were eligible, 77 percent of them chose to enroll in MTM, thereby providing a clear indication that beneficiaries find this benefit to be valuable. In addition to the unnecessarily restrictive criteria for MTM eligibility, beneficiaries do not have access to a consistent menu of MTM interventions in Part D plans. As a result, when beneficiaries switch from one plan to another, they may not be able to obtain the same MTM benefits.

CMS recently improved MTM targeting criteria and menu of interventions through guidance in its annual call letter. As a result, starting in 2010, plans may not require that a beneficiary have more than 3 chronic diseases or be on more than 8 part D medications to be considered eligible for MTM. The call letter also requires that plans offer a defined menu of MTM interventions for beneficiaries that include, at a minimum, the following:

- Annual comprehensive medication review (CMR) which provides each eligible beneficiary an interactive, real-time, person to person consultation with a pharmacist or other qualified provider. The CMR would include a review of the individual's medications, the creation of a personal medication record and a recommended medication action plan in consultation with the individual and the prescriber, and a written summary.
- Targeted mediation reviews (TMR) no less often than quarterly, to assess medication use and issues since annual CMR, monitor unresolved issues, problems with new drug therapies, or if the beneficiary has experienced a transition in care. Plans would be required to assess findings of the TMR to determine if a follow-up intervention with beneficiary or provider is necessary.

We believe such standardization of MTM eligibility and offerings is critical to the success of the program and to ensure that a beneficiary could switch plans without fear of losing MTM programs they prefer. We strongly urge Congress to codify these important enhancements.

5. Mr. Kelly, you state that Congress must act now to provide relief to pharmacies with respect to accreditation and surety bond requirements. Can you explain why?

Mr. Deal, pharmacies have to become accredited by September 30, 2009, and must obtain a surety bond in the amount of $50,000 per location by October 2, 2009. These deadlines are fast approaching and pharmacies would have to spend considerable time and resources in preparing for accreditation and surety bonds. If pharmacies are unable to obtain surety bonds and accreditation due to the expenses involved, Medicare beneficiaries may find it difficult to access their Medicare Part B medications (such as oral anti-cancer drugs and immunosuppressants) and durable medical equipment (such as diabetic testing supplies) after these deadlines. Gaps in therapy or diabetes monitoring could harm beneficiaries' health and raise healthcare costs for the Medicare program. Therefore, Congress should provide relief from these requirements immediately so pharmacies can continue serving Medicare beneficiaries.

6. Mr. Kelly you state in your testimony that pharmacies deserve an exemption from accreditation and surety bond requirements given their status as state-licensed healthcare providers. Can you explain a bit more about what that means in terns of the safeguards it brings to the Medicare program?

The state licensure and oversight of pharmacies provides many safeguards for the Medicare program. State licensed pharmacies are subject to a comprehensive set of requirements through pharmacy laws and regulations that regulate every aspect of pharmacy practice. Before any pharmacy is licensed to begin operation to provide drugs, devices, and services or supplies to patients, the pharmacy must meet the regulatory requirements including an inspection by the state board of pharmacy before the pharmacy is permitted to open, and ongoing state board of pharmacy oversight and periodic inspections after initial licensure. Pharmacy licenses must be renewed on average every one to two years. All state pharmacy licensure laws and regulations require that a state-licensed pharmacist be on duty while the pharmacy is open. Other requirements include providing patient counseling services, maintaining comprehensive patient records, and being subject to disciplinary action by state boards of pharmacy for unprofessional conduct and violations of the requirements. In addition, pharmacy laws and regulations mandate that each pharmacy have a specific pharmacist-in-charge for each pharmacy.

Pharmacists are highly educated to provide patients with patient care services. Pharmacists must graduate from an accredited pharmacy school and be licensed in the state where they practice pharmacy. All pharmacists are now required to graduate with a Doctor of Pharmacy degree that requires a minimum of 6 years of education including 4

years of pharmacy school. Pharmacists' educational program is extensive and includes clinical training that includes patient assessment, treatment assessment, and providing recommendations for patient care.

These are examples of the extensive state requirements for pharmacies and pharmacists that provide numerous safeguards for Medicare beneficiaries and the Medicare program.

7. Mr. Kelly HR 616 introduced by Reps. Marion Berry (D-AR) and Jerry Moran (R-KS) seeks to provide relief to pharmacies from the accreditation requirement by providing conditional exemption for pharmacies. Can you explain what conditional exemption would mean for pharmacies?

Mr. Deal, these bills provide a very limited exemption for pharmacies that is essential to protect Medicare beneficiaries' access to their necessary DMEPOS supplies from their trusted retail community pharmacies and pharmacists. This limited exception will allow community pharmacies and pharmacists to continue to provide these vulnerable Medicare beneficiaries with advice and counseling on their supplies and drug therapy. The conditional exemption would mean that pharmacies receive the same conditional exemption that is granted to all other health care providers, as provided by the Medicare Improvements for Patients and Providers Act (P.L. 110-275).

8. Mr. Kelly, H.R. 1970 introduced by Reps. Zack Space (D-OH) and Jo Ann Emerson (R-MO) would exempt state-licensed retail pharmacies from the surety bond requirements unless they have a negative history with the Medicare program. Can you explain how this exemption would work?

Mr. Deal, H.R. 1970 exempts state-licensed retail pharmacies from the surety bond requirement. However, those pharmacies that have a negative history (i.e. revocation of Medicare billing privileges, loss of accreditation or licensure to provide healthcare, conviction of a federal or state felony offense, or exclusion from a federal or state healthcare program) within the past 10 years of enrollment would be subject to the surety bond requirement. These "adverse actions" are the same ones that CMS has identified as events that would necessitate a higher bond amount. We agree that bonding should be required where the supplier may pose a risk. Pharmacies are not a part of the problem, as they are heavily regulated by state boards of pharmacy, which helps enhance the integrity of the Medicare program. The risk-based approach of H.R. 1970 will help ensure that beneficiaries' access to drugs and supplies are not limited, recognizing that legitimate pharmacies should not be saddled with this onerous requirement.

COMPREHENSIVE HEALTH CARE REFORM DISCUSSION DRAFT—DAY 3

THURSDAY, JUNE 25, 2009

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The Subcommittee met, pursuant to call, at 9:35 a.m., in Room 2123 of the Rayburn House Office Building, Hon. Frank Pallone, Jr. [Chairman of the Subcommittee] presiding.

Members present: Representatives Pallone, Dingell, Gordon, Eshoo, Green, DeGette, Capps, Schakowsky, Baldwin, Matheson, Harman, Gonzalez, Barrow, Christensen, Castor, Sarbanes, Murphy of Connecticut, Space, Braley, Deal, Whitfield, Shimkus, Shadegg, Buyer, Pitts, Murphy of Pennsylvania, Burgess, Blackburn, Gingrey, and Barton (ex officio).

Staff present: Karen Nelson, Deputy Committee Staff Director for Health; Any Schneider, Chief Health Counsel; Jack Ebeler, Senior Advisor on Health Policy; Brian Cohen, Senior Investigator and Policy Advisor; Robert Clark, Policy Advisor; Tim Gronniger, Professional Staff Member; Anne Morris, Professional Staff Member; Stephen Cha, Professional Staff Member; Allison Corr, Special Assistant; Alvin Banks, Special Assistant; Jon Donenberg, Fellow; Karen Lightfoot, Communications Director, Senior Policy Advisor; Caren Auchman, Communications Associate; Lindsay Vidal, Special Assistant; Earley Green, Chief Clerk; Mitchell Smiley, Special Assistant; Brandon Clark; Ryan Long; Marie Fishpaw; Aarti Shah; William Carty; Chad Grant; Abe Frohman; Melissa Bartlett; Clay Alspach, and Nathan Crow.

Mr. PALLONE. The Subcommittee on Health will reconvene our hearing on comprehensive health care reform on the discussion draft, and we have actually four panels today, and we are going to get started. So our first panel is on Medicare payment, and let me introduce our two witnesses. First, on my left, is Glenn M. Hackbarth, who is the chair of the Medicare Payment Advisory Commission, better known as MedPAC. And then next to him is the Honorable Daniel R. Levinson, who is the Inspector General for the U.S. Department of Health and Human Services.

We are starting fresh today. If you had been here at seven o'clock last night, it wouldn't have been as—we would have all looked very tired, but now we are all fresh, so—you know the drill. We ask you to talk about 5 minutes, and your complete testimony becomes part of the record, and then we will have questions, and so we will start with Chairman Hackbarth.

STATEMENTS OF GLENN M. HACKBARTH, CHAIR, MEDICARE PAYMENT ADVISORY COMMISSION; AND HON. DANIEL R. LEVINSON, INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF GLENN M. HACKBARTH

Mr. HACKBARTH. Thank you, Chairman Pallone, and Ranking Member Deal, members of the Subcommittee. I appreciate the opportunity to talk about the Medicare Payment Advisory Commission's recommendations for improving the Medicare program.

As you know, MedPAC is a non-partisan Congressional advisory body. Our mission is to support you, the Congress, in assuring Medicare beneficiaries have access to high quality care, while protecting the taxpayers from undue financial burden. MedPAC has 17 commissioners. Six of the Commissioners are trained as clinicians. Seven of the commissioners have experience either as executives or Board members of health care providers or health plants. Three commissioners have high level experience in Congressional support agencies, or CMS, and we have four researchers who add intellectual rigor to our work. And some commissioners have more than one of these credentials. In addition to that, we have a terrific staff, headed by Mark Miller, the executive director.

I want to emphasize the credentials of the commissioners, to emphasize that we are from the health care system in no small measure. As such MedPAC commissioners recognize the talent and commitment of the professionals who serve within the health care system. We are not outsiders, critics who have no appreciation of the challenges of being on the front line. MedPAC recommendations may be right, they may be wrong. The issues are complex, and rarely are they clear cut. But if we are wrong, it isn't because we are inexperienced, or lack a stake in the success of the system. We also take pride in our ability to reach consensus on even complex and sensitive issues. For example, in our March 2009 report, we voted on 22 different recommendations. On those 22 recommendations, there were roughly 300 yes votes and only 4 no votes, and 3 abstentions.

All of the MedPAC commissioners agree that Medicare is an indispensable part of our health care system. Not only is it financed care for many millions of senior citizens and disabled citizens, it has helped finance investments in health care delivery that have benefited all Americans. But we also know that Medicare is unsustainable in its current form. We must slow the increase in costs, even while maintaining or improving quality if care and access. We believe accomplishing that task will in turn require both restraint and payment increases under Medicare's current payment systems and a major overhaul of those payment systems.

Medicare's payment systems, and, I would add, those used by most private payors, reward volume and complexity without regard to the value of the care for the patient. Moreover, those payment systems facilitate siloed or fragmented practice, whereby provides caring for the very same patient to often work independently of one another. When care is well integrated and coordinated, it is usually testimony to the professionalism of the clinicians involved. That co-

ordination and integration is too rarely support or rewarded by our payment systems.

The resulting fragmented approach to care is not only expensive, it is dangerous, especially for complex patients, of which there are many in the Medicare program. It is MedPAC's belief that we need payment reform that rewards the efficient use of precious resources and the integration and coordination of care. But it is not enough to simply change how we pay health care providers. We also must engage Medicare beneficiaries in making more cost conscious choices, or being sensitive to the complex nature of the decisions that must be made, and the limited financial means of many beneficiaries.

It is our belief that the cost challenge facing the Medicare program, and indeed the country, is so great that we need to engage everyone, patients, provides and insurers, in striving for a more efficient system. In the last several years, MedPAC has recommended a series of changes in the Medicare program that we believe would help improve the efficiency of the care delivered, while maintaining or improving quality. Let me just quickly mention a few of those recommendations.

First is increase payment for primary care services, and perhaps a different method of payment as well. Abundant research has shown that a strong system of primary care is a keystone of a well functioning health care system.

Second, we have recommended that the Congress take a number of steps to increase physician and hospital collaboration, including gain sharing, that would encourage collaboration between physicians and hospitals in reducing cost and improving quality.

Third, we have recommended reduced payment for hospitals experiencing high levels of potentially avoidable re-admissions. As you know, about 18 to 20 percent of all Medicare admissions are followed by a re-admission within 30 days, at a cost of roughly $15 billion a year to the Medicare program.

Next, we have recommended a pilot of bundling, whereby payment for hospital and physician services provided during an admission would be combined into a single payment, and perhaps combined with payment for post-acute services as well.

Next, we have recommended reform of the Medicare advantage program so that participating private plans are engaged in promoting high performance in our health care system, instead of offering plants that mimic Medicare——

Mr. PALLONE. Mr. Hackbarth, I want you to finish, but I just want you to know you are minute over, so——

Mr. HACKBARTH. OK. I am to the last step, Mr. Chairman. Let me just close with two cautionary statements. One is changing payment systems, and we must change them, and doing so with some speed is going to require more resources and broader discretion for CMS than it now has.

The second caution is that, while we need to reform payment, it is going to take some time, and in the meantime, we need to continue pressure on the prices under our existing payment systems in the Medicare program. Thank you.

[The prepared statement of Mr. Hackbarth follows:]

MEDPAC Medicare Payment Advisory Commission

TESTIMONY

Reforming the Health Care Delivery System

June 25, 2009

Statement of
Glenn M. Hackbarth, J.D.

Chairman
Medicare Payment Advisory Commission

Before the
Committee on Energy and Commerce
Subcommittee on Health
U.S. House of Representatives

Chairman Waxman, Chairman Pallone, Ranking Member Barton, Ranking Member Deal, distinguished Committee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning.

The health care delivery system we see today is not a true system: Care coordination is rare, specialist care is favored over primary care, quality of care is often poor, and costs are high and increasing at an unsustainable rate. Part of the problem is that Medicare's fee-for-service (FFS) payment systems reward more care, and more complex care, without regard to the value of that care. In addition, Medicare's payment systems create separate payment "silos" (e.g., inpatient hospitals, physicians, post-acute care providers) and do not encourage coordination among providers within a silo or across the silos. We must address those limitations—creating new payment methods that will reward efficient use of our limited resources and encourage the effective integration of care.

Medicare has not been the sole cause of the problem, nor should it be the only participant in the solution. Private payer rates and incentives perpetuate system inefficiencies, and the current disconnect among different payers creates mixed signals to providers. This contributes to the perception that one payer is cross-subsidizing other payers and further exacerbates the problem. Private and other public payers will need to change payment systems to bring about the conditions needed to change the broader health care delivery system. But Medicare should not wait for others to act first; it can lead the way to broader delivery system reform.

Why is fundamental change needed?

The Medicare program should provide its beneficiaries with access to appropriate, high quality care while spending the money entrusted to it by the taxpayers as carefully as possible. But too often that goal is not being realized, and we see evidence of poor-quality care and spending growth that threatens the program's fiscal sustainability.

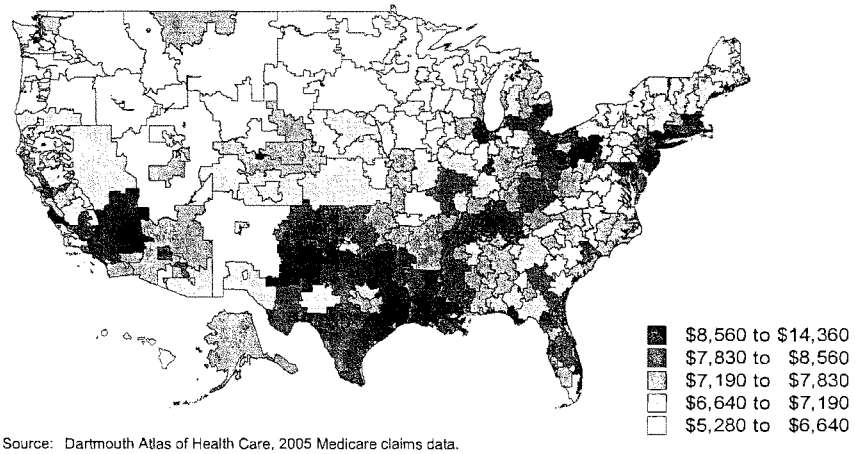
Poor quality

Many studies show serious quality problems in the American health care system. McGlynn found that participants received about half of the recommended care (McGlynn et al. 2003). Schoen found wide variation across states in hospital admissions for ambulatory-care-

sensitive conditions (i.e., admissions that are potentially preventable with improved ambulatory care) (Schoen et al 2006). In *Crossing the Quality Chasm*, the Institute of Medicine pointed out serious shortcomings in quality of care and the absence of real progress toward restructuring heath care systems to address both quality and cost concerns (IOM 2001).

At the same time that Americans are not receiving enough of the recommended care, the care they are receiving may not be appropriate. For 30 years, researchers at Dartmouth's Center for the Evaluative Clinical Sciences have documented the wide variation across the United States in Medicare spending and rates of service use (Figure 1). Most of this variation is not driven by differences in the payment rates across the country but instead by the use of services. Dartmouth finds most of the variation is caused by differing rates of use for supply-sensitive services—that is, services whose use is likely driven by a geographic area's supply of specialists and technology (Wennberg et al. 2002). Areas with higher ratios of specialty care to primary care physicians also show higher use of services.

Figure 1. Total Medicare spending by Hospital Referral Region



Source: Dartmouth Atlas of Health Care, 2005 Medicare claims data.

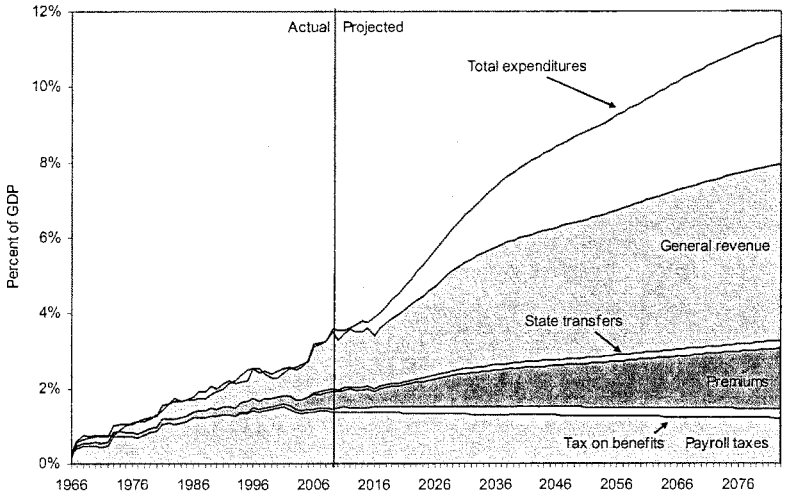
The higher rates of use are often not associated with better outcomes or quality and instead suggest inefficiencies. In fact, a recent analysis by Davis and Schoen shows at the state level that no relationship exists between health care spending per capita and mortality amenable to medical care, that an inverse relationship exists between spending and rankings on quality of care, and that high correlations exist between spending and both preventable hospitalizations and hospitalizations for ambulatory-care-sensitive conditions (Davis and Schoen 2007). These findings point to inefficient spending patterns and opportunities for improvement.

Sustainability concerns

This inefficiency costs the federal government many billions of dollars each year, expenditures we can ill afford. The share of the nation's GDP committed to Medicare is projected to grow to unprecedented levels, squeezing other priorities in the federal budget (Figure 2). For example, the Supplementary Medical Insurance Trust Fund (which covers outpatient and physician services, and prescription drugs) is financed automatically with general revenues and beneficiary premiums, but the trustees point out that financing from the federal government's general fund, which is funded primarily through income taxes, would have to increase sharply to match the expected growth in spending.

In addition, expenditures from the Hospital Insurance (HI) trust fund, which funds inpatient stays and other post-acute care, exceeded its annual income from taxes in 2008. In their most recent report, the Medicare trustees project that, under intermediate assumptions, the assets of the HI trust fund will be exhausted in 2017. Income from payroll taxes collected in that year would cover 81 percent of projected benefit expenditures.

Figure 2. Medicare faces serious challenges with long-term financing



Note: GDP (gross domestic product), HI (Hospital Insurance). These projections are based on the trustees' intermediate set of assumptions. Tax on benefits refers to a portion of income taxes that higher income individuals pay on Social Security benefits that is designated for Medicare. State transfers (often called the Part D "clawback") refer to payments called for within the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 from the states to Medicare for assuming primary responsibility for prescription drug spending.

Source: 2009 annual report of the Board of Trustees of the Medicare Trust Funds.

Rapid growth in Medicare spending has implications for beneficiaries and taxpayers. Between 2000 and 2007, Medicare beneficiaries faced average annual increases in the Part B premium of nearly 9.8 percent. Meanwhile, monthly Social Security benefits grew by about 4 percent annually over the same period. The average cost of SMI premiums and cost sharing for Part B and Part D absorbs about 26 percent of Social Security benefits. Growth in Medicare premiums and cost sharing will continue to absorb an increasing share of Social Security income. At the same time, Medicare's lack of a catastrophic cap on cost sharing will continue to represent a financial risk for beneficiaries. Almost 60 percent of beneficiaries (or their former employers) now buy supplemental coverage to help offset this risk and Medicare's cost sharing.

Barriers to achieving value in Medicare

Many of the barriers that prevent Medicare from improving quality and controlling costs—obtaining better value—stem from the incentives in Medicare's payment systems. Medicare's payment systems are primarily fee-for-service (FFS). That is, Medicare pays for each service delivered to a beneficiary by a provider meeting the conditions of participation for the program. FFS payment systems reward providers who increase the volume of services they provide regardless of the benefit of the service. As discussed earlier, the volume of services per beneficiary varies widely across the country, but areas with higher volume do not have better outcomes. FFS systems are not designed to reward higher quality; payments are not increased if quality improves and in some cases may increase in response to low-quality care. For example, some hospital readmissions may be a result of poor-quality care and currently those readmissions are fully paid for by Medicare.

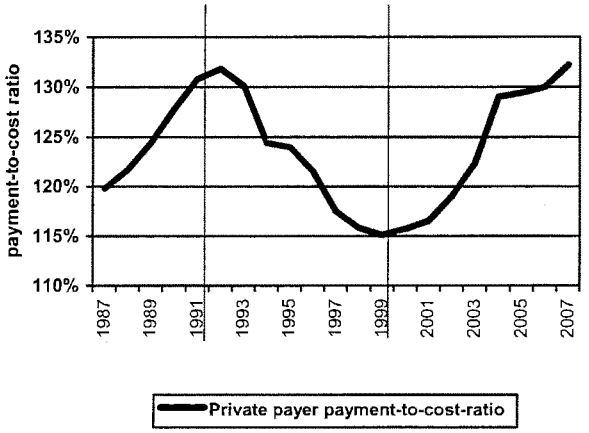
While this testimony focuses on changes to Medicare FFS payment systems that would encourage delivery system reform, the payment system for Medicare Advantage (MA) plans also needs reform, as we have previously reported. In aggregate, the MA program continues to be more costly than the traditional program. Plan bids for the traditional Medicare benefit package average 102 percent of FFS in 2009, compared with 101 percent of FFS in 2008. In 2009, MA payments per enrollee are projected to be 114 percent of comparable FFS spending for 2009, compared with 113 percent in 2008. Many MA plans have not changed the way care is delivered and often function much like the Medicare FFS program. High MA payments provide a signal to plans that the Medicare program is willing to pay more for the same services in MA than it does in FFS. Similarly, these higher payments signal to beneficiaries that they should join MA plans because they offer richer benefits, albeit financed by taxpayer dollars. This is inconsistent with MedPAC's position supporting financial neutrality between FFS and MA. To encourage efficiency across the Medicare program, Medicare needs to exert comparable and consistent financial pressure on both the FFS and MA programs, coupled with meaningful quality measurement and pay-for-performance (P4P) programs, to maximize the value it receives for the dollars it spends.

MedPAC has identified five specific problems that make it difficult for Medicare to achieve its goals: lack of fiscal pressure, price distortion, lack of accountability, lack of care coordination, and lack of information. These are discussed below.

Lack of fiscal pressure. Medicare payment policies ought to exert fiscal pressure on providers. In a fully competitive market, this happens automatically through the "invisible hand" of competition. Under Medicare's administered price systems, however, the Congress must exert this pressure by limiting updates to Medicare rates—or even reducing base rates in some instances (e.g., home health). MedPAC's research shows that provider costs are not immutable; they vary according to how much pressure is applied on rates. Providers under significant cost pressure have lower costs than those under less pressure. Moreover, MedPAC research demonstrates that providers can provide high-quality care even while maintaining much lower costs.

Our analysis shows that in 2007 hospitals under low financial pressure in the prior years had higher standardized costs per discharge ($6,400) than hospitals under high financial pressure ($5,800). Over time, aggregate hospital cost growth has moved in parallel with margins on private-payer patients (Figure 3). Due to managed care restraining private-payer payment rates in the 1990s, hospitals' rate of cost growth in that period was below input price inflation. However, from 2001 through 2007, after profits from private payers increased, hospitals' rate of cost growth was higher than the rate of increase in the market basket of input prices. All things being equal, increases in providers' costs will result in lower Medicare margins. We also found that hospitals with the highest private payments and most robust non-Medicare sources of revenues have lower Medicare margins (–11.7 percent) than hospitals under greater fiscal pressure (4.2 percent).

Figure 3. Three periods to the private-payer payment-to-cost ratio



Note: Private-payer margins do not include Medicare Advantage and Medicaid managed care patients.
Source: MedPAC analysis of data from the American Hospital Association.

Price distortion. Within Medicare's payment systems, the payment rates for individual products and services may not be accurate. Inaccurate payment rates in Medicare's payment systems can lead to unduly disadvantaging some providers and unintentionally rewarding others. For example, under the physician fee schedule, fees are relatively low for primary care and may be too high for specialty care and procedures. This payment system bias has signaled to physicians that they will be more generously paid for procedures and specialty care, and signals providers to generate more volume. In turn, these signals could influence the supply of providers, resulting in oversupply of specialized services and inadequate numbers of primary care providers. In fact, the share of U.S. medical school graduates entering primary care residency programs has declined in the last decade, and internal medicine residents are increasingly choosing to sub-specialize rather than practice as generalists.

Lack of accountability. Providers may provide quality care to uphold professional standards and to have satisfied patients, but Medicare does not hold them accountable for the quality of care they provide. Moreover, providers are not accountable for the full spectrum of care a

beneficiary may use, even when they make the referrals that dictate resource use. For example, physicians ordering tests or hospital discharge planners recommending post-acute care do not have to consider the quality outcomes or the financial implications of the care that other providers may furnish. This fragmentation of care puts quality of care and efficiency at risk.

Lack of care coordination. Growing out of the lack of accountability, there is no incentive for providers to coordinate care. Each provider may treat one aspect of a patient's care without regard to what other providers are doing. There is a focus on procedures and services rather than on the beneficiary's total needs. This becomes a particular problem for beneficiaries with several chronic conditions and for those transitioning between care providers, such as at hospital discharge. Poorly coordinated care may result in patient confusion, over-treatment, duplicative service use, higher spending, and lower quality of care.

Lack of information and the tools to use it. Medicare and its providers lack the information and tools needed to improve quality and use program resources efficiently. For example, Medicare lacks quality data from many settings of care, does not have timely cost or market data to set accurate prices, and does not generally provide feedback on resource use or quality scores to providers. Individually, providers may have clinical data, but they may not have that data in electronic form, leaving them without an efficient means to process it or an ability to act on it. Crucial information on clinical effectiveness and standards of care either may not exist or may not have wide acceptance. In this environment, it is difficult to determine what health care treatments and procedures are needed, and thus what resource use is appropriate, particularly for Medicare patients, many of whom have multiple comorbidities. In addition, beneficiaries are now being called on to make complex choices among delivery systems, drug plans, and providers. But information for beneficiaries that could help them choose higher quality providers and improve their satisfaction is just beginning to become available.

Commission recommendations to increase efficiency and improve quality

In previous reports, the Commission has recommended that Medicare adopt tools to surmount barriers to increasing efficiency and improving quality within the current Medicare

payment systems. These tools include:

- *Creating pressure for efficiency through payment updates.* Although the update is a somewhat blunt tool for constraining cost growth (updates are the same for all providers in a sector, both those with high costs and those with low costs), constrained updates will create more pressure on those with higher costs. In our March 2009 Report to the Congress, the Commission offers a set of payment update recommendations that exert fiscal pressure on providers to constrain costs. For example, the Commission recommends a zero update for home health agencies in 2010, coupled with an acceleration of payment adjustments due to coding practices, totaling a 5.5 percent cut in home health payments for 2010. Another example is the Commission's recommendation to reduce overpayments to MA plans by setting the MA benchmarks equal to 100 percent of Medicare FFS expenditures. This recommendation is consistent with the Commission's commitment to retaining high-quality, low-cost private plans in Medicare.

- *Improving payment accuracy within Medicare payment systems.* In our 2005 report on specialty hospitals, the Commission made recommendations to improve the accuracy of DRG payments to account for patient severity. Those recommendations corrected distortions in the payment system that—among other things—contributed to the formation of hospitals specializing in the treatment of a limited set of profitable DRGs. In another example, in our June 2008 and March 2009 Reports to the Congress, the Commission recommended increasing fee schedule payments for primary care services furnished by clinicians focused on delivering primary care. This budget-neutral adjustment would redistribute Medicare payments toward those primary care services provided by practitioners—physicians, advanced practice nurses, and physician assistants—whose practices focus on primary care. This recommendation recognizes that a well functioning primary care network is essential to help improve quality and control Medicare spending (MedPAC 2008, MedPAC 2009).

- *Linking payment to quality.* In a series of reports, we have recommended that Medicare change payment system incentives by basing a portion of provider payment on the quality of care they provide and recommended that the Congress establish a quality incentive

payment policy for physicians, Medicare Advantage plans, dialysis facilities, hospitals, home health agencies, and skilled nursing facilities. In March 2005, the Commission recommended setting standards for providers of diagnostic imaging studies to enhance the quality of care and help control Medicare spending.

- *Measuring resource use and providing feedback.* In our March 2008 and 2005 Reports to the Congress, we recommended that CMS measure physicians' resource use per episode of care over time and share the results with physicians. Those who used comparatively more resources than their peers could assess their practice styles and modify them as appropriate.

- *Encouraging use of comparative-effectiveness information and public reporting of provider quality and financial relationships.* In our June 2007 Report to the Congress, we found that not enough credible, empirically based information is available for health care providers and patients to make informed decisions about alternative services for diagnosing and treating most common clinical conditions. The Commission recommended that the Congress charge an independent entity to sponsor credible research on comparative effectiveness of health care services and disseminate this information to patients, providers, and public and private payers. Second, the Commission recommended public reporting to provide beneficiaries with better information and encourage providers to improve their quality. Third, the Commission has recommended that manufacturers of drugs and medical devices be required to publicly report their financial relationships with physicians to better understand the types of financial associations that may influence patterns of patient care.

The need for more fundamental reform

The recommendations discussed above would make the current Medicare FFS payment systems function better, but they will not fix the problems inherent in those systems for two reasons. First, they cannot overcome the strong incentives inherent in any fee-for-service system to increase volume, thus it will be difficult to make the program sustainable. Second, they cannot switch the focus to the patient rather than the procedure because they cannot directly reward care coordination or joint accountability that cut across current

payment system "silos," such as the physician fee schedule or the inpatient prospective payment system.

There is evidence that more fundamental reforms could improve the quality of care and potentially lower costs. For example, patient access to high-quality primary care is essential for a well-functioning health care delivery system. Research suggests that reducing reliance on specialty care may improve the efficiency and quality of health care delivery. States with a greater proportion of primary care physicians have better health outcomes and higher scores on performance measures (Baicker and Chandra 2004). Moreover, areas with higher rates of specialty care per person are associated with higher spending but not improved access to care, higher quality, better outcomes, or greater patient satisfaction (Fisher et al. 2003, Kravet et al. 2008, Wennberg 2006). Countries with greater dependence on primary care have lower rates of premature deaths and deaths from treatable conditions, even after accounting for differences in demographics and GDP (Starfield and Shi 2002). Changing the balance in the delivery system between primary and specialist care may have high payoffs for Medicare.

Evidence points to other potential reforms:

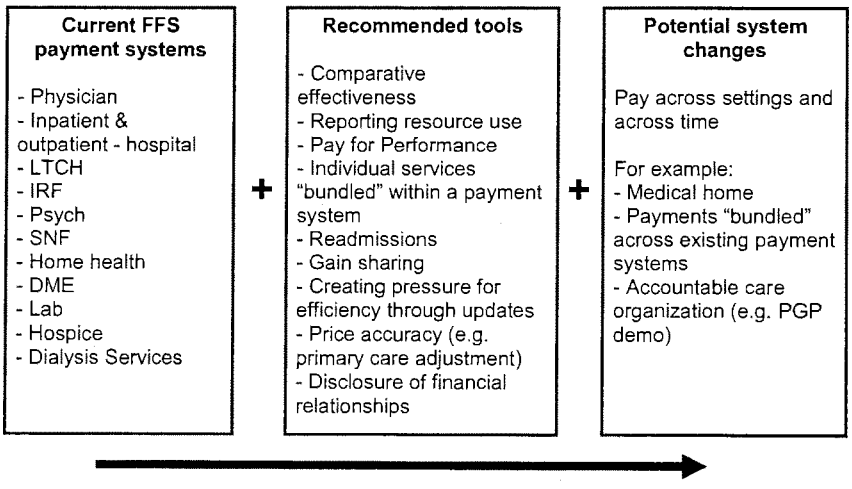
- *Greater care coordination.* Evidence shows that care coordination can improve quality. As we discussed in our June 2006 Report to the Congress, studies show self management programs, access to personal health records, and transition coaches have resulted in improved care or better outcomes, such as reduced readmission for patients with chronic conditions.
- *Reducing preventable readmissions.* Savings from preventing readmissions could be considerable. About 18 percent of Medicare hospital admissions result in readmissions within 30 days of discharge, accounting for $15 billion in spending. The Commission found that Medicare spends about $12 billion on potentially preventable readmissions.
- *Increasing the use of bundled payments.* The Medicare Participating Heart Bypass Center demonstration of the 1990s found that bundling hospital DRG payments and inpatient physician payments could increase providers' efficiency and reduce Medicare's costs. Most of the participating sites found that, under a bundled payment, hospitals and physicians reduced laboratory, pharmacy, and ICU spending. Spending on consulting physicians and post-discharge care decreased and quality remained high.

A direction for payment and delivery system reform

To increase value for the Medicare program, its beneficiaries, and the taxpayers, we are looking at payment policies that go beyond the current FFS payment system boundaries of scope and time. This new direction would pay for care that spans across provider types and time and would hold providers jointly accountable for the quality of that care and the resources used to provide it. It would create payment systems that reward value and encourage closer provider integration—delivery system reform. For example, if Medicare held physicians and hospitals jointly responsible for outcomes and resource use, new efficiencies—such as programs to avoid readmissions and standardization of operating room supplies—could be pursued. In the longer term, joint responsibility could lead to closer integration and development of a more coordinated health care delivery system.

This direction is illustrated in Figure 4. The potential payment system changes shown are not the end point for reform and further reforms could move the payment systems away from FFS and toward systems of providers who accept some level of risk, driving delivery system reform.

Figure 4. Direction for payment and delivery system reform



History provides numerous examples that providers will respond to financial incentives. The advent of the inpatient prospective payment system in 1983 led to shorter inpatient lengths of stay and increasing use of post acute care services. Physician services have increased as payments have been restrained by volume control mechanisms. Finally, a greater proportion of patients in skilled nursing facilities (SNFs) were given therapy, and more of it, in response to the SNF prospective payment system incentives. Financial incentives can also result in structural changes in the health care delivery system. In the 1990s, the rise of HMOs and the prospect of capitation led doctors and hospitals to form physician–hospital organizations whose primary purpose was to allocate capitated payments. Paying differently will motivate providers to interact differently with each other, and—if reforms are carefully designed for joint accountability—to pay more attention to outcomes and costs. To be sure, implementing these changes will not be easy. Changes of this magnitude will undoubtedly be met with opposition from providers and other stakeholders. In addition, the administrative component of the proposed payment system changes will require refinement over time.

Recommended system changes

We discuss three recommendations the Commission has made that might move Medicare in the direction of better coordination and more accountable care: a medical home pilot program, changing payments for hospital readmissions, and bundling payments for services around a hospital admission.

Medical home

A medical home is a clinical setting that serves as a central resource for a patient's ongoing care. The Commission considers medical homes to be a promising concept to explore. Accordingly, it recommends that Medicare establish a medical home pilot program for beneficiaries with chronic conditions to assess whether beneficiaries with medical homes receive higher quality, more coordinated care, without incurring higher Medicare spending. Qualifying medical homes could be primary care practices, multispeciality practices, or specialty practices that focus on care for certain chronic

conditions, such as endocrinology for people with diabetes. Geriatric practices would be ideal candidates for Medicare medical homes.

In addition to receiving payments for fee-schedule services, qualifying medical homes would receive monthly, per beneficiary payments that could be used to support infrastructure and activities that promote ongoing comprehensive care management. To be eligible for these monthly payments, medical homes would be required to meet stringent criteria. Medical homes must:

- furnish primary care (including coordinating appropriate preventive, maintenance, and acute health services);
- use of a team to conduct care management;
- use health information technology (IT) for active clinical decision support;
- have a formal quality improvement program;
- maintain 24-hour patient communication and rapid access;
- keep up-to-date records of beneficiaries' advance directives; and
- maintain a written understanding with each beneficiary designating the provider as a medical home.

These stringent criteria are necessary to ensure that the pilot evaluates outcomes of the kind of coordinated, timely, high-quality care that has the highest probability to improve cost, quality, and access. The pilot must assess a true intervention rather than care that is essentially business as usual.

In rural areas, the pilot could test the ability for medical homes to provide high-quality, efficient care with somewhat modified structural requirements.

Beneficiaries with multiple chronic conditions would be eligible to participate because they are most in need of improved care coordination. About 60 percent of FFS beneficiaries have two or more chronic conditions. Beneficiaries would not incur any additional cost sharing for the medical home fees. As a basic principle, medical home practitioners would discuss with beneficiaries the importance of seeking guidance from the medical home before obtaining specialty services. Participating beneficiaries would, however, retain their ability to see

specialists and other practitioners of their choice. Under the pilot, Medicare should also provide medical homes with timely data on patients' Medicare-covered utilization outside the medical home, including services under Part A and Part B and drugs under Part D.

A medical home pilot provides an excellent opportunity to implement and test physician pay-for-performance (P4P) with payment incentives based on quality and efficiency. Under the pilot project, the Commission envisions that the P4P incentives would allow for rewards and penalties based on performance. Efficiency measures should be calculated from spending on Part A, Part B, and Part D, and efficiency incentives could take the form of shared savings models similar to those under Medicare's ongoing physician group practice demonstration. Bonuses for efficiency should be available only to medical homes that have first met quality goals and that have a sufficient number of patients to permit reliable spending comparisons. Medical homes that are consistently unable to meet minimum quality requirements would become ineligible to continue participation.

It is imperative that the medical home pilot be on a large enough scale to provide statistically reliable results with a relatively short testing cycle. Additionally, the pilot must have clear and explicit results-based thresholds for determining whether it should be expanded into the full Medicare program or discontinued entirely. Focusing on beneficiaries with multiple chronic conditions and medical homes meeting stringent criteria should provide a good test of the medical home concept.

Readmissions and bundled payments around a hospitalization

Evidence suggests there is an enormous opportunity to improve care and address the lack of coordination at hospital discharge. Discharge from the hospital is a very vulnerable time for patients, and in particular for Medicare beneficiaries, who often cope with multiple chronic conditions. Often they are expected to assume a self-management role in recovery with little support or preparation. They may not understand their discharge instructions on what medications to take, know whom to call with questions, or know what signs indicate the need for immediate follow-up care. Often they do not receive timely follow-up care and communication between their hospital providers and post-acute care providers is uneven. These disjointed patterns of care can result in poorer health outcomes for beneficiaries, and

in many cases, the need for additional health care services and expenditures.

The variation in spending around hospitalization episodes suggests lower spending is possible. There is a 65 percent difference in spending on readmissions between hospitals in the top quartile and the average of all hospitals; the top quartile is almost four times higher than the bottom quartile. The spread between high- and low-use hospitals is even larger than spending for post-acute care. These high-spending hospitals often treat the beneficiaries with the costliest care. Greater coordination of care is needed for this population, and changing incentives around their hospital care could be the catalyst.

How can Medicare policy change the way care is provided? First, the Commission recommends that the Secretary confidentially report to hospitals and physicians information about readmission rates and resource use around hospitalization episodes (e.g., 30 days post-discharge) for select conditions. This information would allow a given hospital and the physicians who practice in it to compare their risk-adjusted performance relative to other hospitals, physicians, and post-acute care providers. Once equipped with this information, providers may consider ways to adjust their practice styles and coordinate care to reduce service use. After two years of confidential disclosure to providers, this information should be publicly available.

Information alone, however, will not likely inspire the degree of change needed. Payment incentives are needed. We have two recommendations—one to change payment for readmissions and one to bundle payments across a hospitalization episode. Either policy could be pursued independently, but the Commission views them as complementary. A change in readmissions payment policy could be a critical step in creating an environment of joint accountability among providers that would, in turn, enable more providers to be ready for bundled payment.

Readmissions

The Commission recommends changing payment to hold providers financially accountable for service use around a hospitalization episode. Specifically, it would reduce payment to hospitals with relatively high readmission rates for select conditions. Conditions with high volume and high readmissions rates may be good candidates for selection. Focusing on *rates*

rather than *numbers* of readmissions serves to penalize hospitals that consistently perform worse than other hospitals, rather than those that treat sicker patients. The Commission recommends that this payment change be made in tandem with a previously recommended change in law (often referred to as gainsharing or shared accountability) to allow hospitals and physicians to share in the savings that result from re-engineering inefficient care processes during the episode of care.

Currently, Medicare pays for all admissions based on the patient's diagnosis regardless of whether it is an initial stay or a readmission for the same or a related condition. This is a concern because we know that some readmissions are avoidable and in fact are a sign of poor care or a missed opportunity to better coordinate care.

Penalizing high rates of readmissions encourages providers to do the kinds of things that lead to good care, but are not reliably done now. For example, the kinds of strategies that appear to reduce avoidable readmissions include preventing adverse events during the admission, reviewing each patient's medications at discharge for appropriateness, and communicating more clearly with beneficiaries about their self-care at discharge. In addition, hospitals, working with physicians, can better communicate with providers caring for patients after discharge and help facilitate patients' follow-up care.

Spending on readmissions is considerable. We have found that Medicare spends $15 billion on all-cause readmissions and $12 billion if we exclude certain readmissions (for example, those that were planned or for situations such as unrelated traumatic events occurring after discharge). Of this $12 billion, some is spent on readmissions that were avoidable and some on readmissions that were not. To target policy to avoidable readmissions, Medicare could compare hospitals' rates of potentially preventable readmissions and penalize those with high rates. The savings from this policy would be determined by where the benchmark that defines a high rate is set, the size of the penalty, the number and type of conditions selected, and the responsiveness of providers.

The Commission recognizes that hospitals need physician cooperation in making practice changes that lead to a lower readmission rate. Therefore, hospitals should be permitted to financially reward physicians for helping to reduce readmission rates. Sharing in the financial

rewards or cost savings associated with re-engineering clinical care in the hospital is called gainsharing or shared accountability. Allowing hospitals this flexibility in aligning incentives could help them make the goal of reducing unnecessary readmissions a joint one between hospitals and physicians. As discussed in a 2005 MedPAC report to the Congress, shared accountability arrangements should be subject to safeguards to minimize the undesirable incentives potentially associated with these arrangements. For example, physicians who participate should not be rewarded for increasing referrals, stinting on care, or reducing quality.

Bundled payments for care over a hospitalization episode

Under bundled payment, Medicare would pay a single provider entity an amount intended to cover the costs of providing the full range of care needed over the hospitalization episode. Because we are concerned about care transitions and creating incentives for coordination at this juncture, the hospitalization episode should include time post-discharge (e.g., 30 days). With the bundle extending across providers, providers would not only be motivated to contain their own costs but also have a financial incentive to better collaborate with their partners to improve their collective performance. Providers involved in the episode could develop new ways to allocate this payment among themselves. Ideally, this flexibility gives providers a greater incentive to work together and to be mindful of the impact their service use has on the overall quality of care, the volume of services provided, and the cost of providing each service. In the early 1990s, Medicare conducted a successful demonstration of a combined physician–hospital payment for coronary artery bypass graft admissions, showing that costs per admission could be reduced without lowering quality.

The Commission recommends that CMS conduct a voluntary pilot program to test bundled payment for all services around a hospitalization for select conditions. Candidate conditions might be those with high costs and high volumes. This pilot program would be concurrent with information dissemination and a change in payment for high rates of readmissions.

Bundled payment raises a wide set of implementation issues. It requires not only that Medicare create a new payment rate for a bundle of services but also that providers decide how they will share the payment and what behavior they will reward. A pilot allows CMS to

resolve the attendant design and implementation issues, while giving providers who are ready the chance to start receiving a bundled payment.

The objective of the pilot should be to determine whether bundled payment for all covered services under Part A and Part B associated with a hospitalization episode (e.g., the stay plus 30 days) improves coordination of care, reduces the incentive for providers to furnish services of low value, improves providers' efficiency, and reduces Medicare spending while not otherwise adversely affecting the quality of care. The pilot should begin applying payment changes to only a selected set of medical conditions.

Conclusion

As you have heard here, Medicare's financial sustainability is deteriorating. That deterioration can be traced in part to the dysfunctional delivery system that the current payment systems have helped to create. Those payment systems must be fundamentally reformed, and the recommendations we have made are a first step on that path. They are, however, only a first step; they fall far short of being a "solution" for Medicare's long-term challenges. MedPAC looks forward to continuing to work with you to reform Medicare's payment systems and help bring the health care delivery system into the 21st century. I thank the Committee for its attention today.

References

Baicker, K., and A. Chandra. 2004. Medicare spending, the physician workforce, and beneficiaries' quality of care. *Health Affairs* (April): 184–196.

BNA. U.S. Health Care Spending Reached $2.4 Trillion in 2008, CMS Report Says. *BNA* (February 24, 2009).

Davis, K., and C. Schoen, 2007. State health system performance and state health reform. Health Affairs Web Exclusive (September 18): w664–w666.

Fisher, E., D. Wennberg, T. Stukel, et al. 2003a. The implications of regional variations in Medicare spending. Part 1: The content, quality, and accessibility of care. *Annals of Internal Medicine* 138, no. 4 (February 18): 273–287.

Fisher, E., D. Wennberg, T. Stukel, et al. 2003b. The implications of regional variations in Medicare spending. Part 2: Health outcomes and satisfaction with care. *Annals of Internal Medicine* 138, no. 4 (February 18): 288–298.

Institute of Medicine. 2001a. *Crossing the quality chasm: A new health system for the 21st century.* Washington, DC: National Academy Press.

Kravet, S., Andrew D. Shore, Redonda Miller, et al. 2008. Health care utilization and the proportion of primary care physicians. *American Journal of Medicine* 121, no. 2: 142–148.

Medicare Payment Advisory Commission. 2005. *Issues in a Modernized Medicare Program.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2008. *Delivery system reform.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2009. *Medicare payment policy.* Washington, DC: MedPAC.

McGlynn, E. A., S. M. Asch, J. Adams, et al. 2003. The quality of health care delivered to adults in the United States. *New England Journal of Medicine* 348, no. 26 (June 26): 2635–2645.

Schoen, C., K. Davis, S. K. H. How, et al. 2006. U.S. health system performance: A national scorecard. *Health Affairs Web Exclusives* (September 20): W457–W475.

Starfield, B., and L. Shi. 2002. Policy relevant determinants of health: An international perspective. *Health Policy* 60: 201–218.

Wennberg, J. E., E. S. Fisher, and J. S. Skinner. 2002. Geography and the debate over Medicare reform. *Health Affairs Web Exclusives* Suppl. (July–December): W96–W114.

Wennberg, J., E. Fischer, S. Sharp. 2006 Dartmouth Atlas of Health Care 2006: The care of patients with severe chronic illness. http://www.dartmouthatlas.org/atlases/2006_Chronic_Care_Atlas.pdf.

Mr. PALLONE. Thank you very much for what is really important in terms of what we are trying to accomplish here. I appreciate it.
Mr. Levinson?

STATEMENT OF HON. DANIEL R. LEVINSON

Mr. LEVINSON. Good morning, Chairman Pallone, Ranking Member Deal, and members of the Subcommittee.

Mr. PALLONE. Your mike may not be on, or maybe it is not close enough. Try to move it—no, I think you have got to press—you have to—when the green light is on, it—green light on?

Mr. LEVINSON. It is.

Mr. PALLONE. Now you are fine.

Mr. LEVINSON. OK. Thank you. Chairman Pallone, Ranking Member Deal, members of the Subcommittee, good morning. I thank you for the opportunity to discuss the Office of Inspector General's work at this very important time of deliberations over health care reform.

Based on our experience and expertise, our office has identified five principles that we believe should guide the development of any national health care integrity strategy. And consistent with these principles, OIG has developed specific recommendations to better safeguard Federal health care programs. My office has provided technical assistance, as requested, to staff from the Committee, and we welcome the fact that many of OIG's recommendations have been incorporated into the House Tri-Committee health reform discussion draft.

Principle one, enrollment. Scrutinize those who want to participate as providers and suppliers prior to their enrollment in the Federal health care programs. Provider enrollment standards and screening should be strengthened, making participation in Federal health care programs a privilege, not a right.

As my written testimony describes, a lack of effective provider and supplier screening gives dishonest and unethical individuals access to a system that they can easily exploit. Heightened screening measures for high risk items and services could include requiring providers to meet accreditation standards, requiring proof of business integrity or surety bonds, periodically certification and on site verification that conditions of participation have been met, and full disclosure of ownership and controlled interests.

Principle two, payment. Establish payment methodologies that are reasonable and responsive to changes in the marketplace.

Through extensive audits and evaluations, our office has determined that Medicare and Medicaid pay too much for certain items and services. When pricing policies are not aligned with the marketplace, the programs and their beneficiaries bear the additional cost.

In addition to wasting health care dollars, these excessive payments are a lucrative target for unethical and dishonest individuals. These criminals can re-invest some of their profit in kickbacks, thus using the program's funds to perpetuate the fraud schemes.

Medicare and Medicaid payments should be sufficient to ensure access to care without wasteful overspending. Payment methodology should also be responsive to changes in the marketplace,

medical practice and technology. Although CMS has the authority to make certain adjustments to fee schedules and other payment methodologies, some changes require Congressional action.

Principle three, compliance. Assist health care providers in adopting practices that promote compliance with program requirements.

Health care providers can be our partners in ensuring the integrity of our health care programs by adopting measures that promote compliance with program requirements. The importance of health care compliance programs is well recognized. In some health care sectors, such as hospitals, compliance programs are widespread and often very sophisticated. New York requires provides and suppliers to implement an effective compliance programs as a condition of participation in its Medicaid program. Medicare Part D prescription drug plan sponsors are also required to have compliance programs.

Compliance programs are an important component of a comprehensive integrity and strategy, and we recommend that providers and suppliers should be required to adopt compliance programs as a condition of participating in Medicare and Medicaid.

Principle four, oversight. Vigilantly monitor the programs for evidence of fraud, waste and abuse.

The health care system compiles an enormous amount of data on patients, providers and the delivery of health care items and services. However, Federal health care programs often fail to use data and technology effectively to identify improper claims before they are paid and to uncover fraud schemes. For example, Medicare should not pay a clinic for HIV infusion when the beneficiary has not been diagnosed with the illness, or pay twice for the same service.

Better collection, monitoring and coordination of data would allow Medicare and Medicaid to detect these problems earlier and avoid making improper payments. Moreover, this would enhance the government's ability to detect fraud schemes more quickly.

As fraud schemes evolve and migrate rapidly, access to real time data and the use of advance data analysis to monitor claims and provider characteristics are critically important. OIG is using innovative technology to detect and deter fraud, and we continue to develop our efforts to support a data driven anti-fraud approach. However, more must be done to ensure that we and other government agencies are able to access and utilize data effectively in the fight against health care fraud.

Final principle, response. Respond swiftly to detected fraud, impose sufficient punishment to deter others, and promptly remedy program vulnerabilities.

Health care fraud attracts criminals because the penalties are lower than those for other criminal offenses, there are low barriers to entry, schemes are easily replicated, and there is a perception of a low risk of detection. We need to alter the criminal's cost/benefit analysis by increasing the risk of swift detection and a certainty of punishment.

As part of this strategy, law enforcement is accelerating our response to fraud schemes. The HHS/DOG Medical Fraud Strike Force model describe in my written testimony is a power anti-fraud

tool, and represents a tremendous return on investment. These strike forces have proven highly effective in prosecuting criminals, recovering payments for fraudulent claims and preventing fraud through a powerful sentinel effect.

In conclusion, our experiences and results in protecting HHS programs and beneficiaries has applicability to the current discussions on health care reform. We believe that our five principle strategy provides the framework to identify new ways to protect the integrity of the programs, meet the needs of beneficiaries, and keep Federal health care programs solvent for future generations.

We appreciate the opportunity to work with the Committee, and welcome your questions. Thank you.

[The prepared statement of Mr. Levinson follows:]

Testimony before the House Energy and Commerce Committee
Subcommittee on Health

U.S. House of Representatives

"Health Care Reform: Opportunities to Address Waste, Fraud and Abuse"

Testimony of Daniel R. Levinson
Inspector General

June 25, 2009
9:30 a.m.
2123 Rayburn House Office Building

Daniel R. Levinson, Inspector General
Department of Health and Human Services

Testimony of:
Daniel R. Levinson
Inspector General
Office of Inspector General, U.S. Department of Health and Human Services

COMBATING FRAUD, WASTE, AND ABUSE IN FEDERAL HEALTH CARE PROGRAMS

INTRODUCTION

Good morning Chairman Pallone, Ranking Member Deal, and distinguished members of the Subcommittee. I am Daniel Levinson, Inspector General of the U.S. Department of Health and Human Services (HHS). In the context of current discussions about health care reform, it is critical that the Government pursue a comprehensive strategy to combat fraud, waste, and abuse to ensure that Federal health care programs remain solvent and best serve the needs of beneficiaries. I thank you for the opportunity to discuss the Office of Inspector General's (OIG) work in this area.

OIG has devoted considerable resources toward fighting fraud, waste, and abuse involving HHS's Federal health care programs. We have performed evaluations, investigations, and audits on a wide variety of issues, including fraudulent activity by health care providers; excessive payments for medical services, equipment, and prescription drugs; and financial conflicts of interests within the institutions charged with protecting the health of the American public. Through this work, we have helped identify and recover billions of dollars in fraudulent, abusive, or wasteful payments and also raised awareness of these critical issues among policy makers, government agencies, and the health care community at large. We have recommended improvements to program safeguards and payment methodologies to prevent fraud, waste, and abuse and to ensure health care quality and beneficiary safety. We have also reached out to the health care community to promote compliance. Moving forward, OIG is committed to building on our successes and achieving even greater results in protecting the integrity of government health care programs and the health and welfare of people served by them.

In my testimony this morning, I will begin by describing OIG's unique role in combating fraud, waste, and abuse in Medicare and Medicaid. I then will provide an overview of vulnerabilities in these programs and discuss current initiatives that expand our efforts to identify, investigate, and prosecute health care fraud. Finally, I will discuss OIG's "Five Principles" strategy for combating fraud, waste, and abuse, which we believe are applicable to any health care program.

OIG'S ROLE AND PARTNERS IN COMBATING FRAUD, WASTE, AND ABUSE

OIG is an independent, nonpartisan agency committed to protecting the integrity of the more than 300 programs administered by HHS. OIG's mandate is to protect the integrity of the programs of HHS, as well as the health and welfare of the beneficiaries of those programs. Thanks to the work of our 1,500 employees and our law enforcement partners, from FY 2006 through fiscal year (FY) 2008, OIG's investigative receivables averaged $2 billion per year and

our audit disallowances resulting from Medicare and Medicaid oversight averaged $1 billion per year. The result was a Medicare- and Medicaid-specific return on investment of $17 to $1 for OIG oversight. In addition, in FY 2008, implemented OIG recommendations resulted in $16 billion in savings and funds put to better use.

Further, as reflected in OIG's Semiannual Report to Congress released earlier this month, OIG's expected recoveries for the period of October 2008 through March 2009 include $274.8 million in audit disallowances and $2.2 billion in investigative receivables, which includes nearly $552 million in non-HHS receivables resulting from OIG work (e.g., the States' share of Medicaid restitution).

It comes as no surprise that the large Federal Government expenditures on health care programs attract individuals and entities seeking to exploit the health care system for their own financial gain. The National Health Care Anti-Fraud Association estimates conservatively that at least 3 percent of health care spending is lost to fraud. In FY 2009, Medicare is expected to cover an estimated 45.5 million beneficiaries at a total cost of $486 billion to the Federal Government and Medicaid is expected to cover an estimated 51 million beneficiaries and cost the Federal Government over $217 billion. Though the vast majority of health care providers and suppliers are honest and well intended, even a small percentage of providers and suppliers intent on defrauding the programs can have significant detrimental effects. Although it is not possible to measure precisely the extent of fraud in Medicare and Medicaid, virtually everywhere we look OIG continues to find fraud, waste, and abuse in these programs. Therefore, OIG works closely with HHS officials, the Department of Justice (DOJ), other agencies in the Executive Branch, Congress, and States to bring about systemic changes in program operations, successful prosecutions, negotiated settlements, and recovery of funds.

Collaboration and innovation are essential in the fight against fraud. On May 20, 2009, HHS Secretary Kathleen Sebelius and Attorney General Eric Holder announced a new initiative to marshal significant resources across the Government to prevent health care waste, fraud, and abuse; crack down on fraud perpetrators; and enhance existing partnerships between HHS and DOJ to reduce fraud and recover taxpayer dollars. To further this effort, the Secretary and Attorney General created the Health Care Fraud Prevention and Enforcement Action Team (HEAT) joint task force consisting of senior level leadership from both departments. Among other activities, HEAT is building on the successful OIG-DOJ Medicare Fraud Strike Force initiated in south Florida, discussed in greater detail later, by expanding Strike Forces to other metropolitan areas across the country. These Strike Forces use advanced data analysis techniques to identify criminals operating as health care providers and detect emerging or migrating fraud schemes. HEAT is also focusing on prevention strategies to combat health care fraud. For example, HEAT will expand a Centers for Medicare and Medicaid Services (CMS) demonstration project in south Florida that uses site visits to potential durable medical equipment (DME) suppliers to ensure that applicants are legitimate businesses, not criminals. HEAT also plans to enlist health care providers in the fight against fraud by increasing training about program requirements and effective compliance measures that help ensure integrity of billing practices.
Strike Force activities are one part of the Government's enforcement efforts; OIG also works with our law enforcement partners to pursue other criminal cases as well as civil and

administrative cases. In FY 2008, OIG investigations resulted in 455 criminal actions against individuals or entities that engaged in crimes against departmental programs and 337 civil and administrative actions, which included False Claims Act and unjust enrichment lawsuits filed in Federal district court, Civil Monetary Penalties Law settlements, and administrative recoveries related to provider self-disclosure matters. Also in FY 2008, OIG excluded from the Federal health care programs 3,129 individuals and entities for fraud or abuse that affected Federal health care programs and/or beneficiaries.

The collaborative antifraud efforts of HHS and DOJ are rooted in the Health Insurance Portability and Accountability Act of 1996, P. L. No. 104-191 (HIPAA), which directed the Secretary of HHS, acting through OIG and the Attorney General, to promulgate a joint Health Care Fraud and Abuse Control (HCFAC) Program. The HCFAC Program and Guidelines went into effect on January 1, 1997. HIPAA requires HHS and DOJ to report annually to Congress on HCFAC Program results and accomplishments. HCFAC activities are supported by a dedicated funding stream within the Hospital Insurance Trust Fund.

In its 11th year of operation, the HCFAC continues to demonstrate the success of a collaborative approach to identify and prosecute health care fraud, prevent future fraud and abuse, and protect Medicare and Medicaid beneficiaries. Since its inception, HCFAC activities have returned over $11.2 billion to the Medicare Trust Fund. As I will discuss, the Government's efforts to address DME and infusion fraud in south Florida illustrate the benefits of a collaborative approach. Although I will highlight efforts focused on DME and infusion fraud in particular geographic hot spots, fraud, waste, and abuse occur among all types of health care providers and suppliers and can affect all types of services covered by Medicare and Medicaid in all geographic areas.

VULNERABILITIES IN FEDERAL HEALTH CARE PROGRAMS

Strike Force Activities Have Uncovered Numerous Program Vulnerabilities

OIG and our law enforcement partners are focusing antifraud efforts in geographic areas at high risk for Medicare fraud. In 2007, OIG and DOJ launched a Strike Force effort in south Florida consisting of staff from OIG, DOJ, the U.S. Attorney's Office for the Southern District of Florida, the Federal Bureau of Investigation (FBI), and CMS to identify, investigate, and prosecute DME suppliers and infusion clinics suspected of Medicare fraud. Building on the success in south Florida, the Strike Force was expanded to Los Angeles in March 2008 and to Houston and Detroit in May 2009 in connection with the HEAT initiative.

The Strike Force model has proven highly successful. To date, the south Florida Strike Force has opened 161 cases, convicted 151 of its targets, and secured $187 million in criminal fines and civil recoveries. In addition to prosecuting criminals and recovering funds for the Medicare Trust Fund, the south Florida Strike Force has had a powerful sentinel effect. Medicare claims data show that during the first 12 months of the Strike Force (March 1, 2007, to February 29, 2008), claim amounts submitted for DME in south Florida decreased by 63 percent to just over $1 billion from nearly $2.76 billion during the preceding 12 months.

In March 2008, DOJ and OIG established a second Strike Force in Los Angeles. Since operations began, the Los Angeles Strike Force has opened 48 cases and is targeting individuals and organizations that have submitted fraudulent claims to the Medicare program. The schemes include false claims for wheelchairs, orthotics, and other DME that was medically unnecessary and/or was not provided to the beneficiaries identified in claims.

The recent Strike Force investigation and prosecution of Medcore Group LLC (Medcore) and M&P Group of South Florida (M&P) illustrate key vulnerabilities in the Medicare program. Medcore and M&P operated as Miami-based HIV clinics from approximately 2004 through 2006, billed approximately $5.3 million to the Medicare program, and received payments of more $2.5 million. From their inception, Medcore and M&P were set up as criminal enterprises designed to defraud Medicare. The scheme was to submit claims for medically unnecessary HIV infusion and injection treatments. The three owners of Medcore and M&P included a former gas station attendant, a trained cosmetologist, and an individual currently incarcerated for Medicare fraud involving a separate DME company he operated from 2001 to 2003. None had a medical background.

At trial, one of Medcore's owners, Tony Marrero, testified that the scheme was so profitable so quickly that he became concerned about getting caught and decided to set up a second fraudulent clinic, M&P, in the name of his wife. M&P was located in the same building as Medcore, had the same employees, submitted claims under the Medicare provider number of the same physician, and submitted claims on behalf of six of the same patients. In fact, the same physician was associated with other Miami-area infusion clinics, which billed Medicare for more than $60 million between 2004 and the end of 2005.

Mr. Marerro also testified at trial that he had an arrangement with a pharmaceutical wholesale company to buy invoices that showed the purchase of large amounts of medications, when only small amounts were actually purchased. One of the medical assistants testified that she manipulated the patients' blood samples to ensure that laboratory results would appear to support the Medicare claims.

Like many infusion fraud schemes, Medcore and M&P gained the cooperation of patients by giving them kickbacks of up to $200 per visit. Four patients testified that they took kickbacks and never received any medication at the clinics. One patient testified that he used his payments from the clinics to support his cocaine addiction. Another patient testified that he did not have HIV, even though the clinics' documents showed that he was being infused with medication to treat HIV. By the patients' own admission, they had been receiving kickbacks from numerous Miami clinics for many years. On March 17, 2009, a Federal jury in Miami convicted two physicians and two medical assistants who worked for Medcore and M&P in connection with the fraud scheme. The Government obtained 6 pleas before trial, resulting in 10 convictions in total.

OIG's fraud-fighting efforts in south Florida also draw on the expertise of our auditors and evaluators. For example, OIG identified weaknesses in Medicare's supplier enrollment process and its supplier oversight activities. In 2006, OIG conducted unannounced site visits to 1,581 DME suppliers in south Florida and found that 31 percent, i.e., 491 suppliers, did not maintain physical facilities or were not open and staffed during business hours, contrary to

Medicare requirements. The 491 suppliers were referred to CMS so that CMS could consider revoking their billing privileges, which it subsequently did. Billing privileges were reinstated by hearing officers for 222 of the 243 suppliers who appealed. Subsequently, 74 percent of the suppliers whose billing privileges were reinstated by hearing officers (165 of 222) had their privileges revoked again or inactivated by CMS. Between April and September 2007, the U.S. Attorney's Office indicted 18 individuals connected to 15 of the 222 reinstated suppliers. As of April 2008, 10 of the 18 individuals had been convicted, sentenced to jail terms, and ordered to pay restitution. Six of the eight remaining individuals have since been sentenced to jail terms and ordered to pay restitution. Two of the eight individuals are currently fugitives. OIG's work demonstrates how important it is to strengthen the enrollment screening process and improve program safeguards.

As a further result of OIG's work in south Florida, our analysis of Medicare billing patterns for inhalation drugs used with DME has uncovered evidence of abusive billing. Despite CMS's efforts to address inappropriate payments, problems persist. For example, in 2007, Medicare paid almost $143 million for inhalation drugs in Miami-Dade County alone—an amount 20 times greater than the amount paid in Cook County, Illinois, the county (outside south Florida) with the next highest total payments. However, according to Medicare enrollment data, Cook County is home to almost twice as many Medicare beneficiaries as Miami-Dade County. Medicare's average per-beneficiary spending on inhalation drugs was five times higher in south Florida than in the rest of the country. Further, 75 percent of south Florida beneficiaries who received a particular inhalation drug, budesonide, had Medicare-paid claims that exceeded Medicare utilization guidelines, compared to 14 percent of beneficiaries in the rest of the country. For 62 percent of south Florida inhalation drug claims, the beneficiaries on these claims did not have a Medicare-billed office visit or other service in the past 3 years with the physician who reportedly prescribed the drug. Finally, 10 south Florida physicians were each listed as the ordering physician on more than $3.3 million in submitted inhalation drug claims in 2007, or an average of $12,000 per day.

Similarly, OIG found that CMS has had limited success controlling aberrant billing by infusion clinics. In the second half of 2006, claims originating in three south Florida counties accounted for 79 percent of the amount submitted to Medicare nationally for drug claims involving HIV/AIDS patients and constituted 37 percent of the total amount Medicare paid for services for beneficiaries with HIV/AIDS. However, only 10 percent of Medicare beneficiaries with HIV/AIDS lived in these three counties.

Other Program Vulnerabilities

As part of its core mission, OIG identifies vulnerabilities that put programs and beneficiaries at risk and makes recommendations to address these vulnerabilities. OIG reviews have identified payments for unallowable services, improper coding, and other types of improper payments. Improper payments range from reimbursement for services not adequately documented and inadvertent mistakes to payments that result from outright fraud and abuse. We have identified program integrity risks and vulnerabilities in every part of Medicare, as well as Medicaid. These vulnerabilities affect services ranging from inpatient hospital and skilled nursing services

to outpatient services provided by physicians and other health professionals, to payment for prescription drugs and medical equipment. Examples include:

Durable Medicare Equipment

OIG has an extensive body of work identifying Medicare fraud, waste, and abuse related to DME. Problems include DME suppliers circumventing enrollment and billing controls, high payment error rates, kickbacks, and excessive reimbursement rates for certain DME. OIG has made recommendations to CMS to strengthen program integrity and DME oversight. OIG also has recommended stronger enrollment safeguards and payment reforms to align Medicare reimbursement for DME more closely with widely available market prices.

OIG has long identified several types of DME that are particularly vulnerable to billing abuses. For example, an investigation of a large wheelchair supplier found that the company had submitted false claims to Medicare and Medicaid, including claims for power wheelchairs that beneficiaries did not want, did not need, or could not use. In 2007, the company agreed to pay $4 million and relinquish its right to approximately $13 million in claims initially denied for payment by CMS. Nationally, in 2004, OIG estimated that Medicare and its beneficiaries paid $96 million for claims that did not meet Medicare's coverage criteria for any type of wheelchair or scooter and that they overspent an additional $82 million for claims that could have been billed using a code for a less expensive mobility device.

In addition, OIG has identified reimbursement rates for certain items and services that are too high. For example, in 2006, OIG reported that Medicare had allowed, on average, $7,215 for the rental of an oxygen concentrator that costs approximately $600 to purchase new. Additionally, beneficiaries incurred, on average, $1,443 in coinsurance charges. We determined that if home oxygen payments were limited to 13 months rather than the current 36 months, Medicare and its beneficiaries would save $3.2 billion over 5 years.

Further, in March 2009, OIG reported that Medicare reimbursed suppliers for negative pressure wound therapy pumps based on a purchase price of more than $17,000, but that suppliers paid, on average, approximately $3,600 for new models. Negative pressure wound therapy pumps are a type of DME used to treat ulcers and other serious wounds. When Medicare first started covering wound pumps in 2001, it covered only one model, which was manufactured and supplied by one company. Medicare paid for this pump based on the purchase price as identified by that company. In 2005, Medicare expanded its coverage to include several new pump models manufactured by other companies. However, Medicare reimburses suppliers for these new pumps based on the original pump's purchase price, which is more than four times the average price paid by suppliers.

Home Health/Personal Care Services

In general, OIG has identified fraud, waste, and abuse vulnerabilities in home health and personal care services similar to those described above for DME.

In a report released this month, OIG estimated that New York State improperly claimed over $275 million in Federal Medicaid reimbursement during our January 1, 2004, through December 31, 2006, audit period for personal care services from providers in New York City that did not meet coverage requirements. These improper payments occurred because the State did not adequately monitor New York City's personal care services program for compliance with certain Federal and State requirements. In addition, we identified quality and safety concerns. Cases are being pursued involving allegations that beneficiaries were physically abused by personal care aides, and their property was stolen. In addition, we have investigated complaints from beneficiaries that aides have abandoned them.

Prescription Drugs

OIG has an extensive body of work identifying fraud, waste, and abuse related to prescription drug coverage under Medicaid, Medicare Part B, and Medicare Part D. Fraud concerns include pharmaceutical companies misreporting pricing information that is used as the basis of reimbursement and/or Medicaid rebates; illegal marketing tactics, including kickbacks and off-label/off-compendium promotion; pharmacies switching drugs to maximize reimbursement; and drug diversion. OIG also is concerned that Medicaid reimbursement for prescription drugs, particularly generic drugs, does not accurately reflect drug costs. For Medicare Part D, OIG has identified vulnerabilities related to sponsors' bids and the resulting payments and premiums to plan sponsors, as well as deficiencies in Part D integrity safeguards.

Medicaid-specific Services

Medicare and Medicaid share many of the same vulnerabilities, including DME, home health, and prescription drugs. Medicaid-specific vulnerabilities include improper payments for school-based health services, case management services, and disproportionate share hospital payments. For example, in 2006, OIG found that a State Medicaid agency claimed Federal Medicaid funding totaling $86 million for unallowable targeted case management services. In a series of reviews in several States, OIG consistently found that schools had not adequately supported their Medicaid claims for school-based health services and identified almost a billion dollars in improper Medicaid payments.

Other Outpatient Services

OIG also continues to identify vulnerabilities related to certain types of services provided by physicians and other health professionals, including services related to advanced imaging, pain management, mental health services, clinical labs, and transportation services. For example, OIG found that from 1995 to 2005, advanced imaging paid under the Medicare Physician Fee Schedule grew more than fourfold, from 1.4 million to 6.2 million services. Allowed charges and utilization rate per beneficiary grew by a similar magnitude, to $3.5 billion and 163 services per 1,000 beneficiaries. Services provided by independent diagnostic testing facilities (IDTF) accounted for nearly 30 percent of this growth. OIG work has found problems with IDTFs, including noncompliance with Medicare requirements and billing for services that were not reasonable and necessary.

Inpatient Services

Expenditures for inpatient services, including those provided by inpatient hospitals and skilled nursing facilities, account for one-third of all Medicare expenditures. Problems identified by OIG include hospitals taking advantage of enhanced payments by improperly manipulating billing; hospitals reporting inaccurate wage data, which affects future Medicare payments; inpatient facilities that may be gaming prospective payment reimbursement systems by discharging or transferring patients to other facilities for financial rather than clinical reasons; and kickback schemes.

OIG Recommendations

In addition to pursuing those who violate the law, we also alert program administrators and other departmental officials to problems and offer solutions. These recommendations for corrective action are found in OIG's audit and evaluation reports, management implication reports resulting from OIG's investigative work, and other communications. In 2008, implemented OIG recommendations resulted in an estimated $16 billion in program savings and funds put to better use. In addition, OIG recommendations have resulted in substantial improvements in efficiency, effectiveness, and quality, as well as fraud prevention, whose impacts are more difficult to quantify.

To preserve its independence and objectivity, OIG is not authorized to implement or operate the HHS programs it oversees, nor can OIG compel the Department to implement our recommendations. However, we take several steps to follow up with program officials on the status of OIG recommendations and to encourage actions to address the vulnerabilities that we have identified. For example, the Principal Deputy Inspector General and I meet regularly with the CMS Administrator and other senior CMS officials to discuss unimplemented recommendations and other program integrity concerns. OIG is implementing a new recommendations management system that will further enhance our ability to track and follow up on OIG recommendations.

Each year we issue a Compendium of Unimplemented OIG Recommendations. The Compendium consolidates significant unimplemented monetary and nonmonetary recommendations addressed to the Department that we expect would, if adopted, result in cost savings, improved program integrity, and/or greater program efficiencies. These recommendations require legislative, regulatory, and/or administrative action. While implementation of monetary recommendations would have fiscal impacts, implementation of nonmonetary recommendations would improve program operations in other ways. In some cases, the agency agrees with our recommendations but has not yet fully implemented them; in others, the agency disagrees with our recommendations.

OIG's unimplemented recommendations provide a useful roadmap for focusing efforts to safeguard and improve the efficiency and effectiveness of the HHS programs OIG oversees. However, it is difficult to draw conclusions about overall savings from these recommendations. Estimates of potential monetary benefits listed in the Compendium are unique to each recommendation and are not comparable. These are typically point-in-time estimates and are often specific to the scope and timing of OIG's underlying work. When OIG reports

implemented recommendations and resulting savings in our Semiannual Reports to Congress, we typically rely on savings estimates produced by the Congressional Budget Office (CBO) or other HHS sources. However, with respect to unimplemented recommendations, CBO or other sources for scoring potential savings frequently are not available. Therefore, OIG may use findings from our reports or other sources, as available, to estimate potential savings. Several of our recommendations that we expect would produce savings do not include estimates of those savings. Notwithstanding the limitations in estimating potential savings, the Compendium is an important tool for identifying program vulnerabilities and improvements.

ENSURING THE INTEGRITY OF FEDERAL HEALTH CARE PROGRAMS

OIG's Five-Principle Strategy to Combat Health Care Fraud, Waste, and Abuse

For Federal health care programs to best serve beneficiaries and remain solvent for future generations, the Government must pursue a comprehensive strategy to prevent, detect and remediate fraud, waste, and abuse. Based on OIG's extensive experience in combating health care fraud, waste, and abuse, we have identified the following five principles that we believe should guide the development of any national health care integrity strategy.

1. **Enrollment** – Scrutinize individuals and entities that want to participate as providers and suppliers prior to their enrollment in health care programs.

2. **Payment** – Establish payment methodologies that are reasonable and responsive to changes in the marketplace.

3. **Compliance** – Assist health care providers and suppliers in adopting practices that promote compliance with program requirements, including quality and safety standards.

4. **Oversight** – Vigilantly monitor programs for evidence of fraud, waste, and abuse.

5. **Response** – Respond swiftly to detected fraud, impose sufficient punishment to deter others, and promptly remedy program vulnerabilities.

We believe that these principles provide a useful framework for designing and implementing program benefits and integrity safeguards. Consistent with these principles, OIG offers the following recommendations to strengthen the integrity of Federal health care programs.

Enrollment

Scrutinize individuals and entities that want to participate as providers and suppliers prior to their enrollment in health care programs.

Medicare and Medicaid provider enrollment standards and screening should be strengthened, making participation in Federal health care programs as a provider or supplier a privilege, not a right. It is more efficient and effective to protect the programs and beneficiaries from unqualified, fraudulent, or abusive providers and suppliers up front than to try to recover

payments or redress fraud or abuse after it occurs. Greater transparency in the enrollment process will help the Government know with whom it is doing business.

For example, as the Medcore and M&P case described above demonstrates, a lack of effective screening measures gives dishonest and unethical individuals access to a system they can easily exploit. Even after Medcore had billed Medicare for $4 million in fraudulent claims, it was easy for the clinic's owner to obtain a provider number in his wife's name for a second clinic, M&P, operating in the same building as Medcore, with the same medical director, employees, and patients. One of the owners, Mr. Marrero, testified that when he ultimately sold M&P for $100,000 in cash, he went to a lawyer's office so the lawyer could fill out paperwork to put ownership of the clinic in the name of two nominee owners. The sale was structured as a stock sale so that the new "owners" would have 90 days to notify Medicare of the change in ownership, allowing a window of time for the fraud to continue under new "ownership." In our experience, it is too easy for unscrupulous individuals to recruit nominee owners of fraudulent companies.

Providers and suppliers applying for enrollment in Medicare or Medicaid should be screened before they are granted billing privileges. Heightened screening measures for high-risk items and services could include requiring providers to meet accreditation standards, requiring proof of business integrity or surety bonds, periodic recertification and onsite verification that conditions of participation have been met, and full disclosure of ownership and control interests. The cost of this screening could be covered by charging application fees. New providers and suppliers should also be subject to a provisional period during which they are subject to enhanced oversight, such as prepayment review and payment caps.

Payment

Establish payment methodologies that are reasonable and responsive to changes in the marketplace.

We support efforts to pay appropriately for the items and services covered by Federal health care programs. Medicare and Medicaid payments should be sufficient to ensure access to care without wasteful overspending. Payment methodologies should also be responsive to changes in the marketplace, medical practice, and technology. Although CMS has the authority to make certain adjustments to fee schedules and other payment methodologies, for some changes, congressional action is needed.

OIG has conducted extensive reviews of Medicare and Medicaid payment methodologies and has determined that the programs pay too much for certain items and services. As OIG's reviews of home oxygen equipment and wound therapy pump payments demonstrate, when reimbursement methodologies do not respond effectively to changes in the marketplace, the program and its beneficiaries bear the cost. As the experience of south Florida illustrates, excessive payments also are a lucrative target for criminals. These criminals can reinvest some of their profit in kickbacks for additional referrals, thus using the program's funds to perpetuate the fraud scheme.

All payment methodologies create incentives and fraud risks that should be identified and addressed. For example, fee-for-service payments create financial incentives to maximize the number and complexity of services provided, even when such services are not medically necessary. Conversely, under a fixed, prospective payment system, financial incentives encourage fewer services and patients may not receive all of the care that they need and for which the program is paying. In considering any payment structure, it is imperative to identify the incentives that it creates and associated risks and to implement necessary safeguards to remediate the negative incentives and reduce fraud risks.

Compliance

Assist health care providers and suppliers in adopting practices that promote compliance with program requirements.

Health care providers and suppliers must be our partners in ensuring the integrity of Federal health care programs and should adopt internal controls and other measures that promote compliance and help prevent, detect, and respond to health care fraud, waste, and abuse. To this end, OIG has published on its Website extensive resources to assist industry stakeholders in understanding the fraud and abuse laws and designing and implementing effective compliance programs. These resources include sector-specific Compliance Program Guidance that describes the elements of an effective compliance program and identifies risk areas, advisory opinions, and fraud alerts and bulletins.

In many sectors of the health care industry, such as hospitals, compliance programs are widespread and often very sophisticated; other sectors have been slower to adopt internal compliance practices. Compliance programs not only benefit the Federal health care programs; they also benefit industry stakeholders by improving their business practices, by fostering early detection and correction of emerging problems, and by reducing the risk that they will become the subject of a whistleblower complaint or fraud prosecution.

States also have begun to recognize the value of compliance systems. For example, New York now requires providers and suppliers to implement an effective compliance program as a condition of participation in its Medicaid program. Medicare Part D also requires that prescription drug plan sponsors have compliance plans that address certain required elements.

Although compliance programs do not guarantee reduced fraud and abuse, they are an important component of a comprehensive government-industry partnership to promote program integrity. We advocate that providers and suppliers be required to adopt compliance programs as a condition of participating in the Medicare and Medicaid programs. Further, the obligation of providers and suppliers to repay overpayments they discover through compliance efforts or otherwise should be made explicit in the statute. There should be no question that providers and suppliers must return taxpayer dollars they should not have received in the first place.

Oversight

Vigilantly monitor the programs for evidence of fraud, waste, and abuse.

As fraud schemes become more sophisticated and migratory, access to real time data and the use of advanced data analysis to monitor claims and provider characteristics are critically important. OIG is using innovative technology to detect and deter fraud, and we continue to develop and implement cutting edge initiatives to enhance our technology infrastructure and support a data-driven antifraud approach. More must be done to ensure that agencies governmentwide are able to use 21st century information technology effectively in the fight against health care fraud.

This data-driven approach should underpin the development of fraud enforcement and prevention activities. The health care system compiles an enormous amount of data on patients, providers, and the delivery of health care items and services. However, Federal health care programs often fail to use claims-processing edits and other information technology effectively to identify improper claims before they are paid and to uncover fraud schemes. For example, Medicare should not pay a clinic for HIV infusion when the beneficiary has not been diagnosed with the illness, pay twice for the same service, or process claims that rely on the provider identifiers of deceased physicians. Better collection, monitoring, and coordination of data would allow Medicare and Medicaid to detect these problems earlier and avoid making improper payments. Moreover, effective use of data would enhance the Government's ability to detect and respond to fraud schemes more quickly.

Needed improvements in program oversight include real-time access to data for law enforcement; uniform, comprehensive data elements; more timely collection and validation of data; robust reporting of data by States and others; interoperability of systems; consistent data extraction methods; and the ability to draw and analyze claims and provider data across Medicare Parts A, B, C, D, and Medicaid. CMS is building an Integrated Data Repository (IDR) that will, when completed, contain a wealth of data across several programs. Although the system is still under development, the prospect of such a comprehensive data warehouse holds considerable promise for detecting and preventing fraud and abuse.

In addition, we advocate the consolidation and expansion of the various provider databases, including the Health Care Integrity and Protection Data Bank (HIPDB), the National Practitioner Data Bank (NPDB), and OIG's List of Excluded Individuals/Entities (LEIE). Providing a centralized, comprehensive, and public database of adverse actions and other sanctions -- including a national registry of patient abuse and neglect -- would be an effective means of preventing providers and suppliers with problem backgrounds from moving from State to State unnoticed by licensing, government, and health plan officials.

Response

Respond swiftly to detected fraud, impose sufficient punishment to deter others, and promptly remedy program vulnerabilities.

To ensure the integrity of Federal health programs, law enforcement is working to accelerate the Government's response to fraud schemes by reducing the time needed to detect, investigate, and prosecute fraud. The Government's Strike Force model has proven highly successful in this regard, and although resource intensive, is a powerful antifraud tool and represents a tremendous return on investment. In addition to prosecuting criminals and recovering funds for the Medicare Trust Fund, the Strike Forces have had a strong sentinel effect, as evidenced by the 63 percent decrease in DME claims submitted in south Florida over the first 12 months of Strike Force operations there.

Even the best antifraud efforts are ineffective if fraud is not promptly detected and, once detected, promptly punished and deterred. For example, our investigations have found evidence of an increase in organized crime in health care. Health care fraud is attractive to organized crime because the penalties are lower than those for other organized-crime-related offenses (e.g., offenses related to illegal drugs); there are low barriers to entry (e.g., a criminal can easily obtain a supplier number, gather some beneficiary numbers, and bill the program); schemes are easily replicated; and detection efforts often are hampered by lack of access to real-time data. We need to alter the cost-benefit analysis by increasing the risk of swift detection and the certainty of punishment.

In addition, it is currently difficult to stop the flow of Medicare dollars to criminals who are under investigation for known health care fraud schemes. An explicit payment suspension authority would enable Medicare to keep taxpayer dollars out of the pockets of criminals in cases where the Government has credible evidence of fraud. These criminals often take the money and disappear before the Government can complete an investigation and prosecute them. An explicit payment suspension authority is a critical, money-saving tool in these situations.

OIG currently uses a range of administrative sanctions, including civil monetary penalties (CMP) and program exclusions, as an adjunct to criminal and civil enforcement. However, OIG has identified a number of enhancements to these administrative authorities that would increase our ability to address emerging schemes, such as authorizing CMPs for false provider enrollment applications and for the ordering or prescribing of items or services by an excluded entity. Amending the law to align our CMP authorities with the recent False Claims Act amendments would also be helpful.

In addition, in the course of our investigations, audits, and evaluations, OIG often identifies program vulnerabilities that have been or could be exploited and recommends corrective actions. Program administrators and policy makers have important roles in responding quickly to address these vulnerabilities and reduce the risk of future fraud, waste, and abuse.

CONCLUSION

In conclusion, in the context of health care reform, it is an especially important time to consider how to best safeguard health care programs from fraud, waste, and abuse to protect beneficiaries and taxpayer dollars. OIG's mission is to protect the integrity of HHS programs, including the Medicare and Medicaid programs, and the well-being of program beneficiaries. In fulfilling our mission, OIG has identified for recovery billions of dollars lost to fraud, waste, and abuse; helped remove thousands of fraudulent providers from Federal health care programs; pinpointed numerous items and services for which the Government is substantially overpaying; and recommended actions to better protect programs and beneficiaries. These experiences and results have applicability to the current discussions of health care reform. It is critical that the Government pursue a comprehensive strategy to combat fraud, waste, and abuse. We believe that our "Five Principles" strategy provides the framework to identify new ways to protect the integrity of the programs, meet the needs of beneficiaries, and keep Federal health care programs solvent for future generations. We look forward to working with the Committee on these issues, including providing you with information and technical assistance. This concludes my testimony, and I would be pleased to answer any questions.

Mr. PALLONE. Thank you. Thank you both. I am going to ask my questions of Mr. Hackbarth, but not because what you said is not important, Mr. Levinson. I think this whole issue of enforcement and fraud and abuse is really crucial.

But I—yesterday, Mr. Hackbarth, I asked basically the same question of Secretary Sebelius. In other words, you know, on the one hand we are talking about reductions in payments for certain Medicare and Medicaid programs. On the other hand, we are talking about enhancements and, you know, actually spending more on other aspects of Medicare and Medicaid, for example, Medicare Part D, filling up the doughnut hole, and you do both. In other words, my understanding is that, you know, your recommendations, which we—many of which are incorporated in this discussion draft, accomplish both purposes.

So—what I wanted to do, though, is—I think there is more media attention on cuts than there is on what you do to enhance programs, so I wanted you to talk a little bit about what motivates MedPAC to propose some of the reductions we are contemplating, you know, like the Medicare Advantage, the home health rebasing, productivity into payments updates and the rest. But why is it that MedPAC sees these as important policy proposals on their own terms, not because of, you know, cost savings?

Mr. HACKBARTH. Um-hum. Well, Mr. Chairman, we believe that pressure on the prices in the Medicare payment system is important to force the system towards more efficiency. As you and the other members of the Committee know, Medicare has administered price systems. They are set through a government process, as opposed to market prices.

We believe that what we have to do with that administered price system is mimic, so far as possible, the sort of pressure that exists in a competitive marketplace. The taxpayers who finance the Medicare program face relentless pressure, often from international competition, for example, forcing the firms that they work for to lower their costs, day in and day out. We think the health care system must experience the same sort of pressure.

Mr. PALLONE. And then the solvency of the trust fund is extended, and premiums are reduced, and the program is maintained for future generations, so that is the ultimate goal?

Mr. HACKBARTH. Absolutely.

Mr. PALLONE. And let me ask you another question about—you know, we get this argument from some—not too many, but some employers and providers complain about alleged cost shifting from Medicare to the private sector. The argument is, like—something like if Medicare would pay more, private plans could pay less, and so health care would be cheaper for employers and others. I don't understand how increasing Medicare payment rates would lead a private hospital to decrease the prices it charges private insurers, and—can you explain this to me? You know—I mean, I know I am asking you the opposite of what you believe, but——

Mr. HACKBARTH. Yes.

Mr. PALLONE [continuing]. I mean, what——

Mr. HACKBARTH. Yes. Well, let me start by saying that we believe that Medicare payment rates are adequate. We don't believe that they are too low. We don't believe that they should be in-

creased. And we—let me focus on hospital services as an example of that. We look at the data in several different ways. We have looked at time series data, and you see there is a pretty consistent relationship in periods where private payments are generous, Medicare margins become negative. And it is our belief that that is because when the private payments are generous, hospitals have more money to spend, and they spend it. It is a largely not-for-profit industry. If they get revenue, they will spend it.

And—then we see the same pattern when we look at individual hospitals, so what we have identified is a group of hospitals that don't have a lot of generous payment from private payers. They have constrained resources. Those institutions lower their costs and actually have a positive margin on Medicare business. They don't have the luxury of additional private money flowing into their institutions. They are forced to control costs, and they do control costs as a result.

Mr. PALLONE. And so you disagree with claims that Medicare is responsible for high health insurance premiums?

Mr. HACKBARTH. No. I—if institutions—clearly the rates paid by Medicare and private payers are different. Private payers pay higher rates. It does not follow from that, however, if you increase Medicare rates that the private rates would fall.

Mr. PALLONE. OK. Now, let me just—one more thing about access. You know, we hear about, in some parts of the country that, you know, Medicare enrollees say that they can't find a doctor willing to accept new patients. Based on your research, do you have any reason to believe that we have a crisis of access in Medicare, that—basically providers not taking Medicare in a significant way?

Mr. HACKBARTH. Each year we do a careful study of access for Medicare beneficiaries, asking both patients and physicians. Our most recent patient survey, which was done in the Fall of 2008, found that Medicare beneficiaries are most satisfied with their access to care than private patients, privately insured patients, in the 50–64 age group.

The one area of concern that we do have is around access to primary care services, especially for Medicare beneficiaries looking for a new physician, for example, because they have moved. That is the area where we see Medicare beneficiaries reporting the most problem, but we also see privately insured patients in the same circumstance reporting problems as well. So we don't think the issue is a function of Medicare payment rates, but rather too few primary care physicians.

Mr. PALLONE. Which was one of the things we were trying to address in this discussion draft. Thank you.

Mr. Deal.

Mr. DEAL. Mr. Hackbarth, let me follow up on one of your comments about your look at those hospitals that have higher ratios of Medicare patients and lower ratios of private paying patients.

Mr. HACKBARTH. Um-hum.

Mr. DEAL. And I believe your statement was that they are able to make a profit and, in fact, be more profitable than some of the ones who have lower volume of Medicare patients. Don't those hospitals receive dish payments, as a general rule?

Mr. HACKBARTH. Some of them may, yes.

Mr. DEAL. Does your recommendation in any way address whether dish payments should continue or be abolished?

Mr. HACKBARTH. We have had some discussion, Mr. Deal, about refocusing dish payments. We have not recommended abolishing them.

Mr. DEAL. OK. Mr. Levinson, the draft talks about expanding Medicaid coverage and providing Federal payment of 100 percent for some of this expansion of new populations so that the states don't have to pick up even their matching share in their Medicaid formula. If that is the case, if the Federal government picks up 100 percent of this cost, are you concerned that states will no longer have the incentive to look for the waste and the fraud and the abuse because they don't really have any stake dollars in that pot? Is that a concern, from your standpoint?

Mr. LEVINSON. Well, it is certainly always a concern about what is occurring with the Federal share of Medicaid, and indeed, as we look for a larger share of that on the Federal side, it becomes of greater interest to us at the Federal level. It is an issue, actually, that I, as a member of the Recovery Act Accountability and Transparency Board, is already dealing with, with my colleagues on the Board, because the ARA does include a significant increase in the Federal share funding to alleviate states of some of the Medicaid burden. And in some of the states, particularly in the south central part of the United States, we are approaching a level where states give little, if any, contribution to Medicaid. So we are focusing on ensuring that there are controls in place to make sure that the, you know, the Medicaid dollar is protected, but as the Federal involvement becomes greater, the need for more Federal monitoring of those dollars also becomes greater.

Mr. DEAL. Because the states have been the primary enforcement—first line of enforcement against fraud and abuse, with oversight from the Federal. So you are saying that there may be a need for more Federal oversight?

Mr. LEVINSON. That is correct. Historically the Medicaid Fraud Control Units, which exist in nearly every state of the union, have been really the first protectors, as it is, of the Medicaid program. We have provided oversight. In the last several years, though, Congress has provided additional funding to be more involved in the monitoring of those Medicaid dollars as the Federal share has increased.

Mr. DEAL. Mr. Hackbarth, in your testimony, you make reference, I think, to the fact that about 60 percent of beneficiaries now buy supplemental policies to cover part of their Medicare cost. That seems, to me, a little bit inconsistent with your conclusion that the Medicare reimbursement rates are adequate. I know one is from the provider standpoint and the other being from the patient standpoint.

Do you foresee, from the patient standpoint, that if we model everything after the Medicare reimbursement rates and the Medicare model, that there is going to be a need for even more purchasing of supplemental insurance by the individual patients?

Mr. HACKBARTH. Well, as you say, Mr. Deal, there are two distinct issues. One is the adequacy of payments rates to providers, and we believe those payment rates are adequate. The Medicare

benefit package is probably not designed the way any of us would design it if we were starting with a clean piece of paper. The design could be streamlined, and that process may reduce the need for beneficiaries to buy supplemental coverage. For example, if we were to add catastrophic coverage, a key missing component on Medicare, that might reduce the perceived need for supplemental coverage.

Mr. DEAL. OK.

Mr. HACKBARTH. We have begun looking at that redesign issue.

Mr. DEAL. Real quickly, you were going through your principles that you have recommended, and you got through most of them, I think. In the very short time that I have left, are there any of those principles that you are concerned that are not being addressed in this discussion draft, in particular any that you have great concern about?

Mr. HACKBARTH. Off the top of my head, Mr. Deal, I can't think of one.

Mr. DEAL. OK. Thank you, Mr. Chairman.

Mrs. CAPPS. The chair now recognizes Mr. Murphy for his questions.

Mr. MURPHY of Connecticut. Thank you very much, Madam Chair, and Mr. Hackbarth, thank you so much for all the work that you have done guiding this Congress on this issue of moving away from a volume based system to a system that attempts to really reward outcome and performance.

And I think—I, for one, am worried that if don't take advantage of this moment in time, with this health care reform debate, to make those changes, that we may never be able to make them. And so—I know Mr. Deal just asked you a general question about whether there were points of reform that you have pushed that aren't in this bill, but I wanted to ask specifically on this issue of payment reform.

Mr. HACKBARTH. Um-hum.

Mr. MURPHY of Connecticut. Have you taken a look at this bill with regard to payment reform, and how do you think it measures up versus what you think could be potentially done through this Reform Act, with regard to transforming our payment system?

Mr. HACKBARTH. Yes. As I indicated to Mr. Deal, I think that the bill's provisions on Medicare are pretty comprehensive, and address the major issues that MedPAC has raised about the Medicare program. Having said that, some of the provisions—let me take an example, accountable care organizations rebuttalling. You know, the bill provides for pilots of these new ideas, and, in fact, that is what MedPAC has recommended. These are complex ideas that will take time to develop and refine. So, the bill includes provisions. We shouldn't assume from that that, oh, it is a done deal. There is lots of work that needs to be done in CMS, in particular, to make these things a reality.

Mr. MURPHY of Connecticut. Well—and that was going to be my second question. You have had a lot of experience in pilot programs, and I think one of the things that some of us worry about is that it is—that there has been a lot of research done on, for instance, the issue of accountable care organizations and bundling, and I think the majority of evidence is that they work. That they

get good outcomes, and they can reduce costs. And so if we are going to go into a bill that pilots these, how do we make sure that if the pilots turn up with the outcomes that pretty much every other—all other work on these payment reforms have done, how do we make sure that then that becomes a system-wide reform?

Mr. HACKBARTH. Yes. This is an issue that I think we discussed last time I was with the Committee. The pace at which we make changes, reform the Medicare payment systems, is way too slow, and one of the things that we have recommended is broader use of pilots, as opposed to demonstrations. And the difference, in our mind, is that under a pilot, the Secretary has the authority to move to implementation if the pilot achieves stated objectives. It doesn't have to come back through the legislative process. We think that is a very important step.

And again, I would emphasize CMS needs more resources to do these things both quickly and effectively. They are operating on a shoestring, and the work is too important, too complex, to allow that to continue.

Mr. MURPHY of Connecticut. And let me ask specifically about this issue of accountable care organizations. And—it seems to me that one of the ways that you expand out to a system of outcome based performance is that you try to encourage physicians to join in and collaborate.

Mr. HACKBARTH. Right.

Mr. MURPHY of Connecticut. We have put an enormous amount of money in the stimulus bill into giving physicians and hospitals the information technology to create those interaction and that coordination. And I guess I would ask you what are the ways that we need to be looking at in order to try to provide some real incentives for physicians to coordinate, become part of multi-specialty groups, enter into cooperative agreements? And then should we be looking at only incentives, or should we be looking at something tougher than incentives to try to move more quickly to a system by which physicians aren't operating in their own independent silos?

Mr. HACKBARTH. Yes. Well, the fact that we have a fragmented delivery system, I believe, is the result of how we have paid for medical care not just in Medicare, but also in private insurance programs for so many years. We basically enabled a sort of siloed, independent practice without coordination. The most important step we can take is change the payment systems so that services are bundled together, and physicians of various specialties and the various types of providers must work together. And there is abundant evidence that when they do that, we not only get lower costs, we get better quality.

Mr. MURPHY of Connecticut. Thank you very much, Madam Chair.

Mrs. CAPPS [presiding]. Thank you. The Chair now recognizes Congressman Burgess for his questions.

Mr. BURGESS. Thank you, Madam Chair. Mr. Hackbarth, always good to see you, and I have several questions that I am going to submit in writing because time is so short during these Q&As, and I was going to reserve all my questions, in fact, for the Inspector

General, but I just have to pick up on a point that we just expressed.

And under accountable care organization within Medicare, just within the Medicare system, with Medicare being an entirely Federal system—it is not a state system, it is a Federal system, so we don't have state mandates in Medicare. It functions across state lines.

If we were to provide an incentive, that is a backstop on liability under the Federal Tort Claims Act for doctors practicing within the Medicare system who practice under the guidelines of whatever we decide the accountable care organization—the proper accountable care organization should be, would that not be the types of incentive that we could offer to physicians that would not require increase in payments, but yet would bring doctors—increase their interest in practicing within these accountable care organizations?

Mr. HACKBARTH. Yes. Dr. Burgess, MedPAC has not looked specifically at the malpractice issue. We principally focus on Federal issues. You know, that is our——

Mr. BURGESS. But, if I could, we could make liability a Federal issue within the Medicare system because defensive medicine does cost the Federal system additional dollars, as Dr. McClellan's great article from 1996 showed.

Mr. HACKBARTH. Right. And my point is that there's no MedPAC position on malpractice issues. As you know, though, I am formerly a CEO of a very large medical group, so I have lot of experience working with physicians, and I know how large malpractice looms in the minds of physicians. Because I have not studied the issue in detail, I don't have a specific recommendation, but I think addressing physician concerns about malpractice is a reasonable thing to do.

Mr. BURGESS. Well, one of the things that really bothers me about these discussion in this Committee, you have so many people here who have never run a medical practice, as you have, and as some of us have. Doctors tend to be very goal directed individuals. That is why the fee for service system has worked for so long, because you tell us what to do and what the rules are, and we make a living at it. I am not a big fan of bundling. I don't trust hospital administrators, as a general rule, and I would not trust them to appropriately apportion out the payments, so not a big fan there. But are there—there ought to be other ways to tap into the goal directed nature of America's physicians to achieve the goals that you are trying to get, and right now I don't think, at least from what I have seen, we are quite there.

I am going to actually go to Mr. Levinson, because what you have talked about is so terribly important, and—let me just ask a question. Right now, within the discussion draft we are talking about, I don't think the numbers are filled in as far as the budget, the numbers—the dollar numbers that are going to be there. What do you need today in order to do your job more effectively?

Mr. LEVINSON. Well, we certainly need the resources that we have been given by the Congress and by the Executive, and it is certainly being used, I think, in an optimum way. But as the mission gets larger, the need for greater resources also is there.

Mr. BURGESS. And I am going to interrupt you, that is an extremely important point, because we have increased the FMAP on—in the stimulus bill and some of the other things that we are talking about doing. Is that not going to increase the burden, the pressure, that is placed on you and your organization in order to provide the proper oversight?

Mr. LEVINSON. Certainly our mission has been heading north for the last few years, and we are really pressed to enlist really the best investigators, evaluators, lawyers and auditors we can find to handle, you know, a much larger budget than historically we ever have had before.

Mr. BURGESS. And it is not just you, because my understanding, from talking to folks back home in the Dallas/Fort Worth area, from—within the HHS Inspector General's shop, and within the Department of Justice's jurisdiction, there is actually a deficit of prosecutorial assets, or, actually, assets have been—been had to use for other things, Homeland Security, narcotics trafficking, and there is not the prosecutors to devote to the cases that you all develop, to bring those cases to trial.

Mr. LEVINSON. That is a very important point, and sometimes it is overlooked how key it is to understand that the resources that are used to fight health care fraud really require a collaborative effort across several different government entities. And if you have the Justice Department personnel, but don't have the IG personnel——

Mr. BURGESS. Right.

Mr. LEVINSON [continuing]. And vice versa, you really have a significant problem.

Mr. BURGESS. And just one last point—I will submit several questions in writing—on the issue that we are hearing so much about in McAllen, Texas, where the—McAllen appears to be an outlier. Many physicians from the Texas border area were in town yesterday. I don't represent the border area, but they discussed it with me. They are concerned, obviously, about the negative press that they have been getting over the report by Dr. Guande in the New Yorker magazine. Is there any special focus that you are putting on that area because of the possibility of diversion of Medicare/Medicaid dollars within other ancillary agencies, imaging, drugs, home health? Are—is the possibility that this number is skewed not because of practitioners in the area, but because, in fact, the—we don't have the resources to devote to the investigation of fraud, the prosecution of fraud when it is uncovered?

Mr. LEVINSON. Well, there are a number of high profile areas that we oversee that we do need to concentrate on, because they do tend to be areas where fraud, waste and abuse tends to become a lot more serious than perhaps others. The durable medical equipment area, for example, especially in South Florida, has triggered our need to develop a strike force that is specifically devoted to trying to uncover and, to the extent possible, eliminate DME fraud in South Florida. We have had very good results there, actually, in being able to clean up many of the problems areas. I can point to other parts of the country where other kinds of issues have arisen that really require a concentrated effort by us, working with our

law enforcement partners. I can't speak specifically to McAllen, Texas.

Mr. BURGESS. Are—is that on your radar screen to pull that into the investigative process?

Mr. LEVINSON. I can only say that the entire nation is on our screen, because we have such an extensive jurisdictional requirement.

Mr. BURGESS. All right. Thank you, Mr. Chairman.

Mrs. CAPPS. The Chair now recognizes Mr. Green for his questions.

Mr. GREEN. Thank you.

Mr. Hackbarth, in your testimony, you cited lack of care coordination and lack of incentive of providers to actually coordinate care as a cost burden, and I agree, and we have several coordination bills pending before our committee. One is the Realigning Care Act, which focuses on geriatric care coordination. Your testimony cites geriatrics as an area in which care coordination is especially necessary. Can you elaborate on how geriatric care coordination could help lower health care costs? And again, we are dealing with Medicare, but maybe we could also deal with whatever we create as a—in the national health care.

Mr. HACKBARTH. Yes. Geriatricians, as you know, tend to focus on elderly patients who have very complex multiple illnesses. And for those patients, not only is the potential for inappropriate, unnecessary care large, the risk to the patient of uncoordinated care is very large indeed. And so such patients really need somebody who is going to follow them at each step, not hand them off to specialists, and then they are handed to another specialist and another. They need somebody as that home base to integrate and coordinate the services.

Mr. GREEN. And I know that is our goal, is to talk about a medical home, you know, where someone could—any of us—a number of us had elderly parents who we have had to monitor the number of doctor's visits simply because they also take lots of different medications, and there is nobody coordinating that, except maybe a family member.

Mr. HACKBARTH. And the problem, as you well know, Mr. Green, is that Medicare really doesn't pay for that activity, outside of the patient visit, the phone calls that need to be made to pull together the services of the well integrated. So we have made a series of recommendations to increase payment for primary care and the medical home, which in addition to the fee based payments, has a per patient sum to support that sort of activity.

Mr. GREEN. And since we are all so concerned about the scoring, did MedPAC look at—by creating this benefit of coordinated care, could we save on the back end? Is there something we could quantify, say, to CBO, or someone could say, we—over a period of time, let us— we think we can save ultimately?

Mr. HACKBARTH. Yes. Well, it is our hope, and perhaps even our expectation, that there would be savings. But what we have recommended, and what the Congress has done, is a large scale pilot, so that, in fact, we can hopefully document those savings and to have a resulting CBO score from it.

Mr. GREEN. OK. And I know we have your—under current law we have your welcome to Medicare exam. That—do you think that could fit in there with what we would call a geriatric assessment initially, and then build on using that primary care?

Mr. HACKBARTH. Well, potentially, because it gives the physician, hopefully a strong primary care physician, an introductory assessment of all of the patient's problems right from the outset.

Mr. GREEN. OK. And again, I know there is a provision in the bill, and a lot of us have that interest, and that is one of the good things about this bill that we are dealing with, but, again, since we are looking at scoring, say, you know—and it is hard to get CBO to say at the end we can save money. Not only save money, but almost—much more humane dealing Medicare, or any patient, in all honesty.

Mr. HACKBARTH. Well, what I can say, Mr. Green, is that—as I said in my opening comment, there is abundant evidence that systems that have strong primary care have lower costs and higher quality than systems that don't have strong primary care. You see that in international comparisons. You see that in studies within the United States that compare regions with one another. You see that within health systems. So there is lots of evidence of that sort. Whether CBO considers that strong enough to score is——

Mr. GREEN. Well——

Mr. HACKBARTH [continuing]. A CBO issue, not a——

Mr. GREEN [continuing]. Maybe by your testimony we can encourage CBO to look at other countries that have a primary care emphasis, and how that can reduce the cost. So maybe the bean counters can actually say, this works, and so—I appreciate your testimony, and hopefully we will get that in our response when we are—when we get that score, so—thank you.

Chairman—Madam Chairman, I yield back my time.

Mrs. CAPPS. Congressman Gingrey is now recognized.

Mr. GINGREY. Madam Chairman, thank you. And I am going to direct my questions to Mr. Hackbarth.

Mr. Hackbarth, one of the barriers to achieving value in Medicare cited in your testimony—you state that Medicare payment policies "ought to exert physical pressure on providers."

Mr. HACKBARTH. Um-hum.

Mr. GINGREY. You go on to state that in a fully competitive market, which I am guessing infers that Medicare does not compete in a fully competitive market, that this physical pressure happens automatically in a fully competitive market. In the absence of such a competitive market, you suggest that Congress must exert this pressure by limiting payment updates to Medicare physician updates.

When created Medicare Part D, Congress considered instituting a set payment rate in lieu of creating a competitive market, where competition among the pharmacy benefit plans might automatically keep the cost down. In the end, this Congress elected to go with that competitive model and forego payment rates set in statute, some of those that exist under current Medicare fee for service. The results, as we all now know, is that, due to the private market pressure, rather than government price setting, Part D premiums are much lower than anticipated, and drug prices have gone down.

So, instead of exerting the physical pressure on providers that you suggest must be exerted due to the lack of a competitive market to do it automatically, I am curious as to your thoughts on how using a competitive bidding process, like what we did in Medicare Part D, might achieve the same sort of efficiencies you suggest are required in traditional Medicare, but without having to resort to restricting of payments.

Mr. HACKBARTH. Um-hum. Well, let me approach it from two directions, Dr. Gingrey. If we look at private insurers, and the private insurance marketplace, and we compare the costs of those programs with Medicare costs, what we see is that, on average, and my evidence here is from the Medicare Advantage Program, is that the bids submitted by the private plans are higher than Medicare's costs, they are not lower. Now, there are some plans that bid lower, but on average, the private bids are higher.

So that is an opportunity for private plans to come in and compete and show that they can reduce costs, and by their own bids, they have not done that.

Mr. GINGREY. You are talking Medicare Advantage?

Mr. HACKBARTH. Medicare Advantage.

Mr. GINGREY. But, of course, they—Mr. Hackbarth, they do provide something that these three committees that have come up with this draft legislation, if you will, really want, and that is, of course, emphasis on things other than just episodic care, treatment of pain and suffering, but also wellness prevention and that sort of thing.

Mr. HACKBARTH. Yes. Some do, some don't. The private plans are quite variable in their structure, how they deal with providers, what sort of care coordination programs they have, and most importantly, they are quite variable in their bottom line results. Some are outstanding, some are not.

Mr. GINGREY. Yes. Let me go on to another question. I thank you for that response. One of the foundations of your testimony today is that the American health care system has serious quality problems. You—"At the same time that Americans are not receiving enough of the recommended care, the care they are receiving may not be appropriate." And then you go on to cite the Dartmouth Center for the Evaluative Clinical Services as proof of a wide variation in Medicare spending and rates of service used.

Just to be clear, when you say the American system, Mr. Hackbarth, are you referring to the American Medicare system, and not the entire American health care system? Am I correct in that assumption, given that the Dartmouth study used only Medicare data for its findings? We are talking about the American Medicare system and not the entire health care system?

Mr. HACKBARTH. Well, in fact, the Dartmouth study is done using Medicare data because it is the most readily available comprehensive database. I don't think there is any reason to believe that physicians are practicing different for Medicare patients and private patients, but my personal experience in working closely with physicians is that it is a matter of principle that they don't vary their care based on the insurance coverage of the patient. They treat the patient based on what the patient needs.

So I think it is a reasonable inference, if you see this variation of Medicare, likely you have the same variation——

Mr. GREEN. Well, I know my time is up, Madam Chairman, but I—the reason I ask you this question, Mr. Hackbarth, because we are going to have another panel, probably several more panels today, but I think there are going to be some physicians that are practicing in the private market that might want to dispute what you just said. But thank you so much for your response, and I yield back, Madam Chairman.

Mrs. CAPPS. Thank you. I now yield myself my time for questions, and I thank you both for your testimony today. Mr. Hackbarth, we are sort of picking on you, I think, but you can tell from the questions that Medicare payment reform seems to be a very pressing issue for many of us. And one of the Medicare payment reforms that we are suggesting in this legislation is a change to the Gypsy formula in California so that it is now based on MSAs, Metropolitan Statistical Area.

Two of the counties I represent in California are negatively impacted by the current payment formula. Physicians in both San Luis Obispo and Santa Barbara Counties are paid less, much less they would say, than the actual cost of practicing medicine. My question to you is in general, but also specifically toward California. Will the Gypsy provisions improve the accuracy of payments in the new fee schedule areas that you—across the country, as you have envisioned them?

Mr. HACKBARTH. Yes. The provision related to California in the bill is based on one of two options that MedPAC developed for CMS back in—I think it was 2007. So approach in the bill is consistent with the advice that we have given CMS.

Mrs. CAPPS. Excellent. And then maybe you could elaborate a little bit on the benefit, obviously, that you are seeing from having physician payment areas aligned with hospital payment areas, and is that, again, consistent around the nation, once we get our alignment correct in California?

Mr. HACKBARTH. Well, the issue that we focused on was specific to California. As you know, the Gypsies work differently in different states, and so our recommendation wasn't that this approach be applied everywhere, but we saw it as a reasonable solution to the California issues that you and other members have raised.

Mrs. CAPPS. Now, we have seen that other area of the country have this disparity as well, but you think those are best resolved on a regional basis?

Mr. HACKBARTH. Yes. Different states have elected to resolve it differently, and we think the problems are not national in scope, but more isolated, and more tailored approaches are the best way to go.

Mrs. CAPPS. And that would be a pattern that you might suggest in other areas as well, that we look at regional issues, particularly—at least in the payment schedules?

Mr. HACKBARTH. Yes. Well, you know, that is a big statement, and I——

Mrs. CAPPS. Well, I am just wanting to see how far you want to go——

Mr. HACKBARTH. Yes. I would like to take a look at—consider the issues one by one, as opposed to make that as a broad policy statement.

Mrs. CAPPS. Well, I know our—my California colleague said this has been a real serious detriment to Medicare, and the practice of Medicare in our state. In many of the regions that the cost of living has been——

Mr. HACKBARTH. Right.

Mrs. CAPPS. [continuing]. Very different from what the allotment has been, so this becomes, for us, a really vital component of Medicare reform——

Mr. HACKBARTH. Yes.

Mrs. CAPPS [continuing]. Under this bill.

Mr. HACKBARTH. Yes. And to say we think the approach in the bill is a reasonable one, and it is one of the options that we recommended to see in this.

Mrs. CAPPS. OK. I am going to yield back my time, and recognize Mr. Buyer for his questions.

Mr. BUYER. I see a company in Tampa just shut their doors to 500 jobs due to the S–CHIP bill. They are going to send the tobacco—those cigars to be made offshore. Just thought I would let everybody know who really cares, I guess.

This has been a challenge to get my arms around this in a short period of time, just to be very honest with you, so—I am trying to understand—I just went through that tobacco bill, where the majority froze the market, so they are—now they love this talk about competition, and they love to freeze the market in place, and I am getting a sense that that is what you are doing in this bill also, freezing the market. So those of whom had existing plans, you freeze it, grandfather it, and then you have got to figure out how you move people into the exchange, and if you—and when we freeze that market—so help me here with my logic, because I am trying to figure out what you are trying to do. We freeze that market, and you want to move a population into an exchange. You can—we will grandfather, so people can keep their existing coverage, but if, at some point in time, that employee chooses to move to a government plan, then the employer has to be an eight percent tax on it. Is that right?

Mr. HACKBARTH. Is that——

Mr. BUYER. Yes.

Mr. HACKBARTH [continuing]. Mr. Buyer?

Mr. BUYER. Congressman Buyer.

Mr. HACKBARTH. Buyer, I am sorry.

Mr. BUYER. OK.

Mr. HACKBARTH. Our focus is on the Medicare provisions of the bill, and the bill is not our bill. We—our advisory——

Mr. BUYER. OK. So you——

Mr. HACKBARTH [continuing]. Our body——

Mr. BUYER [continuing]. Can't answer that question?

Mr. HACKBARTH. Absolutely——

Mr. BUYER. Right

Mr. HACKBARTH [continuing]. Not. That is beyond our jurisdiction.

Mr. BUYER. No, that is oK. Well, let me ask a question, then, that is within your jurisdiction. You had—sir, you had suggested that encouraging the use of comparative effectiveness information would facilitate informed decisions by providers and patients about alternative services for diagnosing and treatment of most common clinical conditions, is that correct?

Mr. HACKBARTH. Um-hum.

Mr. BUYER. Uh-huh means yes?

Mr. HACKBARTH. Yes, sir.

Mr. BUYER. Thank you. Following your line of reasoning, could the Medicare program also use this research to exert fiscal pressure on drug and device makers, or even restrict certain procedures based solely on price?

Mr. HACKBARTH. What MedPAC has recommended is that the Federal government invest in comparative effectiveness research, make it available to physicians, patients, insurers, for them to make their own decisions about how to use the information.

Mr. BUYER. Then how best do we, i.e. Congress—how best do we make sure that this research is used to inform the consumer and providers without being an excuse to exclude or ration certain types of care? How do we best do that?

Mr. HACKBARTH. Well, decisions about how Medicare would use the information are issues on which Congress can legislate. What MedPAC has recommended is investment in information to be used in a de-centralized way by all of the participants in the system.

Mr. BUYER. All right. Mr. Levinson, the—one of the great concerns I have is—can you—would you be able to address a comparison or an analogy on Medicaid? I know you are Medicare—you guys are claiming lanes of jurisdiction here.

Mr. LEVINSON. Mr. Buyer, we actually—as an Office of Inspector General, we oversee all 300 programs of——

Mr. BUYER. OK.

Mr. LEVINSON [continuing]. Of the Department, so——

Mr. BUYER. All right.

Mr. LEVINSON [continuing]. We also have——

Mr. BUYER. Most of the——

Mr. LEVINSON [continuing]. Side of Medicaid.

Mr. BUYER. All right, thank you. So most of the fraud cases, with regard to Medicaid, are they discovered by the states or are they discovered by the Federal government?

Mr. LEVINSON. Medicaid cases can be developed along a very wide spectrum of possible sources.

Mr. BUYER. I understand, but are most cases discovered in the states or by the Federal government?

Mr. LEVINSON. I would have to find out those numbers for you. I suspect it would be mostly states in terms of absolute number. But in terms of dollars, because some of the biggest——

Mr. BUYER. All right. Don't do it by dollars, do it by cases.

Mr. LEVINSON. By the number of cases——

Mr. BUYER. I think common sense tells us—let me jump ahead.

Mr. LEVINSON. Given the Medicaid fraud——

Mr. BUYER. I think common sense is going to tell us that if states had a stake in the game, that they have an incentive, then, to make sure they go after fraud cases. If the Federal government

picks that up at 100 percent, my concern is are we disincentivizing states with this oversight responsibility, which places more on you, and is that a concern to you?

Mr. LEVINSON. It is a—certainly a very important concern that we make sure that every Medicaid dollar—and we, of course, have responsibility for the Federal share of that Medicaid—is accounted for as much as possible. And as the Federal share, as the FMAP goes north, goes up, obviously our reach needs to be greater, our concern needs to be elevated on the Medicaid side, absolutely.

Mr. PALLONE. Thank you. The gentleman from Iowa, Mr. Braley.

Mr. BRALEY. Thank you, Mr. Chairman.

Mr. Levinson, to follow up on that point, all of us on this Subcommittee are strongly opposed to fraud in any health care delivery system, so let us start with that premise. I think the real elephant in the room is that fraud is a small component of what the real obstacle is to meeting full health care reform, and that is waste. Because, according to many reliable projections, there are $700 billion annually of waste in Medicare delivery, which is a much greater problem. Because if you take that number and multiply it over the 10 year period of this health care bill we are talking about, you are talking about $7 trillion of cost savings that would more than pay for the entire cost of the program we are talking about. So isn't it waste that is really the problem here?

Mr. LEVINSON. Mr. Braley, we try to identify and correct issues of fraud, waste and abuse, and we do not have solid figures in which to share with you exactly how that pie may be divided specifically. But all of those kinds of issues are of great concern to the office, and we have work that supports recommendations on—in all of those areas.

Mr. BRALEY. And they should be of concern to American taxpayers also?

Mr. LEVINSON. Absolutely.

Mr. BRALEY. OK. Mr. Hackbarth, I really appreciate the effort that you and MedPAC have put into this. You mentioned the objectives of health care reform being high quality care and protecting taxpayers from undue financial burdens, and getting back to my point that I just made, under the current health care delivery system and reimbursement model, we are wasting billions of dollars every year, aren't we?

Mr. HACKBARTH. It is our belief that, yes, we can do better with less, and there is lots of research to support that.

Mr. BRALEY. Well—and one of the problems that my health care providers and I will have is that for years they consistently rank in the top five in every objective quality measurement, and at the very bottom of Medicare reimbursement. Isn't that a summary of what is wrong with our health care model today?

Mr. HACKBARTH. Well, my home state of Oregon is also——

Mr. BRALEY. Exactly.

Mr. HACKBARTH [continuing]. With you in Iowa, and—so that is a type of evidence that we can do better for less in Medicare. You know, I think it is good for Iowa, good for Oregon, that we have got low health care costs and high quality. Not only does it hold down Medicare expenditures, it is good for our beneficiaries. It holds down their out of pocket expenses, the Medigap premiums.

So I don't want to increase Iowa and Oregon to be more like some of the high cost states.

Mr. BRALEY. Exactly.

Mr. HACKBARTH. I want to bring the high cost states down to Iowa and Oregon.

Mr. BRALEY. And isn't that the problem? Because under Medicare's proposed pay for performance system, the modeling is based upon improvement in efficiency. So if you are a state like Oregon and Iowa, who is already delivering efficient, low cost, high quality health care, you get no incentive from a model of reimbursement that is based only on improvement, isn't that true?

Mr. HACKBARTH. Well, as we move to new payment systems, move away from our siloed fee for service system to bundle payment systems or ACOs, one of the critical decisions that is going to have to be addressed is how to set those initial rates for these new types——

Mr. BRALEY. Right.

Mr. HACKBARTH [continuing]. Of payment systems. And in that is an opportunity to address some of these regional inequity issues that have come up in the program.

Mr. BRALEY. But if you are going to base a public health insurance option on a Medicare model that already has built-in inefficiencies and inequities in reimbursement, what reform hope does that give to this country?

Mr. HACKBARTH. Yes. We need to change the Medicare model. Independent of the public plan issue, for Medicare's own sake, for the taxpayers' sake, for the beneficiaries' sake, we have to change the Medicare model.

Mr. BRALEY. Well—and I am glad you mentioned that, because Congressman Ron Kind and I have introduced the Medicare Payment Improvement Act of 2009, H.R. 2844, that attempts to do just that by identifying clear, objective quality measurements that are highly recommended by a number of health care organizations that are looking to improve efficiencies and increase quality. It examines things like health outcomes and health status of the Medicare population, patient safety, patient satisfaction, hospital readmission rates, hospital emergency department utilization, hospital admissions for conditions, mortality related to health care, and other items determined by HHS.

Isn't it true that until we move to some transformational type of health care reimbursement we are ignoring the real cost opportunities to transform health care and provide expanded access to coverage?

Mr. HACKBARTH. Yes. We believe that we need to adjust payment to reflect the quality of care. That is one type of change. But we also believe that we need to move away from fragmented fee for service payment to paying for larger bundles, paying for populations of Medicare patients.

The big difference between Iowa and the high cost states is on the utilization of services. How many hospital days per 1,000, how many referrals to specialists and the like. Iowa tends to be low on those things, and the high cost states tend to be high on those things. If we move towards a payment system that advantages

places with lower utilization, like Iowa, that will begin to address these regional inequity issues that you are focused on.

Mr. BRALEY. Thank you.

Mr. PALLONE. Thank you, Mr. Braley. Mr. Shimkus?

Mr. SHIMKUS. Thank you, Mr. Chairman, and I appreciated the little comments we had before my questioning.

I am going to follow up on something I addressed last night, and—addressing just the basic FMAP formula, which has been a bone of contention for me for many years, because I believe it has been flawed, and does not accurately reflect a given state's need to meet its Medicaid obligations. So that is kind of where I am coming from.

The formula does not accurately reflect the difference between a state's fiscal earnings, low income citizens, or cost of delivery of service. This results in states like mine, and I think other states, if my colleagues would do some research, which—only having a match of around 50 percent. We know in the testimony yesterday we had New Jersey here, we had California. They are also 50 percent match states, and I have got the list here where every state falls. But it falls short of its needs, yet other states have matches as high as 75 percent.

Overall, the FMAP formula has resulted in the Federal government's financing remaining around 57 percent across the board, yet the discussion draft seeks to have states enroll childless adults ages 19 to 64, up to 137 of poverty line, and have the Federal government finance 100 percent of this new Medicaid population. That was part of the discussion we were having offline. Do you think it is fair that we continue to have these inequities among states when it comes to FMAP, given we aren't meeting the needs of many states, especially those with low matches?

Mr. LEVINSON. Mr. Shimkus, would you like me to respond to that——

Mr. SHIMKUS. Both.

Mr. LEVINSON [continuing]. Question?

Mr. SHIMKUS. It is a question to both.

Mr. LEVINSON. Because I would have to say that our office, not being a policy office, we don't actually establish the FMAP rates. We certainly audit those among our auditors, but we are not a program office. We oversee that. So I can't——

Mr. SHIMKUS. So as an auditing office, you wouldn't disagree with that analysis that I have given?

Mr. LEVINSON. Well, actually, the rate is higher now in some of the states as a result of the American——

Mr. SHIMKUS. Yes, and that is——

Mr. LEVINSON [continuing]. Recovery——

Mr. SHIMKUS. That is—yes, that is true, but there are still percentage inequities. So you have a 75 percent state that is now up to 83 percent. You have a 50 percent state that is up to maybe 60 percent, but, of course, there is no assumption—I mean, depending upon what we do on a bill, there is no assumption that those amounts remain, because the stimulus bill was a short term bill, and there is no certainty that that input of money will remain.

Mr. LEVINSON. Mr. Shimkus, we work with the numbers that we are given, as opposed to——

Mr. SHIMKUS. OK. That is——

Mr. LEVINSON [continuing]. The numbers ourselves.

Mr. SHIMKUS. Mr. Hackbarth?

Mr. HACKBARTH. Mr. Shimkus, we focus exclusively on Medicare issues, not Medicaid. That is our jurisdiction under the statute.

Mr. SHIMKUS. OK. Let me just—then let me go with a few other questions, just to put it—you know, our frustration with this process of rushing through and having a draft is we have got to ask these questions when we have—and I want to get these out. Would it be appropriate, in the context of health reform, to address the inequity of FMAP by recalculating the FMAP to accurately reflect needs, or, at the very least, level the playing field for every state? Mr. Levinson, do you want to——

Mr. LEVINSON. Mr. Shimkus, that is really beyond my charter.

Mr. SHIMKUS. Good. OK. Mr. Hackbarth, same answer?

Mr. HACKBARTH. Yes.

Mr. SHIMKUS. OK. So what I am trying to establish is this. Illinois is a 50/50 match state, which means that for every dollar spent on Medicaid, we will write a check to the state for 50 cents, OK? There are states out there that for every dollar they spend on Medicaid, the Federal government sends them 75 cents. If we are doing health care reform, and the premise of this bill is when we add people to Medicaid, 100 percent of that will be spent, but it still does not affect the basic fundamental inequity of the FMAP. So what states have to do is they have to game the system. They have to go to HHS, they have to find past additional tax incentives to get additional rebates. We have the tax increase on beds in hospitals that we passed, so they pass a tax. They remit the tax back to the Federal government, the Federal government gives the tax back to them, plus some additional revenue.

So I would encourage folks to look—my colleagues to look at their FMAP percentage. And if we are going to move on streamlining health care and reimbursement that—even as we increase the amount for the new Medicaid people we bring on, we really bring some clarity and equality across the state lines and FMAP.

And Mr. Chairman, thank you for letting me go 13 seconds over, and I yield back my time.

Mr. PALLONE. Thank you. The gentlewoman from Florida, Ms. Castor.

Ms. CASTOR. Thank you, Mr. Chairman. Good morning. Mr. Hackbarth, you state in your testimony that the payment system for Medicare Advantage plans needs reform. Medicare Advantage—the Medicare Advantage program continues to be more costly than traditional Medicare health services. The Medicare Advantage government payments per enrollee are projected to be 114 percent of comparable fee for service spending in 2009. It is up from 2008. The high Medicare Advantage payments provide a signal to plans that the Medicare program is willing to pay more for the same services in Medicare Advantage than it does in traditional Medicare and fee for service.

Our discussion draft tackles the overpayment issue, but what would happen if we did not do this?

Mr. HACKBARTH. Well, let me begin by saying that MedPAC very much supports giving Medicare beneficiaries the option to enroll in

private plans, so we are enthusiastic about that. Our objections are to the current payment system, which, as you say, pays significantly more on average for private plans that it would cost traditional Medicare to pay for the same patients. If we were to lower the rate, one of the effects of that would be to send a marked signal to private plans about what we want to buy as a Medicare program, and we reward plans that take steps to be more efficient, more effective in the care that they provide.

So long as we continue to pay more, the signal that we are sending is mimicking Medicare, traditional Medicare, just at a higher cost, is OK with us. And so long as we send that signal, we will get more of that. We have got to change the signal to get the market response that we desire.

Ms. CASTOR. And ultimately help us control costs across the board?

Mr. HACKBARTH. Absolutely. Even control costs for the beneficiaries as well——

Ms. CASTOR. Um-hum.

Mr. HACKBARTH [continuing]. ecause all beneficiaries, even those who aren't enrolled in private plans, are paying part of the additional costs for Medicare Advantage.

Ms. CASTOR. And I am afraid these overpayments have created incentives for extensive unethical behavior by insurance companies. Three-fourths of the states report marketing abuses in Medicare, and I have some firsthand experience with this, talking to seniors at retirement centers in my hometown, where insurance salesmen have come in, targeted seniors with dementia, who have—were on traditional Medicare and signed them up for Medical Advantage, sometimes under the guise of coming in and selling their Medicare Part D policies, and then switching them out.

And what happens is that senior, who has a longtime relationship with their doctor, oftentimes they lose access to that doctor they had under traditional Medicare because their Medicare Advantage plan doesn't have the same doctor. There have been cases that—where cash incentives have been provided to insurance salesmen, and this shouldn't be—we shouldn't have these incentives for fraudulent behavior. They—I think it has gotten out of hand, and unfortunately, CMS has all but abdicated its oversight role.

The Congress, some years ago, took the states' ability away, their ability to regulate and oversee these terrible marketing abuses. Now, our discussion draft, it makes some very subtle change in—with enhanced penalties for Medicare Advantage and Part D marketing violations, but don't you think we need to go back to having as robust a strike force as we possibly can so—and give the states the ability—you know, they are closer to the ground—the ability they had before to tackle the marketing abuses? The National Associations on Insurance Commissioner supports such a move.

Without it—unless we do this, we will continue to have this huge regulatory gap, but what is your view?

Mr. LEVINSON. Ms. Castor, we certainly work with the states to—as much as possible to protect the Medicare and the Medicaid programs. We have a very good collaborative relationship with our state auditors and state and local law enforcement. There are jurisdictional divides, and we try to respect those. But to the extent

that we can actually understand schemes that are broader than just one particular matter, that really allows us to do our work more effectively because the fact of the matter is, although we are one of the larger Inspector General offices in government, given the size of our programs, we are very stretched. We only have a few hundred criminal investigators to handle, you know, billions and billions of dollars stretched across the country in a variety of health care contexts.

But I certainly would underscore the importance of being able to work very much hand in glove with our state and local partners.

Mr. PALLONE. Thank you. Gentleman from Pennsylvania, Mr. Murphy.

Mr. MURPHY of Pennsylvania. Thank you, Mr. Chairman. I thank the panelists for being here.

Some questions about Medicare. It was founded in 1965. In the ensuing years, has there ever been a time when any president or any Congress has really gone back and overhauled the program, and—this program being established back inpre-CT scan and MRI days. Has there ever been a comprehensive overhaul of the system to modernize it, reform it, make it work more effectively?

Mr. HACKBARTH. Well, the payment systems have changed. Medicare began with payment systems——

Mr. MURPHY of Pennsylvania. Right.

Mr. HACKBARTH [continuing]. Were based on cost reimbursement.

Mr. MURPHY of Pennsylvania. And in terms of how it—because today you are talking about a number of interesting reforms, and has that ever been attempted before?

Mr. HACKBARTH. Well, the payment systems have been reformed. They have changed substantially over the life of the program.

Mr. MURPHY of Pennsylvania. But I mean——

Mr. HACKBARTH. We think more changes are warranted.

Mr. MURPHY of Pennsylvania. You are talking about the delivery—like, care coordination and preventing re-admissions and things like that. That has never been attempted, right? I mean, in terms of overall reforms in the system.

Mr. HACKBARTH. In terms—there has not been payment reforms focused on re-admissions, no.

Mr. MURPHY of Pennsylvania. OK. I am assuming you are talking about more than just payment reforms today, because your report has a lot more than just how the money gets spent. OK. And in that—I mean, I noted in the 110th Congress there was 452 bills put in by Members of Congress to make some reforms to Medicare and Medicaid, I think 12 passed, and some 13,000 co-sponsors of these bills came through members of Congress. So I look upon this—and Members of Congress themselves recognize there needs to be some changes in Medicare and Medicaid, but it seems to come slow.

I am wondering in this process, where—some of the changes you recommend here—and I applaud them, because they are things I have been asking for for a long time too. Care coordination, I mean, we will pay to amputate the legs of a diabetic, won't pay to have some nurse call them with these cases. We will—we recognize one in five chronic illnesses gets re-admitted to the hospital, but we

haven't been working at keeping them out. Those are major changes to make here.

Mr. HACKBARTH. Yes.

Mr. MURPHY of Pennsylvania. My concern is the speed at which the Federal government moves to make changes, number one, and two, does the Federal government have to run its own insurance plan, given its track record of not being very good at coming up with timely changes? Can we come up with some of these changes with the Federal government pushing for and mandating some of these changes in the private market——

Mr. HACKBARTH. Yes.

Mr. MURPHY of Pennsylvania [continuing]. And in the meantime Medicare pushing some within itself? Is that possible to do that?

Mr. HACKBARTH. Well, I think we need to do some of each. The potential for Medicare Advantage is to invite private plans to enroll Medicare beneficiaries, do things differently to get better results for both the beneficiaries and the program. Because of the way Medicare Advantage works, the way the prices are set, it has not fulfilled that potential. It has allowed private plans to enroll Medicare beneficiaries, essentially mimic traditional Medicare, with all the same problems. So one of the reasons we believe Medicare Advantage reform is so important is to reward private plans that do it better.

Mr. MURPHY of Pennsylvania. OK. So that is—so, in other words, you know, they can just continue on with business as usual, but Medicare Advantage, they should really be using these things for what it was designed to be, and that is really work at prevention, really working at care coordination, am I correct on that?

There was something else mentioned, or you—a point that was made earlier, encouraging use of comparative effectiveness information, public reporting, provider quality, et cetera. This also relates to the issue of evidence based medicine and evidence based treatments that many people referred to. Throughout medicine, there are many branches that have their own standards and protocols, College of Surgeons, American Academy of Pediatrics. Would those be things that Congress or the FDA or HHS could look towards in terms of what these standards might be, in terms of what is the best practices and what would be the standards and protocols to use?

Mr. HACKBARTH. Well, specialties are quite variable in how they develop those standards, those protocols. It is difficult to generalize about them. Let me focus on the area of imaging as one example. We had as a witness before the MedPAC the president of College of Cardiology to talk about imaging issues, and one of the things that she called for was more information so they can move from just consensus based guidelines to evidence based guidelines.

The potential in comparative effectiveness research is that we give physicians and societies the raw material to do a better job at what they want to do.

Mr. MURPHY of Pennsylvania. So—and this is a critically important point, and one that we should not rush, because it is going to have long term implications. So the College of Cardiologists or Radiologists or whatever that is, we have to make sure it isn't just they have all sat down and voted that—best thing, but there really

needs to be a demand, and this is where a valuable role of government—the HHS or FDA to have oversight to say, we want to see evidence based medicine here. Is that what you are suggesting?

Mr. HACKBARTH. That is the goal. We need information for physicians, as well as patients, to guide that.

Mr. MURPHY of Pennsylvania. I mean, this is a critical thing, Mr. Chairman, and one I hope we continue dialogue on because it is going to be a factor that I think makes or breaks the budget, is how we go through there, and I think also deal with the issue of who is making the decisions, and I think a valuable place where this Committee can have tremendous oversight in working with medicine, and with that, I yield back. Thank you, sir.

Mr. PALLONE. Thank you, Mr. Murphy. Gentlewoman from Wisconsin, Ms. Baldwin.

Ms. BALDWIN. Thank you, Mr. Chairman.

Mr. Hackbarth, welcome back to the Subcommittee. I recall when you were here in March we had quite a dialogue about—as we have today, about the difference between pilot projects and demonstration projects, and you expressed then, as you have here today, some hesitation about the administrative and regulatory burdens associated with demonstration projects, and how that affects the ability to scale those up, if they have proven successful.

This draft health care reform legislation offers new pilot projects in accountable care organizations and medical home models, and I am wondering if it is your sense that these pilots will provide us, the Congress, and MedPAC with sufficient evidence to make broader payment reforms. And also, if you have examined these provisions in the draft, if you have any recommendations for further improvement.

Mr. HACKBARTH. Well, on the issue of pilots, we welcome the fact that the Committee is looking at pilots, and what MedPAC has advocated, and we have talked about this before, is that Congress give the Secretary discretion to test a new payment method and to implement it, if the pilot is successful, establish goals in advance, and then give the Secretary discretion, plus the resources necessary.

And an important part of this, I think, is a much larger budget for the Department to not just test ideas that come through the Congress, but to generate new ideas independently in the Department. Right now the demonstration budget is way too small for that.

Ms. BALDWIN. In your—in MedPAC's most recent reports, there is an interest sidebar concerning the physician group practice demonstration, which serves, really, as a foundation for the accountable care organization pilot in the draft bill that we are looking at. You noted that a surprising number of the sites for the physician group practice demonstration project had high cost growth, and it is linked to the risk profiles of the patients at those sites. And it strikes me that basically there is an inference that these demonstration sites may be picking up more of their patients' medical issues, resulting in more treatments, and increasing costs. What lessons do you suggest that we take from this demonstration?

Mr. HACKBARTH. Well, in setting payment rates for new payments systems like ACO, the details are very important, and how

the targets are set, how the potential gains are shared between the providers in the Medicare program, and how you adjust for things like risk, the risk profile of the patients. And so there are important steps that have to be taken from endorsement of a broad concept, like ACOs, to making it an operational effective idea. And this is part of why we think the Secretary needs some flexibility and discretion and design in the resources, to be able to do that quickly and effectively.

On an idea like ACOs, we are unlikely to get it exactly right the first time, so there needs to be ongoing cycles of refinement and improvement. That requires discretion and resources.

Ms. BALDWIN. And we can certainly relate to the difficulty to create a national program to rein in Medicare spending. And on the ACOs, the idea is to set spending targets to hold the providers accountable to the targets. If you tied spending targets to national averages, I guess I would like to ask how are we going to attain or incent participation in higher cost areas, and do you have any ideas of how we would address that challenge?

Mr. HACKBARTH. Yes. Well, this goes back to the dialogue that I had with Mr. Braley. One of the very important details in these new payment systems, like ACOs, is how you set those targets. If you take a group that has a very low historic level of utilization, they have been very efficient, very high quality, and say, oK, we are going to set your target at your historic level of costs, it is going to be more difficult for them to beat that and earn rewards than for a practice that is in a very high cost state and performing very poorly. That is not an equitable way to get to where we want to go, so setting the target rate so that your reward historic performance, as well as future performance is, for me, a goal in the target setting.

Now, in order to do that, you are going to have to squeeze someplace else. You are going to have to squeeze those high cost places to offset the cost. So the—again, the details in this are very important, and the Secretary needs to be given the latitude to strike that balance.

Mr. PALLONE. Thank you. Mr. Pitts is next.

Mr. PITTS. Thank you, Mr. Chairman.

Mr. Levinson, in your testimony, you mentioned Medicaid specific services that—there are services unique to Medicaid that could lead to significant savings, and one example you cite is school based health services. You say that OIG "consistently found that school had not adequately supported their Medicaid claims for school based health services, and identified almost a billion dollars in improper Medicaid payments." Can you go into this further?

Mr. LEVINSON. Mr. Pitts, we do make audit recommendations to the Centers for Medicare and Medicaid Services based on our audit findings, as our auditors look at programs that are supported by the program, and that is an area that the OIG has identified over the last few years as one that CMS needs to focus on more clearly to make sure that those dollars are really spent appropriately.

Mr. PITTS. Well, what were some examples of these improper payments? What was Medicaid paying for?

Mr. LEVINSON. Well, overall, they were paying for those kinds of services that are not included in the program, but I would need to provide more detail to you as a follow up to our hearing.

Mr. PITTS. Now, the Bush administration proposed regulations which would stop these fraudulent services and stop wasting taxpayer dollars. However, the present Administration has put a moratorium on these regulations. Do you believe that this moratorium should be lifted?

Mr. LEVINSON. We do not comment on what the Executive Branch decides to do with those kinds of regulations or not. We certainly, you know, advance what we believe would be appropriate ways of being able to account for the Medicare dollars better, and our recommendations are given in the first instance, in these kinds of cases, to the Centers for Medicare and Medicaid Services.

Mr. PITTS. Do you have any idea how much money in total might have been wasted in this way?

Mr. LEVINSON. Our audit findings will indicate the dollars that we believe are not appropriately spent under the Medicare program, and I don't have that dollar figure immediately at my fingertips. We will certainly provide as much detail as we can, based on the audit findings we already have.

Mr. PITTS. All right. In your testimony, you mention the creation of the Health Care Fraud Prevention and Enforcement Action Team. Can you give me some examples of what cases this team is currently addressing?

Mr. LEVINSON. Well, the most recent example would be the case that was publicized yesterday in Detroit, a Medicare infusion drug fraud case that has resulted in 53 indictments. There have been 40 arrests so far. 40 of our agents have been involved in what is claimed as $50 million in false claims.

This is a strike team in which we are working with the FBI and local law enforcement to clean up a significant Medicare infusion drug problem that now infects the city of Detroit. Some of these issues have actually migrated from South Florida, so the strike force effort is to try to provide both national and regional focus on those kinds of frauds that not only tend to plague particular cities in the country, but that also have regional impact. We already have strike forces in operation in a number of cities, but the effort now will be to extend that to more cities over the course of the next year.

Mr. PITTS. Mr. Chairman, I don't know——

Mr. PALLONE. You want the time? You have a minute left.

Mr. PITTS. One minute left?

Mr. PALLONE. I am sorry——

Mr. PITTS. How do you get the provider ID—the criminals get the provider ID numbers?

Mr. LEVINSON. Well, obviously through a variety of fraudulent means, but it is too easy at this point in our system to get provider numbers, and that has been a constant theme of our office over the years, that enrollment standards have not been sufficiently rigorous to ensure that we are not allowing, in effect, criminals to masquerade as health care providers.

Mr. PITTS. Um-hum.

Mr. LEVINSON. And that has been a significant problem not just in Detroit and Miami, but really throughout the country. And one of the key principles we have in terms of our anti-fraud fighting effort is to make more rigorous who actually gets in the program, because historically there has been too much a right to access, as opposed to the privilege of actually being enrolled in the program.

Mr. PITTS. Mr. Buyer wants to follow up.

Mr. BUYER. I guess—to be responsive here. How are they—are they relying on insiders within the system to get these ID numbers, or you don't want to tell us so that others will know how to—I mean, we can always—you can tell us offline.

Mr. PALLONE. Mr. Buyer—let him answer the question, but the time is expired. I have to apologize. The electronics have gone off again, so I am going to just have to tell everybody when their 5 minutes is up. But go ahead and answer your question.

Mr. LEVINSON. Thank you. I think it probably would be better to have an offline conversation, because the schemes are varied, and some of them are rather sophisticated, and it is probably better not to discuss in any detail what actually occurs in a public hearing.

Mr. PITTS. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. Next is Ms. Eshoo, and I will just tell you when the 5 minutes are up.

Ms. ESHOO. Thank you, Mr. Chairman. Gentlemen, thank you for your testimony today, and to the Chairman for this series of hearings with many panels this week.

As we look to reshape America's health care system, we have very clear goals that we have set down. We want it to be universal, it needs to be affordable. We think that choice is important. We believe that many of the rules that—need to be rewritten that the insurers, the private insurers, employ, amongst them knocking people out because they have pre-existing conditions and gender based issues, et cetera. So that is on the—kind of on the one side of the ledger.

The other side of the ledger, in my view, are two major issues. One, that we be able to achieve this without raising taxes, and number two—maybe I should have said number one. Number one, that we reform Medicare and strengthen it. We have read the report of the trustees. We know that they shaved off two years, and that we have got until 2017. 2017, believe it or not, is not that—it sounds like it is another century away. It is a handful of years away. So my question to both of you is what are the large ticket items that you can name today for us that will strengthen Medicare?

Now, Mr. Levinson, I recall a hearing here many years ago on waste, fraud and abuse and what—essentially the private sector ripping off the public sector, and you have touched on that today. In fact, we had testimony from someone whose case had been adjudicated, and he was on his way to prison, and he came here and explained how he had ripped Medicare off. And it was, essentially, the private sector ripping off the public sector. So what are the price tags that you can tell us about in these efforts that will save us money, save Medicare money, and overall strengthen Medicare as we come through this large effort, this overall effort, to reform our nation's health care system? Because I believe if we don't re-

form and strengthen Medicare that we will not have accomplished what needs to be accomplished.

Mr. HACKBARTH. I am going to go first. I would name four things. One is that we need to continue to apply pressure under the existing payment systems of Medicare.

Ms. ESHOO. Can you speak a little louder, please? Can you speak just a little louder?

Mr. HACKBARTH. We need to continue to apply pressure to the update factors in the existing payments systems.

Ms. ESHOO. And what is that going to—what do you think that is going to save us?

Mr. HACKBARTH. Well, you know, it depends on exactly what the levels are, but it is, you know——

Ms. ESHOO. Has MedPAC done that work?

Mr. HACKBARTH. Well, the CBO does the estimates of the budget impact of different recommendations.

Ms. ESHOO. Do you have any idea what that might be?

Mr. HACKBARTH. You know, we are—again, it depends on the specific level, but tens of billions or more over a 10 year horizon. A second area that I had mentioned is Medicare Advantage. There, as I think you know, the CBO estimate is higher than $150 billion over 10 years. A third area that I mentioned is re-admissions, excess re-admissions, and off the top of my head I don't know what the estimate is for that, but there was a proposed one. President Obama's budget on that—a fairly significant number. And the fourth area that I would emphasize is assuring primary care. Now, that doesn't lead to a direct savings, but I mention it here because if we allow things to go as they are right now, our primary care base is going to continue to erode away money.

Ms. ESHOO. You spoke to that earlier, so I appreciate that.

Mr. Levinson?

Mr. LEVINSON. Yes, Ms. Eshoo——

Ms. ESHOO. And thank you for your wonderful work as IG.

Mr. LEVINSON. Thank you very much.

Ms. ESHOO. We really can't function well and do oversight without the IGs, and I just think that you all should be canonized, so——

Mr. LEVINSON. Well, on behalf of——

Ms. ESHOO. Be interesting to have a Levinson canonized, right? I am pretty ecumenical, though, so——

Mr. LEVINSON. Well, it so happens that, of course, Dante was talking about fraud 700 years ago——

Ms. ESHOO. That is right.

Mr. LEVINSON [continuing]. So it is an issue that is both timely——

Ms. ESHOO. Right.

Mr. LEVINSON [continuing]. And has a long——

Ms. ESHOO. Um-hum.

Mr. LEVINSON [continuing]. And very troublesome pedigree. But on behalf of 1,600 very dedicated auditors and evaluators and investigators and lawyers——

Mr. PALLONE. Somebody want to tell her——

Mr. LEVINSON [continuing]. Thank you so much.

Mr. PALLONE [continuing]. Time has——

Ms. ESHOO. Um-hum.

Mr. PALLONE [continuing]. Expired?

Mr. LEVINSON. And just—as I look at some of the recommendations that are in our compendium of unimplemented recommendations, our auditors estimate that we could—the program could save $3.2 billion over 5 years if we just limited the rental time for oxygen equipment. I mean, I think that there are specific areas where there are significant savings that can be had.

As I look at just our most recent semi-annual report, in terms of monies returned to the Treasury, we are expecting, just in the first 6 months of the fiscal year, $275 million in audit receivables and $2.2 billion in investigative receivables. A lot of that has to do with pharmaceutical cases. Pharmaceutical pricing, of course, is a very significant area that can also, if properly addressed, can save significant dollars.

It would be hard to come up with total figures on a list of top ten, but certainly pharmaceuticals, DME, getting the dish payments right. We think that it is important to clarify exactly what Medicare should be paying, the Medicare and the Medicaid dish payments, and how the states handle those dollars. We need to avoid gaming the Federal dollar, so that it is clear, it is transparent about who is actually paying for what, and how the states account for the dollars that come from Washington.

I would hesitate to put a dollar savings on it, but I think that there is a great need for much more significant transparency and accountability in our programs, and that is a very helpful trend, from the standpoint of our office.

Ms. ESHOO. Do I have any time left, Mr. Chairman?

Mr. PALLONE. No. I am trying not to——

Ms. ESHOO. OK. Thank you very much.

Mr. PALLONE [continuing]. Interrupt now.

Ms. ESHOO. Thank you.

Mr. PALLONE. Sure. Next is the gentlewoman from Illinois, Ms. Schakowsky. I am going to just tell everybody when the 5 minutes are up, just so you know. Thanks.

Ms. SCHAKOWSKY. Mr. Levinson, one of the biggest single expenditures out of Medicaid is for long term nursing home care, and I have been working with Chairman Waxman and Chairman Stark on a nursing home quality and transparency legislation, which has been included in the draft bill. And I would like to know what you have found, in terms of problems with nursing homes, that would necessitate more transparency and oversight of them.

Mr. LEVINSON. Yes. Congresswoman, it has been difficult, actually, to find out who makes the decisions when we investigate substandard care in nursing homes and try to locate exactly who, financially, is in charge. So I think the effort to create greater transparency in terms of ownership, in terms of management, and get a clear understanding of actually who is in charge would help our investigators and lawyers significantly in being able to both investigate and resolve some of the very serious quality of care cases that have emerged in the nursing home area.

Ms. SCHAKOWSKY. We are going to hear some testimony a bit later that disparages the notion that there is any substantial fraud

or wasteful spending on the part of some doctors that participate in the Medicare program. Would you agree with that assessment?

Mr. LEVINSON. Well, I can only point to individual cases that we have actually worked on. We try not to generalize. Our investigators and auditors are very focused, very anchored on particular instances when it comes to either individual venues or a larger corporate structure, and we do have an existing, and unfortunately a growing, case load, work load.

Ms. SCHAKOWSKY. But let me ask this, though. Would you say that some may be fraudulent, some may be wasteful, but that in general the decisions about utilization are provider driven, as opposed to the kind of fraud of—or wasteful spending that is generated by individuals in the program?

Mr. LEVINSON. You know, I would hesitate, again, to make any kind of generalizations because these individual cases are very much focused on the facts as we find them. But there are certainly cases in which we have found that we are frustrated in our ability to actually understand who makes the decisions in the nursing home chain.

Ms. SCHAKOWSKY. Let me ask Mr. Hackbarth about the Medicare Advantage plans. It is great that, in the Medicare program, consumers can actually go online and find out what Medicare pays for health care services. To your knowledge, is there a place where consumers can actually access rates that Medicare Advantage plans pay providers, or other private insurers?

Mr. HACKBARTH. The actual payment rates for——

Ms. SCHAKOWSKY. Uh-huh.

Mr. HACKBARTH [continuing]. Providers? Not to my knowledge. I think most private plans consider that information proprietary business information.

Ms. SCHAKOWSKY. In your view, will Medicare Advantage plans remain in the market if we eliminate overpayments?

Mr. HACKBARTH. I believe that they will, many will. Some will leave the market because they have a model that can't compete with traditional Medicare. But, as I said earlier, we would be sending an important market signal about the type of plan we want to participate. We want plans that can help us improve the efficiency of the system, not plans that just add more cost to the system. And when you send that signal, I believe, in the market, I believe that we will get more plans that can compete effectively with traditional Medicare.

Ms. SCHAKOWSKY. What mechanisms will we need to ensure that Medicare Advantage plans and private insurers in the exchange meet a minimum loss requirement—a minimum loss ration requirement?

Mr. HACKBARTH. Yes. The minimum loss ratio, I think, is—it is a tricky issue. As you may know, I used to work for Harvard Community Health Plan, Harvard Pilgrim Health Care, two very well regarded HMOs, and this was a big issue for us sometimes with employers, how you calculate loss ratios. Our piece of the organization, the one I ran, is an integrated pre-paid group practice, and we have a lot of clinical programs that we believe improve patient care that sometimes employers wanted to characterize not as medical care, but as administrative cost, so the—and that works

against you, in terms of calculating the loss ratio. So the details of this can be pretty tricky, in my personal experience. I am always a little uneasy about just having simple rules on loss ratios. How you define those loss ratios is very important.

Ms. SCHAKOWSKY. Thank you.

Mr. PALLONE. The time is expired. I am sorry. Thank you, and next is the gentleman from Maryland, Mr. Sarbanes.

Mr. SARBANES. Thank you, Mr. Chairman. Thank you all. I have got a couple of quick questions at the outset.

Mr. Levinson, you talked about the—trying to step up efforts to curb some of the fraud, and particularly you talked about, in response to one question, the application process for new provider numbers, and having that vet properly. Have resources been an issue, in terms of the capacity of those people that do the processing and the review? Has resource, in terms of the number of folks that can do that, been an issue or not an issue?

Mr. LEVINSON. Well, that is an important question, Mr. Sarbanes, that, in the first instance, I think needs to be addressed and responded to by CMS, which is the agency that runs the program. And, as an office that looks to see where the vulnerabilities, where the weaknesses are in the administration of a program, we have identified for some years now that enrollment standards are too lax, especially in specific areas of vulnerability, like DME. And whether or not there are resource issues, we find too many of the wrong kinds of people are getting into the program, and, therefore, we have urged—we have recommended, over the course of the last few years, that enrollment standards be strengthened.

Mr. SARBANES. Well, I would imagine—I mean, I used to do some of that work, and I would imagine that the best way to vet it on the front end is with a little more intensity of resources applied. Actually going out and finding out who is behind these applications that are being filed.

Let me shift gears. I was really intrigued by the discussion on the school based health centers, and some of the findings of fraud. In that discussion, there was an allusion to the possibility that there were services being—that reimbursement was being sought for services that were not actually provided, but possibly there were other services being provided that might—that one might view as important services, they just aren't services that Medicare or Medicaid reimburses. And I wanted to ask the question of whether this phenomenon—and this is—in my view, the problem is whether you are talking about fee for service or you are talking about capitation, either one of those can work OK if you are paying for quality, as opposed to paying for quantity, and if you are paying for the right things, as opposed to not paying for the right things. But maybe both of you could comment on whether the potential for fraud is greater when you have a system that pays for quantity versus quality, or is paying for the wrong things.

And while I don't want to excuse fraud, if somebody is trying to find some payment for what they view as a very important service that is not covered under Medicare or Medicaid, that is a different kind of impulse than seeking to get paid for a service that is not being provided at all. And it seems to me the way the system is structured right now, and it is so distorted, that it leads to that

kind of thing, because people say, this service is valuable, but Medicare won't pay me for it. And if we can move in a direction where we are paying smarter for things that make a difference, we might actually make some progress on this fraud issue. So maybe you could each——

Mr. LEVINSON. Well, I do think the facts that you have laid out, Mr. Sarbanes, are important ones to focus on. The notion that there can be monies spent that are just not appropriately covered by the program, and in many instances we are really not talking about fraud in terms of the legal definition of fraud. We are talking about dollars that Congress—that the program says should be directed in a particular way, and our audit people, not our criminal investigators, find have not been spent appropriately, and then we make the appropriate findings and recommendations to CMS.

Not all of our recommendations are acted upon by CMS. There unquestionably are judgments. Perhaps some of the kinds of judgments you are talking about here and judgments that, programmatically, are made by CMS over the course of looking of our recommends, because—just by the fact that we make those recommendations doesn't necessarily mean that the dollars will actually be collected. And I do think that it is important to distinguish, you know, between those who have an intent to take advantage of the program and those who, unfortunately, are simply not paying appropriate attention to our rules. But, of course, given the precious resources, we take the rules as set by Congress and the Department seriously, and we report accordingly.

Mr. PALLONE. Now the time has expired. I am sorry. Next is Ms. DeGette.

Ms. DEGETTE. Thank you very much, Mr. Chairman, and thanks to this Committee.

I know you have discussed some of the issues in general that I want to talk about, I would like to hone in on them a little more. My first question is you talked about—actually, Mr. Hackbarth, the MedPAC has talked about changing the Medicare payment system incentives by basing a portion of provider payment on quality of care, and to do this, Congress could establish a quality incentive payment policy for physicians and other plans, Medicare Advantage plans, health care facilities. I am wondering if you have some specific recommendations you can make as to what kind of quality measures people would have to include to be—or to develop to be included in a quality incentive payment policy.

Mr. HACKBARTH. Well, let me focus on a few different areas of the program. For example, in the Medicare Advantage program, we have long advocated that a piece of the payment be adjusted to reflect the quality, and——

Ms. DEGETTE. How do you do that?

Mr. HACKBARTH. There are well established industry measures developed by NCQA that private employers use to assess health plans. We believe Medicare should be doing the same and adjusting payment accordingly. In the case of dialysis services, again, there is a pretty strong consensus about what the critical quality measures are. We have advocated that the dialysis payments be adjusted to reflect those outcomes for patients.

Likewise, in hospitals, we think there are some strong consensus measures. In fact, Medicare requires, as you know, specific measures be reported. We would like to see payment——

Ms. DEGETTE. Do you think that the current—and I do know that, because my heroine, Patty Gabow from Denver Health, is here on the next panel——

Mr. HACKBARTH. Um-hum.

Ms. DEGETTE [continuing]. But do you think that we could—do you think that the—that these quality measures that we have in place now are sufficient as we move forward with a comprehensive health care plan? Do we need some kind of additional mechanism? Do we need additional quality measures? What do we need——

Mr. HACKBARTH. Yes, I think the measures need to evolve over time. I think we have got starter sets, if you will, for a lot of providers, but we need to invest in developing in the long term.

Ms. DEGETTE. And who should do that?

Mr. HACKBARTH. Well, Congress has invested some money now in NQF, the National Quality Forum, which I think is a wise investment to build infrastructure for ongoing improvement and quality measures.

Ms. DEGETTE. And do you think some of these quality measures that you talk about for Medicare Advantage can also be used for physicians in other types of health care facilities, like hospitals and community health facilities?

Mr. HACKBARTH. Well, each provider group presents its own challenges and will require unique measures. I mentioned three areas, Medicare Advantage, ESRD and hospitals, but I think there is a pretty strong consensus on a starter set of measures. Other areas are more challenging. Physicians are more challenging just because of the nature of a medical practice. You often have small groups, or even solo physicians, so not a lot of numbers to do measurement.

Ms. DEGETTE. But you know what, though, people like Geisinger and Kaiser and others have been able to develop quality measures for doctors, that it would seem to me you could develop, and if you don't develop those for physicians, then it is hard to see how you can get the improvement in medical care at the same time that you get the cost containment in our system.

Mr. HACKBARTH. And I agree with that, that we do have initial measures—they are not comprehensive measures for physicians. They tend to be very focused process measures.

Ms. DEGETTE. Right.

Mr. HACKBARTH. I think we can do a better job in assessing physician performance as we move to bundle payment systems. Where we get groups of physicians working together, we can start to measure outcomes, not just——

Ms. DEGETTE. That was my next question. So to develop those measures, again, what kind of mechanism do you think—would it be the same one you talked about that Congress—there is a group of us——

Mr. HACKBARTH. Yes?

Ms. DEGETTE [continuing]. Senator Whitehouse and myself and others who are very concerned that if we don't develop quality measures throughout the system——

Mr. HACKBARTH. Yes.

Ms. DEGETTE [continuing]. That we are really not going to have——

Mr. HACKBARTH. Yes.

Ms. DEGETTE [continuing]. Improvements in patient outcomes.

Mr. HACKBARTH. So we need a process for forging consensus and establishing a set of measures.

Ms. DEGETTE. Right.

Mr. HACKBARTH. You don't want, you know, 12 different ones——

Ms. DEGETTE. Right.

Mr. HACKBARTH [continuing]. And everybody using different measures.

Ms. DEGETTE. Right.

Mr. HACKBARTH. That is a burden on providers.

Ms. DEGETTE. Right.

Mr. HACKBARTH. And NQF can be that process. It can grow into that process, where we have consensus. Then we also have to invest in the research about what works——

Ms. DEGETTE. What works.

Mr. HACKBARTH [continuing]. And that is where comparative effectiveness comes in. That can provide raw material for specialty societies and the like to develop guidelines on what constitutes good care, and that can also feed, ultimately, into the assessment process.

Ms. DEGETTE. Thank you. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. Gentleman from Texas, Mr. Gonzalez.

Mr. GONZALEZ. Thank you very much, Mr. Chairman. This will go to the Chairman.

There are two major components of what we are considering, and the experience gleaned from Medicare is going to be used either by the proponents or the opponents. Just—again, it will be the performance of Medicare in the eye of the beholder. One is the public option, the other is the health insurance exchange. So I am going to pose a couple of questions, and then just let you respond, and that way the—it will be the Chairman that will be advising you that my five minutes are over.

But first, I haven't met with a group of doctors in San Antonio yet that have agreed with the compensation adequacy. And what they are all saying is that you guys are basically working with stale data and information, that it is at least two years behind the times of what modern medicine, in its practice, entails. That is the first question, and I know that we have touched on it more or less, but that is going to be very important as we go out there with a broader plan that, again, has something that will mimic what we have been doing under Medicare. So that is the first complaint that we get.

My colleague, Ms. DeGette, also touched on something, and that was how do you establish proper protocols? What is acceptable—practices and standards? On the Small Business Committee, we had Governor Pawlenty who came up, and I asked him that, because my doctors asked the same thing. Different patient populations may dictate different practices and such.

Well, Governor Pawlenty told me, he says, we have got Mayo. They establish the standards, pretty much, and no one is going to argue with them. The question to you is how do we ever really

achieve nationwide standards that may address diverse populations and such? The last question is somewhat interesting, one, because it presents a real dilemma for me back home. Texas has probably the greatest number of specialty hospitals. The question really is how is modern medicine being delivered in this country, and—to keep up with that?

There are portions of this bill that would discourage, of course, specialty hospitals, yet we are looking at what we refer to as bundling, and that is more centralization, more coordination, medical home, all that that entails. But in essence, isn't that what specialty hospitals and many of these specialty practices provide? And that is, when a patient goes into those settings, that there are many different services that are being provided within that environment that otherwise would be separated out to different locales, offices and other doctors. And we even have different specialists that argue among themselves as to what extent they should be able to do that. And I would just like your views on those three points, and again, thank you for your service.

Mr. HACKBARTH. OK. That is a lot of ground to cover in just a minute or two. Starting with the stale data, I imagine what your physician constituents are referring to is Medicare claims data, which, in fact, is a couple years old by the time it is used in the policy process. That is a problem. That is an area where I think some wise investments in Medicare infrastructure would pay dividends. I am not sure, however, that the age of the data would alter any of the recommendations we are talking about for reforming the payment system.

With regard to standard setting, I do believe it is very important to have a process that is coherent and credible from the perspective of providers. I fear that sometimes we have embarrassment of riches. We have a lot of different people saying this is what constitutes quality of care. Some of it is well-founded in research, other pieces of it are not. If we want to send clear, consistent, signals to providers, not just from Medicare but from private insurers as well, we need to have a coherent standard setting process.

As I said a minute ago, Congress, I think, wisely has invested some money in NQF to start building that infrastructure.

On the last issue of specialty hospitals, roughly 2 years ago now MedPAC at Congress' request invested a lot of effort in analyzing specialty hospitals. Our basic findings were that when physician-owned specialty hospitals enter the market, costs tended to increase, not decrease. More procedures were done. The evidence on the quality of care was there was not definitive evidence one way or the other that it was better or worse. It seemed to be about the same.

At the time we did our analysis, our big concern, our immediate concern was that at least some physician-owned specialty hospitals were exploiting flaws in the Medicare payment system. They were focused on procedures where the Medicare rates were too high. We made recommendations which Congress adopted and CMS has now largely implemented to change payment rates so there aren't those gaping opportunities to exploit the system.

Mr. PALLONE. Thank you.

Mr. Matheson is next.

Mr. MATHESON. Thank you, Mr. Chairman.

I am sorry I was not able to be here for all your testimony but I do appreciate your coming before the committee today. A question I wanted to raise is, MedPAC has had the opportunity to make a lot of recommendations about how we can achieve greater efficiencies or greater value or good practices, and often when it comes to implementation, Congress has not necessarily followed through on that. Do you have suggestions if there would be a better structure to help assist in allowing these recommendations to be implemented in a more effective way?

Mr. HACKBARTH. Well, one of my themes this morning has been that I think the Secretary of Health and Human Services and CMS need both more discretion and more resources so they need the flexibility to refine change, payment systems, overtime to achieve goals established by the Congress. For every small change to have to come back through the legislative process is a very cumbersome process and it makes progress very slow and I am not sure that is a luxury we can afford at this point, so more discretion and more resources for the Department would be my first recommendation.

Mr. MATHESON. Do you have—in terms of making that recommendation, is there a specific proposal about what the resource needs might be or is that something that we can look to maybe get some information?

Mr. HACKBARTH. I would urge you to go to the Department for that information. They are the best judges of exactly what they need.

Mr. MATHESON. Do you feel like the way MedPAC is structured right now that you are adequately insulated from having Members of Congress come in and tell you here is what we think you really ought to be doing?

Mr. HACKBARTH. Well, we welcome our exchange with Members of Congress and the MedPAC staff works very closely with both the committee and personal staffs to understand Congressional perspective. I have never felt undue pressure from any Member of Congress.

Mr. MATHESON. Do you feel like you are adequately structured to be an independent entity? I guess that is what I am asking.

Mr. HACKBARTH. Yes.

Mr. MATHESON. OK. Thanks, Mr. Chairman. That will be it for me.

Mr. PALLONE. Thank you.

Mr. Barrow.

Mr. BARROW. Thank you, Mr. Chairman, and thank you gentlemen for being here today. I too along with Jim had several other meetings this morning so I apologize for being a little late but I am glad to have the chance to visit with you. Thank you for coming and offering your testimony.

You know, fixing what is broke with Medicare Part D is a large part of comprehensive health care reform and a lot of attention has been given to ways and means of trying to plug the donut hole, among other things. I want to focus on a problem with the Medicare Part D program that has bedeviled the people I represent. I hear about it at every one of my town hall meetings, and that is the excessive degree of discretion and variety in the formularies

that all of these various for-profit insurers are paid by the public essentially to assume a public risk and the incredible confusion. You know, there is such a thing as too much of a good thing. When there is too much variety and choice in the marketplace, you have a hard time finding what you need and you have to do a lot of hunting and trying to find the drug that you want and then with a potential for bait and switch that can exist and the formulary being changed on you. That just makes things so much worse.

My question to you is, and I guess Chairman Hackbarth, you are probably in the best position to answer this, is any thought being given, since this is a public financed plan, to get the for-profit insurance industry to compete with each other to make money trying to offer a benefits package to assume a public risk in providing this benefit? Any thought given to trying to make more—to have a centralized or more standardized formula that is comprehensive in its scope but provides all of the necessary flexibility and variety to allow doctors to opt out when there is a medical necessity that they know about, a generally good reason to do so, but to make it clear that when folks go into this very confusing marketplace with so many people competing for the customers' business that they know that they are comparing apples to apples, they know that the benefits package is substantially the same just as the entity that is paying for this is substantially the same, just as what you hope to get is substantially the same. Is any effort being made to do that?

Mr. HACKBARTH. Well, you are absolutely right, that the choices that Medicare beneficiaries face are complicated and choosing among plans because of, among other things, differences in formularies. I would add that it doesn't stop with the beneficiaries. You know, differences in formularies also have a significant impact on practicing physicians and how they deal with patients. What they prescribe needs to vary according to the plan that the patient is covered by, and that can be a real problem for physicians. There is a tradeoff here, though. The flexibility around formularies and the exact benefit structure, those are tools that private plans can use to try to offer a better value for Medicare beneficiaries. Those are the tools that they can use to reduce the cost of the plan, and so there is a tradeoff to be made.

Mr. BARROW. If you have a plan that is designed to the health profile of the patient, in theory you can get yourself into a much smaller risk pool and be shopping for something that is just tailored for you, but the point is, at least the quality of the insurance and it takes on the quality of being sort of a revolving loan program.

Mr. HACKBARTH. And some people have expressed concern in particular about specialty drugs, very high-cost drugs for patients with serious illnesses.

Mr. BARROW. Well, there is a medical necessity for that. The smaller the risk pool of folks buying into the program, the more expensive that is going to be when it is absolutely necessary to get it, so that sort of drives up the cost for those folks who need it when they need it I guess what I am getting at is, if you really have too much choice, you don't know what you are choosing and the other party on the other side of this deal can change the deal on you after you have signed up. We make this thing much more

complicated and much user friendly than it has to be, and I want to make sure we are not driving up the cost by having exotic stuff driving up the cost for the ordinary, everyday stuff but there is a profile, there is a comprehensive scope of conditions that we can treat effectively, cost-effectively with medication, and it seems to me the more we can eliminate the confusion in this, the more—and make it genuinely available and comprehensive in its scope, the better service we are providing all our customers. Because after all, we are paying these folks to assume this public risk and we ought to make sure that folks know what they are getting when they go into the marketplace. What is MedPAC doing about this? Are you all looking into this?

Mr. HACKBARTH. Well, on the specific issue of the complexity, we have looked at the choices that Medicare beneficiaries have to make in choosing among plans, and looked at the tools that beneficiaries have available to them. CMS does have some tools, as you know, to try to help beneficiaries compare plans and choices. We think here again this is another area where some investment could pay dividends in helping beneficiaries understand their choices. There is no way around, though, the ultimate tradeoff that you are going to face between complexity on the one hand and flexibility for plans to manage the costs on the other. There is no answer on how to strike that balance.

Mr. BARROW. I think doctors——

Mr. PALLONE. Your time is expired, but if you want to say something——

Mr. BARROW. I think doctors ought to be able to make those calls. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you.

Unless anyone else has questions, we are going to proceed to the next panel, so thank you very much. Your input is obviously very important as we proceed on this and we appreciate your being here this morning. Thank you.

I ask the next panel to come forward. Could we ask that everyone be seated and that everyone else clear the room, because we do have to get moving. We have three more panels. Those who are talking and socializing, please leave the room.

OK. Our second panel is on doctor, nurse, hospital and other provider views, and as you can see, it is a rather large panel so we want to get started, and let me—I don't think I have seen such a large panel. We will start on my left with Dr. Ted Epperly, who is president of the American Academy of Family Physicians, and then we have Dr. M. Todd Williamson, who is president of the Medical Association of Georgia, and then is Dr. Karl Ulrich, who is clinical president and CEO of the Marshfield Clinic, and Dr. Janet Wright, who is vice president of Science and Quality at the American College of Cardiology, Dr. Kathleen White, who is chair of the Congress on Nursing Practice and Economics at the American Nurses Association, Dr. Patricia Gabow, who is chief executive officer of the Denver Health and Hospital Authority for the National Association—well, she will be speaking for the National Association of Public Hospitals, Dan Hawkins, who is senior vice president of public policy of research for the National Association of Community Health Centers, and Bruce Roberts, who is executive vice president

and CEO of the National Community Pharmacists Association, Bruce Yarwood, president and CEO of the American Health Care Association, and Alissa Fox, who is senior vice president of the Office of Policy and Representation for the Blue Cross Blue Shield Association.

Now, before we begin, I just wanted to point something out that I believe has been shared with staff but I think needs to be repeated because of the panel. It would touch upon some of the things particularly with regard to community health centers. In several sections of the draft—well, I should say in several sections of that part of the draft that deals with the public health and workforce development, in that division, a sentence that was supposed to be an addition to current authorizations was instead drafted to take the place of them. So instead of "in addition" it says "to take the place of" in that decision, and this is an error. It was caught on Friday afternoon shortly after the draft was announced and we did notify both Democrat and Republican committee staff of the mistake and corrections have been sent to the Office of Legislative Counsel, but I did want to point that out before I started here today because I wasn't sure that all of you who are testifying were aware of that. The mistake is particularly glaring in the provision related to community health centers, and I think Mr. Hawkins knows this, but just let me point it out to everyone, that the draft is supposed to include an additional $12 billion over 5 years in new money and that is over and above the current appropriation. Again, that is why we have drafts, I guess.

But let us start. As you know, we ask you to keep your oral comments to 5 minutes and of course all of your written testimony will be included in the record, and we will start with Dr. Epperly.

STATEMENTS OF TED D. EPPERLY, M.D., PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS; M. TODD WILLIAMSON, M.D., PRESIDENT, MEDICAL ASSOCIATION OF GEORGIA; KARL J. ULRICH, M.D., CLINIC PRESIDENT AND CEO, MARSHFIELD CLINIC; JANET WRIGHT, M.D., VICE PRESIDENT, SCIENCE AND QUALITY, AMERICAN COLLEGE OF CARDIOLOGY; KATHLEEN M. WHITE, PH.D., CHAIR, CONGRESS ON NURSING PRACTICE AND ECONOMICS, AMERICAN NURSES ASSOCIATION; PATRICIA GABOW, M.D., CHIEF EXECUTIVE OFFICER, DENVER HEALTH AND HOSPITAL AUTHORITY, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS; DAN HAWKINS, SENIOR VICE PRESIDENT, PUBLIC POLICY AND RESEARCH, NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS; BRUCE T. ROBERTS, RPH, EXECUTIVE VICE PRESIDENT AND CEO, NATIONAL COMMUNITY PHARMACISTS ASSOCIATION; BRUCE YARWOOD, PRESIDENT AND CEO, AMERICAN HEALTH CARE ASSOCIATION; AND ALISSA FOX, SENIOR VICE PRESIDENT, OFFICE OF POLICY AND REPRESENTATION, BLUE CROSS BLUE SHIELD ASSOCIATION

STATEMENT OF TED D. EPPERLY

Dr. EPPERLY. Chairman Pallone, Ranking Member Deal and members of the Energy and Commerce Health Subcommittee, I am Ted Epperly, president of the American Academy of Family Physicians, which represents 94,600 members across the United States.

I am a practicing family physician from Boise, Idaho. I am delighted to say that your draft bill goes a long way towards providing quality, affordable health care coverage for everyone in the United States.

The AAFP has called for fundamental reform of our health care system for over 2 decades. We commend you for your leadership and commitment to find solutions to this complex national priority. We appreciate efforts to improve primary care through this draft bill. The Academy believes 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 and has the most effect on health care outcomes. Primary care is performed and managed by a personal physician leading a team, collaborating with other health professionals and using consultation or referral as needed.

Many studies demonstrate that primary care is high quality and cost-effective because it includes coordination and integration of health care services. The Academy believes the key to designing a new health care system is to emphasize the centrality of primary care by including the patient-centered medical home where every patient has a personal physician, emphasizing cognitive clinical decision making rather than procedures, and ensuring the adequacy of our primary care workforce and aligning incentives to embrace value over volume.

Many of these key provisions are contained in your draft legislation. Specifically, we applaud the committee for including a medical home pilot program in Medicare as a step towards a primary care system. Your definition of the patient-centered medical home is consistent with the one established by the AAFP and other primary care organizations. We also support the PCMH demonstration project in Medicaid. Use of the medical home will achieve savings and improve quality. We appreciate the inclusion of a bonus of 5 percent for primary care services and up to 10 percent for services provided in a health profession shortage area. We urge you to make this bonus permanent.

Medicare is a critical component of the U.S. health system and must be preserved and protected. With this draft, you take the first bold steps needed to remedy the Medicare physician payment system. The AAFP appreciates your recognition of the longstanding problems with the dysfunctional formula known as the sustainable growth rate, or SGR. We thank you for proposing that it be rebased. This is an important, necessary and welcome step.

We also appreciate the bill's attention to workforce issues. Numerous studies indicate that more Americans depend on family physicians than on any other medical specialty. We are deeply 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 majority of health care is provided in physicians' offices now and will be in the future. We must revitalize the programs to train the primary care physician workforce that will meet our needs in those locations.

We thank you for reauthorizing and providing a substantial investment in section 747 of the health professions primary care medicine training program. The National Health Care Workforce

Commission in the discussion draft is needed to recommend the appropriate numbers and distribution of physicians.

The AAFP is also pleased that the Medicaid title provides for a substantial expansion of coverage to the uninsured. In particular, we support increases to the Medicaid primary care payment so that it is equal to Medicare by 2012. The AAFP supports a public plan option consistent with the principles included in our written testimony. Patients should have a choice of health plans and a public plan should be one of them. However, the public plan should not be Medicare. We acknowledge that for transition purposes, there may be some similarities to the federal program but we urge Congress to delink the public plan from Medicare by a date certain.

The AAFP strongly supports the inclusion of comparative effectiveness research in the draft bill. We appreciate the establishment of a center within the Agency for Health Care Research and Quality. If we wish to improve the 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.

Finally, we support a number of insurance market changes that will help our patients in regards to the health insurance exchange where they can one-stop shop for a health care plan, a sliding-scale subsidy so that people can purchase meaningful coverage, guaranteed availability and renewability of coverage, prohibition of preexisting conditions exclusions and denials, and benefit packages that allow consumers to select the one that best meets their needs as well as a requirement for a core set of benefits.

In conclusion, the Academy believes that health care should be a shared responsibility and applauds the section of the bill that requires all individuals have coverage. Now is the time to provide affordable, high-quality health care coverage. 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, Mr. Chairman.

[The prepared statement of Dr. Epperly follows:]

AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Statement of the American Academy of Family Physicians

Before the Energy and Commerce Committee
U.S. House of Representatives

Regarding
Health Reform Legislation

Presented By
Ted Epperly, MD, FAAFP
President
American Academy of Family Physicians

June 25, 2009

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Chairman Waxman, Ranking Member Barton and members of the Energy and Commerce 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 Energy and Commerce, Ways and Means, 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 Physicians, 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 is 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 incentivize 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

irrelevant 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.

Medicaid
The AAFP is pleased that the Medicaid/CHIP title provides for a substantial expansion of coverage to the uninsured. In particular, we are supportive of the fact that the bill increases Medicaid primary care payment to be equal to Medicare by 2012. We also support the CMS-run Medicaid Medical Home Demonstration Program and payments for Graduate Medical Education, which would place Medicaid GME payments in statute for the first time.

We also are pleased that the legislation allows for expanded coverage of proven, evidence-based preventive services, such as services graded "A" and "B" by the US Preventive Services Task Force, vaccines recommended by the Centers for Disease Control and Prevention, smoking cessation medications and smoking cessation counseling for pregnant women.

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 and fraud and abuse.

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. PALLONE. Thank you, Dr. Epperly.
Dr. Williamson.

STATEMENT OF M. TODD WILLIAMSON

Dr. WILLIAMSON. Good morning, Chairman Pallone and Mr. Deal. My name is Todd Williamson, and I want to thank you for the opportunity to speak to you today. I am a neurologist from Atlanta and I serve as the president of the Medical Association of Georgia, and I am speaking on behalf of that association.

I recently had the privilege on speaking on behalf of a coalition of 20 State and specialty medical societies representing more than 100,000 physicians, which is nearly half of the practicing physicians in the United States. This coalition believes that ensuring the patient's right to privately contract with their physician is the single most important step we could take to reform our medical care system.

I would like to begin by addressing three assumptions that underpin the discussion draft. The first relates to geographic disparities in spending. Peter Orszag recently said that nearly 30 percent of Medicare's costs could be saved without negatively affecting health outcomes of spending in high- and medium-cost areas could be reduced to the level in low-cost areas. We do not agree. This flawed claim was first made by the Dartmouth Group, which used only Medicare data to analyze spending and quality. Please consider the work of Dr. Richard Cooper, which shows that an examination of total medical spending per capita reveals that quality and cost are indeed connected. He also demonstrates that Medicare payments are disproportionately higher in States with high poverty levels and low overall medical care spending. The suggestion that our medical care expenditures are greater than other countries is also misleading, countries that account for expenditures such as out-of-pocket payments and the cost of long-term care in different ways. Some countries drive down costs by rationing care. The cost of research and development distorts our expenditures as well.

A third faulty assumption is that medical care outcomes in the United States are worse than in other countries. America's oftencited infant mortality statistics cannot be directly compared to statistics from other countries that do not record the deaths of low birth weight newborns that we try to save. Comparisons of a host of specific diseases such as diabetes clearly show our outcomes are superior.

We cannot support and would actively oppose the discussion draft. As I noted, we believe that allowing patients and physicians to privately contract is the single most important step we can take towards reforming the Nation's medical care system. This will empower patients to choose their physician, spend their own money on medical care and make their own medical decisions. Medical expenditures can only be appropriately controlled and allocated where there is complete transparency and acknowledgement of necessity and value at the time of the patient-physician interaction. Private contracting will enhance access to medical care. Many physicians opt out of government plans because payments do not cover costs. If private contracting was allowed, every patient would have access to every doctor. This option is currently not available under

government plans and is prohibited in the discussion draft. Critics cite that private contracting will disadvantage impoverished patients. I would argue that they will benefit from increased access and competition in the medical community and their physicians will be at liberty to waive copays, which is currently forbidden in government plans.

We applaud the draft sponsors for planning to rebase the SGR payment system but we remain concerned that they continue to rely on a target-based approach. We support the emphasis on prevention, wellness and claims transparency. We agree that primary care should receive greater support and administrative burdens should be reduced. We do not believe that the federal government should replace current research and development mechanisms or the training and judgment of physicians with federally controlled comparative effectiveness research.

While we recognize the need for reform, we believe that the private marketplace should remain the primary means of obtaining insurance. A government-sponsored health insurance program for working-age adults will invariably eliminate private options. Recall that Medicare was originally introduced as an option for seniors but today it has essentially become their only choice.

We can reduce obstacles to individual ownership and control of mental illness by adopting new tax policies. This would eliminate the phenomenon of preexisting conditions because individuals could carry their insurance with them for life independent of their occupation or employer. To those who assert that the private sector has failed our patients, I say that our patients have been disadvantaged in the marketplace by a tax system that penalizes individual ownership of health insurance. When all Americans own their policies, insurance companies will be forced to compete for the business of millions of individuals and they will focus on satisfying the patient, not the patient's employer. Finally, we can significantly reduce health care expenditures and improve access by enacting proven, effective medical liability reform measures.

I appreciate this opportunity to present the views of practicing physicians to you today. Thank you.

[The prepared statement of Dr. Williamson follows:]

Statement

M. Todd Williamson, M.D.

President, Medical Association of Georgia

Committee on Energy & Commerce

Re: Health Care Reform Discussion Draft

June 25, 2009

Good morning, Mr. Chairman and members of the committee. My name is Todd Williamson, and I want to thank you for the opportunity to speak to you today on reforming the nation's health care system and preserving the private practice of medicine. This is an issue that is vitally important to the medical profession, our patients, and our country.

I'm a board certified neurologist. I treat patients on a daily basis in Lawrenceville, Georgia, which is northeast of Atlanta. I also have the privilege of serving as the president of the Medical Association of Georgia, which is the leading voice for physicians in the state. And I have had the great privilege of speaking on behalf of a coalition of twenty state and specialty medical societies[1] that represents more than 100,000 physicians. This coalition was responsible for elevating a physician's right to privately contact with his or her patients to the top of the American Medical Association's advocacy agenda. We believe it is the single most important action we can take to reform the medical care system in this country. I'll come back to that in just a few moments, but I want to begin my testimony by addressing some of the assumptions that serve as the basis for the discussion draft.

[1] Medical Association of the State of Alabama, Arkansas Medical Society, Medical Society of Delaware, Medical Society of the District of Columbia, Florida Medical Association, Medical Association of Georgia, Guam Medical Society, Kansas Medical Society, Louisiana State Medical Society, Medical Society of New Jersey, North Carolina Medical Society, Oklahoma State Medical Association, South Carolina Medical Association, Tennessee Medical Association, Texas Medical Association, Medical Society of Virginia, West Virginia State Medical Association, The Triological Society, American Academy of Facial Plastic and Reconstructive Surgery, American Academy of Neurology.

Peter Orzag, the Director of the Office of Management and Budget, recently said that, "Nearly 30 percent 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." We disagree with the stance that we can simultaneously reduce health care expenditures and improve the quality of care by eliminating the so-called "unexplained" geographic disparities. The claim that there is no relationship between how much we spend on health care services and the quality of our care is flawed and emanate from a single source: the Dartmouth Atlas and Health Policy Group. The Dartmouth group is known for its "30 Percent Solution" theory.

The Dartmouth group uses Medicare data on spending and quality to postulate that there is no difference between high and low spending areas in terms of quality of care or outcome. This is the same data and thought process used by Atul Gawande in his New Yorker article, *The Cost Conundrum.* They are convinced that there are too many doctors ordering too many tests. A member of the Dartmouth group went so far as to say in *The Atlantic* magazine that, "if we sent 30 percent of the doctors in this country to Africa, we might raise the level of health on both continents."

The comments are offensive but, more importantly, the theory is simply wrong.

I would urge members of this committee to look at the work of Dr. Richard Cooper, who is a Professor of Medicine at the University of Pennsylvania's Wharton School. Dr. Cooper has raised some serious questions about the methodology and assumptions that the Dartmouth group used to come to its conclusions.

First, he points out that Dartmouth's conclusions are based solely on Medicare data, which represents just a fraction of the health care expenditures. That means Dartmouth's data is incomplete. In an article that was published in the journal *Health Affairs*, (attached) Dr. Cooper demonstrated the weakness in the conclusion. The article abstract read that, "Based on broad measures of health system quality and performance, states with more total health spending per capita have better quality care. Quality results from

the total funds available and not from Medicare or any other single set of payer data. Moreover, Medicare payments are disproportionately high in states that have a large social burden (due to poverty and associated factors) and low overall health care spending." [emphasis added]

Second, Dr. Cooper says a cursory examination of the data reveals that the communities that were studied differed in significant ways. He says that factors like poverty – and associated factors like education, inadequate family and social support – are far stronger data points for predicting health care spending and outcomes than Medicare data.

The vast majority of physicians have dedicated their lives to treating disease and easing pain and suffering. Yes, "greedy doctors" do exist – but they are few. They don't reflect my profession, and they certainly don't exist in the kinds of numbers that would be needed to validate the Dartmouth theory.

If the 30 percent theory is wrong, then not only will we fall short of realizing the large savings attributed to the discussion draft, but the new regulatory and administrative burdens that are embedded in the discussion draft will raise costs and divert funds away from what is really needed – patient care.

The suggestion that health care expenditures in the U.S. are greater than other countries is also false and misleading. Different countries account for medical spending – including out-of-pocket payments and the costs of long term care – in different ways. Some countries do not count the cost of nursing home care as a health care expenditure. And countries can most certainly drive down costs if they deny or ration patient care based on age. The percentage of patients receiving kidney dialysis in the U.S. is nine times higher than for age-matched patients in Great Britain. This age disparity is caused by rationing in the U.K. which does not cover dialysis for people over age 65. Additionally, the cost associated with researching and developing the world's medications, medical devices and procedures distort our costs in the U.S. And, because we are more affluent, Americans are more likely to pursue elective treatments for significant, but non-life threatening

conditions like migraine headaches. It's imperative that we compare apples to apples when we examine health care expenditures on a global basis.

Another faulty assumption that we believe has been used as the basis for the discussion draft is the notion that health care outcomes are worse in the U.S. than in other countries. The physicians I know believe that the medical care we provide in the United States is the best in the world. Let the global community choose where they would prefer to receive their medical care, and people from around the world would line up at our borders.

Just like expenditures, we need to make the apples-to-apples comparison on outcomes. Infant mortality statistics in this country are skewed because other countries do not record the deaths of the low birth-weight newborns that we try to save in the U.S. Infant mortality is affected in significant ways by cultural and social factors, as well as individual behavior that has no direct relationship to the practice of medicine or whether patients have insurance. The death rates among children in Louisiana are the highest in the nation, and infant mortality rates in that state are the second highest in the U.S. But just 55 percent of children in Louisiana actually make it to the doctor's office for their recommended "Well-Child" visits despite the fact that 95 percent of children have insurance, mostly Medicaid. I have attached to my testimony a paper published by John Goodman of the National Center For Policy Analysis which addresses these international comparisons in more detail. The bottom line is that outcome for many types of cancer, heart disease, diabetes, and high blood pressure is clearly better in the U.S. than in the rest of the world.

As I noted in my introductory comments, we believe that allowing patients and physicians to enter into private contractual agreements is the single most important step we can take to reform the nation's medical care system.

Doing so will empower the patient to spend their own health care dollars and make their own health care decisions – regardless of third party payers like Medicare – as they see

fit, without constraint. Patients should be able to choose their physician, and they should be able to make decisions about their health care in concert with their physician.

Private contracting will promote transparency, accountability, and cost control at the individual level. Patients who are more directly involved in their health care will be better able to detect and prevent fraud and abuse. Medical expenditures can only be appropriately controlled and allocated when there is complete transparency and acknowledgement of necessity and value at the time of the patient-physician interaction.

Private contracting also will enhance access to medical care. Many physicians opt out of government health care plans because the payment systems do not cover the cost of providing care. If patients in these programs were given the opportunity to privately contract with the doctor of their choice, every patient would have access to every doctor. These patients and their physicians could then decide what care they need, and they could negotiate the fees for that care on an individual basis. The patient's unique health care insurance circumstances would serve as the baseline for that negotiation. This means the doctor could charge his or her full fee, a reduced fee, or no fee at all based on individual circumstances – an option currently not available under current government systems and prohibited in the discussion draft. As a bottom line, private contracting will preserve the kind of patient-physician relationship that has served as the foundation for the best medical care in the world. Moreover, restoring the right of patients and physicians to privately contract will help us attain the fiscal results our country desperately needs.

There are some elements of the discussion draft that we support. We appreciate the fact that the draft deals with the flawed and "unsustainable" Sustainable Growth Rate in a meaningful way. Rebasing the SGR is a necessary step in the right direction. That said, I would be remiss if I did not note that we remain concerned that the discussion draft includes language that would have us rely on a target-based system.

We support the emphasis on prevention and wellness as well as the timely payment of claims, transparency in the claims payment process, and administrative simplifications

such as a uniform claims form. We agree that the practice of primary care should be made more feasible, and we appreciate the provisions that facilitate the utilization of all available residency training slots.

However, we cannot support – and would actively oppose – the discussion draft. As I have noted, it is fundamentally flawed and based on faulty assumptions. We believe that it unleashes the heavy hand of the government to influence how we as physicians will treat our patients. We do not believe that the federal government, which serves as the single largest payer for medical care should replace the current methods for research and development or substitute the training and judgment of physicians, with federally controlled comparative effectiveness research. This simply is not in the best interest of our patients. We cannot achieve excellence in care by following government "quality" standards. Efficiency studies can seldom be applied directly to a given patient without considering that patient's unique circumstances. We're not talking about widgets here; we're talking about individual patients and individual circumstances. These circumstances require that physicians practice the art of medicine with the full knowledge of the science of medicine.

It's also worth noting that the discussion draft contains some new administrative reporting requirements and "gotcha" provisions that will drive the best and the brightest students into other professions. The administrative hassle factor associated with medicine has gotten to that point. The 2008 survey of 12,000 physicians by the Physician's Foundation revealed that 94% of doctors say the time they devote to non-clinical paperwork has increased in the last three years and 63% said that the same paperwork has caused them to spend less time per patient. A staggering 60% of doctors would not recommend medicine as a career to young people. [Executive Summary Attached]

I recently overheard a newly-trained physician express her frustration when she told a friend "As soon as I finish repaying my school loans, I will be getting out of medicine." My thoughts went to all of the patients she could help if she stayed in medicine, and how badly we need physicians in so many areas of our nation.

We believe that there is a clear need to change the way we finance medical care in this country. However, we believe that the private marketplace should remain the primary means of insurance for all non-disabled, working-age adults, and we believe that seniors should have more choices than those currently offered under Medicare. We have serious concerns that a government-sponsored health insurance program for working-age adults will invariably eliminate some or all private options. Remember that Medicare was originally introduced as an "option" for seniors, but today it has essentially become their only choice.

We oppose the bundling of physician payments. We believe this will drive a large wedge between patients and physicians much the same way as have capitated payments. In his recent address to the AMA, President Obama promoted a formal "team" approach to medical care – such as "accountable care organizations." Physicians have always embraced the value of working as a team when providing care. This is what medical and surgical residents are taught in hospitals. But physicians in private practice communities across the nation also work as part of a team, albeit in a variety of models. We strongly disagree that the basing payment on participation in a "team" created by the government is the appropriate model for payment and delivery systems.

As an early adopter, I see the incredible potential for electronic health records. But I also offer a word of caution when it comes to managing our expectations for EHR cost savings. We must also continue to take steps to safeguard patient privacy.

In terms of solutions, and as I have noted, we believe that the single most important step we can take to reform the medical care system is giving patients and physicians the right to enter into private contractual agreements.

We can also eliminate the obstacles to health care insurance for all Americans by changing the tax code. We can accomplish this by adopting a tax equity policy for the

purchase of insurance, by using pooling mechanisms for increased purchasing power, and by placing a greater emphasis on tax deductions and tax credits.

We must transform the health insurance model into one that's owned and controlled by patients. Most Americans receive their health care coverage through a third party, which means their health care decisions are influenced by their employer or the government. People should be able to purchase the health insurance product that best fits their individual needs. Doing so drives the accountability and flexibility needed to ensure that we maintain the quality of our care, while lowering costs. This approach would also eliminate the phenomenon of "pre-existing conditions" because individuals could carry their insurance with them for life, independent of their occupation or employer.

Finally, we can significantly reduce health care expenditures by enacting proven, effective medical liability reform measures that will eliminate the need for so-called "defensive medicine." Georgia serves as a great model. We passed significant tort reform in Georgia in 2005; claims are down by nearly 40 percent, professional liability insurance costs for physicians are down by 18 percent, and we're seeing fewer frivolous lawsuits. We've also seen professional liability insurance carriers come back into the state. The result? Increased access to affordable, quality health care.

I appreciate this opportunity to present the views of practicing physicians to you today. I'd be pleased to answer any questions.

States With More Health Care Spending Have Better-Quality Health Care: Lessons About Medicare

Health care spending is an important contributor to quality, but the determinants of quality reach more deeply into a community's sociodemographic fabric.

by Richard A. Cooper

ABSTRACT: Based on broad measures of health system quality and performance, states with more total health spending per capita have better-quality care. This fact contrasts with a previous finding that states with higher Medicare spending per enrollee have poorer-quality care. However, quality results from the total funds available and not from Medicare or any single payer. Moreover, Medicare payments are disproportionately high in states that have a disproportionately large social burden and low health care spending overall. These and other vagaries of Medicare spending pose critical challenges to research that depends on Medicare spending to define regional variation in health care. [*Health Affairs* 28, no. 1 (2009): w103–w115 (published online 4 December 2008; 10.1377/hlthaff.28.1.w103)]

HEALTH CARE SPENDING CONTINUES TO GROW at a pace that exceeds the overall rate of economic expansion. This creates an ever-stronger imperative to understand the dynamics of its growth and the value of this spending. An important source of information that bears on this problem is the extensive base of Medicare administrative data maintained by the Centers for Medicare and Medicaid Services (CMS).[1] Drawing on this source, researchers associated with the *Dartmouth Atlas* project have found much variation in Medicare spending per enrollee across regions of the country and have concluded that higher spending is not associated with better-quality health care.[2] Indeed, at the state level, more Medicare spending per enrollee is associated with poorer health care quality.[3]

The notion that quality is poorer in the face of more health care spending is extremely important. But is it correct? Answering this question requires answering

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three. First, does Medicare spending provide a valid assessment of health care spending overall? Second, are commonly used "quality" standards valid measures of the value of health care spending? And third, is regional variation in Medicare spending a valid tool for assessing the dynamics of the health care system?

The answer to the first question is "no." Medicare spending per enrollee correlates poorly with total health care spending per capita.[4] Although "quality," as measured by broad indices, correlates negatively with Medicare spending, this paper shows that quality is better in states with higher total per capita health care spending. Medicare cannot be used as a proxy for health care spending overall.

The answer to the second question is also "no." Although more health care spending correlates with better quality, causality between health care spending and quality should not be inferred, since, as described below, both spending and quality also correlate with a host of other parameters that reflect the sociodemographic context in which health care resides.

And finally, is regional variation in Medicare spending a valid metric of health system performance? The answer, again, is "no," which calls into question the vast array of studies that depend on cross-sectional analyses of Medicare spending to assess regional variation in health care.

Study Data And Methods

Estimates of health care spending for 2000 and 2004 were obtained from the CMS, and data on spending for 2000 were also obtained from Katherine Baicker.[5] The latter had been adjusted for age, sex, race, and cost of living. Population estimates were from the Census Bureau, and estimates of per capita income were from the Bureau of Economic Analysis.[6] Data at the state level concerning race and ethnicity, economic status, mortality rates, poverty rates, insurance status, K–12 education spending, prison incarceration rates, and related sociodemographic characteristics were obtained from the Commonwealth Fund, the Henry J. Kaiser Family Foundation, the Census Bureau, and other public sources.[7] Relationships were analyzed by means of linear regressions and expressed as Pearson correlation coefficients.[8] All correlations that were not significant at the 0.05 level are so indicated. In general, correlations above 0.30 were significant at the 0.01 level, and correlations between 0.25 and 0.30 were significant at the 0.05 level.

Quality was expressed as state rankings of health system performance, as developed by Stephen Jencks and colleagues and used in the previous study by Baicker and Amitabh Chandra, and as developed by the Commonwealth Fund for its recent State Scorecard.[9] The Jencks quality rankings for 1998 and 2000, which correlated closely with each other ($r = 0.91$), were averaged. Most items in the Jencks scale relate to screening and prevention or to processes of care (for example, appropriate use of discharge medications), and only one-third relate directly to medical care for conditions such as heart disease, stroke, or pneumonia. Similarly, most items in the Commonwealth Fund's scale, which was constructed from data

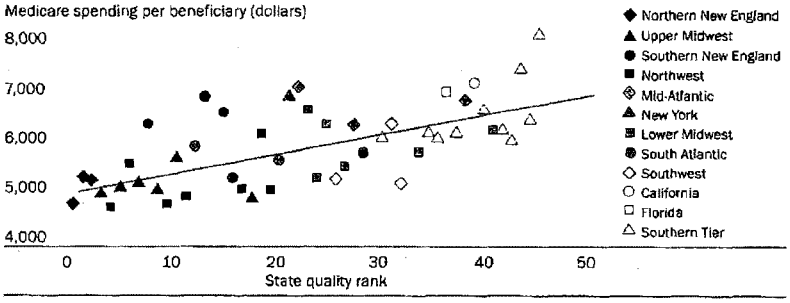
gathered in 2006, relate to screening, prevention, access, referral, satisfaction, equity, and custodial care, and only a few, such as postoperative care and the treatment of acute myocardial infarction (AMI), congestive heart failure (CHF), and pneumonia, relate directly to the goals of most health care expenditures. The similarity of the Jencks and Commonwealth scales is evident by the strong correlation between the state quality rankings obtained with each ($r = 0.85$). Both ranking systems assign higher numbers to states with poor quality. Therefore, positive correlations between spending and quality would indicate that more spending is associated with lesser quality.

For descriptive purposes, states were grouped as follows: Northern New England (ME, NH, VT); Southern New England (MA, CT, RI); Mid-Atlantic (NJ, PA, MD); Upper Midwest (WI, MN, IA, ND, SD, NE); Northwest (WA, OR, UT, ID, MT, WY, CO); Lower Midwest (KS, MO, IN, IL, MI, OH); South Atlantic (DE, VA, NC, SC); Southern Tier (WV, TN, KY, GA, AL, AR, MS, LA, OK, TX); and Southwest (AZ, NV, NM).Because of their size and prominence, California, Florida, and New York are shown individually. The District of Columbia, Alaska, and Hawaii were excluded.

Study Results

■ **Quality and Medicare spending.** Using the Jencks quality scale and adjusted Medicare spending data from 2000, we observed a strong correlation between Medicare spending per enrollee and state quality rankings ($r = 0.65$; Exhibit 1), with poorer quality associated with higher spending, as previously reported.[10] Similar correlations between spending and quality, as measured by the Jencks scale, were

EXHIBIT 1
Quality And Medicare Spending Per Beneficiary, By Census Region, 2000



SOURCES: Medicare spending data from 2000, adjusted for age, sex, race, and cost of living, were obtained from Katherine Baicker and were previously published: K. Baicker and A. Chandra, "Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care," *Health Affairs* 23 (2004): w184–w197. Quality rankings are the averages from S.F. Jencks et al., "Quality of Medical Care Delivered to Medicare Beneficiaries," *Journal of the American Medical Association* 284, no. 13 (2000): 1670–1676; and S.F. Jencks, E.D. Huff, and T. Cuerdon, "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289, no. 3 (2003): 305–312.
NOTES: Correlation coefficient = 0.65. Lower numbers on the quality rank indicate better quality.

observed with unadjusted Medicare spending data from both 2000 and 2004, and significant correlations between more Medicare spending and poorer state quality rankings were also obtained using the Commonwealth quality scale (Exhibit 2). Thus, over a period of years and with two different (although overlapping) quality scales, there was a consistent association between more Medicare spending per enrollee and poorer state quality rankings.

■ **Quality and total health care spending.** A very different picture emerges when state quality rankings are compared with total health care spending per capita. Using unadjusted spending data from 2004, we observed strong correlations between total per capita spending and better quality, with either the Jencks or the Commonwealth scales (Exhibit 2). Note that because better quality is associated with a lower numerical ranking, the signs of these correlations are negative. Correlations were even stronger when Medicare spending and enrollees were excluded and spending per capita for the non-Medicare portion of the population was compared with quality, using the Jencks ($r = -0.47$) or Commonwealth ($r = -0.62$) scales (Exhibits 2 and 3). Thus, while more Medicare spending is associated with poorer health care quality at the state level, more non-Medicare spending and more total

EXHIBIT 2
Health Care Spending Correlations

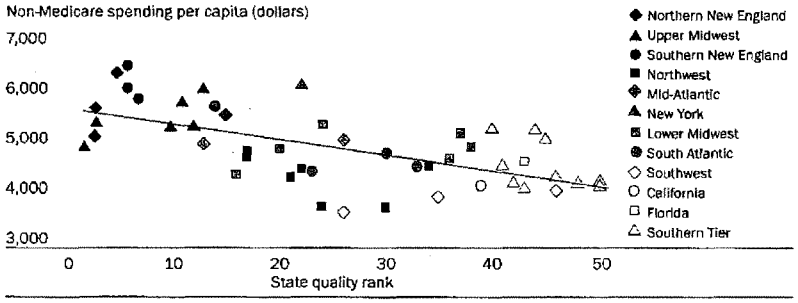
	Medicare 2000 (adjusted)	Medicare 2000 (unadjusted)	Medicare 2004 (unadjusted)	Non-Medicare 2004 (unadjusted)	Total 2004 (unadjusted)	Ratio 2004
Jencks quality rank	0.65	0.53	0.44	−0.47	−0.34	0.69
Commonwealth quality rank	0.41	0.28	0.25	−0.62	−0.51	0.64
Percent black plus Latino	0.59	0.59	0.52	−0.46	−0.34	0.76
Percent non-Hispanic white	−0.56	−0.53	−0.45	0.44	0.34	−0.69
Percent poverty	0.26[a]	0.10[a]	0.03[a]	−0.41	−0.37	0.35
Percent DSH	0.42	0.46	0.40	−0.17[a]	−0.04[a]	0.45
Percent employer-sponsored health insurance	−0.25[a]	0.01[a]	0.09[a]	0.39	0.38	−0.27
Medicaid spending per enrollee	0.00[a]	0.12[a]	0.10[a]	0.73	0.70	−0.49
Percent uninsured	0.38	0.22[a]	0.30	−0.62	−0.56	0.60
Percent of adults with usual source of care	−0.05[a]	0.13[a]	0.13[a]	0.55	0.56	−0.36
Infant mortality rate	0.32	0.25	0.29	−0.27	−0.17[a]	0.39
Preventable mortality rate, white	0.46	0.38	0.37	−0.25	−0.14[a]	0.46
Preventable mortality rate, black	0.52	0.34	0.36	−0.22	−0.13[a]	0.45
K–12 spending per pupil	0.21	0.38	0.22	0.68	0.66	−0.37
Prison incarceration rate	0.57	0.53	0.45	−0.30	−0.20[a]	0.60

SOURCES: See Notes 5, 6, and 7 in text.

NOTES: Correlations are expressed as Pearson coefficients. DSH is disproportionate-share hospital.

[a]Not significant at alpha = 0.05.

EXHIBIT 3
Quality And Non-Medicare Spending Per Capita, By Census Region, 2004



SOURCES: Health spending data for 2004 were obtained from Centers for Medicare and Medicaid Services, "Health Expenditures by State of Provider, 1991–2004," September 2007, http://www.cms.hhs.gov/NationalHealthExpendData/05_NationalHealthAccountsStateHealthAccounts.asp (accessed 8 October 2008). Quality rankings were obtained from Commonwealth Commission on a High Performance Health System, *Aiming Higher—Results from a State Scorecard on Health System Performance* (New York: Commonwealth Fund, 2007).
NOTES: Correlation coefficient = 0.62. Lower numbers on the quality rank indicate better quality.

spending are associated with better quality.

The fact that Medicare and non-Medicare spending behave differently with respect to quality is reflected most simply in the associated fact that although both sources of reimbursement vary among states by approximately 30 percent, the relationship between the two channels of payment was not significant ($r = 0.19$), as noted previously.[11]

This pattern of divergence extends to other health-related parameters. For example, preventable mortality among both blacks and whites is greater in states with higher Medicare spending and less in states with higher non-Medicare spending (Exhibit 2). Infant mortality follows the same pattern. More adults in states with higher non-Medicare spending report having a usual source of care ($r = 0.55$), while there is no association between Medicare spending and the existence of a usual source of care. Correspondingly, the frequency with which Medicare patients obtain timely mammography correlates positively with non-Medicare spending ($r = 0.44$) and negatively with Medicare spending ($r = -0.37$).[12]

■ **Regional relationships.** These differences in Medicare and non-Medicare spending and their relation to quality are not randomly distributed geographically. Rather, they follow distinct regional patterns (Exhibits 1 and 3). Quality is best in New England, the Upper Midwest, and the Northwest, and it is poorest in the Southern Tier states, extending from Georgia and Florida across to Texas and Oklahoma, and in California.

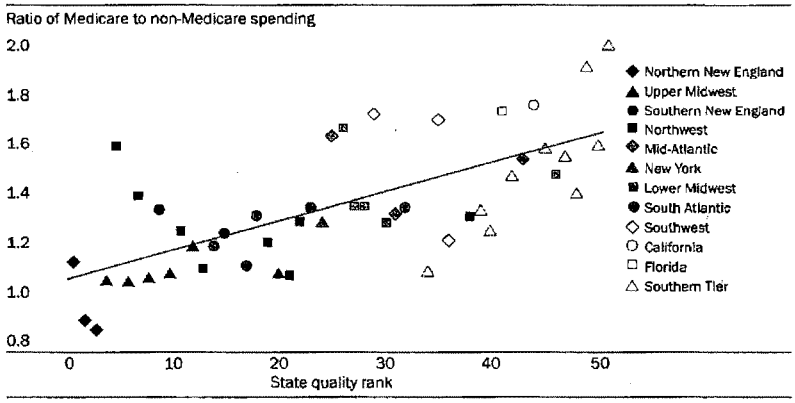
Medicare spending is lowest in Northern New England and the Upper Midwest, where quality is high, and these states have among the highest non-Medicare spending. Conversely, Medicare spending are highest in the Southern

Tier states and in California, where quality is poor, and these states have among the lowest rates of non-Medicare spending. Also, Southern New England and New York, where quality is average to high, have high spending through both Medicare and non-Medicare channels, whereas the Northwest, with similar quality, has lower spending through both channels.

The contrast between Medicare and non-Medicare spending in relation to quality was most pronounced when the data were expressed as a correlation between quality and the ratio of Medicare to non-Medicare spending (Exhibits 2 and 4). Ratios closest to 1.0 tend to be associated with the best quality, and they were found in Northern New England and the Upper Midwest (Exhibit 4). Conversely, ratios closest to 2.0, representing disproportionate Medicare spending, were found principally in the South, and they were associated with the poorest quality. The overall polarity displayed in Exhibit 3 starkly separates regions of the country in terms of spending patterns and quality.

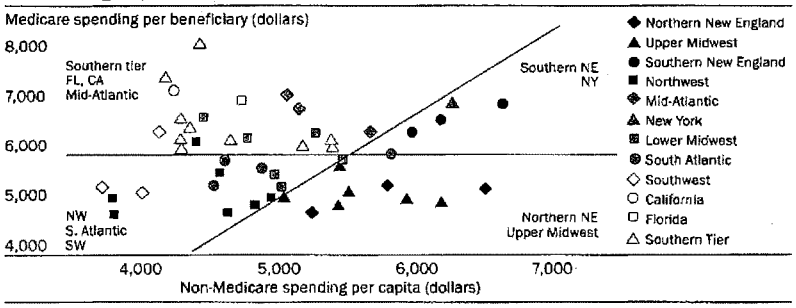
■ **Medicare versus non-Medicare spending.** Exhibit 5 independently displays Medicare and non-Medicare spending in the various states. Four general patterns were observed: low/low—states that had both low Medicare and low non-Medicare spending were principally in the Northwest, Southwest, and South Atlantic regions. High/high—states with high levels of spending through both channels included New York and Southern New England. Low Medicare/high non-Medicare—like Southern New England, Northern New England had high levels of non-Medicare

EXHIBIT 4
Quality And Ratio Of Medicare To Non-Medicare Spending, By Census Region, 2004



SOURCES: Health spending data for 2004 were obtained from Centers for Medicare and Medicaid Services, "Health Expenditures by State of Provider, 1991–2004," September 2007, http://www.cms.hhs.gov/NationalHealthExpendData/05_NationalHealthAccountsStateHealthAccounts.asp (accessed 8 October 2008). State quality rankings were obtained from Commonwealth Commission on a High Performance Health System, *Aiming Higher—Results from a State Scorecard on Health System Performance* (New York: Commonwealth Fund, 2007).
NOTES: Correlation coefficient = 0.89. Lower numbers on the quality rank indicate better quality.

EXHIBIT 5
Medicare Spending Per Beneficiary And Non-Medicare Spending Per Capita, By Census Region, 2004



SOURCES: Health spending data for 2004 were obtained from Centers for Medicare and Medicaid Services, "Health Expenditures by State of Provider, 1991–2004," September 2007, http://www.cms.hhs.gov/NationalHealthExpendData/05_NationalHealthAccountsStateHealthAccounts.asp (accessed 8 October 2008).

spending, but Medicare spending was low, and this pattern was also found in the Upper Midwest. High Medicare/low non-Medicare—a pattern of higher Medicare spending in association with lower non-Medicare spending was found in states within the Southern Tier, including Florida; in California; and in the populous Mid-Atlantic states.

Thus, high Medicare spending tends to follow a band extending from the California across the Southern Tier and up the East Coast through New York into Southern New England, a pattern that is evident both at the state level and at the level of Hospital Referral Regions (HRRs).[13] However, because Medicare and non-Medicare spending vary independently, some states with high levels of Medicare spending have low levels of non-Medicare spending, whereas others have high levels of both. Examples of the former include Texas, Louisiana, Florida, and Mississippi, while examples of the latter include Massachusetts, Connecticut, and New York. Aggregating and averaging individuals from these high-Medicare-spending states, some with high total spending and other with low total spending, as has been done in studies reported by the Dartmouth group, creates unintelligible units of observation.[14]

■ **Sociodemographic correlates.** Insight into the causes of this divergence between Medicare and non-Medicare spending is provided by various sociodemographic correlates. States with higher non-Medicare spending tended to have lower percentages of blacks and Latinos and higher percentages of non-Hispanic whites; lower percentages of individuals below the poverty level and higher percentages of workers in professional and technical jobs; and lower percentages of uninsured people and higher percentages covered by employment-sponsored health insurance (Exhibit 2). Conversely, states with higher Medicare spending per enrollee tended to have larger percentages of individuals who are black and Latino and smaller per-

centages who are non-Hispanic white; higher percentages of uninsured people; and, correspondingly, higher percentages of Medicare reimbursement based on disproportionate-share hospital (DSH) funding. Assessing relationships such as these in terms of the ratio of Medicare to non-Medicare spending yielded even stronger correlations (Exhibit 2). Examples include the positive correlations between the Medicare to non-Medicare ratio and the states' percentages of blacks and Latinos ($r = 0.76$) and uninsured people ($r = 0.60$).

Additional insight into community differences that correspond to Medicare and non-Medicare reimbursement can be found by examining characteristics that reflect other aspects of a community's social strengths. Two such characteristics are its investment in K–12 education and its rates of prison incarceration. Non-Medicare spending correlated strongly and positively with per pupil spending for K–12 education ($r = 0.68$) and negatively with per capita rates of prison incarceration, whereas Medicare spending per enrollee correlated weakly with K–12 expenditures but had a strong and positive correlation with prison incarceration rates (Exhibit 2).

■ **Sociodemographic correlates of quality.** Demographic characteristics, such as those described above, relate independently to quality (Exhibit 6). For example, quality is poorer in states where higher percentages of the population are black and Latino, uninsured, in poverty, and in prison; and mortality is higher in such states by

EXHIBIT 6
Health Care Quality Correlations

	Jencks quality rank	Commonwealth quality rank
Percent black plus Latino	0.65	0.56
Percent non-Hispanic white	−0.63	−0.51
Percent poverty	0.60	0.58
Percent Medicare disability	0.48	0.58
Percent DSH	0.58	0.50
Percent uninsured	0.60	0.75
Medicaid spending per enrollee	−0.45	−0.58
Percent employer-sponsored health insurance	−0.49	−0.62
Percent adults with usual source of care	−0.30	−0.51
K–12 spending per pupil	−0.31	−0.53
Prison incarceration rate	0.59	0.46
Per capita income	−0.33	−0.51
Age-adjusted mortality, all	0.66	0.75
Age-adjusted mortality, white	0.63	0.76
Age-adjusted mortality, black	0.58	0.55
Infant mortality rate	0.58	0.55
Preventable mortality rate, white	0.72	0.71
Preventable mortality rate, black	0.64	0.53

SOURCES: See Notes 5, 6, and 7 in text.
NOTES: Correlations are expressed as Pearson coefficients. DSH is disproportionate-share hospital.

all measures. Conversely, quality is better in states where higher percentages of populations are non-Hispanic white, where more have employment-sponsored insurance, and where more is spent on K–12 education. Per capita income correlates positively with better quality. Thus, a web of economic, demographic, and health spending patterns independently and collectively unite quality, health care spending, and social structure. The picture that emerges is that states with higher Medicare spending per enrollee tend to have a higher social burden and poorer quality, while states with more non-Medicare spending have greater economic and social strength and better quality.

■ **Medicare's special characteristics.** It is important to note that Medicare reimbursement accounts for only half of the total spending for the care of Medicare enrollees, with the rest provided through either other public programs (such as through Medicaid or the Department of Veterans Affairs) or private sources (such as through supplemental insurance or out-of-pocket payments).[15] In addition, although reimbursement through Medicaid and other local and state programs and through employers is generally influenced by local economic conditions, Medicare reimbursement results from policies at the national level that are designed not only to reimburse caregivers but also to achieve particular social or political goals.[16] These features of Medicare reimbursement help explain why it is a poor proxy for health care spending overall.

Disability. Although Medicare is generally thought of as the health plan for older Americans, 19 percent of Medicare beneficiaries in 2005 were under age sixty-five, up from 15 percent seven years earlier. Most nonelderly beneficiaries are covered under Social Security disability, but this category also includes 300,000 people in the end-stage renal disease (ESRD) program. The percentage of enrollees who are on disability varies widely among the states, from 10 percent in North Dakota to 25 percent in Mississippi, and these percentages correlate directly with lower quality and higher rates of preventable mortality (Exhibit 6).

DSH. DSH payments are allotted to hospitals that provide disproportionate amounts of care for the poor. These payments account for approximately 3 percent of total Medicare reimbursement. This amount does not distort the relationships discussed herein; however, it is noteworthy that states in which DSH payments account for a higher percentage of Medicare reimbursement have higher total Medicare spending per enrollee and lower-quality health care (Exhibits 2 and 6).

Graduate medical education. Medicare reimbursement also includes the direct costs of medical education (DME) and the associated indirect medical education (IME) payments, which are meant to reimburse teaching hospitals for other unusual costs. These, too, differ among states.

Input costs. Another factor that influences reimbursement is the manner in which Medicare adjusts its payments for input costs. Although the health care component of the cost of living index varies among the states by approximately 10 percent, Medicare's wage index, which adjusts its payments to hospitals for local la-

bor costs, varies by more than 20 percent, often because of congressional mandates. Indeed, given the plethora of issues and inconsistencies that surround the current wage index, the Medicare Payment Advisory Commission (MedPAC) has recommended changes in methodology, which Congress has directed the Department of Health and Human Services to consider for fiscal year 2009.[17]

■ **Economic correlates of non-Medicare spending.** Medicaid and employer-sponsored insurance are the two largest components of non-Medicare spending, and both relate to fiscal resources in the community. The effects of state and local economic considerations on eligibility criteria and reimbursement levels for Medicaid are reflected by a strong correlation between state per capita income and Medicaid spending per enrollee ($r = 0.59$). Conversely, the percentage of the population that is uninsured correlates inversely with state per capita income ($r = -0.35$).

Similar considerations apply to the prevalence of employment-sponsored insurance, which correlates strongly with state per capita income ($r = 0.60$). At the level of Metropolitan Statistical Areas (MSAs), Richard Kronick and colleagues have found that both personal income and aggregate communal income are important.[18] They attributed two-thirds of the likelihood that workers would be covered by employer-sponsored insurance to the workers' individual characteristics (principally income) and one-third to communal characteristics (principally aggregate income in the same MSA). Ultimately, the interplay of both was most strongly predictive. These factors spill over to supplemental insurance, which is less than half as prevalent among Medicare enrollees who are black or poor.[19]

Concluding Comments

■ **Quality depends on total health care spending.** Higher Medicare spending per enrollee correlates with poorer-quality health care at the state level, which has led members of the Dartmouth group to conclude that higher Medicare spending is attributable to waste and inefficiency.[20] However, the observed relationship between Medicare spending and quality is principally due to the fact that many states in the South have high Medicare spending per enrollee but low health care spending per capita, and their poor quality correlates with their overall low levels of health care spending. Medicare patients within a given hospital or health care market would not be expected to experience better or worse quality because of the payment levels from Medicare alone. Staffing decisions, the availability of information technology, preventive services, and other investments that contribute to quality and system performance depend on total funds available, not on the funds from any particular reimbursement stream. In that light, it seems reasonable to expect better quality in states with higher per capita spending overall, as was observed.

■ **Quality relates to a broad array of sociodemographic characteristics.** The relationship between health care spending and quality at the state level may have elements of causality. It seems likely that more spending would lead to stronger local health care systems. However, quality, as assessed in this and similar studies, reflects

"The evidence that Medicare spending is a poor proxy for overall health care spending seems clear."

a broad set of health care system attributes, whereas most health care spending is directed more narrowly to hospital and physician services. Moreover, quality rankings correlate not only with health care spending but also with other sociodemographic characteristics, such as income, race, and spending for K–12 education. Similar relationships have been observed between spending for education and other public services and all-cause mortality.[21] These observations suggest that although health care spending is an important contributor to quality, the determinants of quality reach more deeply into the sociodemographic fabric of the community.

■ **Medicare spending among states is a misleading indicator.** Although levels of non-Medicare spending relate to services provided, Medicare reimbursement is influenced by other factors. Some are created by legislative and administrative mandates that reward particular regions, institutions, or contractors—a process that Bruce Vladeck has termed "interest-group politics."[22] Others are in response to sociodemographic differences, such as those noted above. David Cutler and Louise Sheiner have attributed two-thirds of the variation in Medicare spending to health status and demographics, and MedPAC has attributed 55 percent to demographics and practice patterns.[23] Indeed, Medicare is a major means of income redistribution among areas of the country. Considerations such as these led Daniel Zabinski and Robert Reischauer to conclude that Medicare spending at the state level is "misleading" for analyzing variation in the amount of care provided to beneficiaries.[24]

■ **Medicare spending is a poor proxy for health care spending overall.** The evidence that Medicare spending is a poor proxy for overall health care spending seems clear. First, there is no significant correlation between Medicare and non-Medicare spending. Second, although more Medicare spending per enrollee correlates with poorer health care quality, more non-Medicare spending per capita correlates with better quality. Third, although more Medicare spending correlates with community characteristics that reflect greater social needs, more non-Medicare spending correlates with characteristics that reflect more economic strength.

Observations such as these lead inevitably to the conclusion that regional variation in Medicare spending does not reflect the behavior of the health care system overall. This is a critical point, since Medicare spending data form the basis for many studies of regional variation, including those that are associated with the *Dartmouth Atlas* project.[25] The supposition in each is that Medicare is a proxy for the whole. Indeed, Dartmouth researchers recently claimed that "state-level Medicare spending is closely correlated with overall per capita spending."[26] Yet the cited source stated unequivocally that "Medicare spending does not explain much of the variation in total per capita personal health care spending."[27] Thus, the vagaries of Medicare spending across the nation pose critical challenges to any re-

search that depends on this index of spending to define the behavior of physician practices, hospitals, or the health care system overall.

The dual realization that more health care spending at the state level is associated with better-quality health care and that Medicare spending, which bears an inverse relationship to quality, is not a proxy for the whole should refocus thinking about the impact of health care spending on society, as politicians and the public prepare to address the vexing issues of national health care reform.

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NOTES

1. Centers for Medicare and Medicaid Services, "Health Expenditures by State of Residence, 1991–2004," September 2007, http://www.cms.hhs.gov/NationalHealthExpendData/05_NationalHealthAccountsStateHealthAccounts.asp (accessed 15 January 2008).
2. J.S. Skinner, D.O. Staiger, and E.S. Fisher, "Is Technological Change in Medicine Always Worth It? The Case of Acute Myocardial Infarction," *Health Affairs* 25 (2006): w34–w47 (published online 7 February 2006; 10.1377/hlthaff.25.w34); E.S. Fisher et al., "The Implications of Regional Variations in Medicare Spending, Part 1: The Content, Quality, and Accessibility of Care," *Annals of Internal Medicine* 138, no. 4 (2003): 273–287; E.S. Fisher et al., "The Implications of Regional Variations in Medicare Spending, Part 2: Health Outcomes and Satisfaction with Care," *Annals of Internal Medicine* 138, no. 4 (2003): 288–298; and Center for the Evaluative Clinical Sciences, Dartmouth Medical School, "Supply-Sensitive Care," *Dartmouth Atlas* Project Topic Brief, 2007, http://www.dartmouthatlas.org (accessed 15 December 2007).
3. K. Baicker and A. Chandra, "Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care," *Health Affairs* 23 (2004): w184–w197 (published online 7 April 2004; 10.1377/hlthaff.w4.184).
4. A.B. Martin et al., "Health Spending by State of Residence, 1991–2004," *Health Affairs* 26, no. 6 (2007): w651–w663 (published online 18 September 2007; 10.1377/hlthaff.26.6.w651).
5. CMS, "Health Expenditures"; and Baicker and Chandra, "Medicare Spending." Adjusted Medicare data were kindly provided by Katherine Baicker. Details about the adjustments made can be found in Baicker and Chandra, "Medicare Spending."
6. U.S. Census Bureau, "American FactFinder," http://factfinder.census.gov (accessed 15 January 2008); and Bureau of Economic Analysis, "Regional Economic Accounts," http://www.bea.gov/regional/index.htm (accessed 15 January 2008).
7. Commonwealth Commission on a High Performance Health System, *Aiming Higher—Results from a State Scorecard on Health System Performance* (New York: Commonwealth Fund, 2007); Henry J. Kaiser Family Foundation, "State Health Facts," http://statehealthfacts.org/index.jsp (accessed 15 January 2008); National Archives of Criminal Justice Data, "Prison and Jail Inmates at Midyear 2005," http://www.icpsr.umich.edu/NACJD (accessed 15 January 2008); U.S. Census Bureau, *Statistical Abstract of the United States, 2000–1995*, http://www.census.gov/prod/www/abs/statabl995_2000.html (accessed 7 October 2008); and National Center for Education Statistics, "Student Membership and Current Expenditures per Pupil for Public Elementary and Secondary Education, 2006," http://nces.ed.gov/pubs2008/expenditures/xls/table_03.xls (accessed 12 May 2008).
8. E.W. Corty, *Using and Interpreting Statistics: A Practical Text for the Health, Behavioral, and Social Sciences* (St. Louis: Mosby, 2006).
9. S.F. Jencks et al., "Quality of Medical Care Delivered to Medicare Beneficiaries: A Profile at State and National Levels," *Journal of the American Medical Association* 284, no. 13 (2000): 1670–1676; S.F. Jencks, E.D. Huff, and T. Cuerdon, "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289, no. 3 (2003): 305–312; Commonwealth Commission, *Aiming Higher*; and Baicker and Chandra, "Medicare Spending."
10. Baicker and Chandra, "Medicare Spending."

11. Martin et al., "Health Spending."
12. A negative association between Medicare spending and timely mammography was reported by Baicker and Chandra, "Medicare Spending." Mammography data were kindly provided by Katherine Baicker.
13. Fisher et al., "The Implications of Regional Variations in Medicare Spending, Part 1."
14. Ibid.; and Fisher et al., "The Implications of Regional Variations in Medicare Spending, Part 2."
15. C. Caplan, "What Share of Beneficiaries' Total Health Care Costs Does Medicare Pay?" Data Digest no. 78 (Washington: AARP Public Policy Institute, September 2002).
16. R. Kronick, T. Gilmer, and T. Rice, "The Kindness of Strangers: Community Effects on the Rate of Employer Coverage," *Health Affairs* 23 (2004): 328–340 (published online 2 June 2004; 10.1377/hlthaff.w4.328); and B.C. Vladeck, "The Political Economy of Medicare," *Health Affairs* 18, no. 1 (1999): 22–36.
17. Medicare Payment Advisory Commission, "An Alternative Method to Compute the Wage Index," chap. 6 in *Report to the Congress: Promoting Greater Efficiency in Medicare* (Washington: MedPAC, June 2007); and *Tax Relief and Health Care Act of 2006*, HR 6111, PL 109-432, 109th Cong., 2nd sess., 20 December 2006.
18. Kronick et al., "The Kindness of Strangers."
19. M.A. Laschober et al., "Trends In Medicare Supplemental Insurance and Prescription Drug Coverage, 1996–1999," *Health Affairs* 21 (2002): w127–w138 (published online 27 February 2002; 10.1377/hlthaff.w2.127).
20. J.E. Wennberg, E.S. Fisher, and J.S. Skinner, "Geography and the Debate over Medicare Reform," *Health Affairs* 21 (2002): w96–w114 (published online 13 February 2002; 10.1377/hlthaff.w2.96); Fisher et al., "The Implications of Regional Variations in Medicare Spending, Part 1;" and Baicker and Chandra, "Medicare Spending."
21. J.R. Dunn, B. Burgess, and N.A. Ross, "Income Distribution, Public Services Expenditures, and All Cause Mortality in U.S. States," *Journal of Epidemiology and Community Health* 59, no. 9 (2005): 768–774.
22. Vladeck, "The Political Economy of Medicare."
23. D.M. Cutler and L. Sheiner, "The Geography of Medicare," *American Economic Review* 89, no. 2 (1999): 228–233; and MedPAC, *Report to the Congress: Variation and Innovation in Medicare* (Washington: MedPAC, June 2003).
24. D. Zabinski and R. Reischauer, "Geographic Variation in Per Beneficiary Medicare Expenditures, 2003," Presentation at the Tenth Princeton Conference, 2003, http://council.brandeis.edu/pubs/Prince10/Reischauer-Zabinsky%20slides.pdf (accessed 15 May 2008).
25. Wennberg et al., "Geography"; and Fisher et al., "The Implications of Regional Variations in Medicare Spending, Part 1."
26. B. Sirovich et al., "Discretionary Decision Making by Primary Care Physicians and the Cost of U.S. Health Care," *Health Affairs* 27, no. 3 (2008): 813–823.
27. Martin et al., "Health Spending."

ABSTRACT

Many arguments for the superiority of other health care systems have been repeated often: the United States spends more than any other country, but its health outcomes are often worse. Whereas no one is ever denied care because of an inability to pay in countries with universal coverage, as many as 18,000 people in the U.S. die each year because they are uninsured and more than half of all bankruptcies are caused by medical debts. Also, other countries avoid our high administrative costs.

Yet these and other assertions are debatable. Some are demonstrably false.

Health Care Reform: Do Other Countries Have the Answers?

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The health care systems of all developed countries face three unrelenting problems: rising costs, inadequate quality, and incomplete access to care. Much analysis published in medical journals suggests that other countries have found superior solutions to these problems.[1] This conclusion is at odds with economic research that is published in journals physicians seldom read, using methodologies that are unfamiliar to physicians. In this essay, we attempt to shed light on topics frequently discussed in proposals for health care reform, drawing on the relevant medical and economics literature.

Does the United States Spend Too Much on Health Care?

International statistics show that 2005 United States (US) per capita health care spending was 2.3 times greater than the median Organization for Economic Cooperation and Development (OECD) country ($6,401 vs. $2,759, based on purchasing power parity) and 1.5 times larger than Norway, the country that followed Luxembourg in the spending ranking.[2] However, normal market forces have been so suppressed throughout the developed world that purchasers rarely see a real price for any medical service. As a result, summing over all transactions produces aggregate numbers in which one can have little confidence. In addition, other countries more aggressively disguise costs, especially by suppressing provider incomes.

Economists have long known that international health care spending comparisons are fraught with potential error. Even for uncomplicated dental fillings, reimbursement data underestimate total costs by 50% in nine European countries.[3] Countries account for long term care and out-of-pocket spending differently. The accounting treatment of overhead and capital costs also varies.[4] An OECD project to harmonize national accounting methods began in 2000,

but even when methods are harmonized, the choice of a price adjustment method can alter hospital cost estimates by as much as 400%.[5]

The US compares more favorably when real resources are measured rather than monetary accounts. Per capita, the US uses fewer physicians, nurses, hospital beds, physician visits, and hospitals days than the median OECD country.[6]

Even taking the monetary totals at their face value, the US has been neither worse nor better than the rest of the developed world at controlling expenditure growth. The average annual rate of growth of real per capita US health care spending is slightly below OECD average over the last decade (3.7% vs. 3.8%), and over the past four decades (4.4% vs. 4.5%).[7] Despite common perceptions, a country's financing method—public vs. private financing, general revenue vs. payroll taxes, third-party vs. out-of-pocket spending—is unrelated to its ability to control spending.[8]

For the US, the practical question is, can the adoption of another country's health care system offer a reasonable chance of improving US private sector methods? An answer in the negative is suggested by a comparison of the British National Health Service and California's Kaiser Permanente found that Kaiser provided more comprehensive and convenient primary care and more rapid access to specialists for roughly the same cost.[9]

Finally, international spending comparisons typically ignore costs generated by limits on supply. In 2002-2004, dialysis patients waited 16 days for permanent blood vessel access in the US, 20 days in Europe, and 62 days in Canada.[10] Waiting for care has economic costs in terms of sick pay and lost productivity, as well as negative health consequences. In the late 1990s, an estimated 5 to 10% of English waiting list patients were on sick leave. Norway is trying to reduce waiting times for patients "in order to reduce the cost of sickness benefits." Finland

calculates that the cost of waiting (sickness benefits, medicines, and social welfare expenses) can exceed the cost of treatment.[11]

Are US Outcomes No Better and in Some Respects Worse Than Those of Other Nations?

Analyses that answer this question in the affirmative are often based on data showing that US life expectancy is similar to that of other developed countries and that its infant mortality rate is among the highest.[12] Yet within the US, life expectancy at birth varies enormously among racial and ethnic groups, from state to state, and across US counties.[13] These differences often are attributed to such lifestyle choices as diet, exercise and smoking rather than to differences in the quality of health care.[14] Similarly, US infant mortality varies by a factor of two or three to one across racial and ethnic groups, across the largest cities, and across the states for reasons apparently having little to do with health care.[15] The low US international ranking reflects national differences in the definition of a live birth.[16] Eberstat finds that US infants, stratified by birthweight, have a high likelihood of survival, regardless of race or economic circumstances.[17]

Health care likely plays a leading role in determining outcomes for diseases such as cancer, diabetes, and hypertension. Comparing cancer outcomes, the largest international study to date found that the five-year survival rate for all types of cancer among both men and women was higher in the US than in Europe.[18] US women have a 63% chance of living at least five years after a cancer diagnosis, compared with 56% for European women. Survival after diagnosis of breast cancer was 90% and 79%, respectively. Men in the US have a five-year survival rate of 66%, compared to only 47% for European men. Survival after diagnosis of prostate cancer was 99% and 78%, respectively.[19]

Higher US spending on prescription drugs may explain why there is a steeper increase in blood pressure with advancing age in Europe and a 60% higher prevalence of hypertension. [20] While half of all diabetics have high blood pressure, it is controlled in 36% of US cases compared with only 9% in Canada.[21] The rate of adverse events in US hospitals is only about half that in England, Australia, and New Zealand.[22] The aggressive treatment offered US cardiac patients apparently improves survival and functioning compared with Canadian patients.[23] Fewer health and disability related problems occur among US spinal cord injury patients than among Canadian and British patients.[24]

The US has better relative survival rates than Norway for colorectal and breast cancer, lower rates of vaccine-preventable pertussis, measles, and Hepatitis B, and shorter waiting lists.[25] In 2000, Norwegian patients waited an average of 133 days for hip replacement, 63 days for cataract surgery, 160 days for a knee replacement, and 46 days for bypass surgery after being approved for treatment.[26] Short waits for cataract surgery produce better outcomes; prompt coronary artery bypass reduces mortality; and rapid hip replacement reduces disability and death.[27]

Britain has only one-fourth as many CT scanners as the US and one-third as many MRI scanners. The rate at which the British provide coronary bypass surgery or angioplasty to heart patients is only one-fourth of the US rate, and hip replacements are only two-thirds of the US rate. The rate for treating kidney failure (dialysis or transplant) is five times higher in the US for patients age 45 to 84 and nine times higher for patients 85 years of age or older.[28] Overall, nearly 1.8 million people are waiting to enter hospitals or for outpatient treatments at any given time.[29]

Canada is often said to deliver comparable care, produce comparable outcomes, and still spend less than the US.[30] However, the proportion of middle-aged Canadian women who have never had a mammogram is twice the US rate, and three times as many Canadian women have never had a pap smear. Fewer than 20% of Canadian men have ever been tested for prostate-specific antigen, compared with about 50% of US men. Only 10% of adult Canadians have ever had a colonoscopy, compared with 30% of US adults. These differences in screening may partly explain why the mortality rate in Canada is 25% higher for breast cancer, 18% higher for prostate cancer, and 13% higher for colorectal cancer.[31]

In view of such differences, it is not clear whether the U.S. spends too much on health care or other countries spend too little.

Is the Large Number of Uninsured in the US a Crisis?

The US is the only developed country in which a substantial subpopulation is nominally uninsured. Although this is said to be a crisis because the uninsured lack access to health care, the number of uninsured, and its consequences, are not clear.

The most widely used estimates of the number of US uninsured are from the US Census Bureau's Current Population Survey (CPS). It estimates that 47 million people were uninsured for the entire year in 2005.[32] The Survey of Income and Program Participation (SIPP), another Census Bureau survey, estimates about half that number. The Medical Expenditure Panel Survey (MEPS) and the National Health Interview Survey (NHIS) also generate lower estimates.[33] Many experts believe the CPS estimate is actually an estimate of the number of uninsured at a point-in-time. It is similar to the point-in-time estimates of SIPP (43 million in 2002), MEPS (48 million in 2004) and NHIS (42 million in 2004).[34]

Like unemployment, uninsurance is often transitory: 75% of uninsured spells last one year or less and 91% last two years or less.[35] Although the fraction of the population with health insurance rises and falls with the business cycle, since 1990 the CPS estimate has fluctuated between about 83 and 86% insured, despite an unprecedented influx of immigrants with uninsurance rates 2½ times that of the native-born population.[36] Guaranteed issue laws, state high risk pools, and retroactive Medicaid eligibility make it increasingly easy to obtain insurance after becoming ill.[37]

Of the 46 million nominally uninsured, about 12 million are eligible for such public programs as Medicaid and the State Children's Health Insurance Program (SCHIP).[38] They can usually enroll even at the time of treatment, arguably making them *de facto* insured. About 17 million of the uninsured are living in households with at least $50,000 annual income. More than half of those earn more than $75,000, suggesting that they are uninsured by choice.[39] Although 36% of people in families with incomes under 200% of the poverty level are uninsured, 44% have private coverage, and there are reasons to believe that expansion of private coverage is a better avenue to greater access to care than expansion of public programs.[40]

Does Lack of Health Insurance Cause Premature Death?

A number of studies suggest that the uninsured are more likely to suffer complications of preventable illnesses and more likely to die from them.[41] However, the case is much less solid than most studies in the medical literature have suggested. The consensus among economic studies is that "insurance has a relatively small effect on health."[42] Moreover, the uncertainties about who is uninsured, for how long, and for what reasons suggest that generalized claims about the nationwide impact of uninsurance should be greeted with skepticism.

An Institute of Medicine report in 2002 claimed that 18,000 deaths a year in the US could be attributable to a lack of health insurance.[43] The Urban Institute updated that number to 22,000 in 2006, and Families USA raised it to 26,260 in 2008.[44] However, these reports arrived at their results by extrapolating from an estimate made in a 15-year-old study, using 37-year-old data, and employing questionable methodology.[45] In fact, we do not know how much morbidity and mortality is attributable to lack of health insurance.

Once people see a provider, a RAND study suggests that insurance status has little effect on receipt of recommended care.[46] However, the uninsured and those on Medicaid may be more likely to delay seeking care.[47] An American Cancer Society study found that, relative to people with private insurance, the uninsured and Medicaid-insured were more likely to present with advanced-stage cancer at diagnosis.[48]

Many proposals for universal health care coverage envision enrolling more people in Medicaid, in SCHIP plans paying Medicaid rates, or in private plans paying Medicaid rates.[49] Such efforts encourage people to drop their private coverage. Cutler and Gruber estimate that every extra $1 spent on Medicaid reduces private health insurance by 50-75¢.[50] For SCHIP, the Congressional Budget Office projects a crowd-out rate of 25% to 50% and Gruber estimates it at 60%.[51] Unfortunately, this substitution may lead to worse health outcomes. Low Medicaid reimbursement is associated with lower quality care.[52] Perhaps because of nonprice barriers and low reimbursement for some types of care, being enrolled in Medicaid is only marginally better than being uninsured.[53]

Are Medical Bills Causing Bankruptcy?

A study claiming that more than half of all bankruptcies are caused by medical debt[54] is often cited, but the claim conflicts with four decades of economic research. The label "medical

bankruptcy" was applied if out-of-pocket medical bills exceeded $1,000, even though out-of-pocket expenses of the *average* US household were $2,182 in the year studied.[55] Recalculating the study's data, Dranove and Millenson conclude that only 17% of the sample "had medical expenditure bankruptcies."[56] Well-designed economic studies have found no statistical link between bankruptcies and health problems.[57] In fact, household consumption is largely unchanged even in the face of very large medical bills.[58]

Are Administrative Costs Higher for Private Insurance Than Public Insurance?

The Congressional Research Service has estimated the administrative costs of Medicare at 2% of the total program costs, compared to 10% for private insurance and 12% for HMOs. Some single-payer advocates have used this estimate as an argument for a universal Medicare program.[59] These estimates ignore hidden costs shifted to the providers of care, and the social costs of collecting taxes to fund Medicare. A Milliman & Robertson study estimates that, when these costs are included, Medicare and Medicaid spend two-thirds *more* on administration than private insurance spends on administration: 27 cents, compared to 16 cents, respectively, for every dollar of benefits.[60]

According to Himmelstein and Woolhandler, if the US adopted the Canadian system, the savings on lower administrative costs could pay for insuring the uninsured.[61] Their calculation includes the cost of private insurance premium collection (advertising, agents' fees, etc.), but ignores the cost of tax collection to pay for public insurance. Danzon estimates the deadweight cost of tax finance in Canada to be at least 17% of claims.[62] Using the most conservative estimate of the social cost of collecting taxes, Zycher calculates that the excess burden of a

universal Medicare program would be twice as high as the administrative costs of universal private coverage.[63]

Are Low-Income Families More Disadvantaged in the US System?

Aneurin Bevan, father of the British NHS, declared, "the essence of a satisfactory health service is that rich and poor are treated alike, that poverty is not a disability and wealth is not advantaged."[64] More than thirty years after the NHS founding an official task force found little evidence that the creation of the NHS had equalized health care access.[65] Another study fifty years after the NHS founding concluded that access had become more unequal in the years between the two studies.[66] Other scholarly studies have come to similar conclusions.[67]

In Canada, the wealthy and powerful have significantly greater access to medical specialists than less-well-connected poor.[68] High-profile patients enjoy more frequent services, shorter waiting times and greater choice of specialists.[69] Moreover, among the nonelderly white population, low-income Canadians are 22% more likely to be in poor health than their US counterparts.[70]

For OECD countries generally, among people with similar health conditions, "higher income people use the system more intensively and use more costly services than do lower income people."[71] It seems likely that the same personal characteristics that ensure success in a market economy also enhance success in bureaucratic systems.[72]

Can the Free Market Work in Health Care?

The US system is often portrayed as more market-based than the systems of other countries, but this portrayal may be more perception than reality. While 13 cents of every dollar is paid out-of-

pocket by US patients, the OECD average is 20 cents. [73] Throughout the developed world, third-party payers set fees and pay fees, perversely encouraging patients to overconsume and providers to manipulate reimbursement formulas to increase their incomes.[74] When third-party payment is not a factor, medical markets more closely resemble markets for other goods and services.[75]

In cosmetic surgery, virtually all payments are out-of-pocket and transparent package prices covering all services are the norm. Even though technological progress is frequently assumed to increase health care costs, the real price of cosmetic surgery has declined over the past 15 years, despite substantial technological progress and a six-fold increase in demand and.[76] In corrective vision surgery, out-of-pocket payments and package prices are the norm, and the real price has declined by 30% over the past decade.[77] Price transparency is absent in virtually every other kind of surgery.

Most walk-in clinics in drug stores and shopping malls began outside the third-party payment system. They have already achieved many of the goals included in most reform proposals: they post prices, keep electronic medical records (EMRs) and can prescribe electronically, taking advantage of error-reducing software.[78] Teladoc, which also developed outside the third-party payment system, offers telephone consultations. It maintains personal and portable EMRs, and its physicians prescribe electronically.[79]

Largely because so many drugs are purchased out-of-pocket, Rx.com began selling prescription drugs online, encouraging price competition in a national marketplace. Wal-Mart, a company in search of profits, has expanded its nationally advertised program of low cost generic drugs. Its efforts have spurred other retailers to engage in price competition as well.[80]

Outside the US borders, a vibrant, competitive international marketplace appears to be developing for all manner of medical services.[81] Package prices are customary, as are EMRs, and

information on quality. Moreover, many health centers abroad are affiliated with high-quality US facilities including the Cleveland Clinic, Mayo Foundation, Harvard Medical International, and Johns Hopkins Medicine International.[82]

CONCLUSION

Although national health insurance has considerable support within the medical profession, the degree to which patient empowerment, individual choice, competition, and market incentives are being consciously and successfully used to solve health care problems is far more extensive than is commonly realized. More than 10 million US families are managing some of their own health care dollars through Health Savings Accounts (HSAs) and Health Reimbursement Accounts.[83] More than half the states have Medicaid Cash & Counseling pilot programs underway, allowing the disabled to manage their own supportive care budgets. The satisfaction rate approaches 100%.[84] Internationally, Singapore has had a system of compulsory Medisave Accounts since 1984. China has initiated a pilot program based on the Singapore model.[85] In South Africa, HSA plans have captured more than half the private insurance market.[86] Switzerland, considered by many to have the most egalitarian health care system in the developed world, relies largely on private (although government-mandated) insurance.[87]

In some respects, support for government regulation of health care financing and delivery has been based on a narrow construal of selected data, while all too often ignoring contrary data. We have attempted to correct the record by discussing some specific gaps, and suggest that the discussion of US health care reform would benefit greatly from a careful examination of the current successes and future potential of market-based reforms.

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REFERENCES

[1] American College of Physicians, "Achieving a High-Performance Health Care System with Universal Access: What the United States Can Learn From Other Countries," Annals of Internal Medicine 148, no. 1 (2008): 55-75.

[2] "OECD Health Data: Specialists Outnumber GPs in Most OECD Countries," OECD Health Data 2007 (Paris: Organization for Economic Co-operation and Development, 2007) Chart 4: Health expenditure per capita, public and private, OECD countries, 2005. 2007, http://www.oecd.org/dataoecd/52/34/38976588.pdf (accessed 19 May 2008).

[3] S.S. Tan, WK Redekop and FFH Rutten, "Costs and Prices of Single Dental Fillings in Europe: a Micro-Costing Study," Health Economics 17, 1 Supplement (2008): S83-93.

[4] O. Tiemann, "Variations in Hospitalisation Costs for Acute Myocardial Infarction - a Comparison Across Europe," Health Economics 17, 1 Supplement (2008): S33-45.

[5] E. Orosz and D. Morgan, "SHA-based national health accounts in thirteen OECD countries: a comparative analysis," Health Working Papers no. 16 (Paris: Organization for Economic Co-operation and Development, 2004). "Note On General Comparability of Health Expenditure and Finance Data in OECD Health Data 2007," (Paris: Organization for Economic Co-operation and Development, 2007), http://www.ecosante.fr/ OCDEENG/411.html (accessed 19 May 2008). E. Orosz, "The OECD System of Health Accounts and the US National Health Account: Improving Connections Through Shared Experiences," (2005). Draft paper prepared for the conference on "Adapting National Health Expenditure Accounting to a Changing Health Care Environment" (Washington, D.C.: Centers for Medicare & Medicaid Services), http://www.cms.hhs.gov/NationalHealthExpendData/ downloads/confpaperorosz.pdf (accessed 19 May 2008); Jonas Schreyogg, etal., "Cross-Country Comparisons of Costs: The Use of Episode-Specific Transitive Purchasing Power Parities with Standardised Cost Categories," Health Economics 17, 1 Supplement (2008): S95-103.

[6] G.F. Anderson, B.K. Frogner and U.E. Reinhardt, "Health Spending in OECD Countries in 2004: an Update," Health Affairs 26, no. 5 (2007):1481-1489.

[7] Anderson, Frogner and Reinhardt, "Health spending in OECD countries in 2004: an Update;" Gerard F. Anderson, et al., "Health Spending and Outcomes: Trends in OECD Countries, 1960–1998," Health Affairs 19, no. 3 (2000):150-157.

[8] S.A. Glied, "Health Care Financing, Efficiency, and Equity," NBER Working Paper 13881 (Cambridge, MA: National Bureau of Economic Research, 2008).

[9] R.G. Feachem, H.K Sekhri and L.K. White, "Getting More for their Dollar: a Comparison of the NHS with California's Kaiser Permanente," BMJ 324, no. 7330 (2002):135-143.

[10] D.C. Mendelssohn et al., "Haemodialysis Vascular Access Problems in Canada: Results from the Dialysis Outcomes and Practice Patterns Study (DOPPS II)," Nephrology Dialysis Transplantation 21, no. 3 (2006): 721-728.

[11] J. Hurst and L. Siciliani, "Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries," OECD Health Working Paper no. 6 (Paris: Organization for Economic Co-operation and Development, 2003).

[12] P.S. Hussey et al. "How Does the Quality of Care Compare in Five Countries?" Health Affairs 23, no. 3 (2004):89-99. C. Schoen and S.K.H How and S.C. Schoenbaum, National Scorecard on U.S. Health System Performance: Technical Report (New York: Commonwealth Fund, 2006). R.L. Lichtenstein, "The United States'

Health Care System: Problems and Solutions," Survey of Ophthalmology 39, no. 2 (1994):166-167. L. Champlin "Call for health system reform reaching grassroots level," (Leawood, KS: American Academy of Family Physicians, 8 November 2006), http://www.aafp.org/online/en/home/publications/news/news-now/health-care-reform/20061008grassroots.html (accessed 1 October 2008).

[13] H.C. Kung et al., "Deaths: Final Data for 2005," National Vital Statistics Report 56_10 (Hyattsville, MD: Centers for Disease Control and Prevention, 2008); Harvard University Initiative for Global Health, cited in M. Hitti, "Top States for Life Expectancy," WebMD Medical News, 2006, http://www.webmd.com/news/20060913 /top-states-for-life-expectancy (accessed 1 October 2008); C.J.L. Murray et al., "Eight Americas: Investigating Mortality Disparities across Races, Counties, and Race-Counties in the United States," PLoS Medicine 3, no. 9 (2006): e260 doi:10.1371/journal.pmed.0030260.

[14] "Growing Disparities in Life Expectancy," Economic and Budget Issue Brief (Washington, DC: Congressional Budget Office, 2008).

[15] T.J. Mathews and M.F. MacDorman, "Infant Mortality Statistics from the 2004 Period Linked Birth/Infant Death Data Set," National Vital Statistics Report 55_14 (Hyattsville, MD: Centers for Disease Control and Prevention, 2007); V. Haynatzka et al., "Racial and Ethnic Disparities in Infant Mortality Rates --- 60 Largest U.S. Cities, 1995-1998," Morbidity and Mortality Weekly Report 51, no. 15 (2002): 329-332,343; T.J. Mathews and M.F. MacDorman, "Infant Mortality Statistics from the 2004 Period Linked Birth/Infant Death Data Set," National Vital Statistics Report 55_14 (Hyattsville, MD: Centers for Disease Control and Prevention 2007).

[16] E.M. Howell and B. Blondel, "International Infant Mortality Rates: Bias from Reporting Differences," American Journal of Public Health 84, no. 5 (1994):850-852; S. Sepkowitz "International Rankings of Infant Mortality and the United States Vital Statistics Natality Data Collecting System - Failure and Success," International Journal of Epidemiology 24, no. 3 (1995):583-588; M. Muller et al., "Liveborn and Stillborn Very Low Birthweight Infants in Switzerland: Comparison between Hospital Based Birth Registers And The National Birth Register," Swiss Medical Weekly 135, no. 29 (2005):433-439.

[17] N. Eberstadt, The Tyranny of Numbers: Mismeasurement and Misrule (Washington, DC: The AEI Press, 1995) 43-73.

[18] A. Verdecchia et al., "Recent Cancer Survival in Europe: a 2000–02 Period Analysis of EUROCARE-4 Data," Lancet Oncology 8, no. 9 (2007):784-796.

[19] Verdecchia et al., "Recent Cancer Survival in Europe: a 2000–02 Period Analysis of EUROCARE-4 Data."

[20] J.A. Staessen, T. Kuznetsova and K. Stolarz, "Hypertension Prevalence and Stroke Mortality Across Populations," Journal of the American Medical Association 289, no. 18 (2003):2420-2422. (Online edition, accessed 10 March 2006). K. Wolf-Maier et al., "Hypertension Prevalence and Blood Pressure Levels in 6 European Countries, Canada and the United States," Journal of the American Medical Association 289, no. 18 (2003):2420-2422.

[21] M.R. Joffres et al., "Distribution of Blood Pressure and Hypertension in Canada and the United States," American Journal of Hypertension 14, no. 1 (2001):1099-1105.

[22] G.R. Baker et al., "The Canadian Adverse Events Study: The Incidence of Adverse Events among Hospital Patients in Canada," Canadian Medical Association Journal 170, no. 11 (2004):1678-1686.

[23] P. Kaul et al., "Long-Term Mortality of Patients with Acute Myocardial Infarction in the United States and Canada: Comparison of Patients Enrolled in Global Utilization of Streptokinase and t-PA for Occluded Coronary Arteries (GUSTO)-I," Circulation 110, no. 13 (2004):1754-1760, http://circ.ahajournals.org/cgi/content/full

/110/13/1754 (accessed 27 January 2006); J.L. Roleau et al., "A Comparison of Management Patterns After Acute Myocardial Infarction in Canada and the United States. The SAVE Investigators," New England Journal Medicine 328, no. 11 (1993): 779-784.

[24] M.A. McColl et al., "International Differences in Ageing and Spinal Cord Injury," Spinal Cord 40, no. 3 (2002):128-136.

[25] E. Kelley and J. Hurst, "Health Care Quality Indicators Project Initial Indicators Report," OECD Health Working Papers no. 22 (Paris: Organisation for Economic Co-operation and Development, 2006).

[26] L. Siciliani and J. Hurst, "Explaining Waiting Times Variations for Elective Surgery Across OECD Countries," OECD Health Working Papers no. 72003 (Paris: Organisation for Economic Co-operation and Development, 7 October 2003).

[27] W. Hodge et al., "The Consequences of Waiting for Cataract Surgery: A Systematic Review," Canadian Medical Association Journal 176, no. 9 (2007):1285-1290; B.G. Sobolev et al., "The Risk of Death Associated with Delayed Coronary Artery Bypass Surgery," BMC Health Services Research 6, no. 85 (2006), http://www.pubmedcentral. nih.gov/ picrender.fcgi? artid=1574305&blobtype=pdf (accessed 30 September 2008); E.M. Koomen et al., "Morbidity and Mortality in Patients Waiting for Coronary Artery Bypass Surgery," European Journal of Cardio-Thoracic Surgery 19, no. 3(2001):260-265; D.S. Garbuz et al., "Delays Worsen Quality of Life Outcome of Primary Total Hip Arthroplasty," Clinical Orthopaedics and Related Research 447 (2006):79-84. A.M. Davis et al., "Waiting for Hip Revision Surgery: the Impact on Patient Disability," Canadian Journal of Surgery 51, no. 2 (2008):92-96. V. Novack et al., "Does Delay in Surgery after Hip Fracture Lead to Worse Outcomes? A Multicenter Surgery," International Journal for Quality in Health Care 19, no. 3 (2007):170-176.

[28] H.J Aaron, Can We Say No? The Challenge of Rationing Health Care Health Care (Washington DC: Brookings Institution Press, 2005).

[29] NHS Wales Waiting Times: At End March 2008. Stats Wales 2008. SDR 58/2008. Patients Waiting (Edinburgh: National Services Scotland, 2008). NHS Inpatient and Outpatient Waiting Times Figures. 29 February 2008 and Revised Data for April 2006 – January 2008 (London: Department of Health, 2008).

[30] Physicians for a National Health program, "Proposal of the Physicians' Working Group for Single-Payer National Health Insurance," Journal of the American Medical Association 290, no. 3 (2003):798-805.

[31] J.E. O'Neill and D.M. O'Neill, "Health Status, Health Care and Inequality: Canada vs. the U.S." NBER Working Paper 13429 (Cambridge, MA: National Bureau of Economic Research, 2007).

[32] C. DeNavas-Walt, B.D. Proctor and J. Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2006, " Current Population Reports no. 60-233 (Washington DC: U.S. Census Bureau, 2007).

[33] N. Chockley, H. Pirani and K. Kushner, "A Primer on the CPS Estimate of America's Uninsured," NIHCM Brief (Washington DC: National Institute for Health Care Management, 2006).

[34] Chockley, Pirani and Kushner, "A Primer on the CPS Estimate of America's Uninsured."

[35] R.J. Mills and S. Bhandari, "Health Insurance Coverage in the United States: 2002," Current Population Reports no. P60-223 (Washington DC: U.S. Census Bureau, 2003).

[36] C.H. Lee and S.M Stern, "Health Insurance Estimates from the U.S. Census Bureau: Background for a New Historical Series," (Washington DC: U.S. Census Bureau, 2007), http://www.census.gov/hhes/www/hlthins /usernote/revhlth_paper.pdf (accessed 23 May 2008). "National Health Interview Survey. Early release,"

(Hyattsville, MD: Centers for Disease Control and Prevention, March 2007) Figure 1.1 Percentage of persons of all ages without health insurance coverage at the time of interview: United States, 1997-September 2006, http://www.cdc.gov/nchs/data/nhis/earlyrelease/200703_01.pdf (accessed 23 May 2008); C. DeNavas-Walt, B.D. Proctor and J. Smith, "Income Poverty, and Health Insurance Coverage in the United States: 2006," Current Population Reports no. P60-233 (Washington D.C: U.S. Census Bureau), p. 19.

[37] L. Wachenheim and H. Leida, The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets (Brookline, WI: Milliman, 2007).

[38] "The Uninsured in America," R30-03-014 (Chicago: BlueCross BlueShield Association, 2003).

[39] C. DeNavas-Walt, B.D. Proctor and J. Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2007," Current Population Reports no. 60-235 (Washington DC: U.S. Census Bureau, 2008); H. Kuttner and M.S. Rutledge, "Higher Income And Uninsured: Common or Rare?" Health Affairs 26, no. 6 (2007): 1745–1752 (published online November 2007; 10.1377/hlthaff.26.6.1745).

[40] M.K. Bundorf and M.V. Pauly, "Is Health Insurance Affordable for the Uninsured?" Working Paper no. 9281 (Cambridge, MA: National Bureau of Economic Research, 2002); J.C. Goodman et al. Handbook on State Health Care Reform (Dallas: National Center for Policy Analysis, 2007).

[41] J. Hadley and J. Holahan, "How Much Medical Care do the Uninsured Use, and Who Pays for it?" Health Affairs 22 (2003):w3250-w3265. (published online 12 February 2003; 10.1377/hlthaff.w3.66). J. Hadley, "Sicker and Poorer—The Consequences of Being Uninsured: A Review of the Research on the Relationship Between Health Insurance, Medical Care Use, Health, Work, and Income," Medical Care Research and Review 60, no. 2 supplement (2003):3S-75S.

[42] R. Kronick, "Commentary—Sophisticated Methods but Implausible Results: How Much Does Health Insurance Improve Health?" Health Services Research 41, no. 2 (2006):452–460.

[43] Institute of Medicine, Care without Coverage: Too Little, Too Late (Washington, DC: National Academy Press, 2002).

[44] S. Dorn, Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality (Washington, DC: Urban Institute, 2008); "Dying for Coverage," (Washington, DC: Families USA, 2008), http://familiesusa.org/issues/uninsured/publications/dying-for-coverage.html (accessed 1 October 2008).

[45] P. Franks, C.M. Clancy and M.R. Gold, "Health Insurance and Mortality. Evidence from a National Cohort," Journal of the American Medical Association 270, no. 6 (1993):737-741; L. Gorman, "Dying for (Media) Coverage," Health Alert (Dallas: National Center for Policy Analysis, 2 May 2008), http://www.john-goodman-blog.com/dying-for-media-coverage/ (accessed 1 October 2008).

[46] S.M. Asch et al., "Who is at Greatest Risk for Receiving Poor-Quality Health Care?" New England Journal of Medicine 354, no. 11 (2007):1147-1156.

[47] J.S. Weissman at al., "Delayed Access to Health Care: Risk Factors, Reasons, and Consequences," Annals of Internal Medicine 114, no. 4 (1991):325-331.

[48] M.T. Halpern, E.M. Ward and A.L. Pavluck, "Association of Insurance Status And Ethnicity With Cancer Stage At Diagnosis For 12 Cancer Sites: A Retrospective Analysis," Lancet Oncology 9, no. 3 (2008):222-231.

[49] L. Dubay, C. Moylan and T.R. Oliver, "Advancing Toward Universal Coverage: Are States Able to take the Lead?" Journal of Health Care Law and Policy 7, no. 1 (2004):1-41. M.G. Bloche, "Health Care for All? New England Journal of Medicine 357, no. 12 (2007):1173-1175.

[50] D.M. Cutler and J. Gruber, "Does Public Insurance Crowd Out Private Insurance?" The Quarterly Journal of Economics 111, no. 2 (1996):391–430.

[51] N. Duchovny and L. Nelson, "The State Children's Health Insurance Program," CBO Pub no. 2970 (Washington, DC: Congressional Budget Office, 2007); J. Gruber and K. Simon, "Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Heath Insurance?" Working Paper no. 12858 (Cambridge: National Bureau of Economic Research, 2007).

[52] J.D. Reschovsky and A.S. O'Malley, "Do Primary Care Physicians Treating Minority Patients Report Problems Delivering High-Quality Care?" Health Affairs 27, no. 3 (2008):w221-w231 (published online 22 April 2008; 10.1377/hlthaff.27.3.w222); J.E. Calvin et al., "Insurance Coverage and Care of Patients with non-ST Segment Elevation Acute Coronary Syndrome," Annals of Internal Medicine 145, no. 10 (2006):739-748.

[53] M.T. Halpern, E.M. Ward and A.L. Pavluck, "Association of Insurance Status And Ethnicity With Cancer Stage At Diagnosis For 12 Cancer Sites: A Retrospective Analysis," Lancet Oncology 9, no. 3 (2008):222-231. B.R. Asplin et al., "Insurance Status and Access to Urgent Ambulatory Care Follow-Up Appointments," Journal of the American Medical Association 294, no. 10 (2005):1248-1254.

[54] D.U. Himmelstein, etal., "MarketWatch: Illness and Injury as Contributors to Bankruptcy," Health Affairs 24 (2005): w63-w73 (published online 2 February 2005; 10.1377/hlthaff.w5.63).

[55] T.J. Zywicki, "An Economic Analysis of the Consumer Bankruptcy Crisis," Norwest University Law Review 99, no. 4 (2005):1463-1542.

[56] D. Dranove amd M.L. Millenson, "Medical Bankruptcy: Myth Versus Fact," Health Affairs 25, no. 2 (2005):w74-w83 (published online 28 February 2006; 10.1377/hlthaff.25.w74).

[57] S. Fay, E. Hurst and M. White, "The Household Bankruptcy Decision," American Economic Review 92, no. 3 (2002):706–718.

[58] H. Levy, "The Economic Consequences of Being Uninsured," ERIU Working Paper no. 12 (Ann Arbor, MI: University of Michigan, 2002), http://www.umich.edu/~eriu/pdf/wp12.pdf (accessed 1 October 2008).

[59] S. Woolhandler, T. Campbell and D.U. Himmelstein, "Costs of Health Care Administration in the United States and Canada," New England Journal of Medicine 349, no. 8 (2003):768-775.

[60] M. Litow et al. "Rhetoric vs. Reality: Comparing Public and Private Administrative Costs," (Washington DC: Council for Affordable Health Insurance, 1994).

[61] S. Woolhandler and D.U. Himmelstein, "Paying for National Health Insurance—and not Getting It," Health Affairs 21, no. 4 (2002):88-98.

[62] P.M. Danzon, "Hidden Overhead Costs: Is Canada's System Really Less Expensive?" Health Affairs 11, no. 1 (1992):21-43.

[63] B. Zycher, "Comparing Public and Private Health Insurance: Would a Single-Payer System Save Enough to Cover the Uninsured?" Medical Progress Report no. 5 (New York: Manhattan Institute for Policy Research, 2007).

[64] Economic Models Ltd. The British Health Care System (Chicago: American Medical Association, 1976).

[65] P. Townsend and N. Davidson, Inequities in Health Care, Black Report (Harmondsworth: Penguin, 1982).

[66] Independent Inquiries into Inequity and Health: The Acheson Report (London: Stationary Office, 1998).

[67] R. Mitchell and M. Shaw, Reducing Health Inequities in Britain (York, North Yorkshire: Joseph Roundtree Foundation, 2000).

[68] D.A. Alter et al., "Effects of Socioeconomic Status on Access to Invasive Cardiac Procedures and on Mortality after Acute Myocardial Infarction," New England Journal of Medicine 341, no. 18 (1999):1359-1367.

[69] S. Dunlop, P.C. Coyte and W. McIsaac, "Socio-Economic Status and the Utilisation of Physicians' Services: Results from the Canadian National Population Health Survey," Social Science & Medicine 51, no. 1 (2000):123-133.

[70] J.E. O'Neill and D.M O'Neill, "Health Status, Health Care and Inequality: Canada Vs. The U.S.," NBER Working Paper no. 13429 (Cambridge, MA: National Bureau of Economic Research, 2007).

[71] S.A. Glied, "Health Care Financing, Efficiency, and Equity," NBER Working Paper no. 13881 (Cambridge, MA: National Bureau of Economic Research, 2008).

[72] J.C. Goodman, G.L. Musgrave and D.M. Herrick, Lives at Risk: Single-Payer National Health Insurance around the World (Lanham, MD: Rowman & Littlefield, 2004), Chapter 21.

[73] C.L. Peterson and R. Burton, "U.S. Health Care Spending: Comparison with Other OECD Countries," (Washington DC: Congressional Research Service, 2007).

[74] J.C. Goodman, G.L. Musgrave and D.M. Herrick, Lives at Risk: Single-Payer National Health Insurance around the World (Lanham, MD: Rowman & Littlefield, 2004),

[75] J.C. Goodman and G.L. Musgrave, Patient Power: Solving America's Health Care Crisis, (Washington, D.C.: Cato Institute, 1992).

[76] D.M. Herrick, "Update 2006: Why Are Health Costs Rising?" Brief Analysis no. 572 (Dallas: National Center for Policy Analysis, 2006).

[77] H.T. Tu and J.H May, "Self-Pay Markets in Health Care: Consumer: Nirvana or Caveat Emptor?" Health Affairs 26, no. 2 (2007):w217-w226 (published online 6 February 2007; 10.1377/hlthaff.26.2.w217).

[78] K.J. Alexander, "Health Plans Embrace Retail Clinics," Managed Care 17, no.3 (2008):32-4, 43.

[79] D.M. Herrick, "Convenient Care and Telemedicine," Policy Report no. 305 (Dallas: National Center for Policy Analysis, 2007).

[80] "Use of Generic Prescription Drugs Prompts Decrease in Inflation," Kaiser Daily Health Policy Report (Menlo Park, CA: Henry J. Kaiser Family Foundation, 26 September 2007).

[81] M.D. Horowitz, J.A. Rosensweig and C.A. Jones, "Medical Tourism: Globalization of the Healthcare Marketplace," Medscape General Medicine 9, no. 4 (2007):33.

[82] D.M. Herrick, "Medical Tourism: Global Competition in Health Care," Policy Report no. 304 (Dallas: National Center for Policy Analysis, 2007).

[83] "January 2008 Census Shows 6.1 Million People Covered By HSA/High-Deductible Health Plans," (Washington DC: Americans Health Insurance Plans, 2006).

[84] B.C. Spillman, K.J. Black and B.A. Ormond, "Beyond Cash and Counseling: An Inventory of Individual Budget-based Community Long Term Care Programs for the Elderly," Issue Paper no. 7485 (Washington DC: Kaiser

Family Foundation, 2006). Also see Robert Wood Johnson Foundation, "Cash & Counseling," http://www.cashandcounseling.org/ (accessed 1 October 2008).

[85] N.C. Chia and A.K.C. Tsui, "Medical Savings Accounts in Singapore: How Much is Adequate?" Journal of Health Economics 24, no. 5 (2005): 855-875; "Health Care Trends. International Comparisons: Impact of HSAs on Costs and Utilization in Three Countries," Annual Report on Health Care (Milwaukee: Health Care Trends, 2005).

[86] "Health Care Trends. International Comparisons: Impact of HSAs on Costs and Utilization in Three Countries;" S. Matisonn, "Medical Savings Accounts in South Africa," Policy Report no. 234 (Dallas: National Center for Policy Analysis, June 2000).

[87] R.E. Leu and M. Schellhorn, "The Evolution of Income-Related Inequalities in Health Care Utilization in Switzerland over Time," IZA Discussion Paper no. 1316 (Bonn: Institute for the Study of Labor, 2004), http://ssrn.com/abstract=596941 (accessed 1 October 2008).

THE PHYSICIANS' FOUNDATION

The Physicians' Perspective: Medical Practice in 2008

Executive Summary

Healthcare is an issue of vital concern to most Americans, and has been in the public conversation nearly every day for years. At a time when both major political parties are calling for expanded healthcare access and a new Presidential administration and Congress are preparing to address the issue, one crucial viewpoint has been largely overlooked: that of the physicians themselves.

How do physicians across the country see the medical practice environment? How do they feel about the state of their profession, and that of the industry at large? What plans do they have for the future of their individual practices? Do they believe there are enough of them to handle an influx of more patients?

The Physicians' Foundation determined to answer these questions, and many more, through one of the largest and most comprehensive physician surveys ever conducted in the United States. Its goal was to give physicians a voice, so that their thoughts, ideas and concerns might be better understood by policy makers, employers, insurance companies and the public at large.

Through responses provided by approximately 12,000 physicians nationwide that included more than 800,000 data points – as well as through written comments by more than 4,000 physicians – the survey offers a unique and valuable insight into the practices and mindsets of today's doctors.

The results paint a grim picture that could have drastic implications for the nation's healthcare debate:

- **An overwhelming majority of physicians – 78% – believe there is a shortage of primary care doctors in the United States today.**
- **49% of physicians – more than 150,000 doctors nationwide – said that over the next three years they plan to reduce the number of patients they see or stop practicing entirely.**
- **94% said the time they devote to non-clinical paperwork in the last three years has increased, and 63% said that the same paperwork has caused them to spend less time per patient.**
- **82% of doctors said their practices would be "unsustainable" if proposed cuts to Medicare reimbursement were made.**
- **60% of doctors would not recommend medicine as a career to young people.**

Combine these statistics with recent studies showing that medical schools are graduating fewer and fewer students who will choose to become primary care doctors – and the future for both physicians and their patients seems uncertain at best.

In the years ahead, the condition of America's primary care doctors as a profession will greatly affect the viability of our nation's healthcare system. A positive and functional system of practices and doctors will ensure a motivated workforce as well as encourage a new generation of quality physicians, while widespread physician disincentive could jeopardize the quality of our medical workforce as well as the number of physicians available to see patients.

In the words of one physician who responded to the survey, "something has got to be done, and urgently, to assist physicians, especially primary care physicians" in order to maintain the viability of the medical profession and to ensure timely and effective access to the doctors on whom so many depend.

To read more about The Physicians' Foundation and view their complete survey, please visit www.physiciansfoundation.org.

ABOUT THE SURVEY

The Physicians' Perspective: Medical Practice in 2008 survey was conducted between May and July 2008 by physician search and consulting firm Merritt, Hawkins & Associates. It was mailed to 270,000 primary care doctors and more than 50,000 specialists – virtually every physician engaged in active medical practice in the United States today. The total number of responses received was 11,950. According to an independent analysis by Chad Autry PhD, Professor of Statistics at Texas Christian University, the margin of error for this survey is less than one percent.

ABOUT THE PHYSICIANS' FOUNDATION

The Physicians' Foundation seeks to advance the work of practicing physicians and to improve the quality of healthcare for all Americans. The Foundation is unique in its commitment to working with physicians nationwide to create a more efficient and equitable healthcare system. The Physicians' Foundation pursues its mission through a variety of activities including grantmaking and research. Since 2005, the Foundation has awarded more than $22 million in multi-year grants. The Physicians' Foundation was founded in 2003 through settlement of a class-action lawsuit between physicians, medical societies, and third-party payors. Additional information about The Physicians' Foundation is available online at www.physiciansfoundation.org.

Mr. PALLONE. Thank you, Dr. Williamson.
Dr. Ulrich.

STATEMENT OF KARL J. ULRICH

Dr. ULRICH. Mr. Chairman, Ranking Member Deal and members of the subcommittee, my name is Karl Ulrich and I am president and CEO of Marshfield Clinic in Marshfield, Wisconsin. On behalf of myself, our staff and the tens of thousands of patients that we care for, we commend you for advancing the national health reform debate.

At our clinic, we continue to follow closely this dialog, especially reorienting the system towards quality and efficiency while at the same time ensuring that any meaningful reform is not built upon the flawed incentives of the current program. Therefore, we strongly urge this committee to be bold and address the problems of affordability, quality and disparities in payment that plague the program, hurting beneficiaries and providers alike.

As background, Marshfield Clinic is one of the largest medical group practices in Wisconsin and indeed the United States with almost 800 physicians, 6,500 additional staff and 3.6 million annual patient encounters per year. As a 501(c)(3) not-for-profit organization, our clinic is a public trust serving all who seek care regardless of their ability to pay. As part of our commitment, the clinic has invested in sophisticated tools that complement and support our mission such as an internally developed certified electronic medical record, a data warehouse and an immunization registry. With this infrastructure, the clinic is presently publicly reporting clinical outcomes and providing quality improvement tools to analyze processes, eliminate waste and improve consistency while still reducing unnecessary costs. These initiatives are consistent with the stated goals of the national health reform debate. Our clinic has long used information to facilitate care redesign and we expanded these efforts after becoming a participant in the federal physician group demonstration project. As a result, we have improved care, reduced costs and achieved significant savings for the Medicare program. In the first 2 years of the demonstration, we have saved taxpayers more than $25 million with our redesigns while meeting or exceeding all 27 possible quality metrics. We believe that equivalent or even greater results are possible with the creation of the proposed accountable care organizations, especially if the subcommittee aligns the incentives of the Medicare program reimbursement with value and efficiency.

However, of concern is the current tri-committee mark. The authors have proposed the establishment of a public health insurance option. Providers who voluntarily participate in Medicare would be required to participate in the public option and would be paid at Medicare rates plus some incremental percentage for the first 3 years of operation. This raises substantial financial and operational questions around how the federal government could compel physicians to see those patients. For instance, would this mean that patients must be seen when they present or would providers be compelled to see the patient within a certain time frame? Further, if the public plan pays at Medicare rates, the reduction in commercial service revenue would compel radical restructuring of our institu-

tion, perhaps resulting in our demise. As such and in this current form, Marshfield Clinic strongly opposes the public plan alternative based on the belief that a true level playing field could never exist between public and private providers. In Wisconsin, where commercial rates vary between 180 to 280 percent of Medicare rates, this public plan would have such a profound competitive advantage that one needs to be concerned that providers would uniformly abandon the Medicare program to survive in the practice of medicine.

Further, there is a significant problem with the Medicare payment rates in Wisconsin as well as the rest of rural America. For example, Medicare currently reimburses us at only 51.6 percent of our allowable costs. We believe that this is a result of Medicare's failed formulas for reimbursing physician work and practice expense and Medicare's geographic adjustment. To address these systemic problems, we believe that Congress and CMS must refine Medicare payment systems to address the problems of access and encourage appropriate care by providing incentives that focus on quality and efficiency. Similarly, we are also concerned about the practice expense components of the Medicare physician formula. It is widely agreed that the data used to estimate non-physician wages does not reflect current patterns and practice of medicine. As a result, the formula distorts payments, paying some too much and others too little. To resolve this disparity, we would like to heighten the legislative work of Congressmen Braley and Kind, who have each authored legislation to correct this inequity, and we urge the subcommittee to include these members' thoughtful provisions in any health care reform legislation that advances.

Again, Marshfield Clinic appreciates the opportunity to share our views and we look forward to advancing our shared vision of a healthy America. Thank you.

[The prepared statement of Dr. Ulrich follows:]

Testimony on Health Care Reform
before

The Health Subcommittee of the Committee on Energy and Commerce
U.S. House of Representatives

By
Karl J. Ulrich MD, MMM
President/CEO
Marshfield Clinic
Marshfield, Wisconsin

June 25, 2008

This testimony is presented on behalf of the physicians and staff of Marshfield Clinic, who thank you for conducting this hearing. We commend you for advancing the national health reform debate, and in particular, your commitment to enacting comprehensive health reform legislation this year. At Marshfield Clinic we have followed President Obama's campaign proposals for health system reform very closely. In particular, we believe the President is on the right track with his orientation towards not only improving the quality and efficiency of health care, but that reform cannot build upon the tragically flawed incentives of the current Medicare program. We strongly urge you and all members of this Committee to be as bold as possible with your reform proposals in addressing the problems of affordability, quality, and disparities in payment and access that plague the program.

Marshfield Clinic is the largest medical group practice in Wisconsin, and one of the largest in the United States, with 796 physicians, 6500 additional staff, and 3.6 million annual patient encounters. The Marshfield Clinic system includes 49 regional centers located in northern, central and western Wisconsin, predominantly rural areas. As a 501(c)(3) non-profit organization, Marshfield Clinic is a public trust, and serves all who seek care, regardless of their ability to pay. Although we are a regional system of care, we do have patients who come from virtually all 50 states, as well foreign countries. The Clinic serves multiple federally-designated Health Professional Shortage Areas (HPSAs) providing primary care, dental and mental health services in partnership with our community health center known as the Family Health Center at 13 medical and 4 dental locations in Wisconsin. Recently, we have begun to address critical shortages in dental services that bear a direct relationship on the overall health of the population we serve. Marshfield Clinic has developed and acquired sophisticated tools, technology, and other resources that complement and support the population health management mission and strategy of the Clinic. These include an internally-developed CCHIT-certified electronic medical record, a data warehouse, an immunization registry, and an epidemiological database that enable enhanced definitions of disease states, diagnoses or conditions, and cost analysis of CPT level interventions. Marshfield Clinic's 49 regional centers are fully electronic, paperless, and linked by common information systems. With this infrastructure, the Clinic is presently publicly reporting clinical outcomes, and providing physicians and staff quality improvement tools to analyze their clinical and business processes, eliminate waste and unnecessary redundancies, and improve consistency while simultaneously reducing unnecessary costs.

Marshfield Clinic has long used information systems to facilitate care process redesign for patients with chronic illnesses, and the organization expanded its efforts after becoming a participant in the Center for Medicare and Medicaid Services (CMS) Physician Group Practice (PGP) Demonstration project. As a result of these expanded efforts, Marshfield Clinic reduced hospitalizations and costs, and has achieved significant savings for the Medicare program. By using and integrating EHR tools into rationally designed care and care measurement processes, the Clinic has saved CMS over $25 million in the first two years of this demonstration, while meeting or exceeding 27 out of 27 possible quality metrics. Results of the third year of the demonstration have yet to be released by the

Agency, but leave it to say that our internalized care management processes are demonstrably effective, enhanced through HIT applications, resulting in measurably improved patient outcomes, substantially reduced hospitalizations and profound savings for the Medicare program. We believe that equivalent or better performance by other organizations such as Accountable Care Organizations is imminently achievable and likely if Congress and CMS would take the big leap to appropriately align the incentives of Medicare program reimbursement around value and efficiency. We have made administrative decisions that prioritize the better understanding of healthcare delivery. In addition to rich data-mining processes, we are investing in bioinformatics and a center for healthcare intelligence. These, along with our Personalized Medicine project, will be the cornerstones of how Marshfield Clinic will make a difference in providing high quality, cost-effective care in the future.

Marshfield Clinic also owns and operates Security Health Plan (SHP) of Wisconsin, a physician-sponsored health maintenance organization, which serves more than more than 168,000 people in a 32-county area in northern, western and central Wisconsin, with a network of 42 affiliated hospitals, more than 4,100 affiliated physicians and other providers, and over 55,000 pharmacies nationwide. SHP is the third largest health maintenance organization in Wisconsin and provides insured and self-funded plans to a variety of large and small employers, as well as to individuals and families. SHP has been named to the U.S. News & World Report/America's Best Health Plans (1) ranking for four consecutive years and is accredited by the National Committee for Quality Assurance (NCQA). In November 2008, SHP was named the nation's **19th** best commercial health plan and the **5th** best Medicare plan by U.S. News & World Report.

Public Health Insurance Option

In the current Tri-Committee mark, unveiled last week, you have proposed the establishment of a Public Health Insurance Option available through a Health Insurance Exchange that would be capitalized by the US Treasury. Providers who voluntarily participate in Medicare would be required to participate in the public option, and would be paid at Medicare rates, and in some circumstances, Medicare plus 5% for the first three years of operation of the Public Plan. Under these circumstances the public plan would have a significant competitive advantage over private plans in localities where commercial rates are greater than Medicare rates. This raises substantial serious financial and ethical questions around how the federal government could ever compel physicians to see those patients. For instance, would this mean that patients must be seen when they present, or would providers be compelled to see the patient within a certain time frame?

If the public plan pays its providers for services at Medicare rates it could operate more efficiently than Security Health Plan (SHP) Marshfield Clinic's insurance subsidiary. As patients migrated from our plan to the lower cost public plan, the combined reductions in commercial service revenue, and premiums would compel restructuring of both Marshfield Clinic and Security Health Plan. As such, Marshfield Clinic and SHP strongly oppose this public plan alternative, based on the belief that a level playing field could never exist between public and private providers/insurers. In localities where Medicare rates are higher than commercial rates, the commercial plans would have a competitive advantage. In Wisconsin, however, where commercial rates vary between 180% and 280% of Medicare rates the public plan would have such a profound competitive advantage that providers would uniformly abandon the Medicare program to survive in the practice of medicine.

Further, there is a significant problem with Medicare payment rates in Wisconsin, as well as the entire Midwestern US. By our calculations the Medicare program currently reimburses the Clinic at 51.6% of its Medicare allowable costs, and other providers within Wisconsin and other Midwestern states report a similar inequity in Medicare reimbursements. If all services provided by the Clinic were provided at Medicare payment rates we calculate that the Clinic's current $900 million revenue stream would collapse by more than $ 400 million.

As a not-for-profit 501 (c) 3 institution Marshfield Clinic accepts and treats all patients regardless of their ability to pay. As one might expect, other providers in our Wisconsin service areas are reluctant to see Medicare patients or

accept referrals unless the patients require services that are more highly compensated under Medicare's flawed and regionally variable reimbursement systems. As a result, Clinic encounters for the publicly financed health care population have risen dramatically. While Marshfield Clinic physicians and practitioners make up about one-third of the provider population in our service area, we treat 60 - 70% of the Medicare population. In the same counties we also presently treat 60- 90% of the Medicaid population. Medicaid in Wisconsin reimburses the Clinic at about 48% of our costs. If the public plan could compel other providers to participate in the Medicare program some of our expected losses would be attenuated as other providers in our area us opened their doors to more Medicare patients. If a public plan were created and paid providers based on Medicare rates, or even Medicare plus 10%, Marshfield Clinic would be at risk in terms of its long-term viability. Specifically, as revenues decline we would be compelled to furlough physicians and staff, and close facilities – reducing patient access to care.

We believe that this problem is attributable to the inaccuracy of Medicare's formulas for reimbursing for physician work and practice expense, and Medicare's geographic adjustment of these portions of Medicare payment. At current Medicare rates even a 20 percent increase in Medicare reimbursement yields a payment that would only cover 61.9 percent of our costs. To address these systemic problems we believe that Congress and CMS must refine Medicare payment systems to address the systemic access problems and encourage appropriate clinical care by proving incentives that focus on quality and efficiency.

We also have a number of concerns related to the practice expense (PE) Geographic Practice Cost Index (GPCI) that have direct implications for equitable compensation of physicians under the Medicare fee schedule. We are concerned that the data used to estimate non-physician wages in the current PE GPCI do not properly reflect prevailing relative wage rates for the index occupational groups. We are also concerned that the composition of the PE GPCI, especially the non-physician wage component, is outdated and does not adequately reflect prevailing practice organization realities. Both of these have the potential to distort practice-related expense payments across localities, resulting in the Medicare program paying too much in some localities and too little in others.

Reform of Physician Payment and the Sustainable Growth Rate (SGR) Formula

In Section 1121 of the current Tri-Committee mark, the authors propose to revise the SGR formula via updates in reimbursement for physician services in a manner that will promote primary care and care coordination. The proposal would rebase the SGR using 2009 as the cumulative adjustment period. This would in effect wipe the physician slate clean and repeal the 20% cut expected in 2010. The proposal would divide physician services into two categories: 1) Evaluation and Management services, including primary care and preventive services identified by codes which will be annually subject an expenditure target and growth rate update of GDP + 2%; and 2) All other services identified by codes which will be annually subject an expenditure target and growth rate update of GDP + 1%. In addition the proposal establishes new Accountable Care Organizations (ACOs) similar to the Physician Group Practice Demonstration model that will be separate from the general physician pool and updating categories. This will allow groups of physicians who qualify as an ACO to be measured for their quality and performance on their own merits separate from the larger pool of all other physicians.

Marshfield Clinic commends you for this innovative proposal. We appreciate it for a number of reasons. Rebasing the SGR updating period will eliminate some of the budgeting uncertainty that we have been subject to since physician payment reforms were initiated in 1992. In addition, the segregation of evaluation and management services into a separate bucket will favor primary care over specialty services – reversing the trend that has reduced primary care payment since 1992.

Members such as Chairman Waxman and Rep. Dingell who were on the Commerce Committee that enacted Physician Payment Reform as section 6102 of the Omnibus Budget Reconciliation Act of 1989 will recall that under the Medicare Volume Performance Standard provisions of the Resource-based Relative Value Scale (RBRVS) there were then two buckets of services: 1) Primary Care, which included diagnostics and other ancillary services and 2) Specialty Services. While the congressional intent of RBRVS was to promote primary care and

cognitive service over specialty services, the exact opposite happened, and primary care has suffered ever since. The change that you are recommending today was needed 20 years ago.

Chairman Waxman and Rep. Dingell may also recall that former HHS Secretary Louis Sullivan who was in possession of longstanding research data that demonstrated the greater efficacy and efficiency of multi-specialty physician group practices recommended that they be considered separately for annual payment updates. This provision was opposed by the American Medical Association so Secretary Sullivan's recommendation was amended to become a "Study of Volume Performance Standard Rates of Increase by Geography, Specialty and Type of Service." In the study, the Secretary of HHS was required to "report to Congress on the development of criteria to allow qualified physician groups to opt-out of the national aggregate performance rates of increase and to have separate performance standards." A subsequent study was performed by Stan Wallack, Ph.D, and Christopher Tompkins, Ph.D. of the Institute for Health Policy at Brandeis University and led to the establishment of the Physician Group Practice (PGP) Demonstration in the Benefits, Improvement and Protection Act of 2000 (BIPA), and now 20 years later, we have come full circle to Secretary Sullivan's original proposal. It is a shame that we have wasted 20 years demonstrating the wisdom of Garrett Hardin's understanding of the Tragedy of the Commons. The beauty of this proposal, however, is that physicians will quickly realize that it is disadvantageous to be in the common pool. Consequently, the proposal has the potential to steer physicians towards efficient, integrated multi-specialty practice arrangements that would otherwise be incentivized to behave in the public interest. We believe that if Congress couples this proposal with more aggressive reforms that we suggest below, dramatic score-able reductions in the rate of increase in the cost of Medicare services might be achieved.

Marshfield Clinic believes that, as a part of an American commitment to greater value in health care, there is a role for greater accountability among providers. Our experience as a participant in the Medicare Physician Practice ·oup demonstration project has shown that physician group practices, utilizing population-based care management strategies, and tools like HIT, can achieve better coordination of care at lower costs. However, we have concerns that the criteria for participation in Accountable Care Organizations may be too restrictive to incentivize provider enrollment. Spending targets based upon expected national growth rates will favor the creation of ACOs in high payment localities, but will discourage participation in localities where the culture of medical practice is already conservative. Eligibility thresholds should be structured to maximize physician interest and capitalize participation in delivery reform, and incentive payments should be actuarially sound and risk adjusted based upon complete and accurate coding. These principles will sustain progress toward delivery system reform. Anything less will discourage providers and thwart your laudable objectives.

Reform Must Reward Value

As one of several organizations recognized in recent press accounts in the *New Yorker*, the *New York Times*, and the *Washington Post*, and in research published by Dartmouth School of Medicine as a center of high quality and efficient health care, we believe that health reform must reward value. Marshfield Clinic has addressed multiple challenges regarding quality and variations in care, demonstrating that proposals that shift payment for outcomes can be successful while providing a high level of care to Medicare recipients. The success of health reform rests on providing incentives that emulate this proven performance.

Research has demonstrated that throughout the U.S. there is costly and unjustified variation in the utilization and provision of health care services. In a number of recent addresses, President Obama has called attention to the huge geographic variations in Medicare spending per beneficiary. In the President's own words, "This is what we've got to fix."

Wisconsin Senator Russ Feingold and eleven of his colleagues have called attention to the same problem, asking Senate Finance Committee Chairman Max Baucus and Ranking Member Charles Grassley to provide incentives to healthcare systems that coordinate care and utilize aggressive quality controls to provide Medicare beneficiaries better care for lower cost, and to protect "high efficiency" providers from payment cuts. Chairman David Obey,

who represents Marshfield and central Wisconsin recently told HHS Secretary Sebelius that Medicare "reimbursement disparities are outrageous in my view and I would just hope that the people putting this bill together will understand that they would make a big mistake if they take for granted the support of people from states like Wisconsin or Minnesota if this outrageous disparity in reimbursements isn't corrected to a significant degree. Our states feel like we've been taken for suckers for years. Those outrageous disparities are just going to have to shrink significantly if we're going to get a product that everybody can support."

As the country's single largest purchaser of health care, Medicare can have a profound influence on the entire health care system. Yet, Medicare's fee-for-service (FFS) payment systems continue to reward inefficiency and poor quality, paying many health care providers much more than what it pays the most efficient and effective providers to treat the chronically-ill – individuals that represent less than a quarter of the Medicare population (20%) but account for a growing and disproportionate share of Medicare spending (75%). *If the US health care system mirrored the practice patterns of the most efficient and effective health care providers, Medicare could save billions of dollars annually.*

Problem: Misaligned Financial Incentives – *More* Care Does Not Equal *Better* Care

Research has long-documented glaring variations in the distribution and utilization of U.S. medical resources. The Dartmouth Atlas of Health Care depicts wide variation in the cost of care. Center researchers who produce the Atlas have documented how Medicare and other payers encourage the over-use of acute-care hospital services and the proliferation of medical specialists through misaligned financial incentives, especially for treating chronically-ill people. A recent report by the Congressional Budget Office (CBO) further supports this notion generally, indicating that spending in high-spending regions could be reduced without producing worse outcomes, on average, reductions in the quality of care (CBO - February 2008). The extent of variation in Medicare spending, and the evidence that more care does not necessarily result in better outcomes, leads us to ask if some chronically-ill Americans are receiving more care than they actually want or need.

Recommendation: Paying for Value in Medicare – Physician Fee Schedule and Hospital Payment Reforms
Medicare currently reimburses physicians under the Physician Fee Schedule (PFS) on the basis of: (1) the amount of work required to provide a service; (2) practice expenses related to maintaining a practice; and (3) medical liability insurance costs. Under such system, Medicare rewards physicians based on the volume of services provided without any regard to quality. In addition, the formulas by which Medicare's payments are calculated are widely variable throughout Medicare localities and are based upon outdated data assumptions regarding the cost and organization of medical practice. Mis-measurement of the cost of providing services by the Medicare program leads to systemic inequities in reimbursement that have created access problems throughout the country but especially in rural areas.

A crucial first step to addressing these problems begins with modest changes to Medicare's current payment methodologies:

- **Rewarding Value in the Reimbursement System** – Congress must introduce a "value index" into Medicare Parts A and B, to reward physicians and hospitals who provide safe, high quality care with excellent service to Medicare patients at a reasonable cost. The value index can be constructed for many types of payment models, including hospital DRG payments, physician fees, payment updates, and other payment formulas. We recommend that the geographic adjustment of physician work should be eliminated as recommended in legislation introduced by Senator Feingold (S 712) and Senator Grassley (S 318), and replaced with a quality/efficiency based coefficient for physician work as soon as possible. Legislation that we strongly support and would accomplish this objective, has been introduced by Iowa Rep. Bruce Braley and Wisconsin Rep. Ron Kind in the House and by Minnesota Senator Amy Klobuchar and Wisconsin Senators Feingold and Kohl in the Senate. The Medicare Payment Improvement Act (HR 2844, S 1249) seeks to reform the Medicare system to one that rewards the value of care over quantity of procedures, improving quality and lowering the

total cost of care over time. The bill's outcome-based approach creates the incentive for physicians and hospitals to work together to improve quality and use resources efficiently. According to a study by the McKinsey Institute, fee-for-service reimbursement, the predominant method in outpatient treatment, actually gives providers strong financial incentives to provide more, and more costly, care, not more value. Under the Act, medical professionals who produce more volume will need to take steps to also improve care, or the increased volume will negatively impact reimbursements they receive from Medicare.

- **Practice Expense Payment Floor** – Congress must require the Centers for Medicare & Medicaid Services (CMS) to administratively revise its measurement of the cost of practice to assure the validity and fairness of payment. However, in the interim, a payment floor must be established for practice expense to stem the inequities of the current methodology as proposed by Reps. Braley and Kind in HR 2201, the Medicare Equity and Accessibility Act of 2009. Extreme variation induced by errors in the payment methodology may also be reduced without compromising the relativity of payment by establishing a geographic practice expense index that limits to ½ the difference between relative wages and rents between fee schedule areas and the national average as proposed by Senator Grassley in S 318.

We believe that Congress must refine Medicare payment systems to address the systemic access problems that plague rural areas and encourage appropriate clinical care nationwide by proving incentives that focus on quality and efficiency. If doctors and hospitals have incentives to provide the best care instead of more care, we can help Americans avoid the unnecessary hospital stays, treatments, and tests that drive up costs.

Payments for Efficient Areas and Primary Care Bonuses

Section 1123 of the current Tri-Committee mark, it is proposed that there would be established an Incentive Payment(s) for Efficient Areas. Specifically, this proposal recommends a 5 percent bonus payment for suppliers of physician services in the 5 digit postal ZIP codes where the Secretary of HHS has determined that the per capita spending for services provided falls within the lowest fifth percentile for utilization. We believe that this proposal will modestly improve the circumstances of physicians in those localities. We do not believe that this will be an adequate stimulus to recruit new providers to these areas, even when they are coupled with the additional 5 percent Primary Care bonuses for Family Physicians, Internists, Pediatricians, and Geriatricians and the additional 5 percent if these specialties are practicing in Health Professional Shortage Areas.

Similar provisions were included in the Omnibus Budget Reconciliation Act of 1989 and did not reverse or improve the problems of access in rural and underserved areas. The problem that we urge you to address is that Medicare payment does not cover the cost of providing services. This is especially critical in rural areas, where Medicare and Medicaid patient encounters are a significantly larger proportion of physician practices than in more demographically homogenous areas. Rural physicians have more Medicare patient visits per week than their urban counterparts. In addition, the greater volume of Medicare patient visits among rural county physicians is largely true across all non-surgery service settings (such as office and hospital). Rural county physicians are more dependent on public insurers for revenue. This data, compiled by Mark Miller and Stephen Zuckerman of the Urban Institute in Health Affairs, (Winter 1991) also showed "**no significant difference in average total practice expenses between urban and rural locations, again even after controlling for specialty.**" At that time policy makers presumed that the physician payment reform would lead to improved reimbursement for rural and primary care physicians. As we have seen, this never occurred. Miller and Zuckerman (and others quoted in the article) observed that "Rural physicians now have lower fees but a higher volume of Medicare services, as measured by patient visits, than urban physicians have. This higher volume could be composed of either more patients or more visits per patient. Dor and Holahan found that volume per beneficiary was lower in rural areas. Thus we believe that the higher Medicare volume per rural physician is the result of each physician's seeing more patients, not providing more services per patient." Medicare payments between rural and urban localities vary by more than 30%. If the underlying cost of providing the services is the same, what is the policy justification for the variation in payment?

Adjustment to Medicare Payment Localities for California

In section 1125 of the current Tri-Committee mark, we note that the authors propose addressing the problem of geographic disparities in reimbursement via a proposal authored by your colleague, Rep. Sam Farr of California. We support this request which smooths reimbursement between localities that share identical cost burdens. We believe that this concept should only be applied if it can be applied nationwide to smooth the disparities in reimbursement between urban and rural localities that experience identical practice costs. This simplification might eliminate the complexities of administering 89 separate payment localities across the nation.

Medicare Advantage Reforms

In Section 1161 of the current Tri-Committee mark, the authors propose the phase-in of Medicare Advantage payment rates based on fee-for-service costs beginning in 2011 and completed in 2012. Marshfield Clinic supports parity in reimbursement between traditional fee for service and the Medicare Advantage program. However we believe that this will only result in fair premiums for beneficiaries, equivalent benefits for patients, and fair treatment for providers when the disparities in Medicare reimbursement have been addressed nationwide. Currently the taxes of individuals in low payment areas of the country are subsidizing zero premium plans with generous benefit structures in the high payment localities. This cross-subsidization is one more example of well intended health policies that have been implemented to benefit the wealthy and powerful localities at the expense of the less powerful. We recommend that Congress take steps to correct the inequities between localities.

In addition we commend the authors for including quality bonus payments and improved quality plan adjustments for high performance health plans.

rayments for Care at the End of Life

We believe that significant patient satisfaction and cost savings may be obtained by providing appropriate end of life counseling and care. In order to properly implement such programs on a nationwide basis, providers should receive payment for the use of advanced care planning tools for the chronically ill in their last two years of life. Such a payment mechanism should account for the time and resources of physicians and mid-level practitioners to counsel patients and document an end life care plan using an advance directive, health care power of attorney, or physicians order for life sustaining treatment. This documentation should be portable and accessible to all providers involved in the patient's continuum of care. Finally, provider's compliance with the documented plan of care should be measured and appropriately incentivized. We believe that when properly implemented, end of life care plans have the potential to significantly improve the quality and cost effectiveness of the health care system.

Comparative Effectiveness Research

Marshfield Clinic commends you for your emphasis on comparative effectiveness research on drugs, devices, treatments and other medical interventions centered at the Agency for Health Research and Quality though we respectfully recommend that you increase the funding and accelerate the timetable for implementation of the research agenda. We applaud your establishment of national priorities for performance improvement that focus upon prevalent high-cost chronic diseases, improve patient-centeredness, address variations in care and health disparities across groups and areas, and have the potential for rapid improvement due to existing evidence and standards of care.

Physician Payment Sunshine Act

Marshfield Clinic strongly supports the physician payment transparency proposal. It is the policy of the Clinic and our insurance subsidiary Security Health Plan not to accept gifts or gratuities of any type or value. Individuals who accept gifts or gratuities as agents or employees of MC/SHP are subject to discipline, including termination.

Redistribution of Unused GME Slots

Marshfield Clinic is concerned about having a sufficient supply of primary care physicians in order to meet the demands of an expanding and aging population. This is doubly true for patients and health systems in a rural setting. Currently only about 10% of physicians practice in rural areas while 25% of the population resides there. While 36% allopathic residents and 50% osteopathic residents who are trained in a rural residency end up practicing in a rural area, a recent report by Chen et al [2008] identified that only 4% of the residency training [based on FTEs] actually occurs in rural areas.

An increase in graduate medical education [GME] primary care training positions [be they rural or not] is essential to maintaining high-quality, accessible, and cost efficient care. With its longstanding history of providing GME, Marshfield Clinic supports your proposed recommendations to expand primary care training. A national healthcare workforce strategy should be a part of this process. As a rural community based GME partner, Marshfield Clinic would welcome an opportunity to collaborate with Health and Human Services and other external GME partners in developing and implementing such a strategy.

Payment for Transitional Care Activities

We think payment for transitional care activities and other services that are not paid for under the fee schedule today but demonstrate value to Medicare patients is an important part of the Tri-Committee proposal. Payment for certain care coordination services for chronically ill patients would be a critical component of a policy focused upon improving the quality and efficiency of care processes, and we applaud your efforts to address this important area of concern. We also respectfully ask that the Committee consider ways in which CMS could further promote re for patients with chronic health conditions through greater use of telephonic care assessment and management, coaching, education, and self management support to patients provided by registered nurses in rural areas.

We appreciate the opportunity to share our views regarding health care and delivery system reform. We commend you and your diligent and capable staff for addressing this public challenge and shouldering this responsibility. We look forward to the opportunity to assist you with the resources of the Clinic as you pursue this legislation, moving it to a meaningful resolution.

Mr. PALLONE. Thank you, Dr. Ulrich.
Dr. Wright.

STATEMENT OF JANET WRIGHT

Dr. WRIGHT. Chairman Pallone and Ranking Member Deal and members of the subcommittee, thank you for the opportunity to appear before the subcommittee today. My name is Janet Wright. I am a board-certified cardiologist, having trained in San Francisco and practiced in northern California for 25 years. For the last year I have been serving as the American College of Cardiology's senior vice president for science and quality here in Washington, and in that role I oversee our registries, our scientific documents like guidelines and performance measures and appropriate-use criteria and also our quality improvement projects and programs.

On behalf of the 37,000 members of the ACC, I commend you for setting out the health care reforms in the current draft bill. We see so many improvements and we commend you and applaud your efforts to both attend to and correct the flawed physician payment model. We also register concerns about proposed cuts in imaging and the effect they may have on patients' access to care. But in broad overview, the ACC is completely committed to comprehensive reform and we are very grateful for your attention to the matter.

Ranking Member Barton invited me to speak today about his draft proposal, the Health Care Transparency Commission Act of 2009, and I am delighted to offer these comments. The American College of Cardiology values performance measurements, its analysis and improvement and it demonstrates this commitment through a 25-year history of producing guidelines for clinical practice, the more recent generation of a particular kind of guidance called appropriate-use criteria, to help clinicians choose the appropriate type of treatment or technology or procedure that best fits that patient's clinical scenario, and in our efforts in what is now called implementation science, taking what we know works and trying to get that into the practice of medicine in a systematic way. Examples of that in recent years are the Door To Balloon project of the Alliance for Quality, over 1,100 hospitals here in the United States and beyond trying to shorten up that time from diagnosis of a myocardial infarction until the balloon opens that artery. And more recently we are about to launch a program called Hospital to Home, Excellence in Transition, along with key partnerships, particularly with the Institute for Health Care Improvement. And finally, we are beginning to implement our appropriate-use criteria, both in imaging and soon in revascularization, to help clinicians, their patients and their surgeons make good decisions about revascularization.

In fact, our vision is not just separate projects but a network of practices in hospitals. Our registries are in about 2,300 hospitals around the country and our ambulatory registry called the Improvement Program is just beginning but we are out into about 600 practices in the country. Our fully realized vision is to connect these practices and hospitals in a quality network. Those individuals practicing in the hospitals and outpatient settings are committed to the systematic delivery of scientifically sound patient-centered care, and fully realize that vision will include a primary care

network as well because we understand most of cardiac diseases are actually managed by primary care docs and nurses. In order to effect this vision to make this come true, obviously payment needs to be readjusted from the volume that we have known to the value that we treasure. I enlist and again appreciate your efforts to make that happen.

We believe that good data are the foundation for quality improvement and serve to stimulate innovation, very healthy competition amongst providers and rapid and continuous learning network. As the science of performance measurement improves and the skill of all of us at communicating complicated statistics to lay people, as that skill is honed, consumers will likewise find great value in quality information. The ACC strongly supports the public's right to valid, actionable and current data to help inform and enhance decision making. We find Mr. Barton's proposal to be a laudable one and should Congress proceed in this direction, we recommend consideration of the following principles. These were published in 2008 and I am only going to hit the high points.

But number one, the driving force for performance measurements and public reporting should be quality improvement. We acknowledge and support Mr. Barton's critical inclusion in his draft bill of quality ratings along with pricing information. Number two, public reporting programs should be based on performance measures with scientific validity. Number three, public reporting programs should be developed in partnership with health care professionals, those being measured. Number four, every effort should be made to use standardized data elements to assess and report performance, and to make the submission process uniform across all public reporting programs. This helps reduce the measurement fatigue and the disengagement that we often see in health care professionals who are exhausted with the effort of measuring. Number five, performance reporting should occur at the appropriate level of accountability. I think this is true in all areas of medicine but certainly in cardiology. The most effective care is delivered by teams. Focusing on an individual within that team may skew the measurement and the result of that measurement in a way that has adverse consequences.

Mr. PALLONE. Dr. Wright, you are almost a minute over, so if you could just summarize.

Dr. WRIGHT. Number six is avoiding those unintended consequences. Thank you very much.

[The prepared statement of Dr. Wright follows:]

Written Statement of

Janet Wright, MD, FACC
Vice President, Science and Quality
American College of Cardiology

Before the
House Committee on Energy and Commerce
Subcommittee on Health

June 25, 2009

Chairmen Waxman and Pallone, (Chairman Emeritus Dingell), Ranking Members Barton and Deal, and Members of the Subcommittee, thank you for the opportunity to appear before the subcommittee today. I am Dr. Janet Wright, ACC's Senior Vice President for Science and Quality. I am a board-certified cardiologist having trained in San Francisco and practiced for 25 years in northern California.

On behalf of the 37,000 members of the American College of Cardiology (ACC), I commend you for setting out the many positive reforms in the recently released Tri-Committee health reform discussion draft. ACC believes comprehensive reform of our current health care delivery system is essential and we stand ready to assist in this important effort.

Health Care Transparency Commission Act of 2009
Ranking Member Barton invited me to speak today about his draft proposal, the "Health Care Transparency Commission Act of 2009," and I'm delighted to offer these written comments.

The ACC values performance measurement, analysis, and improvement and demonstrates this commitment by its 25 year history of clinical guideline development; its generation of appropriate use criteria for guidance in the optimal use of technology, procedures, and treatment; its implementation science efforts such as D2B: The Alliance for Quality and H2H: Hospital to Home, Excellence in Transitions; and finally by the development and maintenance of hospital and ambulatory registries/quality improvement programs, now present in over 2300 hospitals and 600 practices around the country.

These data are the foundation of performance and quality improvement (QI) and serve to stimulate innovation, healthy competition, and rapid and continuous learning among providers. As the science of performance measurement improves and the skill of communicating statistics to laypersons is honed, consumers will likewise find great value in quality information. **The College strongly supports the public's right to valid, actionable, current data to inform and enhance decision-making.** We have

committed to preparing our multiple registries for transparency and find Mr. Barton's proposal to be a laudable one and, should Congress proceed in this direction, we recommend consideration of the following principles:

1. The driving force behind physician performance measurement and public reporting systems should be to promote quality improvement. Ideally, any assessment program should promote improvement in the quality and outcomes of care and have limited unintended consequences. A well-designed public reporting program should, therefore, be aimed at raising the performance of all providers and thereby increase access to high-quality care for everyone.

2. Public reporting programs should be based on performance measures with scientific validity. The evidence supporting the clinical processes that are the focus of the measures being used should be explicitly stated, transparent with respect to data sources, the validation of the data collection, and the statistical and reporting methodologies used including the limitations of those methodologies. Physicians, through their specialty societies, are well-qualified to understand the clinically relevant issues facing the field as well as how these can be translated into credible performance measures.

3. Public reporting programs should be developed in partnership with physicians. Clinicians are responsible for the burden of data collection and should be ultimately the drivers of provider quality improvement. Therefore, physicians should participate in testing the measurement system prior to any public reporting and should be offered feedback in a manner that would help inform and stimulate practice change.

4. Every effort should be made to use standardized data elements to assess and report performance and to make the submission process uniform across all public reporting programs. A universal reporting format will lower the administrative burden of data entry; facilitate comparative analyses; maximize provider participation; and, therefore, create the most meaningful platform for performance assessment and improvement.

5. Performance reporting should occur at the appropriate level of accountability. The modern practice of cardiovascular medicine is accomplished by teams of providers that include nurses, nurse practitioners, physician assistants, primary care physicians, and physicians in the various subspecialties of cardiology. While individual provider data have value to the team in its effort to improve quality, these data are unlikely to be useful to payers and consumers. Attributing an outcome or measure to a single physician oversimplifies performance measurement at best. At its worst, such an approach undermines the preferred model of team-based care and the ideal collaborative design necessary to deliver patient-centered, effective, and safe health care.

6. All public reporting programs should include a formal process for evaluating the impact of the program on the quality and cost of health care including an assessment of unintended consequences. Physician performance measurement,

particularly in the ambulatory setting, is still in its early stage and there is limited experience with public reporting of these measures. The potential impact of unintended consequences on the quality and cost of care is great, especially with respect to patient access to care and physicians' practice patterns. Those who choose to publicly report data should be accountable for analyzing their program's consequences—both good and bad; reporting the results of those analyses to all of the involved constituencies; and modifying the program in order to achieve maximum benefit for patients. These rigorous analyses will not only serve to make reporting programs more effective but should also provide a stimulus for focused health-services research and offer the potential for providing an invaluable laboratory for quality improvement.

Conclusion

At its best, public reporting is intended to stimulate focused efforts to eliminate the gaps in care that jeopardize the health of patients and contribute to excessive expenditures. Poorly designed programs risk misleading patients about the quality of their care, damaging the therapeutic relationships with their providers, and creating greater disparities in care delivery.

In closing, let me again congratulate the Committee for its discussion draft to reform America's health care system. The College appreciates how the draft seeks to reform the Medicare physician payment system ("the SGR"). We have some additional ideas on how we can improve cardiovascular care in such a way that will greatly improve quality, produce better patient outcomes, and reduce cost. We have significant concern, however, in the discussion draft's arbitrary adjustment to the utilization rate of imaging equipment from 50 percent to 75 percent and what impact that will have on patient access to imaging services.

I would be happy to address these or any other issues or assist your work in any way.

Mr. PALLONE. Thank you. Sorry.
Dr. White.

STATEMENT OF KATHLEEN M. WHITE

Ms. WHITE. Chairman Pallone, Ranking Member Deal, distinguished committee members and Congressional staff, I am Kathleen White, a registered nurse, speaking today on behalf of the American Nurses Association, and we thank you for this opportunity to testify. The ANA is the only full-service national association representing the interests of the Nation's 2.9 million registered nurses in all educational and practice settings. ANA advances the nursing profession by fostering high standards of nursing practice.

ANA comments the committee for its work in the tri-committee's draft legislation which represents a movement toward much-needed comprehensive and meaningful reform for our health care system. We appreciate the committee's recognition that in order to meet our Nation's health care needs, that we must have an integrated and well-resourced national workforce policy that fully recognizes the vital role of nurses and other health care providers and allows each 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 that are patient centered, comprehensive and accessible. We also support a restructured health care system that ensures universal access to a standard package of essential health care services for all.

That is why ANA strongly supports the inclusion of a public health insurance plan option as an essential component of comprehensive health care reform. We believe that inclusion of a 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 peace of mind that is missing from our current health care environment. It will guarantee the availability of quality, affordable coverage for individuals and families no matter what happens and generate needed competition in the insurance market. ANA looks forward to partnering with you to make this plan a reality.

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 drafts, these are precisely the professional skills and services that registered nurses bring to patient care. As the largest group of health care professionals, registered nurses are educated and practice within a holistic framework that views the individual family and committee as an interconnected system. Nurses are the backbone of the health care system and 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.

ANA deeply appreciates the committee's recognition of the need to expand the nursing workforce and thanks you for your commitment to amend the title VIII nursing workforce development programs under the Public Health Service Act and commend the inclu-

sion of the definition of nurse-managed health centers under the title VIII definitions. We applaud the removal of the 10 percent cap on doctoral traineeships under the advanced education nursing grant program and the inclusion of special consideration to eligible entities that increase diversity among advanced educated nurses.

Additionally, the expansion of the loan repayment program eligibility to include graduates who commit to serving as nurse faculty for 2 years will help address this critical shortage of both bedside nurses and nursing faculty. We are also grateful for the funding stream created through the public health investment fund and the commitment of dollars through 2014 that would offer vital resources and much-needed funding stability for these title VIII programs.

ANA applauds the use of community-based multidisciplinary teams to support primary care through the medical home model. ANA is especially pleased that under this proposal nurse practitioners have been recognized as primary care providers and authorized to lead medical homes. Nurse practitioners' skills and education, which emphasize patient- and family-centered whole person care, make them particularly well-suited providers to lead in the medical home model, focused on coordinated chronic care management and wellness and prevention. 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 a strong emphasis on reporting nurse staffing and long-term care settings, both publicly and to the Secretary. The availability of nurse staffing information on the nursing home compare Web site would be vital to help consumers make informed decisions and the full data reported to the Secretary will ensure staffing accountability and enhance resident safety. ANA hopes that in the same vein the committee will look toward incorporating public reporting of similar nurse staffing measures and nursing-sensitive indicators in acute care through the hospital compare Web site as recommended by the National Quality Forum.

Finally, a reformed health care system must value primary care and prevention to achieve improved health status of individuals, families and the community. 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 applauds the committee's recognition of the vital importance of addressing health disparities.

Once again, the American Nurses Association thanks you for the opportunity to testify before this committee. We appreciate your understanding of the important role nurses play in the lives of our patients and the health system at large. Nurses are ready to work with you to support and advance meaningful health care reform today. Thank you.

[The prepared statement of Ms. White follows:]

Committee on Energy and Commerce
United States House of Representatives
Hearing on Health Reform in the 21st Century:
Proposals to Reform the Health System

Testimony Provided by
Kathleen M. White, PhD, RN, CNAA, BC
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June 25, 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. Thorough our 51 constituent member associations, ANA represents RNs across the nation in all practice settings.

ANA commends the work of the House Energy and Commerce, Ways and Means, 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 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 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 health care is a basic human right and that 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, American 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 deeply appreciates the committee's recognition of the need to expand the nursing workforce, and thank you for your commitment to amend the Title VIII Nursing Workforce Development Programs under the Public Health Service Act. We are pleased to see so many important provisions included in the bill that will help address the growing nursing shortage. We appreciate the inclusion of the definition of the Nurse Managed Health Centers under the Title VIII definitions. Moreover, we applaud the removal of the 10% cap on doctoral traineeships

under the Advanced Education Nursing Grant program and the inclusion of special consideration to eligible entities that increase diversity among advanced educated nurses. We appreciate the updated loan provisions under the Title VIII programs. Additionally, the expansion of the Loan Repayment Program eligibility to include graduates who commit to serving as nurse faculty for two years will help address this critical shortage.

We also are grateful for the financial commitment to the Title VIII programs made in the draft. The funding stream created through the Public Health Investment Fund and the dollars committed through 2014 would offer vital resources and much needed funding stability for these important programs.

Finally, we welcome Tri-Committee's acknowledgement that career ladder programs support the advancement of ancillary staff to become registered nurses as highlighted in Section 2502 of this bill. Career advancement opportunities and life-long learning help promote a diverse workforce which reflects the nation's population.

ANA along with the nursing community looks forward to working with you as you move forward to advance these provisions and to discuss further potential inclusion of a few additional Title VIII revisions that would further update the programs and help address the need for expanded faculty and nursing school capacity.

ANA commends the committee for the many measures in the bill that would bolster the nursing profession, 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 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 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 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.*

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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.

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 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 applauds 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 an 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. PALLONE. Thank you, Ms. White.
Dr. Gabow.

STATEMENT OF PATRICIA GABOW

Dr. GABOW. Chairman Pallone, Ranking Member Deal and members of the committee, thank you for the opportunity to testify. I am Dr. Patricia Gabow and I am speaking for Denver Health and National Association of Public Health and Hospital System. Please excuse my voice.

Denver Health is an integrated safety-net institution that includes the State's busiest hospitals, all Denver federally qualified health centers, the public health department, all the school-based clinics and more. Since 1991, we have provided $3.4 billion in uninsured care and have been in the black every year. We have state-of-the art facilities and sophisticated HIT. These characteristics have enabled amazing quality. Ninety-two percent of our children are immunized. Our hospital mortality is one of the lowest in the country. Sixty-one percent of our patients have their blood pressure controlled compared to 34 percent in the country. This is despite the fact that 46 percent of our patients are uninsured, 70 percent are minorities and 85 percent are below 185 percent of federal poverty level.

So you may ask if we are doing so well and meeting patients' needs, why am I here supporting health reform. The answer is straightforward. As the safety-net physician leader, I see every day that America is failing to meet people's health care needs in a coordinated, high-quality, low-cost way. The number of uninsured at our door and the cost of their care increases every year. In 2007, our uninsured care was $275 million. Last year it was $318 million, and is projected to be $360 million this year. This is not sustainable. Moreover, not every American city has a Denver Health. As a doctor, I ask myself why should where you live in America determine if you live. Why should an uninsured cancer patient get care if they live in Denver but not if they live in another Colorado county?

You have included important reform components in your draft bill. We support your goal to ensure affordable, quality care for all. I agree that costs must be reduced if we are to cover everyone and costs can be reduced by developing integrated systems that get patients to the right place at the right time with the right level of care, with the right provider and the right financial incentives. We support your continued investment in DSH hospitals, community health centers and public health. I would encourage incentives to integrated systems. These entities will be important during the transition to full coverage and afterwards to vulnerable patients including Medicaid, which will be a building block for much of the coverage expansion. Integrated systems are cost efficient. Our charges for Medicaid admission are 30 percent below our peer hospitals.

Your investment in primary care and nurse training and the National Health Service Corps is critical. Without this, we will not be able to get patients to the right provider for the right level of care. As a public entity, we believe in the power of the public sector to meet the needs not only of those patients on public programs but

also private patients. We are the major Medicaid provider for our State but our HMO also serves private patients including Denver's mayor. We and other safety-net systems would welcome the opportunity to continue to be a plan of choice.

In summary, as a physician and a GEO of a public safety-net system, I urge you to continue this effort to substantially reform our delivery system, our payment model and to provide care for all Americans. Our current system cannot and should not be sustained. America deserves better. I and NPH are eager to help you in this very important task. Thank you.

[The prepared statement of Dr. Gabow follows:]

Reforming the Healthcare System

Written Statement by Patricia A. Gabow, M.D.
Chief Executive Officer
Denver Health
Denver, Colorado

Before the

U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Health
Room 2123 Rayburn Office Building

June 25, 2009

Chairman Pallone, Ranking Member Deal, and Members of the Committee, thank you for this opportunity to explain why I strongly support your efforts to achieve health care reform. In giving you my personal reflections, based on long years of observing the difficulties inherent in our current health care industry, I speak primarily as CEO of Denver Health, but also as a member of the National Association of Public Hospitals and Health Systems (NAPH), the national association that represents America's safety net health systems. I came to Denver Health 36 years ago because I believed in its core mission of providing health care to America's most vulnerable people.

I would like to begin by extending my thanks to this Committee, Congress and the Administration, for their historic efforts to reform our nation's health care system. In particular, I support your goal of extending comprehensive health coverage to all Americans.

Health reform is needed now in America to create access for the 46 million Americans who do not benefit from the knowledge and care made possible by the advances in American medicine, but, more importantly, do not even have ready access to basic preventive and primary medical, dental and behavioral health care.

Health reform is needed now because America does not deliver the quality of care that we should expect. The Commonwealth Fund's national and state scorecards show that as a nation we get an overall quality grade of 65 out of 100 and that there is enormous variability across states.

Health reform is needed now because America cannot afford to spend twice as much on health care as other developed countries without our businesses losing global competitiveness and without bankrupting our children.

Your Health Care Reform Draft Proposal addresses 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. The Health Care Reform Draft Proposal acknowledges that true health reform must adequately and broadly address the three issues of access, cost and quality. Both Denver Health and NAPH support Congress's efforts to promote integration and care coordination, to address disparities in care, and to invest in primary care training.

My testimony will briefly describe Denver Health and NAPH, and then will address the following topics:

- Cost reduction
- The role of integrated health systems in health reform, including the use of coordinated care networks
- The need for safety nets in health reform
- Workforce issues

Denver Health and NAPH

Denver Health is the integrated safety net institution for Denver and the Rocky Mountain Region. It includes multiple linked components of a public care delivery system. These are: the 911 paramedic ambulance and trauma system; a Disproportionate Share Hospital (DSH) which is the busiest hospital in the state with almost 26,000 discharges; all eight of Denver's federally qualified health centers which provide primary medical and dental care; the county public health department; all twelve school-based clinics; a 100 bed non-medical detoxification center; a call center which includes a regional poison center and a nurse advice line; correctional care; and an HMO which serves Medicaid, SCHIP,

Medicare and commercial patients. The system is staffed by approximately 5,300 employees including 265 employed physicians. Denver Health is an academic teaching hospital and has a formal affiliation with the University of Colorado Denver School of Medicine. All the physicians have full time academic appointments. Medical and nursing students, interns, residents and a myriad other professional trainees receive clinical training at Denver Health. The system has invested more than $300 million in health information technology, which has resulted in a single imaged electronic medical record with a single patient identifier that links all the patient care components of the system. The facilities are state of the art and have been designed for safety and efficiency.

As do all DSH safety net hospital systems that are members of NAPH, Denver Health focuses on the special needs of the entire population through regional trauma services, regional poison center services, public health, 911 and disaster preparedness. These critical roles will remain after health reform.

It also focuses on the needs of special populations that are largely excluded from health care coverage, and often from any health care at all. These populations rely on the safety net, which is composed of institutions such as DSH hospitals and community health centers. These special populations include the poor, the uninsured and underinsured, minorities, non-English speakers, the homeless, the chronically mentally ill, substance abusers, victims of violence such as rape, victims of infectious disease such as HIV/AIDS, and prisoners.

The care provided to these patients in these systems represents America's national health insurance by default. The volume of this care is staggering in its magnitude. NAPH members include more than 140 of the nation's largest metropolitan area safety net hospitals and health systems. These systems have traditionally

served as the primary source of care for 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 Medicaid or Medicare, and another 20 percent are uninsured. Although NAPH members account for only two percent of hospitals nationwide, they provide 20 percent of the nation's uncompensated 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 ten percent increase in uncompensated care costs compared to the same quarter of 2007. In addition, safety net hospitals provide nearly three-fifths of all burn care beds and over 30 percent of all Level 1 Trauma Centers in America's major cities. These disaster care services are critical not only in the event of a major accident, but also during natural disasters and public health crises, such as an influenza epidemic.

Denver Health represents a microcosm of this breadth of care. Forty-six percent of our patients are uninsured, 70 percent are minorities, and 85 percent are below 185% of Federal Poverty Level. Since 1991, we have provided $3.4 billion dollars in uninsured care. Yet we have been in the black every year. The city's payment represents just five percent of our net revenue. The number of uninsured at our door, and the cost for their care, increases every year. In 2007 our uninsured care topped $275 million; last year it was $318 million; and this year is projected to be $360 million. We are good at cost effective care, but this is unsustainable.

Despite this highly vulnerable population, Denver Health has been able to achieve amazing quality—92 percent of our children are immunized; we have one of the lowest hospital mortality rates in

the country with an observed to expected overall mortality of 0.58. Sixty-one percent of our hypertensive patients have their blood pressure under control compared to an average of 34 percent in the country.

While safety nets are there for vulnerable populations, not every American city and town is fortunate enough to have a safety net institution, let alone a comprehensive health care system like Denver Health. The vulnerable populations must not be forgotten in this reform effort. As a safety net physician leader, I see every day that America is failing to meet the health care needs of people in a coordinated, systematic, high quality, low cost way. As a doctor, I ask myself -- why should where you live in America determine if you live? Why should uninsured cancer patients get care if they live in Denver, but not if they live in another Colorado county? This must change. This is why I support meaningful, broad health reform as outlined in the Health Care Reform Draft Proposal.

I believe this Health Care Reform Draft Proposal includes many important reform components. The goal to ensure affordable, quality health care for all is essential.

Reducing Costs

As stated in the Health Care Reform Draft Proposal, costs must be reduced. This is necessary if we are to cover everyone. Costs can be 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. This is not a theoretical construct. For example, our charges per Medicaid day and per Medicaid admission are thirty-two percent below our peer Colorado metropolitan hospitals.

Waste can be removed from our health care delivery systems. Denver Health has adopted Toyota Production Systems or "LEAN" to improve quality by removing waste in all components of our health care system. We have extensively trained 170 employees, including physicians and nurses, in LEAN tools and have realized more than $25 million in financial benefit in less than three years. There are numerous ways to reduce health care costs in our health system without reducing quality. In fact, quality can be enhanced. I offer a number of them here.

1. Develop integrated models of care that provide coordinated care and integration of patient information across the continuum of a patient's life and across the continuum of health and through stages of disease. This will ensure getting the right level of care, at the right place, at the right time, for the right cost.

   Denver Health demonstrates the efficiency and quality of care that can be obtained even among the most vulnerable with this model. Denver Health's charges are lower than the average for metropolitan Denver peer hospitals for all 35 DRGs reported by the Colorado Hospital Association and the lowest in 25 of the 35 (CHA 2007). We are in the top 10 in quality among University Healthsystem Consortium hospitals.

2. Provide incentives to link DSH hospitals, community health centers, school-based clinics and public health departments would aid in this integration. Coordinated Care Networks (CCNs), as proposed by NAPH, have the potential to serve as a vehicle for transitioning to an integrated system to address the needs of vulnerable patients. Attached to my testimony is a proposal NAPH recently delivered to the Committee. 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.

3. Provide alternative points of access rather than direct face-to-face encounters such as Nurse Advice Lines, and other telephone/email management options. This would be particularly valuable for vulnerable populations such as Medicaid and Medicare patients, to whom transportation and co-payments represent a barrier.

   Denver Health created a 24/7 multiple language nurse advice line. The nurse advice line even gives out prescriptions when appropriate. This is especially useful for patients for whom transportation is a barrier. In a published study, we demonstrated that patients frequently choose a lower level of care if they can speak to a nurse. The annual net dollar savings was more than $300,000 for the then small number of callers (30,000.) (American Journal of Managed Care 2004). Now the line takes nearly 100,000 calls a year.

4. Provide incentives to states to move to Medicaid managed care utilizing high performing systems.

5. Integrate care for mental health, substance abuse and physical health rather than having these services delivered in separate entities, which creates difficulties for patients and their families, and adds cost.

6. Facilitate pharmacy programs so that Medicaid patients who are receiving primary care from 340B provider use that provider for pharmacy services. Community Health Centers and DSH hospitals are 340B providers, and many Medicaid patients already are getting care in these entities. Expand 340B pricing to inpatient services.

   Example: The potential savings is demonstrated in our system. The average price per prescription for our Medicaid patients in the marketplace was $62.73 while at Denver Health it was $27.35 (2007).

In this regard, we appreciate this Committee's longstanding support for the 340B program, and the expansion of the program included in the Health Care Reform Draft Proposal. Section 340B of the Public Health Service Act enables hospitals and other providers that serve a large volume of low-income and uninsured patients to access significant discounts on pharmaceuticals We urge you to extend this program to inpatient drugs, ensuring greater access to low-income populations and providing savings to safety net hospitals and the Medicaid program.. Although the discounts available through the program are approximately 20 – 30 percent of the prices available through other purchasing arrangements, they are only available for drugs used in an outpatient setting. Therefore, 340B hospitals are forced to pay significantly more for inpatient pharmaceuticals, amounting to an average of $1.5 million per hospital in additional costs each year.

Moreover, these hospitals must devote significant time and resources to managing their drug inventory to prevent 340B drugs from being used in an inpatient setting. The Safety Net Hospitals for Pharmaceutical Access organization estimates that hospitals participating in 340B would save a combined total of at least $1 billion annually if the program was extended accordingly. These savings would accrue both to the hospitals and the Medicaid program.

The Medicare Modernization Act authorized pharmaceutical manufacturers to voluntarily offer discounted pricing on inpatient drugs to hospitals participating in the 340B program without affecting their Medicaid "best price" and thus the size of the rebates the manufacturers must pay to the entire Medicaid program. Unfortunately, 340B hospitals have been unable to obtain meaningful voluntary inpatient discounts from manufacturers.

Safety Net Health Systems in Healthcare Reform

Enacting comprehensive health reform legislation is a critical step to achieving universal coverage. The Health Care Reform Draft Proposal does not envision full coverage at least until 2013. 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 role of 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 health systems 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 share of these patients.

Given safety net health systems' uninsured volumes, they also are uniquely positioned to facilitate enrolling the uninsured into new coverage vehicles. Health reform most certainly will use Medicaid as a critical building block for expanded coverage for the poor. States likely will rely on safety net systems 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 deep knowledge of our patients' unique needs, safety net health systems will be able to facilitate enrollment in the most suitable plans through the Health Insurance Exchange.

Both Denver Health and NAPH strongly endorse the DSH policy reflected in the Health Care Reform Draft Proposal. Both Medicaid and Medicare DSH payments will continue at their current levels into the foreseeable future, with HHS reporting on both programs by July 1, 2016.

The ongoing need for DSH support is well-illustrated by Massachusetts's experience. Massachusetts paid for its coverage expansion with DSH dollars, assuming that hospitals would recover their costs with the new coverage options. Had payments for the newly-insured been adequate, this assumption may have proven true. Safety net hospitals in Massachusetts suddenly faced significant losses, and the state has been forced to use its economic stimulus dollars to make sure that its safety net hospitals remain viable.

For that reason, we strongly support the approach to both Medicare and Medicaid DSH outlined in the Health Care Reform Draft Proposal in establishing a thoughtful process by which the DSH

programs can be restructured once health reform is fully implemented and only after hospital losses on both the uninsured and Medicaid populations are substantially reduced.

Workforce

The Health Care Reform Draft Proposal's investment in primary care and nurse training, the National Health Service Corps, and scholarships are important and necessary. Without this we will not be able to get patients to the right provider for the right level of care.

As this Committee recognized in the Health Care Reform Draft Proposal, there is no single solution to resolving our workforce issues. We will need to train more physicians. Your proposal takes a step in this direction by redistributing Medicare graduate medical education slots, ensuring that no funded slots remain unused. We will need to attract more medical students to underrepresented specialties, and particularly primary care. Your legislation addresses this issue as well, increasing Medicaid physician primary care payments to Medicare rates and establishing new grant programs for primary care training and preventative medicine.

We also will need to specifically target minority and underserved populations for improved care. Increased funding for the National Health Service Corps is part of the answer, as the program incentivizes new physicians to begin their careers in underserved areas. Denver Health, for example, affiliates with the University of Colorado Denver School of Medicine and trains 3,400 students per year, including medical students, nursing students, interns, residents and a myriad other professional trainees. Our diverse patient populations ensure that physicians training at our facilities learn to deliver culturally competent care and to treat the specialized needs of minority and other vulnerable populations early in their careers.

Concluding Comments

As a public entity, we believe in the power of the public sector to meet the needs, not only of uninsured patients and patients on public programs, but also of commercially insured patients. We are the major Medicaid provider for the state, a major provider of SCHIP and a Medicare provider, but our HMO also serves private patients. Every mayor of Denver for more than 25 years has been in our health plan. Twenty percent of our net revenue is from private patients. We would welcome the opportunity to be a public plan of choice. Other integrated public safety net systems would also welcome the opportunity to be a public plan of choice for the populations covered under public programs like Medicaid and SCHIP and also for the newly insured populations.

In summary, as a physician and a CEO of a public safety net system, I strongly support and urge you to continue this effort to substantially reform our delivery system, our payment system, and to provide care to all Americans in an affordable, cost efficient, high quality, coordinated true system of care. Not only cannot our current system be sustained, but it should not be sustained. America deserves better. You are to be commended for tackling this difficult issue. I would like to thank you for this opportunity to testify on your Health Care Reform Draft Proposal. It is an historic time for our country. I and NAPH will look forward to working with you in any way we can to help achieve meaningful health care reform.

Mr. PALLONE. Thank you, Doctor.
Mr. Hawkins.

STATEMENT OF DAN HAWKINS

Mr. HAWKINS. Well said, Dr. Gabow.

Good morning, Mr. Chairman, Ranking Member Deal and distinguished members of the subcommittee, distinguished meaning present and accounted for. On behalf of the National Association of Community Health Centers, the Nation's more than 1,200 community health center organizations and the more than 18 million people they serve today, thank you for the opportunity to contribute to today's discussion. In community health centers all across the country, we witness the urgent need for fundamental health reform every single day in the faces and the struggles of our patients who for too long have been left behind by our dysfunctional health care system.

Our 43 years' experience in caring for America's medically disenfranchised and underserved has taught us three things. First and foremost, that health reform must achieve universal coverage that is available and affordable for everyone and especially for low-income individuals and families, second, that that coverage must be comprehensive and must emphasize prevention and primary care, and third, that it must guarantee that everyone has access to a medical or a health care home where they can receive high-quality, cost-effective care for their needs.

Mr. Chairman, we believe that the plan we have before us today meets those principles and also moves our Nation much closer to achieving the equity and social justice in health care that has proven so elusive over the past century. Community health centers strongly support the draft legislation's call to expand Medicaid to cover everyone with incomes up to 133 percent of poverty without restriction. This Medicaid expansion may well be the most important and the most essential feature of this plan, especially for the patients we serve.

At the same time, we urge you to ensure that as these Medicaid beneficiaries are potentially moved into the health insurance exchange, they can continue receiving supplemental Medicaid benefits, those key services like outreach, transportation, nutrition and health education, screening and case management that will remain so vital to their health and well-being but will most likely not be covered by their exchange plans. It is also clear that the expansion of insurance coverage, while a vital first step, can only take the country so far. Most importantly, the increased demand for care that comes from expanding coverage must be met with an augmented primary health care system as the people of Massachusetts learned in the wake of their State's reform. Here again, the draft legislation delivers a solid response to this challenge and we applaud its call to expand the health center system of care through increased funding as part of the new public health investment fund. The members of this committee have consistently provided broad, bipartisan support for health centers over the years and we deeply appreciate that, and I can assure that health centers are repaying your trust and your investment in their every day.

For example, a recent national study done in collaboration with the Robert Graham Center found that people who use health centers as their usual source of care have 41 percent lower total health care costs and expenditures than people who get their care elsewhere. As a result, health centers saved the health care system $18 billion last year alone, more than nine times the federal appropriation for the program and better than $2 for every dollar they spent in care. With the new funding in the draft bill, these savings will grow even larger. The National Health Service Corps is a vital tool for health centers and underserved communities seeking to recruit new clinicians and the draft legislation would bring an historic investment to the program, leading to thousands more primary care providers to practice in underserved communities.

The committee has also historically recognized that it makes sense for all insurers to reimburse health centers and other safety-net providers appropriately and predictably for the comprehensive primary and preventive care they provide. In order to accomplish this goal, we recommend that Congress align health center payments from all insurers, public and private, with the structure currently in place under Medicaid. As you continue deliberations, we urge the committee to consider improving the bill further by including language from H.R. 1643, which would align the current Medicare health center payment methodology with the successful Medicaid prospective payment system.

Finally, as full participants in a reformed health care system, America's health centers stand ready to deliver quality improvement, increased access and cost containment that will be necessary to make this reform successful. To that end, we applaud the committee's inclusion of network adequacy standards for all exchange plans to ensure that people living in underserved communities have access to the health centers and other essential community providers located there.

Mr. Chairman and members of the committee, we again thank you for your leadership and your commitment to make health care reform work for all Americans and we pledge ourselves to work with you to make that a reality this year. Thank you.

[The prepared statement of Mr. Hawkins follows:]

Submitted Written Testimony of Daniel R. Hawkins, Jr.
Senior Vice President, Public Policy and Research
National Association of Community Health Centers
Submitted to the Committee on Energy and Commerce
Thursday June 25, 2009

Introduction

Chairman Waxman, Ranking Member Barton, and Distinguished Members of the Committee:

On behalf of the more than 1,200 community health center organizations nationwide, and the more than 18 million patients they serve, I want to thank you for your leadership in taking on this vitally important process, and for the opportunity to contribute to today's discussion. In Community Health Centers across the country, we witness the urgent need for fundamental health reform **every single day,** in our waiting rooms and exam rooms, and in the faces and struggles of our patients, who for too long have been left behind by our current dysfunctional health care system.

Let me begin with a broad outline of what health reform means to us in the health center movement, gleaned from our more than 40 years' worth of experience in caring for those who have been forgotten or left behind, and who have suffered immeasurably as a result. We believe that health reform should strive, first and foremost, to achieve universal coverage that is **available** and **affordable** to everyone, and especially to low-income individuals and families. We believe that coverage must be **comprehensive**, including medical, dental, and mental health services, and should emphasize **prevention and primary care**. And we believe that reform must also strive to guarantee that everyone – and especially those who are medically

underserved – has access to a **medical or health care home**, where they can receive **high quality, cost effective care** for their health needs.

Mr. Chairman, we believe that the plan developed by you and the Chairs of the Ways & Means and the Education & Labor Committees not only meets every one of those principles, but also takes great strides toward moving our nation much closer to achieving the equity and social justice in health care that has proven so elusive over the past century – and for that, Mr. Chairman, we commend you and the Members who worked with you on this history-making collaboration.

Community Health Centers strongly support the draft legislation's efforts to make health insurance coverage more affordable and more accessible to poor and low-income individuals and families – and in particular, its call to expand Medicaid to cover everyone with incomes up to 133% of the federal poverty level without restriction. These are the very people who most need the services and benefits offered through Medicaid – services like health and nutrition education, outreach, transportation, patient case management and language assistance, as well as dental care, mental health services and prescription drugs, that too often are not covered, or inadequately covered, under private insurance policies. This Medicaid expansion may well be the most important and essential features of your plan, Mr. Chairman, and for that we and so many others are grateful. At the same time, we urge you to take forceful steps to ensure that, as these Medicaid beneficiaries are potentially moved in the Health Insurance Exchange following implementation, they are fully able to continue receiving – as supplemental Medicaid benefits – these vital services that are and will remain vital to their health and well-being, even though these services will not be covered by their primary insurers through the Exchange.

We also appreciate the vital subsidies that this draft legislation would provide the lower-income individuals and families who are above the Medicaid eligibility level, not only to make coverage

affordable but also to eliminate barriers to care as well, through cost-sharing protections – and in particular by eliminating cost-sharing for vital preventive care.

In discussions about reforming the health care system, one element remains constant across all platforms and proposals: the need to invest in accessible, affordable, high-quality primary care for all as a down payment on a more effective and efficient health care system. Even before the current recession, a lack of access to affordable primary health care posted one of the most persistent challenges to our health care system. In our 2007 report, *Access Denied*, NACHC found that 56 million people lacked adequate access to primary care because of shortages of physicians in their communities. While even those with insurance coverage can be medically disenfranchised, it is the low income, uninsured, and minority populations that are disproportionately affected. These are the very populations that experience some of the most egregious health care disparities. **In an updated study released in March, we found that the number of medically disenfranchised has risen to 60 million people nationwide.**

This fact is unconscionable, as is the fact that in the wealthiest country on earth, more than 46 million people are uninsured. And yet it is clear that while vital, the expansion of insurance coverage can only take the country so far. From states and communities already experimenting with their own reform efforts, we know that federal, state, and local governments must continue investing in the health care safety net even if universal coverage is achieved. We also know that true progress in resolving this crisis entails removing all barriers to care, including provider shortages, the lack of insurance coverage, and cost, as well as geographic, linguistic, and cultural barriers. Most importantly, the increased demand for care that comes from expanding coverage must be met with an augmented primary care infrastructure.

Here again, Mr. Chairman, your plan delivers a solid response to this challenge: and we applaud you for its call to expand the highly-successful system of care that Community Health Centers represent through increased funding as part of the new Public Health Investment Fund. We also comment you for funding community-based prevention and

wellness programs, and for strengthening the work of state, local, tribal, and territorial health agencies, through the Fund as well.

Mr. Chairman, I have personally seen the power of health centers to lift the health and the lives of individuals and families in our most underserved communities. As a VISTA volunteer assigned to south Texas in the 1960s, I was asked by the residents of the poor farm-worker community I served to help improve access to health care and clean water, and assisted in the development of one of the country's first migrant and community health centers. At the request of community leaders, I stayed on and served as executive director of the health center from 1971 to 1977. That health center is still in operation today, and has expanded to serve more than 40,000 patients annually.

That community empowerment and patient-directed care model thrives today in every one of the country's 1,200 health centers serving more than 7,000 communities across America; I am honored to be able to share their success story and to detail how their growth from a small demonstration project in their early years to an essential element of our nation's primary care infrastructure today uniquely positions them to be key participants in a reformed health care system. I want to thank each Member of this Committee for your consistent, bipartisan support for health centers over the years, and your dedication to the all-important goal of providing affordable, accessible health care to all Americans. With your ongoing support, this cost-effective, high quality system of care will continue to expand toward our goal of eventually reaching every individual in need of a health care home and serving as the model and innovation leader for what primary care practice can become.

And I can assure you that your trust and your investment in health centers is being repaid handsomely every day. Literally dozens of studies – and research over the past three decades and up through this year – have concluded that health center patients are significantly less likely to use hospital emergency rooms or to be hospitalized for avoidable conditions, and are therefore less expensive to treat than patients treated elsewhere.[i] In fact, a recent national

study done in collaboration with the Robert Graham Center found that people who use health centers as their usual source of care have **41% lower total health care expenditures** than people who get most of their care elsewhere.[ii] **As a result, health centers saved the healthcare system up to $18 billion last year alone – more than 9 times the federal appropriation for the program, and better than $2 for every dollar they spent – and with new funding those savings will grow even larger.** The investment in primary and preventive care that federal and state governments make by paying health centers adequately actually *yields significant savings* to the health care system and to taxpayers as well.

As coverage expands, we must also ensure that patients have access to doctors and other health professionals who will treat them. The National Health Service Corps is a vital tool for health centers and underserved communities seeking to recruit new clinicians – and **the draft legislation would bring an historic investment to the NHSC and lead to thousands more providers choosing to practice in underserved communities**. In fact, the draft legislation takes powerful and forthright steps to confront the three most pressing shortcomings affecting today's health care workforce: the well-documented shortage of primary care professionals; the serious lack of diversity in the workforce; and the severe maldistribution of providers which victimizes underserved communities most of all.

Furthermore, in order to increase the pool of new health professionals entering primary care, health centers support **adequate and reliable primary care provider reimbursement** by all public and private payers to reflect the value – in system-wide cost savings and improved health outcomes – that primary care physicians and other health professionals provide. Here, too, your plan makes great strides in fixing a seriously broken payment system that has led to a significant and growing shortage of primary care health professionals – this, too, will be key to the success of health reform.

Health Center Participation in Public and Private Insurance

In the early 1990s, Congress instituted a health center-specific Prospective Payment System (PPS) to guide health center reimbursement under Medicaid, complementing the existing cost-based reimbursement structure under Medicare. The PPS structure ensures that health centers receive adequate payment through an all-inclusive per-visit payment rate that balances both higher and lower costs for all of the services provided to our publicly insured patients. We appreciate the Committee's leadership, as part of the Children's Health Insurance Program Reauthorization Act (CHIPRA) earlier this year, to align health centers' reimbursement under CHIP with the successful Medicaid PPS.

Medicaid and health centers have worked extremely well together to generate cost savings – averaging more than 30% per Medicaid beneficiary – and to improve patient outcomes. Compared to Medicaid patients treated elsewhere, health center Medicaid patients are 19% less likely to use the ER for avoidable conditions and have lower hospital admission rates, lower lengths of hospital stays, less costly admissions, and lower outpatient and other care costs.[iii]

In health reform, **it is critical that insurers enrolling people in underserved communities be required to include health care providers located there, and especially health centers and other primary care safety net providers, in their networks. In that regard, we applaud the Committee's inclusion of network adequacy standards for all Exchange-participating health plans, to ensure the participation of health centers and other essential community providers.** In addition, it makes sense to **align health center payments from <u>all</u> insurers** with the structure currently in place under Medicaid, to assure the continuity and quality of care that health centers have been proven to deliver. The PPS structure for health centers appropriately and predictably reimburses health centers for the comprehensive care they provide. Toward that end, we very much support the inclusion of requirements in the new public health insurance option that providers be paid no less than Medicare levels for the care they furnish; however, we urge the Committee to consider improving the bill further by including language from H.R. 1643, which would align the current Medicare health center payment methodology with the successful Medicaid Prospective Payment System. In fact, we believe that **the same should be**

ensured in any expanded insurance model, whether public or private.

Under a reliable and fair payment structure, and with full participation in the reformed health insurance system, health centers stand ready to provide low-cost, highly effective preventive and primary health care to millions more individuals and families in need. Reimbursing safety net providers like health centers appropriately for the comprehensive, coordinated care they provide will help to grow the primary care infrastructure - an essential step toward ensuring that investments in health reform translate into improved health and wellness for the nation.

Conclusion

Mr. Chairman, every health center administrator, clinician, community Board member, and patient witnesses the need for health reform every day, and we all strongly believe that reform must achieve universal coverage that is available and affordable to everyone, especially to low income individuals and families. As reform moves forward, we look forward to working with you to ensure that the final product also brings access to a health care home for every patient in need.

Thank you.

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[i] McRae T. and Stampfly R. "An Evaluation of the Cost Effectiveness of Federally Qualified Health Centers (FQHCs) Operating in Michigan." October 2006 Institute for Health Care Studies at Michigan State University. www.mpca.net. Falik M, Needleman J, Herbert R, et al. "Comparative Effectiveness of Health Centers as Regular Source of Care." January - March 2006 *Journal of Ambulatory Care Management* 29(1):24-35. Falik M, et al. "Ambulatory Care Sensitive Hospitalizations and Emergency Visits: Experiences of Medicaid Patients Using Federally Qualified Health Centers." 2001 *Medical Care* 39(6):551-56.

[ii] NACHC and the Robert Graham Center. *Access Granted: The Primary Care Payoff.* August 2007. www.nachc.com/access-reports.cfm.

[iii] Falik et al. "Comparative Effectiveness of Health Centers as Regular Sources of Care." 2006. *Journal of Ambulatory Care Management* 29(1):24-35. Falik et al. "Ambulatory Care Sensitive Hospitalizations and Emergency Visits: Experiences of Medicaid Patients Using Federally Qualified Health Centers." 2001. *Medical Care* 39(6):551-56.

Mr. PALLONE. Thank you, Mr. Hawkins.
Mr. Roberts.

STATEMENT OF BRUCE T. ROBERTS

Mr. ROBERTS. Chairman Pallone, Congressman Deal and members of the Health Subcommittee, I am Bruce Roberts, the executive vice president and CEO of the National Community Pharmacists Association, NCPA. I am a licensed pharmacist in the State of Virginia and I have owned four community pharmacies over the last 33 years in Loudon County, Virginia. NCPA represents the owners and operators of 23,000 independent community pharmacies in the United States. We appreciate the opportunity to testify before you today on the role of pharmacy in health care reform.

In many communities throughout the United States, especially in urban and rural areas, independent community pharmacies are often the primary source of a broad range of health care products and services, services such as medication therapy management and immunization programs for seniors under Medicare Part B and D. We believe that a reformed health care system should expand the availability of these programs because they can help improve the quality of care and reduce health care costs.

The reality is that for every dollar the health care system spends paying for prescription medications, we spend at least another additional dollar on health care services to treat the adverse effects of medications that are taken incorrectly or not at all. For example, a primary cause for costly hospital readmissions is the lack of patient adherence to medications used to treat chronic medical conditions such as hypertension and high cholesterol. Pharmacists can play an important role in the post-acute care and helping patients manage their medications through education, training and monitoring. We applaud the fact that the draft House language would allow the involvement of non-physician practitioners such as pharmacists in the medical home pilot project. Pharmacists can help improve the use of prescription medications, especially in those individuals that have multiple chronic diseases.

NCPA is very much appreciative of the fact that the draft House legislation includes reform of the average manufacturer's price, AMP, based reimbursement system for Medicaid generic drugs. We would like to get this fixed this year. We are concerned that the Medicaid generic reimbursement at 130 percent of the weighted average AMP as proposed in the draft House bill combined with low dispensing fees paid by States will in total still significantly underpay pharmacies for the dispensing of low-cost generics in the Medicaid program. This could create a disincentive for the use of generic drugs causing a rise in Medicaid costs over the long term. NCPA asks the committee to consider a higher FUL reimbursement rate for generic medications, especially for critical access community pharmacies that serve a higher percentage of the Medicaid recipients or rural pharmacies.

With respect to our ability to continue to provide durable medical equipment, DME, to Medicare beneficiaries, we believe that requiring State-licensed, State-supervised community retail pharmacies to obtain both accreditation and surety bonds to simply sell

demipost items such as diabetes testing supplies to Medicare beneficiaries is basically overkill. Thousands of pharmacies across the country, mostly small pharmacies, will not be accredited at all or not be finished the accreditation process by October 1, which will mean that they will not be able to provide diabetes testing supplies for Medicare beneficiaries. We applaud the 90 bipartisan members of the House and 13 members of the Energy and Commerce Committee who supported H.R. 616, the bill that was introduced by Congressman Barry and Congressman Moran that would exempt pharmacies from redundant and unnecessary accreditation requirements. We also appreciate the work of Congressman Space in introducing H.R. 1970, which would exempt pharmacies from unnecessary surety bonds. We ask that the provisions from these bills be included in the chairman's mark. If there is willingness to exempt pharmacies from these requirements, we ask that Congress consider acting by October 1, which is the deadline for providers to obtain accreditation and surety bonds.

Finally, I would make a few comments regarding the public plan option. Under the House proposal, payment rates for prescription drugs under the public plan proposal would be negotiated by the Secretary. We would be very concerned giving the Secretary authority to set payment rates for prescription drugs without some basic guidance to how these rates should be established and updated. We also ask that the language be clarified such as the administration of any benefit under the public plan would be accomplished by a pharmacy benefit administrator as opposed to a pharmacy benefit manager. We would prefer a model used in the Medicaid program or in the Department of Defense Tri-Care program where the administrator is used. Under this model, most, if not all, the negotiated drug manufacturer rebates would be passed through to the public program.

In conclusion, we look forward to working with Congress and the Administration to reform the health care system and we look forward to the opportunity to work with you to meet that end.

[The prepared statement of Mr. Roberts follows:]

NCPA
NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

WWW.NCPANET.ORG

Testimony of

Bruce T. Roberts, R.Ph.

Executive Vice President & CEO

National Community Pharmacists Association (NCPA)

House Energy and Commerce Committee

Subcommittee on Health

Thursday, June 25th, 2009

THE VOICE OF THE COMMUNITY PHARMACIST

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Chairman Pallone, Congressman Deal, and Members of the Health Subcommittee, I am Bruce T. Roberts, Executive Vice President and CEO of the National Community Pharmacists Association (NCPA). I am a licensed pharmacist in the state of Virginia and former owner of a community pharmacy in Leesburg, Virginia.

NCPA represents the owners and operators of more than 23,000 independent community pharmacies in the United States. We very much appreciate the opportunity to testify before you today about the role of pharmacy in health care reform and, in particular, our views on the draft House legislation that was released last week.

In many communities throughout the United States, especially in urban and rural areas, independent community pharmacies are often the primary source of a broad range of health care products and services. These include prescription drugs and over-the-counter medications, as well as health care-related products such as diabetes testing supplies, canes, crutches, ostomy supplies and specialty compounded prescription products. Many of our pharmacies also offer free home delivery to their patients.

Incorporate Pharmacists' Services into a Reformed Health Care System

To date, the traditional role of pharmacists in the health care delivery system has been focused on safely dispensing prescription medicines. However, over the last 30 years, the role of the pharmacist has expanded from being solely a reliable dispenser of prescription products to that of provider of patient care services.

All across the country, community-based pharmacists are involved in providing a wide range of patient care programs that help to enhance the use of prescription medications and other health care products. These include medication therapy management services; immunization programs for seniors under Medicare Parts B and D; diabetes self education and training under Medicare Part B; smoking cessation and weight management programs; and other patient-centered programs. We believe that any reformed health care system should expand the availability of these programs because they can help improve quality of care and reduce health care costs.

For every dollar that the health care system spends on paying for prescription medications, we spend at least another dollar on additional health care services to treat the adverse effects of medications that are taken incorrectly or not taken at all. These include hospitalizations, physician office visits, and emergency room visits. That is an unacceptable situation which needs to be addressed.

For example, a primary cause of costly hospital readmissions is the lack of patient adherence to medications used to treat chronic medical conditions, such as hypertension and high cholesterol. Pharmacists can play an important role in post acute care settings in helping patients manage their medications through education, training, and monitoring.

We also know that pharmacists' face-to-face interventions are the most cost-effective interventions in improving health outcomes. Mirixa, a health care company that focuses on providing MTM services, recently did a study of over 10 million Medicare Part D prescription claims and found that face-to-face interventions with pharmacists about their medications help to reduce drug spending by $34 per patient per month, or over $400 per year. Telephone interventions and letters sent to patients were far less effective in proving medication use and reducing costs.

The draft House language appears to allow the involvement of non-physician practitioners – such as pharmacists - in the medical home pilot project. We recommend that this language be clarified and strengthened to make it clear that pharmacists should be included. Pharmacist involvement in a patient's medical home can help improve the use of prescription medications, especially in those individuals that have multiple chronic diseases.

We also believe that health insurance plans offered under the exchange should provide a comprehensive pharmacy benefit, rather than just a prescription drug benefit. This pharmacy benefit would include prescription drugs plus pharmacist-delivered medication therapy management (MTM) services. These MTM services would be provided for select individuals who take a certain number of medications for chronic illnesses, have multiple chronic medical conditions, and incur a certain level of high prescription drug spending each year.

Fix Medicaid Pharmacy Reimbursement System

NCPA very much appreciates the fact that the draft House language includes reforms to the Average Manufacturer Price (AMP)-based reimbursement system for Medicaid generic drugs. We appreciate the Committee's recognition that inadequate Medicaid pharmacy reimbursement could significantly reduce Medicaid recipients' access to prescription services from community retail pharmacies.

The bill would reset the Federal Upper Limit (FUL) for generics at 130% of the weighted average AMP, rather than 250% of the lowest AMP for a particular generic. The current language also attempts to redefine the "retail pharmacy class of trade" to assure that manufacturers only include sales prices to retail pharmacies when calculating AMP. It is important for the AMP definition to reflect only manufacturers' sales to traditional "retail community pharmacies". That is because AMP could become a benchmark for pharmacy reimbursement in Medicaid and Medicare, as well as private commercial prescription drug plans. An AMP definition that includes PBM rebates, or sales to mail order pharmacies, among others, would artificially lower the AMP and underpay retail pharmacies for prescription medications.

For most independent community pharmacies, 90 percent or more of their revenues are derived from prescription sales. Independents serve twice as many Medicaid recipients as larger pharmacies. Many independents operate pharmacies in rural and urban locations where most Medicaid recipients live. Revenues derived from Medicaid prescriptions are a critical source of revenues for independent pharmacies.

For that reason, we are concerned that Medicaid generic drug reimbursement at 130% of the weighted average AMP as proposed in the draft House bill, combined with the low dispensing fees paid by states, will, in total, still significantly underpay pharmacies for dispensing low-cost generic drugs in the Medicaid program. This could raise Medicaid costs in the long term if more higher-cost brand name drugs are dispensed. Last year, we supported H.R. 3700, the Fair Medicaid Drug Payment Act, which would have set FULs at 300% of the weighted average AMP. We believed that setting the FUL at 300% of the weighted average AMP would provide sufficient reimbursement to assure that pharmacies would be able to continue to dispense generics.

Data from the Congressional Budget Office show that FULs set at 130% of the average AMP would be significantly problematic for independent community pharmacies. The CBO found that the average AMP is equal to 68% of the acquisition cost of prescription drugs for independent community pharmacies. *(Congressional Budget Office, Prescription Drug Pricing in the Private Sector, Publication No.2703, January 2007, Table 5, p.19.)* That is, a pharmacy would only be paid 68 cents on the dollar if pharmacies were being paid at the average AMP. Therefore, just to get independent pharmacies back to their acquisition costs of purchasing prescription drugs from wholesalers, the FUL would have to be set at least at 150% of the average AMP.

Reimbursement at anything less than 150% of the weighted AMP will mean that independent community pharmacies are selling their products at a loss under Medicaid. Moreover, while Congress may only want to pay pharmacies their acquisition costs for generic medications, the reality is that state dispensing fees do not cover the costs of dispensing. Currently, the dispensing fee in every state under Medicaid is not high enough to cover the cost of dispensing, which on average is about $10.89 per scription. In fact, many states pay only a third or less of the actual cost of dispensing. Thus, the higher payments for the generic product help to offset low dispensing fees.

Thus, we implore Congress not to address only one side of the Medicaid pharmacy reimbursement equation. Total payment for generic medications and dispensing fees must be adequate to cover pharmacies' costs to purchase and dispense the product. For that reason, NCPA asks that the Committee consider a higher FUL reimbursement rate for generic medications, especially for critical access pharmacies that serve a higher percentage of Medicaid recipients, or rural pharmacies. We also ask that the language include a requirement that states set dispensing fees based on recent cost of dispensing surveys to assure that pharmacies can continue to dispense Medicaid generic prescriptions and keep their doors open.

Modify Pharmacy DMEPOS Accreditation Requirements

Health care reform efforts should start by reducing unnecessary and costly government regulations on health care providers, especially small providers.

For example, we believe that requiring state-licensed, state-supervised community retail pharmacies to obtain both accreditation and surety bonds to sell simple DMEPOS items such as diabetes testing supplies to Medicare beneficiaries is basically overkill.

While we understand the need to assure Medicare program integrity, thousands of pharmacies across the country – mostly small pharmacies – will not be accredited at all or not have finished the DMEPOS accreditation process by October 1st – which will mean they will not be able to provide diabetes testing supplies to Medicare beneficiaries. This is totally contrary to all the efforts being targeted at coordinating care. Medicare beneficiaries tend to obtain their prescription medications and supplies from a single source – their local community pharmacy. Disrupting their source of supply of diabetes testing supplies could result in less frequent blood glucose monitoring and higher costs for hospitalizations and physician visits to treat complications of diabetes.

We applaud the 90 bipartisan Members of the House and the 13 Members of the Energy and Commerce Committee that support H.R. 616, the bill introduced by Congressmen Berry and Moran that would exempt pharmacies from these redundant and unnecessary accreditation requirements. We also appreciate the work of Congressman Space in introducing H.R. 1970, which would exempt pharmacies from additional costly and unnecessary surety bond requirements. If there is a willingness to exempt pharmacies from these requirements, we ask that Congress consider acting before October 1st, which is the deadline for providers to attain accreditation and surety bonds.

Assure Efficient Operation of Public Health Insurance Plan Option

Under the House proposal, payment rates for prescription drugs under the public plan proposal would be negotiated by the Secretary. We have some concerns with the language as drafted. That is because, over the years, community pharmacies have had significant issues with CMS in setting adequate payment rates under Medicaid for generic drugs.

In addition, CMS has also failed to approve reasonable increases in state Medicaid pharmacy dispensing fees when reliable data showed that such increases were warranted. CMS has also been unresponsive to pharmacy concerns in situations where payment rates for generics have been too low.

For these reasons, we would be very concerned with giving authority to set payment rates for prescription drugs to the Secretary without some basic guidance as to how these rates should be established and updated.

We also ask that the language be clarified such that administration of any drug benefit under a public plan would be accomplished by a pharmacy benefits administrator (PBA) rather than a pharmacy benefits manager (PBM). We would prefer a model used by the state Medicaid programs, or the Department of Defense (DOD) TRICARE program, where an "administrator" is used, which we believe will save money for the public program. That is because under a PBA, most if not all negotiated drug manufacturer rebates would be passed through to the public program.

The public plan would also benefit because "spread pricing" would be eliminated. Under "spread pricing", PBMs commonly charge the plan sponsor one price for a prescription, and then pay the pharmacy a lower amount for the prescription, pocketing the difference. Medicare Part D has recently prohibited this practice, known as "spread pricing". The public plan option should fully benefit from any rebates or discounts paid by manufacturers or pharmacies, and not have part of these retained by a PBM intermediary.

With respect to any public plan option established, we also ask that standards be established for payment rates to pharmacies, including the establishment of dispensing fees, and that "any willing pharmacy" be allowed to participate in a public plan option if it is developed.

Conclusion

In conclusion, NCPA believes that the House draft is a good place to start with respect to discussions about how to reform the nation's health care system. In particular, we think there are many opportunitics for pharmacists to help improve the use of prescription medications in a reformed health care system through an expansion of pharmacist-delivered medication therapy management services.

We also believe that Congress should strengthen the community pharmacy infrastructure by assuring appropriate reimbursement for Medicaid prescriptions, given that independent community pharmacies serve a much higher share of Medicaid recipients than other pharmacies.

We also ask that you allow us to continue to serve our Medicare beneficiaries with diabetes by removing the unnecessary burdens of DMEPOS accreditation and surety bonds on small businesses.

Finally, we urge Congress to build transparency and accountability into any public plan option that might be developed, and that, to maximize savings, a pharmacy benefits administrator be used rather than a ırmacy benefits manager. We look forward to working with the Congress and the Administration on reforming our nation's health care system and thank you for the opportunity to testify.

Mr. PALLONE. Thank you, Mr. Roberts.
Mr. Yarwood.

STATEMENT OF BRUCE YARWOOD

Mr. YARWOOD. I should first of all say thank you for including me in the distinguished panel. I mean, doctor, doctor, doctor, doctor, pharmacy, and here is old Yarwood sitting right in between them all. Thank you very much. I appreciate being here.

As you know, I am Bruce Yarwood. I am president and CEO of American Health Care Association and the National Center for Assisted Living, which we represent about 11,000 facilities across the country with a great cross-section of the profession. We have big, we have small, we have rural, we have urban, proprietary, non-proprietary. And I would be remiss if I didn't say we look at ourselves as a pretty significant portion of the economy right now. We are about 1.1 percent of the gross domestic product when you kind of sort it all out.

Now, having said that, we have taken a look at the 800 pages and it is a significant bill, and I must admit one that does not include long-term care reform. At the same time, it includes a whole bunch of stuff that has impact on us. And let me try to synthesize a little bit of the comments.

First, as we move forward and try to do a better job in terms of quality, it is really important for us to have economic stability, and one of the things we find in the bill is we have three pretty big problems with it. First of all, the bill has a provision that would institutionalize what the CMS is doing to cut 3.3 percent out of our Medicare rate based on a formulary mistake that was made by them 4 years ago. Secondly, we are concerned about the discussion draft that will eliminate a part of the market basket and so what we are looking at then is not only a 3.3 percent cut in our rate coming from CMS but then an additional cut coming from the committee that would significantly take resources out in terms of our ability to pay, and as you know, we are two-thirds to three-quarters or 75 percent labor based, and so a significant reduction in reimbursement causes us a big problem in terms of our ability to pay and keep staff.

Third, which is not your doing, but Medicare cuts are being considered at the same time we are looking at what we call the unfortunate reality of Medicaid underfunding. What we have seen, the stimulus package was a help. However, in response to the recession, we see 46 percent of the States are freezing or cutting nursing home rates and that the 75 percent are not keeping up with inflation. So in a short statement, what is occurring is that we are looking down the barrel of a Medicare cut and at the same we are looking across the country at Medicaid rates either staying stable or falling in a period of inflation and so we are feeling caught in an economic vise, if you will.

Now, let me talk a little bit about some other stuff that is I would say very positive. Regarding Part B, we applaud you for the proposal to extend the therapy cap extension process exception process. Second, I think in testimony earlier we talked about Medicare re-hospitalization. We have a re-hospitalization problem and we need to address that issue. We think there are ways to do that.

In a short statement, we find that our re-hospitalization comes on day 2, 3 and 4 of admission and typically they go back to the hospital because they come on the weekend or things of that nature. So we think we should continue work on that together. Third, we think that we should be looking at the whole post-acute setting and trying to integrate that much better than it is now and we have numbers that would show that if we either on a pilot or demonstration basis, we find that if we would integrate and pay based on diagnosis, not on site, we can save multibillion dollars ranging above $50 billion over the next 10 years, and that simply stated is that we can take a knee or a hip that is not an IRF but in a nursing home and do it for about half the cost.

I would be remiss if I didn't respond a little bit to 100 pages of your bill that was addressed somewhat earlier by the prior panel that talks about transparency in long-term care. Very basically put, the question is that what we need to do is take a lot better look at who owns places, how they are owned, who makes the decisions. We have been in discussions with the staff for about the last 18 months and frankly we support the concept and the direction of the committee and we believe firmly that by continuing to work together, the final legislation that we can parse together, we can absolutely support.

I would say there are a few specifics though that I would be remiss if I didn't say that we have a problem with. First, we have a difficult time with what a disclosable party, and in the bill itself, for example, it mentions that we should be disclosing our bankers' boards of directors. That is something we don't have or can't get to. Secondly, we would suggest the provisions that you are looking at be tailored to talk about exactly who we want to disclose. We take a look at the bill and we are in the position of disclosing people like who are landscapers are, painters are and things of that nature that don't have a significant amount so we think we can work that out. Third, we heard a lot about compliance programs from the Inspector General. We have no problem with compliance programs but what we need is to tailor those based on the size of the facility. A compliance program for Kindred Health Care, the largest in the country, versus the compliance program for a 35-bed facility in Oakland are two different things so we just need to be sympathetic as to what those are.

Mr. PALLONE. You are a minute over.

Mr. YARWOOD. Let me say this. Thank you very much for letting us be here. We certainly want to work together and there are great things in the workforce area and the transparency stuff. We are here to make it work for you.

[The prepared statement of Mr. Yarwood follows:]

STATEMENT

Of

BRUCE YARWOOD

On Behalf of

American Health Care Association

National Center for Assisted Living

Before the

U.S. House of Representatives'
Energy and Commerce Committee's Subcommittee on Health

June 25, 2009

Thank you Chairman Pallone, Ranking Member Deal, and the entire Subcommittee. I also commend each member of the Energy and Commerce, Ways and Means, and Education and Labor Committees for working in concert to pursue health care reform in a manner that is cooperative and deliberative, and seeks to achieve President Obama's goals of improving patient care, reducing health care costs, preserving consumer choice, and ensuring access to quality health care – goals that we share. I am Bruce Yarwood, President and CEO of the American Health Care Association and National Center for Assisted Living (AHCA/NCAL). I am grateful for the opportunity to be with you here today to offer our profession's perspective on health care reform and to highlight the crucial role long term and post-acute care fulfills across the spectrum of health services in America.

We agree with the assessment of the Energy and Commerce, Ways and Means, and Education and Labor Committees that the U.S. health care system is in crisis and that rising health care costs affect American families, businesses, and both federal and state health care programs. We applaud the priority placed on reforming our nation's fractured health care delivery system, and the approach taken by the three committees. The discussion draft bill establishes a framework for reform, and I hope that all of us here today can provide insight and input to help shape a final package that serves the best interests of consumers, caregivers, and our nation's commercial infrastructure.

As the largest association of long term and post-acute care providers representing not-for-profit and proprietary facilities, AHCA/NCAL understands the importance and need to address overall health

care reform. We also share your goals of transforming health care through a thoughtful and measured approach that keeps the needs and choices of consumers at the forefront of the discussion. We appreciate the opportunity to contribute to this debate that will ensure, in the final analysis, that the comprehensive health care reform enacted by this Congress will balance the benefits provided to our fellow citizens with the fundamental needs of the professions, industries, and caregivers who provide the foundation for a systemic overhaul of our nation's health care system.

Long term care accounts for 1.1 percent of the Gross Domestic Product (GDP) – $153.8 billion annually. Our sector contributes to the employment of nearly 4.5 million individuals and supports $161 billion in labor income nationally - often, with a long term care facility being the largest employer in a town. As a direct employer, long term care provides more jobs than our nation's entire educational services industry and 40 percent more than Wal-Mart, the world's largest employer. With the long term care profession playing such a significant role – as care providers, employers, and revenue generators – the impact that comprehensive health care reform will have on this sector must be addressed prior to implementing major overhauls to the system.

On behalf of the profession responsible for caring for our nation's most vulnerable citizens, I am proud of the advances we have made in delivering high quality long term care services and we remain committed to sustaining these gains in the years and decades ahead – when, as we all know, demand for long term care will by all accounts dramatically increase.

Long Term & Post-Acute Care: A Crucial Element of an Effective Health Care System

Americans are living longer and our nation's aging population is growing – many of whom have medical or cognitive conditions that require care in a nursing facility. Currently, more than three million Americans rely on the care and services delivered in one of the nearly 16,000 nursing facilities each year, and an additional one million individuals receive care and services in assisted living communities nationwide.

The forecast for the future need for nursing facility care is alarming. A March 2008 report from the National Investment Center for the Seniors Housing & Care Industry (NIC) indicates that the demand for long term care services will more than double by 2040. Coupled with the current need and future increased demand for quality long term and post-acute care services, it is imperative that the changing role of care provided by our sector be recognized. The demographics of the individuals cared for in skilled nursing facilities (SNFs) continue to evolve. In fact, at present there are more Medicare covered "short-stay" post-acute patients cared for in a year than there are "long stay" Medicaid residents.

This week marks the ten year anniversary of the U.S. Supreme Court's *Olmstead* decision, which has resulted in a much needed increase in the availability of home- and community-based long term care services (HCBS). The impact that this landmark Supreme Court decision has had on skilled nursing facilities is that the long-stay patient that we care for today is significantly more frail and disabled

than just ten years ago, requiring substantial health care services and assistance with activities of daily living such as bathing and eating. For these individuals, nursing facility care is essential as their chronic care needs cannot be met in the community.

Quality – AHCA/NCAL's First Priority

Long before "quality" and "transparency" became catch words of the federal government and its oversight of health care, they were truly the compass for AHCA/NCAL and its member facilities.

Our association and our members have been working diligently to change the debate regarding long term and post-acute care to focus on quality – quality of life for patients, residents, and staff; and quality of care for the millions of frail, elderly and disabled individuals who require our services. We have been actively engaged in a broad range of activities that seek to enhance the overall performance excellence of our sector. While keeping patients and their care needs at the center of our collective efforts, we continue challenging ourselves to do better, and to do even more to enhance quality.

Culture of Cooperation – Leading Toward Continuing Quality Improvement

Positive trends related to quality are evidenced by profession-based initiatives, including *Quality First* and *Advancing Excellence in America's Nursing Homes* – both of which are having a significant impact on the quality of care and quality of life for millions of frail, elderly, and disabled Americans who require long term and post-acute care.

Quality First, which was established in 2002, set forth seven core principles that reflect long term care providers' commitment to continuous quality improvement, leadership, and transparency. This profession-based initiative led not only to improvements in care and processes, but to the development of the National Commission for Quality Long-Term Care, co-chaired by your former colleagues The Honorable Bob Kerry and Newt Gingrich. *Quality First* and other initiatives have been recognized by former Secretary of Health & Human Services Tommy Thompson, by former Administrator of the Centers for Medicare & Medicaid Services (CMS) Dr. Mark McClellan, and by former CMS Acting Administrator Leslie Norwalk, who wrote in 2007, "Nursing home providers have been on the leading edge of this quality movement. Long before hospitals, doctors, home health providers, pharmacies, dialysis facilities and others came to the table, the nursing home industry was out front with *Quality First* – a volunteer effort to elevate quality and accountability…Quality measurement has worked in nursing homes….Collaborating to measure quality of long-term care, report it, support it, and improve it – that's the best path to a high-quality, patient-centered, provider-friendly system that everyone can afford."

AHCA is a founding partner of *Advancing Excellence in America's Nursing Homes* – a coordinated initiative among providers, caregivers, consumers, government, and other stakeholders that promote quality. Focusing on eight measurable goals, this effort takes previous initiatives a step further—not only measuring outcomes, but establishing numerical targets and benchmarks. *Advancing Excellence*

also promotes best practices and evidence-based processes that have been proven to enhance patient care and quality of life.

This voluntary initiative is working – and outcomes and processes have improved in the nearly 7,500 participating facilities since its launch in September 2006. Data indicates that there have been demonstrable care quality improvements with reduced incidence of pressure ulcers, reduced use of physical restraints, and improved pain management for long-term and short-stay post-acute nursing home residents. In an April 2009 press release, Mary Jane Koren, M.D., M.P.H., who serves as chair of the *Advancing Excellence* coalition, stated, "We estimate that in the course of the Campaign, there were 1.8 million fewer days where a resident at high risk for developing a pressure sore was suffering from one. Also, during this time, we estimate there were 8.5 million fewer days where a nursing home resident used a physical restraint."

In total, the increased focus on person-centered care, actual care outcomes, increased transparency and public disclosure, enhanced stakeholder collaboration, and the dissemination of best practices models of care delivery is paying off. AHCA/NCAL remains committed to our long-standing practices and programs, which seek to improve the quality of care for our nation's most frail, elderly, and disabled and to enhance the quality of life for patients and caregivers alike.

Funding Stability Is Critical for Profession to Sustain Quality Gains

It is important to recognize that the nursing home of the 21st Century is far different from its predecessors. We are proud to note that patients are returning home more quickly, but remain concerned about threatened cuts to Medicare funding and what such cuts could mean to the care of older, sicker, and more medically complex patients.

While the U.S. House of Representatives "Tri-Committee" discussion draft considers many revisions to the four components of Medicare (Parts A, B, C & D), we have limited this testimony to those provisions that would have the greatest impact on the care and services delivered in our nation's long term and post-acute care facilities.

Medicare Part A – Cuts Could Jeopardize Patient Care & Jobs

AHCA/NCAL appreciate that reforming health care now means that we must address many of the toughest issues, which – if done well – will not only help to contain costs and achieve savings, but also will affect quality. In fact, quality of care is inextricably linked to stable funding – stability that cannot be achieved over the long term without both containing health care costs and making strategic investments in health information technology and other approaches that will yield cost-savings in the future.

With our profession's quality agenda as both a backdrop and a desirable ongoing public policy priority, the matter at hand is relatively simple. When Medicare funding for skilled nursing services is stable, quality of care and services improve. When Medicare funding is inconsistent and unstable –

especially in the face of growing demand – our nation's long term care infrastructure deteriorates to the detriment of every senior today and every retiree tomorrow.

We are very concerned that one of the provisions of the draft would codify in statute what CMS has historically attempted to accomplish through formal rulemaking. Earlier this year, CMS proposed to cut Medicare funding for SNFs by 3.3 percent in FY 2010 to correct a projection error made by the agency in 2005 when it radically changed the SNF patient classification and payment systems through a Notice of Proposed Rule Making (NPRM). The FY 2010 CMS proposed rule (which in effect, has been included in the House legislative proposal) once again seeks to accommodate for a projection error related to the adoption of new patient classification categories four years ago, and would cut SNF Medicare reimbursements by $1.05 billion in FY 2010 alone. Some projections estimate that this proposal would eliminate $18 billion from quality skilled nursing care over the next ten years.

In 2005, CMS revised and expanded the Medicare patient classification system – called Resource Utilization Groups (RUGs) – that is used to set Medicare Part A daily payment rates for seniors needing SNF care. CMS' flawed assumptions failed to account for the increasingly complex patients that seek and receive nursing and rehabilitative care in our nation's nursing homes. The agency's attempt to recoup Medicare funds through implementation of the SNF proposed rule is incongruous with CMS' own policy efforts to encourage certain high-acuity Medicare beneficiaries to receive care in the cost-efficient, quality SNF setting.

The data supports the fact that most of the increase in SNF expenditures was a result of CMS' own Medicare policies and would effectively "take back" payments from providers that are a result of an increase in acuity and real case-mix change. Policies including the *75% Rule* (now set at 60% by Congress) were crafted to ensure that Medicare beneficiaries receive rehabilitative care in the most appropriate and cost-efficient setting for their needs. In testimony before the House Ways and Means Health Subcommittee in May 2007, CMS officials explained that the rule was working as expected, and specified that, "As enforcement of the *75% Rule* gradually phases in from July 1, 2004 through July 1, 2008, Medicare claims data have demonstrated that patients who might have been treated in an [Inpatient Rehabilitation Facility] IRF (but who have clinical conditions appropriate for care outside of an IRF) – are now getting needed care in other more appropriate and less costly settings."

CMS' dismissal of this increase in SNF acuity and real case-mix change puts providers at risk. The agency's approach is fundamentally flawed and inconsistent with the basic premise of a prospective payment system. CMS has developed methodologies in other settings for identifying real case-mix change and there is ample precedent for CMS to pay for real change in acuity and medical practice. CMS should and must continue to pay providers for real case-mix change.

We are also concerned that the discussion draft proposes eliminating the much needed Medicare annual update for SNFs for the final nine months of FY 2010. This would have the unfortunate effect of granting the Market Basket Update – calculated to account for increases in costs – for only

three months, and then eliminating the increase for the remaining nine months of FY 2010. Currently, the annual market basket update for skilled nursing facilities is intended to reflect an increase in the cost to provide quality care. However, the increases in nursing facility costs from 2001 – 2007 exceeded the increases in the market basket updates each year (FY 2002 to FY 2009). It is clear that a full market basket increase is critical to enable nursing homes and Medicare to continue to move forward in providing quality services for our nation's most vulnerable citizens.

Further complicating the issue, CMS has included within this same proposed rule major revisions to its current RUGs system to be implemented in FY 2011 – with only a 60-day comment period ending June 30, 2009. The proposed RUG-IV system has the potential to destabilize and redefine the provision of skilled nursing care.

Essentially, massive Medicare cuts to account for projection errors on the part of CMS, coupled with proposals to significantly reduce a crucial annual update means this profession is facing the potential of a "double barrel shotgun" in funding cuts that could jeopardize the health of the entire sector. We respectfully urge all three committees to reconsider these proposals and suggest their elimination in future iterations of this legislation.

Quality of care is inextricably linked to stable funding – stability that cannot be achieved over the long term without both containing health care costs and making strategic investments in health information technology and other approaches that will yield cost-savings in the future. While we are proud of our gains in enhancing quality, that trend cannot continue if at the same time, funding is drastically reduced.

Medicare & Medicaid Are Inextricably Linked

We are concerned that coupling the proposal to eliminate most of the market basket update for SNFs, with efforts to significantly cut Medicare funding by codifying CMS's "projection error", and with the unfortunate reality of Medicaid underfunding for skilled nursing care, the long term care sector could be destabilized and many jobs could be placed in jeopardy. Taking the "projection error" correction by itself, it is estimated that the $1.05 billion reduction in Medicare nursing facility expenditures on a nationwide level has a substantial impact on the local, state, and national economies – with a reduction of $1.1 billion in labor income, and a loss of more than 30,000 jobs.

Given the prevalence of Medicaid patients in our nation's nursing facilities, special consideration of the relationship between Medicare and Medicaid seems particularly relevant to nursing facility care.

Proposed Medicare cuts are exacerbated by the chronic underfunding by Medicaid for care and services provided in our nation's nursing facilities. A recent *BDO Seidman/Eljay, LLC*, study projected that states cumulatively underfunded the actual cost of providing quality nursing facility care by $4.4 billion in 2007. The analysis further showed the average shortfall in Medicaid nursing home reimbursement was $13.15 per patient day in 2007 - a 45 percent increase from 1999.

Further complicating the chronic Medicaid underfunding of long term care is the reality that, according to recent analysis, in response to the recession 46 percent of states are freezing or cutting nursing home rates, and 75 percent are not keeping up with inflation.

And while financial stability is an essential component of delivering high quality long term care services, it is just as critical for the profession to maintain a stable workforce. Nearly 70 percent of skilled nursing operating costs are labor-related. Ongoing funding shortfalls have a major impact on the front lines of care and negatively influence staffing, jeopardize intra-facility quality improvement efforts, and may cost the jobs of the very staff that make a key difference in the quality of care and quality outcomes.

So we ask you, Mr. Chairman, how can dedicated providers of skilled nursing care meet the ongoing demands of the federal government for increased staffing levels and sustained quality improvements with reduced funding?

As the *American Recovery and Reinvestment Act of 2009* (ARRA) included approximately $87 billion in enhanced Medicaid funding to states, AHCA commends this Subcommittee and its colleagues for directing these critical funds to states at crucial time. In ARRA, Congress made a conscious decision to tell states that these *Federal Medical Assistance Percentage* (FMAP) funds would be watched by establishing oversight provisions that direct states to refrain from depositing these enhanced funds into rainy day accounts, and further stated that these dollars are meant to be used now.

Congress delivered these enhanced federal Medicaid funds to avoid dramatic cutbacks that would threaten the health care safety net during our current strained economic reality. AHCA/NCAL argued then, and continues to contend, that those funds should have come with a strong maintenance of effort (MOE) requirements regarding funding. We are concerned that the overwhelming majority of these enhanced funds were redirected to programs outside of long term care. As providers of essential care services to our nation's frail, elderly and disabled, we request that these enhanced funds reach the providers of these services, as we believe Congress intended – by adding maintenance of effort for provider payments. By doing so we believe you will act to secure critical funds to a stressed industry.

While we are extremely concerned that these critical funds get to those who provide services to our nation's frail elderly and disabled, it is also crucially important that we plan according for the future when this enhanced funding would be eliminated. On January 1, 2011, this enhanced funding runs out creating a cliff in funding leaving states in an impossible position of cutting a safety net program of which we are a part. As a profession, we depend heavily on the Medicaid system, which funds the care of roughly two-thirds of nursing home patients and 12 percent of assisted living residents. Unfortunately, as I have stated, Medicaid has historically paid less than the cost of care. I pledge to work with this Subcommittee and all the other Congressional Committees of jurisdiction to ensure that there is no reduction in care or services for our nation's most vulnerable individuals. We urge this Subcommittee to explore sustained relief to states as ask that any relief include a strong maintenance of effort to ensure funds are allocated properly.

We ask that Congress help intervene with CMS to urge HHS and the agency to lessen the impact of the NPRM with its drastic Medicare cuts. We also request that the Committees be mindful of the impact that reducing the Market Basket Update will have on many skilled nursing facilities – particularly independently owned and rural facilities.

Medicare Part B – Therapy Caps Exceptions Process in the Best Interest of Patient Care

On behalf of the millions of American's receiving Medicare Part B therapies (occupational, physical and speech/language therapies) in settings including skilled nursing facilities, we applaud this Subcommittee and the three Committees of jurisdiction in proposing to extend the "therapy caps exceptions process." Since 1999, Congress has placed a moratorium on imposing very restrictive therapy caps that are not in the best interest of patient care and later created an exceptions process to permit seniors to receive medically necessary therapy services above the cap. According to estimates in 2008, an estimated 700,000 Medicare beneficiaries would have exceeded the limit on their Medicare Part B therapy benefit that year. As the majority of these beneficiaries reside in skilled nursing facilities, we are pleased with this Subcommittees determination to extend the exceptions process for those who require the most extensive therapy services for an additional two years – until December 31, 2011. This extension will effectively protect essential rehabilitative care services for millions and millions of Medicare beneficiaries.

Medicare Parts A & B – Rehospitalization & Bundling

As nursing facilities are the dominant provider of post-acute services in the Medicare program, receiving about 55 percent of all hospital discharges into a post-acute setting of care, the areas of rehospitalization and the development of a post-acute care service payment reform plan will have significant impact on skilled nursing facility providers.

We agree that as a nation, we must address reducing unnecessary rehospitalizations as a step to improving care services and care coordination between acute and post-acute care providers. However, as written the discussion draft refers not to inappropriate rehospitalizion, but to excess readmission to a hospital. When a hospital readmission within 30 days of discharge is clinically appropriate and medically necessary, we believe that reducing funding for both the hospital and the post-acute care provider is unwarranted and bad public policy.

In regard to developing a post-acute bundled payment system, we applaud the Tri-Committee discussion draft which takes a thoughtful and measured approach to this complex and nuanced issue. We are pleased with the direction to pursue a demonstration project that will take into consideration important areas that must not be overlooked, including the nature of payments, the interaction of the acute and post-acute care providers, the development of appropriate quality measures, and programmatic policies such as eliminating the three-day hospital stay.

In an effort to achieve greater budgetary savings, we encourage the Committee to consider the development of a new prospective payment system (PPS) for Medicare post-acute care services to enhance care coordination by basing payments primarily on patient need rather than the setting in which services are delivered. Estimates by Avalere Health LLC, indicate that such a site-neutral payment system could generate as much as $81 billion in savings over a ten year implementation period. We look forward to providing specific legislative language to this Committee to further your consideration of this alternative model.

At a time when our nation's healthcare requires stability and efficiency, we believe that proposals to eliminate most of the SNF market basket update for FY 2010, recoup billion of dollars due to projection errors by CMS, implement funding reductions for rehospitalization – whether appropriate or not – and create post-acute bundled payments, could have dangerous repercussions – jeopardizing quality care and eliminating much needed jobs.

Medicare Part D – Elimination of Part D Co-Pays for Some Dual Eligible Beneficiaries

We would like to commend the Committees for including a much needed improvement to the Medicare Part D drug program in the legislation. Eliminating the Part D cost sharing (co-payments) for full-benefit dual eligible beneficiaries – those eligible for both Medicare and Medicaid covered services – receiving services under Sec. 1915 or 1115 waivers is a crucial improvement for hundreds of thousands of elderly, disabled Americans whose extremely low incomes now make it difficult for them to afford Part D co-payments. This improvement also creates parity with dual eligibles living in nursing homes and other institutions that already have no cost sharing under the Medicare Part D program.

However, we do not believe that this proposal is complete as it does not eliminate cost sharing for dual eligibles in home- and community-based settings that are covered directly under state Medicaid plans. In order to best serve the poor and elderly who receive care and services through home and community based services, we encourage this Subcommittee to expand the elimination of co-pays for Part D covered prescriptions to all dual eligible beneficiaries.

AHCA Has Led Efforts in Transparency in Health Care – But Transparency Can't Come at the Expense of Patient Care

For many years, the long term care profession has been at the forefront of health care providers pursuing transparency, enhanced quality care, and publicly available information as to our performance. We have and continue to be active and willing partners with CMS and HHS in disclosing information that we hope is and will be helpful to consumers when facing the difficult decision of choosing a nursing facility. For the last eighteen months, AHCA and other representatives of the long term and post-acute care profession have been in active discussions with legislators and their staff regarding proposals to address increased transparency for nursing homes. At the outset, it is important to understand that we support the concept and direction of the

Committee and we are optimistic that by continuing to work together the final legislation will be supported by the profession and will achieve its laudable goals.

We agree with the goal of improving consumer-oriented data to help facilitate selecting the most appropriate care setting for a loved one, but as the discussion draft serves as a road map for change we believe it is appropriate to revise some of specific provisions. As "Nursing Home Transparency" comprises nearly 100-pages of the discussion draft, I wish to take this opportunity to address a few significant areas.

I would first like to address disclosure. While we have long supported public reporting and transparency, new calls for increased disclosure on details such as minimal ownership of a nursing facility will not contribute to this effort to help consumers, nor drive improvement of care or services in facilities nationwide. The disclosure of more information, rather than the right information simply for disclosure sake will only add confusion and greater misunderstanding of the quality and services available.

In fact, disclosure of confusing, inaccurate and/or conflicting data will not only lead to misunderstanding but worse, the possible selection and placement of patients in facilities that are not right for them and will not meet their needs and expectations. Rather than promoting disclosure for disclosure's sake, we must ensure that available reported data is in the best interest of consumer needs and fair to those facilities dedicated to meeting their needs. The culture of cooperation should be engaged to ensure that the data reported is the correct – most useful – and accurate information available for consumers to make an informed decision as to the right quality nursing facility.

Rather than the current construct of reportable data and the newly proposed data elements to be disclosed, we believe that data revealing family and patient satisfaction, staff turnover, patient outcome trends, and patient acuity and the facility's specialty areas should be under discussion and consideration. Above all else, we must continue to work together to ensure such data is accurate, up to date and presented in a fashion that is easily understandable and useful to consumers. Any significant, disclosed data should motivate and empower those individuals, including facility operators and administrators, who make decisions which impact the care and services delivered on a daily basis.

Over the last year and a half, prior to the introduction of any "transparency" legislation, AHCA has consistently been working with both the House and Senate authors to improve transparency of information regarding nursing facilities. AHCA supports the goal of promoting transparency, but requiring the disclosure of excessive and, at times, redundant information is not in the best interest of informing consumers, encouraging provider competition in the delivering of quality care and services, nor enhancing government oversight. We also need to be cognizant of the increased costs and administrative burden for providing duplicative information that will in the end not serve to identify nor improve the quality of long term care quality and services.

AHCA and its members have been actively engaged in a broad range of activities which seek to enhance the overall transparency of long term care provider performance. As the long term care profession was the first among health care providers to subscribe to true transparency and publicly available information as to our performance, we were willing partners with CMS and HHS in disclosing more information that we hoped would be helpful to consumers when facing a difficult decision for choosing a nursing facility. We believe that certain transparency provisions for long term care in this bill are redundant and some may actually be harmful rather than helpful in ensuring continued quality improvement and improved patient placement. For example:

- In the area of financial transparency, information such as organizational structure and relationship with affiliated facilities is already reported to the Centers for Medicare and Medicaid (Form 855) and the licensing division of each state. The Medicare cost report also requires disclosure of all related party services on Schedule A-8-1.
    - Under this bill, the disclosure of an entity that provides financial or cash management services to the facility, or accounting or financial services to the facility, would be publicly disclosed. We believe that such disclosure of arms-length financial transactions may have a chilling affect on reducing already limited lending opportunities for nursing homes for necessary upgrades.
    - Further, we believe that definitions contained in this bill should conform to definitions that are currently provided in existing law. For example, the definition of "managing employee" in existing law (Section 1126(b) of the SSA) does not extend to anyone who indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility. By altering definitions in the *Social Security Act*, employees who have no responsibility for ensuring the quality or provision of patient care will be considered part of management staff and would be required to be disclosed as such.

- In the area of staffing transparency, beginning in January 2003 nursing facilities are required to post daily, for each shift, the number of licensed and unlicensed nursing staff directly responsible for resident care in the facility. State Survey Agencies are responsible for ensuring that the appropriate staff information is posted.
    - Under this reform bill, facilities would be required to post on the public website staffing data and tenure information. We contend that staffing data information is not an accurate reflection of the quality of care provided at a facility. The posting of staffing data does nothing to improve or address the root cause of staffing shortages in facilities. We fully believe one cannot look at staffing data in a silo – one must recognize that this is a national nursing workforce shortage that is being felt across all areas of health care hence any shortage that may be present in long term care is simply a reflection of the state of the shortage not a reflection on the facility.
    - New proposals would require facilities to post various staffing data, as well as certain tenure information on the public website. In the face of a well documented and publicized national nursing workforce shortage being felt across all areas of health care, we simply want to ensure that reported staffing information is reflective of the long term care industry's efforts to fill the gaps created by the shortage. When reporting staffing

> data, the data should include all hands-on staff time devoted to patients at the bedside. For example, staff reporting should be indicative of the availability of advanced care practitioners, occupational and physical therapy staff, social workers, dieticians and perhaps even educational staff that serve to enhance not only care-giver time but the level and quality of that care giving. More inclusive publicly disclosed staffing information would more fairly and accurately reflect the facilities commitment to care delivery at levels that assure the consumer his or her needs and expectations can and will be met.

In the area of providing more access to standardized complaint reporting by both patients and staff, it should be noted that nursing facilities are already mandated by federal regulation under the residents right's requirements at 42 CFR 483.10 to "inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing residents conduct and responsibilities." This regulation also gives residents the right to voice grievances without discrimination or reprisal and requires prompt efforts by nursing home staff to resolve grievances. Additionally, nursing homes are already required by federal regulation to post the names, addresses, and telephone numbers of all pertinent state client advocacy groups such as the state survey and certification agency, the state licensure office, the state ombudsman program, the protection and advocacy network and the Medicaid fraud control unit (483.10(b) (7) (iii)), this list could also include the state Attorney General as also required by state law. Under (483.10(b)(7) (iv)), nursing homes must also inform residents upon admission that they may file a complaint with the state survey and certification agency concerning resident abuse, neglect, misappropriation of resident property in the facility and on compliance with the advance directives requirements.

While we support a new standardized complaint form and process available to both consumers and employees, we simply urge any new forms and processes be integrated with current requirements to eliminate duplication that will add administrative cost and more importantly confusion for those filing complaints. We are, however, very concerned that some of the staff-specific whistleblower provisions of this bill will restrict employers' ability to appropriately supervise, manage and discipline employees when appropriate and necessary. We believe that the overly broad whistleblower protections in this bill will have the unintended consequence of making it incredibly difficult for an employer to not only discipline an employee, but could actually impact the reporting or filing of a complaint against a worker to appropriate State professional disciplinary agencies once that worker has filed a "quality of care or other issue" complaint against the facility. Without some qualifying language, we are concerned that this provision could protect unscrupulous employees from disciplinary action because they will be able to preempt discipline with a complaint against the facility, legitimate or not. We also have some concern about the whistleblower provisions effect on current employer/employee contractual mediation and arbitration dispute agreement.

Further, compliance programs crafted by this bill should require that the size of the organization be taken into account. We suggest that the HHS Secretary develop specific elements of a compliance program that consider the size of the organizations, including allowing organizations with fewer than 5 facilities to have more streamlined compliance programs. This is consistent with the Office of

Inspector General's Supplemental Compliance Program Guidance for Nursing Facilities, 73 Fed. Reg. 56834 (Sept. 30, 2008).

We are encouraged to see that a portion of the funds collected from civil money penalties (CMP) may be used for facility improvement initiatives such as joint training of staff and surveyors and technical assistance for facilities under quality assurance programs. However we oppose the increase of CMPs as unnecessary, punitive and not a motivation for improving facility behavior. Increasing monetary fines drains the facility of resources available for patient care.

Imposition of CMPs takes resources away from facilities thus decreasing available resources used to care for other residents There already exists in law an ability to penalize the facility and for the family to be compensated.

While we agree that facilities that harm patients should be held accountable for their actions and that those who violate patients rights should be punished, there is no clear evidence to suggest that increasing civil penalties will deter those facilities from these behaviors. According to a 2007 GAO study requested by Senator Grassley, CMS hesitates to impose some CMPs that are higher than $200 per day because that could bankrupt some nursing homes.

These CMP provision also provide no practical incentive for providers to self-report. There is little, if any, incentive for providers to self-report. The issues surrounding self-disclosure are complex. Properly determining what to disclose (i.e., what actually constitutes a violation of applicable law), when to report it and to whom to report requires careful consideration and a working knowledge of the fraud and abuse laws. If facilities invite the OIG to come in, the OIG and or surveyors will cite the facility for that self-reported deficiency and look for other deficiencies to cite. This is not a motivator to self-report.

It is essential to recognize that today's regulatory and oversight construct of long term and post-acute care providers is based upon yesterday's nursing facility and does not account for the shift in the patient mix and the type of care and services being delivered. Independent studies validate the fact that skilled nursing facilities are providing intensive rehabilitation and nursing care to a growing number of short-stay patients who return to their home and community, often within one month. At the same time, an increasing percentage of the nation's nursing facility population has significant cognitive difficulties – including advanced Alzheimer's disease – and more disabilities. Despite changes in patients and care provided, changes to the oversight system have not kept pace.

AHCA believes that achieving a sustained level of quality care will only be fully realized when there is a collaborative effort to recognize and implement improved health care technologies and best clinical practices designed to improve and enhance patient outcomes. This type of culture change is essential to appropriately address the needs of a growing patient population and a shrinking pool of caregivers.

Today, we know far more about promoting quality, and we have better tools with which to measure it than we did twenty years ago. We need to intelligently change the regulatory process to allow and encourage us to use what we have learned – to place quality over process, care over procedure, and most importantly, put patients at the forefront.

Essential Changes Needed to Inappropriate and Misguided 5 Star Rating Index

While not a focus of the discussion draft, we want to use this opportunity to address CMS' misguided and inappropriate nursing facility rating system. On December 18, 2008, during the last days of the Bush Administration, CMS published the *Five Star Quality Rating System* (Five Star) on its Medicare.gov website. While we agree that this system set out to help consumers make informed decisions, regrettably this rating system is terribly misguided and contains a critical methodological flaw that does not validly nor accurately assess or compare nursing homes. Five Star attempts to rank nursing facilities like restaurants giving them a star rating based on set criteria. Placing a loved one in a nursing facility is a complex decision and the information readily available to consumers must accurately address the components that comprise the complexity of the care provided in a facility.

Five Star utilizes a flawed methodology that allocates star ratings in three categories, survey reports, staffing, and quality measures. AHCA has long contended that the survey system is not an accurate measure of quality as it is subjective in nature and results vary from surveyor to surveyor not to mention from state to state. Further, the survey system is punitive in nature and does not reflect any positive aspects of care. A table found on the CMS website allocates stars for health inspections as follows: 5 stars-10%; 4 stars-23.3%; 3 stars-23.3%; 2 stars-23.3%; 1 star-20%. The survey component is the basis and the most heavily-weighted domain of the rating system.

The staffing standard used by the rating system is based on a study released in 2001 that CMS and Congress acknowledged it would never adopt nor fund due to the exorbitant cost. Additionally, the staffing information included in the rating system does not include all direct care staff. For example, therapy staff and physician extenders cannot be counted. If both CMS and Congress admit that this staffing standard is unattainable, how is it acceptable for facilities ratings to be contingent on such a standard?

The quality measures used in the rating system are also in a forced distribution – that is, only 10 percent of the facilities can receive a 5 Star rating (the highest rating) for this domain and 20 percent of the facilities will receive 1 star (the lowest rating). AHCA has also raised concerns that the patient case mix is not taken into account when assessing star ratings- as one can imagine staffing is heavily dependent on the type of patients being cared for in a given facility.

Apart from beginning with the unsubstantiated assumption that 43.3percent of our nation's nursing homes are below average by definition, under Five Star a facility that may be a five star in one state could be a three or four star or worse in another state. In a time when families are separated by state

lines a rating system that is incompatible from one state to another is not helpful when trying to make a decision on where to place a loved one.

The design of this system makes it impossible for all facilities to ever attaining a five star rating; additionally because of the set percentages of star ratings every nursing home's rating is dependent upon the rating of every other nursing home. The net effect of this methodology is that a nursing home's rating could be changed every month based on inspections of other nursing homes without that nursing home having made any changes at all. Conversely a nursing home that might have made significant improvement could find that its rating remains the same, or worse, declines.

Although the intent of the Five Star System was to be useful to consumers, the information is incomplete incompatible and misleading. AHCA asks that CMS remove the Five Star Rating System from the public website, and convene stakeholder groups to develop a more useful rating system. We ask that CMS test the new system and evaluate its usefulness to consumers with the input of providers. AHCA welcomes the opportunity to work with the new Administration, the Department of Health and Human Services and CMS to develop a rating system that will provide useful and accurate information to consumers that can be used to make informed decisions regarding care.

We ask that Congress urge CMS to withdraw the Five Star system until it can be reviewed by an independent, impartial third party, such as the U.S. Government Accountability Office (GAO) or that this Committee conduct hearings on this subject.

A Stable, Well-trained Workforce is the Building Block of Quality Long Term Care

All of us in this profession are acutely aware that human contact is essential to treating long term care patients and residents, and you will never be able to replace the role that people play in providing long term care. AHCA/NCAL has long recognized that the provision of high quality long term care and services is dependent upon a stable, well-trained workforce. However, America's long term care system is currently suffering from a chronic supply and demand problem when it comes to our labor force. Addressing this challenge on both fronts is the only real means to sustain the provision of high quality long term care.

We remain committed to partnering with Congress, the Administration, and other long term care stakeholders to ensure a qualified and well-trained staff is in place to care for our nation's elderly and disabled today – and in the coming years when the current crisis will hit epidemic proportions unless government intervenes.

The high demand for long term care workers is already documented by the federal government. A recent study by the Department of Health and Human Services (HHS) and Department of Labor (DOL) estimates the U.S. will need between 5.7 million to 6.5 million nurses, nurse aides, and home health and personal care workers by 2050 to care for the 27 million Americans who will require long term care – up more than 100 percent from the 13 million requiring long term care in 2000.

America's nursing facilities have been facing a chronic direct-care workforce shortage for more than a decade. This shortage continues despite the current recession. In a recent study in *Health Affairs*, "The Recent Surge In Nurse Employment: Causes And Implications," the authors discuss the fact that the current recession is spurring dramatic increases in nurse employment, with as many as 243,000 nurses joining (or re-joining) the workforce in 2007-08. Unfortunately, most of the nurses returning to the workplace are not employed by nursing facilities. In the study, the authors also warn policy makers that despite "The recent increase in employment…[and] improving projections of the future supply of RNs… large shortages are still expected in the next decade. Until nursing education capacity is increased, future imbalances in the nurse labor market will be unavoidable."

Data collected and analyzed by AHCA/NCAL reaffirms the findings of the study reported in *Health Affairs*. AHCA's Vacancy & Turnover Survey released in late 2008 indicated that there were more than 110,000 vacant nursing positions nationwide, including Certified Nurse Assistant (CNA), Registered Nurse (RN) and Licensed Practical Nurse (LPN) positions. Since that report, given the current economic realities, AHCA pursued updated results in order to provide a "snapshot" of the current nursing shortages. Based on a limited number of responses, we have learned that while the 110,000 vacancies previously reported have decreased by approximately 50 percent, skilled nursing facilities still have significant numbers of vacancies—estimated to be approximately 50,000 nationwide. It is critical to note; however, that despite the effects of the recession, and the decrease in staffing vacancies, the easing of the staffing shortage is only temporary, so action must be taken now to prepare.

Vacancies and turnover in the long term care profession compromise sustained quality improvements and increase costs. In fact, a recent report from the *National Commission on Nursing Workforce for Long-Term Care* concluded that "efforts to recruit and train new nursing staff are estimated to cost nursing facilities over $4 billion each year – more than $250,000 annually for each nursing home in the nation.

While efforts to recruit and train new qualified long term caregivers are costly, our profession has been aggressively pursuing potential nurses and caregivers. An unfortunate truth exists that nursing education programs are forced to turn away well-qualified applicants for the sole reason that there are not enough nurse educators to train these potential caregivers. In fact, the American Association of Colleges of Nursing found in its annual survey that more that 40,000 qualified applicants were not accepted into nursing programs primarily because of insufficient nurse faculty for the 2007-2008 academic year.

The 2.5 million frail, elderly and disabled patients and residents living in our nation's nursing facilities and assisted living communities deserve an adequate workforce to care for their needs. A strong and capable workforce is essential to meet the needs of those Americans that require nursing care now and in the future. The workforce investments we make now will affect the quality of long term care in the future. A 2008 Institute of Medicine (IOM) report, *Retooling for an Aging America: Building the Health Care Workforce*, called for immediate investments. It stated "The dramatically rising number of older Americans, along with changes in their demographic characteristics, health needs

and settings of care [that] will necessitate transformations related to the education, training, recruitment and retention of the health care workforce serving older adults."

Therefore, we thank this Subcommittee and the three Committees of jurisdiction for recognizing the scarcity of all health care professionals – in addition to Registered Nurses - including administrators, through the inclusion of the Section 2231 Public Health Workforce Loan Repayment program. We also applaud the Committees for creating the Advisory Committee on Health Workforce Evaluation and Assessment and the National Center for Health Care Workforce Analysis to examine and analyze our Nation's health workforce priorities, goals, and policies. Finally, we are especially appreciative of efforts in the Tri-Commitee draft to address the nursing shortage by establishing the nursing career ladder grant programs, which increase capacity across both nursing education and practice settings. In addition, we respectfully request that further consideration be given to health care workforce development issues as the Tri-Committee draft is refined, and we look forward to working with members of this Subcommittee and the full Energy and Commerce Committee to do so.

Conclusion

We agree that not only do consumers deserve the highest quality care and services across the spectrum of health care settings, but also employees deserve well-paid, positive work environments. As the profession responsible for the care of our nation's most vulnerable citizens, we are proud of the advances we have made in delivering high quality long term care services and we remain committed to sustaining these gains in the years and decades ahead.

Given the financial implications and care access problems that could be unfortunate and unintended consequences of reforms that do not provide the appropriate consideration of long term care, we believe it is a crucial time for us to work together to ensure that the future of America's healthcare system continues to meet the skilled nursing and rehabilitative care needs of our nation's seniors.

Thank you for the opportunity to offer these comments on behalf of millions of professional, compassionate long term caregivers and the millions of frail, elderly, and disabled Americans they serve each day. I look forward to responding to your questions.

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Mr. PALLONE. Thank you. Thanks a lot.
Ms. Fox.

STATEMENT OF ALISSA FOX

Ms. FOX. Thank you very much, Chairman Pallone, Ranking Member Deal and other members of the committee. I really appreciate the opportunity to be here today.

Blue Cross Blue Shield plans strongly support enactment of health reform. We must rein in costs, improve quality, and importantly we must cover everyone. Today the Blue system provides coverage to more than 100 million people in every community and every zip code in this country. For the past 2 years we have been supporting five key steps to reform our system.

First, we believe Congress should encourage research on what treatments work best by establishing a comparative effectiveness research institute. We are very pleased the House draft bill recognizes the importance of this key step. Second, in order to attack rising costs, we must change the incentives in the payment systems both private and in Medicare to promote better care instead of just more services. The draft bill includes some of the Medicare delivery system recommendations we support. We also agree with provisions in the bill to help build an adequate medical workforce to care for everyone in the country. Third, consumers and providers should be empowered with information and tools to make more-informed decisions. Fourth, we need to promote health and wellness and prevention and managed care for those with chronic illnesses. Finally, we believe a combination of public and private coverage solutions are needed to make sure everyone is covered. We support a new individual responsibility program for all Americans to obtain coverage along with subsidies to ensure coverage is affordable. We also support expanding Medicaid to cover everyone in poverty. We are also supporting major reforms in our own industry including new federal rules to require insurers to open the doors, accept everyone regardless of preexisting conditions and eliminate the practice of varying premiums based upon health status, and we also support a national system of state exchanges to make it easier for individuals and small employers to purchase coverage. I know there is a perception that this is a new position for the insurance industry. It is not for the Blue system. We had the same position in 1993.

We appreciate this opportunity to comment on the tri-committee bill. We support the broad framework of the bill which includes many of the critical steps we believe are needed. However, we have very strong concerns that specific provisions will have serious unintended consequence that will undermine the committee's goals. Our chief concern is creation of a new government-run health program. We believe a government-run health program is unnecessary for reform and will be very problematic for three reasons. First, many people are likely to lose the private coverage they like and be shifted into the government plan. This is because the government plan will have many price advantages that the private plans won't including paying much lower Medicare rates than the private sector. This is an enormous advantage on its own as Medicare rates are already 20 to 30 percent lower than what we pay in the private

side, and that is a national average. I think here you heard Marshfield Clinic talk about much huger variations in Wisconsin. But there are other advantages in the bill as well. I will give you two examples. Individuals in the government plan, they can only sue in federal court for denied services. However, individuals in private plans can sue in State court for punitive, compensatory and other damages. In addition, private plans would have to meet 1,800 separate State benefit and provider requirements while the government plan would not. Second, the draft bill would underpay providers in the government plan. This is likely to lead to major access issues in the health care system such as long waits for services. And third, the government plan would undermine much-needed delivery system reforms that are critical to controlling costs. We agree Medicare needs to be reformed to reward high-quality care. We commend the committee for including reforms to modernize Medicare. However, history has shown the government can be slow to innovate and implement changes through the complex legislative and regulatory processes. The private sector, on the other hand, is free to innovate, and let me just give you one example from our program that is improving outcomes and lowering costs through our Blue Distinction Centers of Excellence. Recent data shows that readmission rates at our cardiac care centers around the country have 26 to 37 percent lower readmission rates than other hospitals.

In closing, I would like to emphasize the Blue system's strong support for health care reform including major changes in how insurers do business today. We believe the federal government has a vital and expanded role to play in reform by expanding Medicaid to cover everyone in poverty and enrolling all the people that are now eligible for Medicaid coverage, by reforming Medicare to pay for quality and assuring Medicare's long-term solvency and setting strict new rules for insurers to assure access to everyone regardless of their health. We are committed to working with all of you to enact meaningful health care reform this year. Thank you very much.

[The prepared statement of Ms. Fox follows:]

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STATEMENT

Before the

UNITED STATES HOUSE OF REPRESENTATIVES
HOUSE ENERGY AND COMMERCE COMMITTEE
SUBCOMMITTEE ON HEALTH HEARING

On

HOUSE COMMITTEES' DRAFT HEALTH REFORM LEGISLATION

Alissa Fox
Senior Vice President, Office of Policy and Representation
Blue Cross and Blue Shield Association

June 25, 2009

INTRODUCTION

The Blue Cross and Blue Shield Association (BCBSA) commends Chairman Pallone's and Ranking Member Deal's leadership in holding this important House Energy and Commerce Subcommittee on Health hearing on healthcare reform. We are very pleased Congress and the Administration have made healthcare reform a national priority, and we share the commitment to enacting healthcare reform legislation this year that expands coverage to all Americans, reins in costs, and improves the quality and safety of care delivered to patients.

BCBSA strongly believes everyone in our country should have high quality, affordable coverage. It is unacceptable that 46 million people are uninsured, and we appreciate the opportunity to work with Congress, the Administration and all stakeholders to ensure everyone has coverage.

BCSBA represents the 39 independent, community-based Blue Cross and Blue Shield companies that collectively provide health insurance coverage to more than 100 million individuals – one in three Americans. With over 80 years of experience, Blue Cross and Blue Shield Plans offer coverage to individuals, small employers, and large employers in every zip code in our country. We also partner with the government in Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Federal Employees Program. As such, the Blue System has a unique perspective on how to improve our health care system. Our statement today focuses on:

I. BCBSA's recommendations to rein in costs, improve quality and extend coverage to all; and
II. BCBSA's initial comments on the House Committees' draft health reform legislation.

I. BCBSA Recommendations to Rein in Costs, Improve Quality and Cover All

We believe that the most effective way to expand coverage is to build on the employer-based system – which already provides coverage to more than 160 million people today. To attain the goal of having everyone covered, we must also address the underlying problems of our current delivery system.

Our proposal, *The Pathway to Covering America*, seeks to expand coverage, rein in costs, and improve quality through five recommended steps. The first four recommendations focus on attacking costs and improving quality and the fifth seeks to expand coverage.

1. **Encourage research on what works.** Researchers and policymakers agree there is insufficient information on what medical treatments work best, resulting in more costs for sub-optimal care.

   BCBSA urges Congress to create a new independent institute to support research comparing the effectiveness of new and existing procedures, drugs, devices and biologics. We believe the institute should prioritize clinical trials and other research necessary to respond to the needs of frontline-providers and patients who want to know which treatments work best. We are pleased the House draft bill would create a permanent comparative effectiveness entity. We believe this proposal could be strengthened by making it an independent entity to insulate it from political pressures.

2. **Change incentives to promote better care.** The incentives in our system must be changed to advance the best possible care, not just more services with little or no care coordination. We believe Congress should:

   - *Move Medicare away from a system based on fee-for-service* to one that pays based on quality, coordinated and outcome-driven care. Medicare should work with the private sector

to expand pay for quality programs and pilot test new payment models such as accountable care organizations and patient centered medical homes (PCMH).

- *Improve access to generic drugs by giving* FDA authority to approve scientifically feasible and safe generic versions of biological products.

- *Strengthen the delivery system* by expanding the primary care workforce through increased Medicare payments, graduate medical education changes, and additional educational loans and grants, including loan forgiveness for primary care providers who work in medically underserved areas.

Many of these recommendations, which we support, are included in the draft bill.

3. **Empower consumers and providers with information and tools** needed to make more informed decisions. Blue Plans across the U.S. are leading efforts to promote widespread adoption of electronic medical records, e-prescribing, personal health records, and consumer decision-support tools. Many Plans are giving providers and consumers access to comprehensive information on a patient's health and medical history through payer-based electronic health records that enable providers to better coordinate care. BCBSA urges Congress to continue to advance adoption of health information technology with an electronic health record in every doctor's office based on uniform, interoperable standards.

4. **Promote health and wellness.** Today's increased healthcare spending is partly due to unhealthy lifestyles by many Americans. Chronic illness also is a growing problem, with the cost of treating chronic illness estimated to account for 75 percent of healthcare spending.

   BCBSA applauds the Committee for emphasizing prevention, wellness, and coordinated care for those with chronic conditions. Specifically, BCBSA recommends:

   - Removing barriers that hinder employers from encouraging healthy employee lifestyles (e.g., requiring employers to give non-smoker discounts to smokers who enroll in, but do not successfully complete, cessation programs).
   - Supporting school programs that encourage healthy lifestyles and improve the nutritional quality of school meals.
   - Requiring Medicaid cover smoking cessation programs and incorporate wellness and disease prevention incentives.

5. **Foster public-private coverage solutions to address the uninsured.** Whether someone is uninsured because they have difficulty affording coverage within their family budget or are a low-wage worker in a small firm – we need to make sure people get the health coverage they need. Recognizing that the uninsured is a diverse group, BCBSA recommends tailored solutions to help the three key segments:

   Those squeezed out by cost: Approximately 56 percent of the uninsured may have difficulty affording coverage because they are ineligible for government assistance, but earn less than 300 percent of the federal poverty level. BCBSA recommends:

   - *Providing four new types of tax assistance*: Congress should enact: (1) a tax credit for small employers; (2) a refundable tax credit for those whose health premiums represent a large share of their income; (3) a refundable tax credit to help those between jobs; and (4) tax deductibility for those without access to employer coverage.

- *Expanding the government safety net:* Medicaid should be extended to cover everyone under the federal poverty level.

Those missing out on public coverage: Twenty-five percent of the uninsured (12 million) are eligible for Medicaid or SCHIP under current rules, but are not enrolled.

- BCBSA strongly supported reauthorization of the Children's Health Insurance Program, including the additional funding for outreach and enrollment for those who are eligible but not enrolled and the new "Express Lane" expedited eligibility process for states. Ensuring expanded enrollment in CHIP is a critical undertaking. Blue Plans, which serve one-third of CHIP enrollees today, look forward to working with states and the federal government to expand coverage to the estimated 4.1 million additional children who will obtain coverage under the reauthorized program.

- We also supported the inclusion of a new state option for subsidizing employer premiums. Premium assistance is a "win-win" approach to expansion because it leverages employer coverage and employer contributions, and expands access to family coverage for lower-income employees who may not otherwise be able to afford their share of the premium.

Those opting out of coverage: Twenty percent of the uninsured may be able to afford insurance, but may: (1) not value it because they are young or healthy; (2) be unaware of coverage options and their tax deductibility (for the self-employed); or (3) overestimate the cost of coverage. BCBSA recommends:

- *Educating Americans about the importance of being insured*: The public and private sectors should partner on a broad-based educational campaign on the value of insurance.

- *Ensuring all individuals obtain coverage:* create a new health coverage responsibility program as described below.

6. Personal Responsibility for Obtaining Health Coverage

To achieve universal coverage, BCBSA supports a new health coverage responsibility program for all Americans to obtain and maintain health coverage, with subsidies to help those likely to have difficulty affording insurance. This health coverage responsibility program is essential to assuring everyone has coverage and keeping premiums affordable. Along with this new program, BCBSA supports insurance reforms in the individual market with subsidies to make coverage affordable.

It is important to note that subsidies alone are not an adequate substitute for an effective health coverage responsibility program. RAND's Compare Model predicts that even with full subsidies for persons with incomes up to 200 percent of federal poverty level and partial subsidies up to 400 percent of federal poverty level, only 12.4 million individuals would be newly insured. In contrast, combining these subsidies with an effective health coverage responsibility program would increase the newly insured to 33.5 million.

7. Insurance Market Reforms to Assure Everyone has Access to Affordable Insurance

An effective, health coverage responsibility program that includes federal subsidies for those that need help purchasing coverage is essential for insurance market reforms to work. With these components in place, BCBSA supports a new requirement for all insurers to accept everyone in the individual market regardless of their health status ("guarantee issue").

Guaranteed issue can only work if everyone – young and healthy as well as higher risk individuals – purchases coverage.

BCBSA also supports new rating rules in the individual market, including:

- *Prohibitions on Health Status Adjustments.* Insurers should not be allowed to vary premiums based on health status once everyone is covered. Experience shows that bans on health-status rating in voluntary markets lead to significant increases in premiums for many people, especially young and healthy individuals. As healthier people drop coverage because of increased premiums, subsidies for sicker enrollees are lost and the remaining enrollment is left with much higher premiums.

- *Continuation of Age Adjustments.* It is extremely important to continue to allow insurers to vary premiums based on age (5:1) – even with a health coverage responsibility program. Age adjustments are essential to enable younger individuals – who may earn less than older people – to buy coverage and comply with the health coverage responsibility program. Younger people often do not value health insurance because they tend to use fewer medical services. If the premiums are set too high, there is likely to be a backlash among younger people.

- *Continuation of Wellness and Geography Adjustments.* Insurers should be encouraged to adjust premiums based on wellness factors (such as non-smoking) and geography. Wellness adjustments provide important incentives for consumers to engage in healthy behaviors and help prevent chronic illnesses. In addition, given the significant variation in healthcare costs across different regions in the country, premium adjustments to account for geography are critical.

These reforms must be appropriately phased-in, taking into account state variations and actuarial modeling, to avoid disruptions and major premium hikes to consumers currently in the market.

States should continue to be the primary regulators of insurance to best protect consumers. Federal rules should set minimum standards upon which states can build, and all insurers offering coverage in a state should be required to abide by the same rules. States have a long, successful history of regulating health insurance and protecting consumers – a role that could not be replicated effectively at the federal level. Further, we recommend exploring broadly-funded state reinsurance programs with federal funding for persons with high medical costs to ensure that individual market premiums are affordable for everyone.

Health coverage responsibility and adequate subsidies are essential to ensuring that guaranteed issue and community rating reforms work. In the 1990s, several states experimented with guaranteed issue and community rating reforms in voluntary markets. These states experienced an adverse selection spiral, where younger and healthier individuals opted out of the insurance market, causing higher premiums for those remaining in the insurance market – who often tended to be older and less healthy. States saw dramatic premium increases, drastic reductions in the number of individuals buying coverage, and fewer insurance products being available to consumers.

8. Making it Easier to Shop for Coverage by Creating State Exchanges

Today, individuals and small employers often find it difficult to shop for health insurance from multiple health plans. BCBSA supports efforts to make it easier to shop, compare, and enroll in health plans through creation of state-based exchanges.

This model would provide a central point in each state where individuals and small employers could learn about coverage options and apply for subsidies. These state exchanges would enable:

- Comparison of all insurance options in a state based on key factors including benefits, price, quality metrics, and provider networks. Each state would develop easy-to-understand comparison templates to promote transparency and informed decision-making.

- Real-time price quotes from multiple insurers. Each state would develop standard applications that individuals and small businesses could use to apply to several insurers simultaneously to obtain estimated premium quotes instead of completing multiple applications and waiting for each insurer to follow up.

- Calculation of any tax benefits and subsidies available or determination of eligibility for public programs. Enrollees could enter basic financial information, learn about the estimated final cost of coverage, and learn if they are eligible for any public programs such as Medicaid.

- Simplified enrollment in plan of choice. Individuals and small businesses could easily enroll in coverage online or apply for subsidies directly through interfacing with the agency verifying eligibility.

II. BCBSA's Initial Comments on the House Committees' Draft Bill

BCBSA strongly supports passing comprehensive healthcare reform. The recommendations we have laid out today would accomplish the objectives of reform by building on the employer-based system to rein in costs, improve quality and extend coverage to all.

The House Committees' draft bill addresses many of the critical steps required to transform our health care system. BCBSA largely supports the broad framework put forth. Specifically, we are very supportive of:

- Individual responsibility requirement to assure universal coverage with subsidies to make coverage affordable.
- Insurance reforms to assure everyone can obtain coverage and eliminate preexisting condition exclusions and health status-based rating.
- Delivery system reforms in Medicare to transform the program from paying for volume to paying for outcomes.
- Focus on prevention and wellness to keep people healthy and to better manage patients with chronic illnesses.

We have strong concerns that specific provisions will have serious, unintended consequences that undermine the goals the Committees are seeking to achieve.

Why a New Government Plan is Unnecessary and Would Cause Significant Problems

We are deeply concerned with the provisions in the House bill to create a new government-run health insurance plan that would be offered through the national health insurance exchange. A government plan that pays based on Medicare rates, as proposed, for any period of time is unnecessary and would run counter to the goals of reform. It would have devastating consequences because it would:

1. *Cause many people to lose the private coverage they enjoy today*

   Employer-based coverage would be significantly eroded by a government health plan. An independent analysis by the Lewin Group estimates that tens of millions of people would be shifted to a new government plan, if Medicare rates (or some variation) are used.

   This analysis assumes employers would shift to the new government plan because of the lower Medicare payment rates (which results in lower premiums). This would lead to significantly higher costs in the remaining private market because of exacerbated cost-shifting. A recent Milliman study shows the annual cost of employer health insurance is already $1,788 higher per family because of Medicare and Medicaid underpayments. As private premiums skyrocket, private insurance would become unaffordable for most – making the government plan the only affordable option.

2. *Underpay healthcare providers, creating major problems with access to care*

   The House draft bill would underpay health care providers by paying doctors and other healthcare professionals' current Medicare rates plus five percent and hospitals Medicare rates for individuals enrolled in the government plan. Medicare currently pays hospitals and physicians 30 and 20 percent less than private insurers for the same services, respectively. At a time when demand for healthcare will increase as up to 46 million uninsured Americans are brought into the system, these reduced payments are likely to cause major access problems in the healthcare system, such as long waits for services.

   A 2008 MedPAC study found that 29 percent of Medicare beneficiaries surveyed reported having problems finding a physician to take new patients. In addition, the Texas Medical Association in 2008 reported that only 38 percent of primary care physicians in the state will accept new Medicare patients.

3. Undermine much needed delivery system reforms

   It would also jeopardize much needed delivery system reforms critical to controlling costs. We agree Medicare needs to be reformed to reward high quality care and good outcomes rather than just paying for services. We commend the Committees for proposing delivery system reforms to help modernize Medicare. However, history has shown the government can be slow to innovate and implement changes due to the complex legislative and regulatory processes as well as political pressures. For example, the government has not been successful in selectively contracting with the best providers.

   The private sector, on the other hand, is free to innovate, and is having excellent results. BCBSA is significantly improving care outcomes and lowering costs through our national program of nearly 800 Blue Distinction Centers across the country. Readmission rates at our Cardiac Care centers are much lower than at other hospitals (26 percent lower for bypass surgery and 37 percent lower for outpatient angioplasty, based on 30-day cardiac-related readmission rates).

The House draft bill implies that the government plan would operate on a "level playing field" because it would be required to meet the same standards as other private health plans participating in the exchange. While the new government plan would meet some of the same standards as private plans, there are many clear advantages for the government plan in the draft bill. For example:

- Individuals in the government plan could sue only for their denied services in federal court, as under Medicare, while private plans could be sued in state courts for punitive, compensatory, or other damages. This alone is a huge advantage.
- Employers who have ERISA group health plans who choose to purchase private coverage through the Exchange would for the first time be subject to state liability. However, if they purchase the government plan, they would essentially be limited to Medicare remedies – which are similar to current ERISA remedies.
- Private health plans would have to meet 50 different state benefit mandates totaling over 1800 separate benefit and provider requirements, while the government plan would be exempt from these requirements.
- The government plan would be exempt from state premium taxes and other assessments, as well as federal taxes, while private plans would continue to pay taxes and assessments.
- The government plan would enjoy significant funding advantages, including an unspecified amount of start-up funding. While it has to maintain a contingency reserve, the government plan would be exempt from state solvency regulations that are likely to be far more stringent and expensive.

Clearly, the government plan enjoys major costs and regulatory advantages that will tilt the market in its favor and would ultimately lead to the government plan taking over the exchange marketplace.

BCBSA urges the Committees to reject inclusion of a new government plan and instead focus on the new major roles the federal government should undertake with reform:

- Expanding Medicaid to cover all people in poverty and enrolling all those who are eligible.
- Reforming Medicare to pay for quality and assuring Medicare's long-term solvency.
- Establishing new rules for insurers to assure access for everyone regardless of health status.
- Providing subsides to help those who may have difficulty affording coverage.

Other Comments

We are continuing to review the draft bill and intend to submit detailed comments to improve the legislation. However, we want to raise the following key concerns that will have unintended consequences on expanding coverage and ensuring affordability for consumers.

1. **State-based exchanges should be used to simplify purchasing, facilitate competition**

   A state-based approach would be a better alternative to a new national exchange because it would: (1) build on states' expertise as the regulators of today's health insurance market; (2) provide a less costly, less complex, and faster alternative to creating a new federal bureaucracy; and (3) avoid the problem of dual regulation. States have spent years crafting insurance rules and consumer protections and are in the best position to regulate this market. We have several recommendations for the exchange:

   - *Build on existing state infrastructure, rather than creating new entities:* The draft bill establishes a new federal entity to assume many regulatory functions that are currently being performed by the states, including: certifying benefit plans, enforcing consumer protections, handling grievances, investigating complaints, risk pooling, and other functions assumed by the new Commissioner. States already have thousands of staff assigned to these functions. Creating a new federal agency to perform these functions would result in unnecessary, ineffective, and costly dual regulation.

- *Focus the exchange on the goal of simplifying the purchase of insurance and promoting competition.* The draft bill would have the exchange take on a wide range of functions, including selecting the plans available to consumers. This would limit choices for consumers and constrain competition.

  As previously mentioned, we agree that a state exchange is needed to help individuals and small employers shop for coverage. However, the core functions should be limited to those necessary to help consumers and small employers make informed decisions on their coverage, easily enroll in the health plan of their choice, and apply for subsidies.

- *Allow people to purchase coverage outside the exchange with subsidies available to all eligibles.* The draft would make the exchange the sole source for obtaining coverage and subsidies in the individual market. This could cause people to drop their current health plan to obtain subsidies, causing significant disruption in the marketplace. BCBSA recommends that subsidies be available both inside and outside the exchange to minimize disruption for consumers.

- *Keep the employer market intact.* The draft bill would break up small employers within the exchange by permitting employee choice of plan. This would transform the group market into a higher cost individual marketplace that would have higher administrative costs and be prone to adverse selection. There are 4.8 million small employers (under 50) today with 32 million employees. Employee choice would result in increased costs as administrative functions would now have to be performed for each individual employee that receives coverage through the exchange.

In addition, employee choice would result in significant adverse selection problems – choice is likely to be limited to "tight network" coverage as richer, PPO-like benefit packages are driven from the exchange. BCBSA recommends that small employers remain intact and select coverage through the exchange on behalf of their employees. Keeping groups intact is likely to result in lower out-of-pocket costs for employees as their employers will likely provide higher contributions. If Congress wishes to provide employees greater choice, a better alternative would be to allow health plans to offer a choice of plans within their own pool.

2. Assure appropriate pooling to minimize disruption

The House Committees' draft bill appears to require insurers to apply rating rules to large employers and create a single insurance pool for all fully insured lines of business (individual, small group, and large group). These requirements would increase premiums in the small group and individual markets. Large employers with less healthy workers are likely to opt into plans provided by the exchange, while healthier employers likely would self-fund their coverage. This would increase premiums for individuals and smaller employers who may be forced to drop coverage as a result. In addition, these requirements would decrease incentives to adopt wellness initiatives. If forced into a community-rated pool, large employers will know that their premiums will be the same, regardless of whether employees take advantage of wellness programs. Therefore, large employers would be less likely to invest in wellness programs.

3. Incentives are needed to ensure younger people purchase coverage

The draft legislation would limit use of adjustments for age to a range of 2:1. BCBSA strongly urges the Committee to allow greater variation in age adjustments of 5:1 to ensure that young people comply with the personal responsibility requirement. Premium discounts for younger individuals – who earn less and often use fewer services than older people -- are key to getting

them to buy coverage – and thereby provide the cross-subsidies essential to pay for the care of older individuals. Premium affordability issues for older individuals should be addressed by assuring sufficient income-based subsidies are available to them.

***4.* Medicare Advantage**

The House draft bill would reduce Medicare Advantage payments to the level of FFS claims costs over a three year period, while providing bonus payments to plans based on quality. While BCBSA supports the goal of providing quality bonuses, we have significant concerns regarding the level of cuts to Medicare Advantage. Cuts of this magnitude would cause millions of Medicare Advantage enrollees to lose their coverage and lead to significant reductions in benefits or increases in premiums for millions more. We want to work with the Committee to ensure that Medicare Advantage meets the goal of enhancing value for both beneficiaries and the government, while assuring that changes do not threaten access to coverage for the 11 million people who rely on Medicare Advantage.

Conclusion

BCBSA appreciates the opportunity to testify on how to reform our health care system. We look forward to working with this Committee to enact comprehensive health care reform legislation.

Mr. PALLONE. Thank you, Ms. Fox, and now we will have questions starting with me. Obviously I can't reach everyone so I am going to direct my question—I will try to get in three questions about primary care, Medicaid and DSH if I could, and I am going to start with Dr. Epperly on the primary care promotion issue.

We have obviously heard a lot of testimony about the primary care shortages. We have heard that action on a single front is not enough but that concerted action across the health system is going to be required, and the discussion draft reflects these calls for action and proposes major investments, and I will list first increasing the rate paid by Medicaid for primary care services, second, the primary care workforce including increases for the National Health Service Corps and scholarship and loan programs, third, payment increase in Medicare and the public option for primary care practitioners including an immediate 5 percent in payments and high-growth allowances under a reformed physician fee schedule, fourth, an additional payment incentive for primary care physicians in health profession shortage areas, and finally, an expansion of medical home payments and added flexibility for that model of care. The draft also proposes a reform to graduate medical education programs funded by Medicare and Medicaid. Two questions. First, will these proposals help to reverse the decline in interest in primary care among medical students, Dr. Epperly?

Dr. EPPERLY. Absolutely.

Mr. PALLONE. OK.

Dr. EPPERLY. Did you want me to expand on that?

Mr. PALLONE. Well, let me give you the second one and then you can talk. The second is, will the rate increases proposed for primary care services in Medicaid and Medicare help to address problems with access we have seen in those programs over the past several years? So generally will you reverse the decline among medical students, and secondly, what will it do for access to Medicaid and Medicare?

Dr. EPPERLY. Thank you, Mr. Pallone. I would say to you that the return to a primary care-based system in this country is essential. If you will, it is foundational to building the health care system of our future. To get primary care physicians back into a position where they can integrate and coordinate care, lower costs and increase quality, we must do that. Right now, primary care is in crisis. A lot of that has to do with the dysfunctional payment system. Primary care practices are barely making it in regards to their margins, so what we have to do in terms of the reform measures is, number one, make this viable financially for physicians to choose primary care.

Mr. PALLONE. But tell me whether you think these proposals that are in our draft discussion will accomplish that. Will we get more medical students to go into primary care and what will it mean for access to Medicare and Medicaid specifically with this proposal before us?

Dr. EPPERLY. Right. So medical students now are opting not to choose primary care because they can see that incomes can be three to five times higher if they choose subspecialties so the payment reform will help narrow that gap in disparity so that they choose more to do primary care. The derivative effect of that is that

workforce will then be enhanced, access then increases. What we must do in the system is not only coverage people but we have got to have the right types of physicians and the right communities to see them. So it is kind of multifaceted, multilayered. We have got to fix payment, which will increase workforce. Workforce will enhance access. That is how it is all linked. What it saves America is cost in the long run, increases affordability and access as a derivative.

Mr. PALLONE. Do you believe that this discussion draft will accomplish that?

Dr. EPPERLY. Yes.

Mr. PALLONE. OK. Now, let me just ask my Medicaid and DSH question of Dr. Gabow, if I can. Can you talk to us on Medicaid, what will it mean to have Medicaid covering up to 133 percent of the federal poverty level, having subsidies that help people access health care up to 400 percent and to have individuals response to encourage all else to make sure that their dependents have health insurance. So basically, you know, the increase to the poverty level eligibility for Medicaid, the subsidy in the health marketplace and the individual mandate. That is a lot.

Dr. GABOW. Yes. Well, clearly, anything that expands coverage, particularly for low-income, vulnerable people, will reduce our $360 million of uninsured care. But as it relates to Medicaid disproportionate share payment, I think the timing is important. We would like to make sure that we see that the patients actually who are eligible get enrolled and that they are covered and that our uninsured costs go down before there is any change in disproportionate share payments. So we applaud your version of the draft bill regarding DSH. We know that many patients who we hope to get enrolled are the most difficult to enroll, for example, homeless for whom we did over $100 million of care last year, the chronically mentally ill, illiteracy. These patients have been difficult to enroll in Medicaid. So I think expanding Medicaid is terrific. I don't know that immediately it will reduce our need for other coverage. Ultimately it should and I think we have seen in Massachusetts that reduction of DSH at the front end has had negative effect on the two principal safety-net institutions. So I think the expansion of coverage that you are planning will reduce the amount of uninsured care over time and we need to deal with that sequentially as regards DSH.

Mr. PALLONE. Thank you.

Mr. Deal.

Mr. DEAL. Thank you.

I am going to ask for a yes or no answer from a couple of you on this first question. We just heard the preceding panel member who is chairman of MedPAC say that he felt that Medicare reimbursements were adequate, and I would ask if you concur with that. Dr. Williamson?

Dr. WILLIAMSON. No.

Mr. DEAL. Dr. Ulrich?

Dr. ULRICH. No.

Mr. DEAL. Dr. Wright?

Dr. WRIGHT. No.

Mr. DEAL. Dr. Epperly, I am going to ask you that question in the context of the current reimbursements under Medicare, not counting the bonuses that are proposed in this legislation. Do you consider the current Medicare reimbursements to be adequate?

Dr. EPPERLY. No, sir, I don't.

Mr. DEAL. Have you, Dr. Epperly, as a result of that inadequacy seen many of the members of your organization not take Medicare patients?

Dr. EPPERLY. Yes, sir, I have.

Mr. DEAL. Dr. Williamson, first of all, let me acknowledge that he is the president of my Georgia Medical Association and I am pleased to have him here. I made those statements yesterday in your absence as we began these things yesterday. Dr. Williamson, let me ask you what you think the impact would be for the public option plan to adopt the Medicare reimbursement plan as its model. How would that impact the delivery of health care under the public option plan and also as it then migrates, in my opinion, to the private insurance market?

Dr. WILLIAMSON. I think it would have a very adverse impact on access for patients and on the delivery of quality medical care. Right now, access for Medicare patients I think is really a house of cards. A lot of doctors are there simply by inertia, and surveys that have been done in Georgia amongst practicing physicians show that a large percentage of doctors plan on dropping Medicare in the near future, and I think that is just basically a train coming down the track, and I think any system that is modeled on that premise is really going to fail in the short run, not the long run.

Mr. DEAL. The doctor-patient relationship has been really the cornerstone of the importance of our health care delivery system that makes it work. I would ask you, Dr. Williamson, in light of this draft legislation, in particular the comparative effectiveness portion of it, how do you see that potentially impacting that doctor-patient relationship?

Dr. WILLIAMSON. I think it is going to push us farther and farther away from it, which is really I think the opposite direction that we need to be going. I have serious concerns that bundling payments is going to drive a wedge between patients and their physicians. I know that in some clinics that we have looked at as examples, that type of environment works but those are rare and I think they are different than the general practice of medicine across the country and they have a different patient population in some cases. I have grave concerns about comparative effectiveness as well. I think this would essentially give the federal government the ability to practice medicine, and I know that is a strong statement but let me say this. Scientific research is not new. It has always been done and it has always been the basis of medical learning and medical treatment but the art of medicine is taking this science, these large studies and applying it to an individual patient. When you try to treat the individual from the 30,000-foot level, it is very difficult, and I am afraid that this would drastically diminish our choice of options for our patients. I can tell you that I am well aware as a neurologist of the importance of the last 20 years in pharmaceutical research. I have a lot of options for my patients now that weren't available before. And some of these things

are found quite by accident, and we take them and we apply them and they may be off-label drugs and that sort of thing and they may even be therapies that have not been shown to work in large randomized controlled trials that take many years and millions of dollars to accomplish, and if we are limited by that we are going to have a lot of therapies taken off the table for our patients. And I will also tell you that I think it is a bit of a conflict of interest to have the government deciding what is valuable to patients because they are serving as the largest payer. I think that the physician and the patient ought to be able to decide in the context of private contracting what is value and what is appropriate care.

Mr. DEAL. Thank you.

Mr. Roberts, you have alluded to the issue with AMP. As you know earlier this year, I introduced an amendment that I think was more appropriately dealing with this federal upper limit for reimbursement of going to 300 percent of the volume weighted average and also included a minimum prescribing fee for pharmacists, or dispensing fee, I should say, for pharmacists. Which of those options do you prefer, what I offered earlier this year versus what is in this bill?

Mr. ROBERTS. Well, I think, Congressman Deal, that your—the challenge that we have is that we really don't know what this benchmark is so there are changes made in the current version that redefine the benchmark in a way that will make it much better than what it is but the reality of what you are proposing and having a minimum dispensing fee I think is absolutely critical. The challenge that we have is that, you know, the benchmark is just meant to get us to even, to break even on the cost of the product. But the reality is, the States set the dispensing fees and the dispensing fees are all over the place from one State to another. And so unless the federal government takes some action to say, you know, that our costs of dispensing and a small profit are available to the pharmacy, it is going to be very difficult to have pharmacies remain viable.

Mr. DEAL. Mr. Chairman, I take that as an endorsement of my approach and I will yield back.

Mr. PALLONE. Thank you.

Our vice chair, Mrs. Capps.

Mrs. CAPPS. Thank you, Mr. Chairman, and I want to thank again all of the panelists for appearing today. It was a very interesting presentation that each of you made, a lot of linking, which I think is really important for us to have a part of this discussion.

Of course, Dr. White, I want to single you out and thank you for being here today to represent the voice of America's nurses who are so important every day in delivery of health care but also in understanding what this crisis is all about. I was very pleased to hear that the American Nurses Association has endorsed a public plan option. I also support this option and the one that we are developing in this legislation and want to hear your perspective a bit more as a nurse on why this is so essential because it is one of the crucial parts of the choice that people are going to make whether or not they support this reform legislation. I will ask you to do it within this framework. I often speak about the role that nurses have not only as providers of health care and delivering service but

we are also patient advocates, and would you talk about maybe the reason you endorse as ANA the public plan option and why you feel it is best for patients and perhaps are encouraging patients to advocate for this as well as the choice, to have this choice made available?

Ms. WHITE. Thank you, Mrs. Capps. I am happy to answer that question because I do think it is extremely important, the American Nurses Association endorsing a public option plan because, as you said, our role is direct care. We are there 24/7, 24 hours a day, 7 days a week, 365, you know, depending on how long a patient is in there. We don't like to think it is that long. But we see patients and families and how they are dealing with the catastrophic impact of illness whether it is an episode, a single, acute that affects the patient and their family or whether it is a long-term kind of chronic condition that, you know, includes, you know, many admissions or many returns. And not being able to have a choice of insurance I think is key and unfortunately we have seen employer plans rising, the costs of those to patients rising greater than wages over the last several years, and so patients are looking for other ways of paying for their health care insurance and sometimes those plans may not be exactly what they think they are or they may have surprises so certainly a public plan that includes some type of defined or essential benefit package that the patient, the family could be sure will be there when they need it I think it is extremely important.

Mrs. CAPPS. Let me follow this by another aspect of our reform legislation. One of the ways—Dr. Epperly mentioned this but he wasn't the only one on the panel, which was interesting, who is stressing now on primary care as one of the ways we can lower health costs and the ways he discussed on how we can improve our primary care workforce and there are many advanced practice nurses, nurse practitioners and others who can and do serve as primary care providers and this bill ensures that nurse practitioners can be the lead providers in medical home models and increases reimbursements, for example, for certified nurse midwives. Can you discuss this a little bit? You mentioned one bill that I coauthored on nurse-managed clinics but that is not the only avenue, and you might mention a few others for the record.

Ms. WHITE. Absolutely. Obviously the nurse-managed clinics is an extremely important way for many vulnerable populations, inner city, rural areas that get primary care and other—even other follow-up care in those areas, and as far as nurse practitioners, as our advance practice nurses functioning within the primary care medical home and being able to lead those teams, we have seen in the demonstration projects throughout the country that nurse practitioners have been paneled. They do function to their scope of practice in the different states and the different demonstration projects and have been able to lead their panel of patients and provide that primary care. I think it is extremely important when we are talking about the shortage of primary care that all providers be able to be used to the fullest extent of their scope that they can provide the care.

Mrs. CAPPS. Thank you very much. I will yield back.

Mr. PALLONE. The gentleman from Indiana, Mr. Buyer.

Mr. BUYER. The challenge we have with a panel this large is to try to get our questions in, so if you can take out a pen and pad, I am going to rip through some questions. They won't apply to all of you. First I am going to go to Mr. Yarwood. When you stated the provisions in the draft bill would cut Medicare reimbursement rates to skilled nursing facilities by $1.05 billion in fiscal year 2010 alone and ultimately $18 billion from skilled nursing care over 10 years, I would like to know whether you have calculated the number of jobs that would be lost due to these cuts.

The next question I have would go to Dr. Ulrich. The draft bill provides that physicians who treat both Medicare and the public plan, patients would receive Medicare plus 5 percent for treating their public plan, really the government plan, patients for the first 3 years. What is the, quote, magic number, end quote, regarding the percent of Medicare that it would take to keep you whole? Is it Medicare plus 10, plus 12, plus 13, plus 14?

The other question I have for Blue Cross Blue Shield, what are the advantages that the government plan would have over the private insurers? What about State premium taxes, State solvency regulations, State benefit mandate requirements?

And the last question I have, I am going to go right down the line with all of you. Medical liability reform that restricts excess compensatory awards, limits on punitive damages and attorney fees, should this be part of the public plan option? Let us go right down the line. Dr. Epperly?

Dr. EPPERLY. Yes, we believe that——

Mr. BUYER. Dr. Williamson?

Dr. WILLIAMSON. Absolutely.

Mr. BUYER. Dr. Ulrich?

Dr. ULRICH. Yes.

Mr. BUYER. Dr. Wright?

Dr. WRIGHT. Yes.

Mr. BUYER. Dr. White?

Ms. WHITE. Yes.

Dr. GABOW. Yes.

Mr. HAWKINS. We have FTCA coverage so I can't really comment.

Mr. BUYER. All right. One equivocator.

Mr. ROBERTS. Yes.

Mr. HAWKINS. Yes.

Ms. FOX. Yes.

Mr. BUYER. All but one except Mr. Hawkins testified in the affirmative that it should be included. The other is, would everyone on this panel agree that individual liberty is a cornerstone of our society as an inalienable right? Would everyone on this panel agree? OK. Mr. Hawkins, are you in?

Mr. HAWKINS. Yes, I am in.

Mr. BUYER. He is in. All right. Awesome. Now, an individual right, if in this scheme we are moving people into the government plan, what about an individual's right to contract with a physician of their choice? Should an individual in America have the right to contract with an individual doctor of their choice? Yes or no. Dr. Epperly?

Dr. EPPERLY. Yes.

Mr. BUYER. Oh, let me—without penalty from their government. Dr. Epperly?
Dr. EPPERLY. Yes.
Mr. BUYER. Dr. Williamson?
Dr. WILLIAMSON. Yes.
Dr. ULRICH. Yes.
Dr. WRIGHT. Yes.
Ms. WHITE. Individual provider, yes.
Mr. BUYER. Thatta girl.
Dr. GABOW. Yes.
Mr. HAWKINS. With their own money, yes.
Mr. BUYER. Thatta boy.
Mr. ROBERTS. Yes.
Mr. HAWKINS. Yes.
Mr. YARWOOD. Yes.
Ms. FOX. Yes.
Mr. BUYER. We are on a roll. Now, does everyone agree that in the capital economic system that we have, even though we may have a public option plan, that the marketplace should be able to create some type of an instrument that would be a supplement, a potential medical insurance supplement plan? Should that be some type of an option that the marketplace could create? Dr. Epperly?
Dr. EPPERLY. Yes.
Dr. WILLIAMSON. Yes.
Dr. ULRICH. Yes.
Dr. WRIGHT. Yes.
Ms. WHITE. I am not sure.
Mr. BUYER. OK. Dr. White is an unsure.
Dr. GABOW. No.
Mr. BUYER. A no.
Mr. HAWKINS. I am not sure I understand——
Mr. BUYER. I am not sure.
Mr. ROBERTS. I am not sure I do either.
Mr. BUYER. Two I am not——
Mr. YARWOOD. I am number three not sure.
Ms. FOX. Well, we are hoping that there is no public plan.
Mr. BUYER. Pardon?
Ms. FOX. We are hopeful there will be no public plan in the program.
Mr. BUYER. All right. But if there is a public plan, should individuals in the marketplace be able to create supplemental coverage?
Ms. FOX. Yes.
Mr. BUYER. Yes?
Ms. FOX. Yes, like Medicare.
Mr. BUYER. All right. Thank you. Now I will rest and allow those individuals to answer the questions that I had asked.
Dr. ULRICH. The answer is Medicare plus 100, and I can expound as to why if you would prefer. I think in my testimony I cited the fact that we currently in Wisconsin from the private sector get anywhere from 180 to 280 percent of Medicare in payment. Medicine is changing, and this is what is really interesting, is that we have gone from kind of being a cottage industry to now much more high tech. Our costs are very different than what Medicare allocates to

us now. We now employ, for example, systems engineers. Why? Trying to understand efficiency of work flow. We also in our clinic and others as well employ many people in information technology. We developed our own electronic medical record. We have close to 350 employees now, software engineers, et cetera. Our cost structure has shifted dramatically from what the traditional concept of what medical practice is, you know, a nurse practitioner, physician, a nurse, a technician, et cetera, and so the costs keep changing. The other thing I would ask this committee to keep in mind is that medicine as an entity is an ever-evolving one in the sense that we have come from——

Mrs. CHRISTENSEN [presiding]. Dr. Ulrich, could you——

Dr. ULRICH. Yes?

Mrs. CHRISTENSEN. We are way over time. Could you wrap up your response, please?

Dr. ULRICH. I will just stop there, if my initial answer satisfied you.

Mr. BUYER. Mr. Yarwood, do you have an answer?

Mr. YARWOOD. Thirty thousand jobs.

Mr. BUYER. Thirty thousand jobs would be lost?

Mr. YARWOOD. Over 10 years, yes.

Mrs. CHRISTENSEN. Thank you. The gentleman's time has expired. The chair now recognizes Ms. Castor for 5 minutes.

Ms. CASTOR. Thank you, Madam Chair, very much, and I would like to return to the workforce issues.

This bill rightfully targets workforce incentives because we must bolster the primary care workforce especially. Fifty years ago, half of the doctors in America practiced family medicine and pediatrics. Today, 63 percent are specialists and only 37 percent are family doctors, and it is those family doctors and the nurses on the front lines and the pediatricians that really help us contain costs over time. I do not know what I would do if I did not have the ability to call the nurse in my daughter's pediatrician's office and ask a question and they have had a consistent medical home over time and yet millions of American families do not have that type of medical home and relationship with their primary care providers.

So I think our bill does take important steps to bolster primary care workforce but one place that I think it falls short, and I would be very interested in your opinions, is that we are not increasing the residency slots for our medical school graduates, these doctors in training. The discussion draft provides a redistribution of unused residency slots to emphasize primary care, which is a good first step because we are going to hopefully send them to community health centers and other hospitals in need and other communities in need. But we have got to enact the second step, the complementary step, to even out the residency slots because, for example, in my home State of Florida, the fourth largest State in the country, we rank 44th in the number of residency slots and most folks do not understand that those slots are governed by an old, outdated, arbitrary formula that assigned distribution many years ago and has not changed, even though the population of the country has shifted. So I would like to know, do you agree—Dr. Epperly, you might be the one most in tune but I think many of you would have an opinion on that. Do you agree we need to alter

the residency in toto? And then are there sections in the bill—the sections in the bill related to scholarships and loan repayments, are they adequate? Are we doing enough?

Dr. EPPERLY. Yes, ma'am. Can I expand for just a second?

Ms. CASTOR. Yes.

Dr. EPPERLY. In my day job, I am a residency program director of a family medicine program in Boise, Idaho, and you are right on. In fact, the workforce numbers are about 70/30 subspecialists to generalists. We must increase residency training, especially for primary care, and what are we trying to build, what system are we after. We think there should be some regulation of what kind of physicians medical schools are producing. It needs to meet community needs and so we are in agreement with some sort of workforce policy center to kind of take a look at this and what it is we are trying to accomplish. I totally agree with you in terms of scholarships and loan repayment. Scholarships on the front end will be more effective than loan repayment on the back end because it helps shape the types of physicians you are trying to train.

Ms. CASTOR. Does anyone else want to comment quickly? OK. Then I will move on.

Ms. Fox, thank you so much. It is great to hear that Blue Cross is supportive of health care reform. What I wanted to share with you, I had a great meeting last week with the Florida CEO, president and CEO of Blue Cross, and you all are a very important provider in the State of Florida. You have about 32 percent of the market share in the State of Florida. Four million Floridians are enrolled in Blue Cross and depend on you all every day. It was interesting that the CEO from Florida had a slightly different take and spoke much more favorably of the public option because while Blue Cross in Florida has 30 percent of the market share and over 4 million folks enrolled, you know, in Florida we have 5.8 million people who do not have access to health insurance because it is so expensive, and I think that in the discussion we had, he saw it as an opportunity, that you all are so effective that you wouldn't have any trouble competing against a startup public option, and I thought we had a great discussion and exchange and I was heartened to hear that maybe it is not—maybe while big Blue Cross has a certain position, the folks on the ground in my State are not daunted by the challenge ahead.

Ms. FOX. Well, I would respond that I think people are looking at, can you create a level playing field and I think it is very difficult to imagine how you can. I mean, I look at the House draft bill, I just see huge advantages for the government plan ranging from, you know, big advantages in the payment levels to lawsuits to covering different—the government plan would cover a lot fewer benefits than private plans would be required to do. There is just a long list. For example, if the government plan didn't estimate their premiums correctly, would the government step and——

Ms. CASTOR. But where do these 5, almost 6 million residents of my State go now? How do they—we can't afford—America can't pay for all of them to go into subsidized Medicaid. We have got to provide a level playing field and real opportunity for them to access affordable care.

Ms. FOX. We agree we need to cover everyone and we are recommending covering everyone in poverty under Medicaid and then above that having subsidies as you do in your bill for private insurance to help people afford coverage. We think that is absolutely critical. You know, I have been doing health care issues for over 25 years, and it used to be that everybody believed that if you have individual mandate, employer mandate, alliances, insurance reforms, that really would cover everyone. It has only been the past year——

Mrs. CHRISTENSEN. Ms. Fox.

Ms. FOX. —we talked about a public plan. We think it is totally unnecessary and very problematic.

Mrs. CHRISTENSEN. Thank you. The gentlelady's time has expired. I now recognize Mr. Burgess for 5 minutes.

Mr. BURGESS. Thank you, Madam Chairman.

Ms. Fox, let us continue on that and maybe if I could, I think Mr. Buyer was asking a question or you were answering a question when time ran out and maybe we could just get the answer to the question that Mr. Buyer posed about the advantages of a public plan would have over private insurance in premium taxes, State solvency regulations, State benefit mandates.

Ms. FOX. Yes. I mean, private plans have to pay a wide range of premium taxes, assessments, federal taxes. The government would be exempt from that. We have actually prepared a little chart that we would love to submit that actually walks through what are the rules private plans have to abide by.

Mr. BURGESS. If you will suspend for a moment, I would ask unanimous consent that that chart be made available to the members and made part of the record.

Ms. FOX. And raises questions, would the public plan abide by that, and when we look at the draft bill, we see there is a huge unlevel playing field where the government would have so many advantages that you could see why people will estimate that millions of people will leave private coverage that they like today and go into the public plan.

Mr. BURGESS. OK. Great. I appreciate that answer very much.

Dr. Ulrich, let me just address you for a second. I really appreciate—well, I appreciate all of you being here. I know that many of you are taking time off of your private individual practices and it is with great expense and inconvenience to your families, and we have had a long day and appreciate your willingness to be part of the panel here. The physician group practice demonstration project that you referenced at your clinic, I am somewhat familiar with that. I think that does hold a lot of promise. In fact, you may have heard me question Mr. Hackbarth from MedPAC about the feasibility of using the Federal Tort Claims Act for Medicare providers under a physician group practice model, the accountable care model if you comport with all of the requirements, disease management, care coordination, the IT, the e-prescribing, if you do all of those things, getting some relief from liability under the Federal Tort Claims Act. Do you think that is—is that a reasonable thing to look at?

Dr. ULRICH. Absolutely.

Mr. BURGESS. Thank you. I appreciate your brevity. Let me ask you this, since we are in agreement. One of the things about the physician group practice demonstration project was you were going to actually benefit financially by doing things better, faster, cheaper, smarter, and in fact there are some great lessons for us that have come out of that, those management techniques. But there is a barrier to entry. Do you think the bar to that has been set too high? You have got to make a lot of initial investment when you get into that and then your return for your doctors, for the people in your practice is a little slow in coming. Is that not correct?

Dr. ULRICH. Dr. Burgess, you show keen insight here into this, and if I can just take a second to explain this?

Mr. BURGESS. Sure.

Dr. ULRICH. As part of the group demonstration project, what we are finding is that it is not just trying to strive for quality outcomes. There are operational changes that you need to make in how you deliver care. For example, we have consolidated all of our anticoagulation patients into one entity. Rather than being in each physician's practice, we now share that coordinated care under one entity, and what we found is that our capacity to have bleeding times, for example, are much better within the therapeutic range. We also are consolidating care of congestive heart failure rather than being in a particular individual physician's office, whether it be a cardiologist or a primary care physician into a congestive heart failure clinic. Physicians craft the criteria we want. Our nurses watch those. We are proactive in working with the patients. The problem with doing all that is no one pays us, you know, to undertake those operational changes at first. What we are hoping and why we partnered with the federal government through the CMS PGP project is that we are trying to prove that yes, by undertaking these, ultimately there are cost savings. Lastly, I would just make the point that we are just beginning the process of understanding the cost of care in chronic illness over time. We understand what the costs are to provide care on an individual visit but not over time.

Mr. BURGESS. One of the things that concerns me about our approach to things and what little I know of the great successes you have shown, for example, like bringing a hospitalized CHF patient back to the doctor's office within 5 days, not just you make an appointment in 2 weeks, you get that patient back to the office in 5 days and you really reduce the re-hospitalization rate significantly and yet you have got CMS now writing a rule that says well, if that is the case and you can do that, we are just going to pay for one hospitalization every 30 days and that will cut our costs down. It is absolutely backward way of looking at what the data that you all are generating, and instead of building on your successes in fact we are going to make things punitive then for Dr. Williamson in Georgia who may have an entirely different type of practice. Again, that is one of the things that concerns me about this. Do you have a concept? You mentioned about the rate of reimbursement on the Medicare side. What would that multiplier have to be in your accountable care organization or physician group practice? What would that Medicare multiplier have to be in a public plan?

Dr. ULRICH. We would say Medicare plus 100.

Mr. BURGESS. Medicare plus 100 percent?

Dr. ULRICH. Yes.

Mr. BURGESS. So double what the Medicare rates are?

Dr. ULRICH. Exactly.

Mr. BURGESS. That is fairly significant.

Dr. ULRICH. That is significant, but it is also a realistic significantly——

Mr. BURGESS. And do you have data to back that up that you can share with the committee?

Dr. ULRICH. I would be happy to provide information to you in written form relative to that, yes.

Mr. BURGESS. That would be tremendous.

Dr. Williamson, in words of one syllable, we heard Glenn Hackbarth say that no doctors are not seeing Medicare patients now because of the reimbursement rate. Is that your sense? Do you think doctors are restricting their practice because of the reimbursement rates in Medicare?

Dr. WILLIAMSON. Yes.

Mr. BURGESS. Thank you.

Mrs. CHRISTENSEN. Thank you. The gentleman's time has expired. I now recognize myself for 5 minutes.

Let me just welcome everyone. It is great to have such a diverse panel of witnesses here and we thank you for all of the good work that all of you have been doing in this dysfunctional system that really doesn't always give you the kind of support that you need, and I want to particularly welcome Dr. Epperly, president of the American Academy of Family Physicians. I want to direct my first question to you, Dr. Epperly. In meetings, for example, with the tri-caucus, we are on record as supporting a public plan, and I do support a public plan but also a public plan that is linked to Medicare. I have raised concerns about that in our meetings and I would like you to elaborate on your concerns about linking the public plan to Medicare.

Dr. EPPERLY. Yes, ma'am. Thank you. First, we are definitely in support of a public plan option but we do have a couple caveats. One of them is linked to Medicare, just as you are saying. We recognize there is going to be a huge infrastructure cost in getting this thing up and running so our position is that it can be the Medicare rate for the first 2 years but with a date certain then to elevate that. More of just Medicare rates won't cut it for the physicians across America. It is already a problem. But we recognize that there is going to be a transition period. We recognize that flexibility. So what we would say is yes, we are in favor of a public plan. Medicare rates could be what it would be aimed at for the first 2 years but by a date certain that has to elevate.

Mrs. CHRISTENSEN. Thank you. And I guess I can't ask everyone this question, so Dr. Epperly, Dr. Gabow and Mr. Hawkins, you have heard reference to bundling of payments by Mr. Hackbarth of MedPAC and I wanted to know if you are in support of the proposal to bundle payments to providers. Dr. Epperly?

Dr. EPPERLY. Yes, ma'am. We are in favor of bundling in terms of a team approach. We do have concerns that we would want to make sure that primary care and the patient-centered medical home is a very important part of that bundling was not denigrated

nor belittled into its importance. For instance, with the heart failure example, we are talking about heart failure patients and readmissions. Let us prevent it in the first place. So with a bundling model, which looks at already this has occurred, it is in the hospital, how do we pay for this, why don't we take a better approach and look at what it takes to prevent that in the first place. So therefore the patient-centered medical home, primary care is critical in that. Bundling could be a very interesting option if the primary care is reincorporated into that in a big way.

Mrs. CHRISTENSEN. Dr. Gabow?

Dr. GABOW. As an integrated system that deploys physicians, we favor moving away from fee for service to a more global payment, and we would favor the ultimate bundle, capitation, and think that capitation or more global bundling would have less administrative costs than if you bundle small things. I would encourage it to be global but we favor it given a big, integrated system.

Mr. HAWKINS. Congresswoman, or——

Mrs. CHRISTENSEN. Would it affect——

Mr. HAWKINS. Madam Chair——

Mrs. CHRISTENSEN. Would it affect community health centers?

Mr. HAWKINS. Really, there are some important points to make here. On today's panel, we are very fortunate to be joined by Dr. Epperly, who runs a family medicine residency program, Dr. Ulrich, who runs the Marshfield Clinic, and Dr. Gabow, who runs Denver Health, unique and especially with the last two, fully integrated health care systems. What may not be known generally but should be is that all three are community health centers or have community health centers embedded in them. As such, two examples, Denver Health and Marshfield Clinic, are good examples of integrated health systems that include community health centers, but I am sure, as Dr. Gabow and Dr. Ulrich would agree, the primary care component, the very issue that Dr. Epperly expressed concern, appropriate concern over, is identified and, I am not going to say separate but it is able to function on a sort of co-equal basis with the specialty and inpatient care components of their institutions. To the extent that that is done, I think that is what Dr. Epperly was relating to when he said primary care needs to be recognized and appropriately integrated. We would agree. The notion of integrated care systems, accountable care organizations and the like and rewarding results is something that we all absolutely support. What should not be lost, however, in the integration of care, the vertical integration of care across primary, secondary, tertiary care is the small ambulatory care practice, be it independent practice, private practice physicians, health centers or other forms of ambulatory care within the context of a large, multilevel institution like Denver Health, and I am sure Dr. Gabow would agree with that.

Mrs. CHRISTENSEN. Thank you. To be a good example, my time is up but I want to also without objection accept the chart from Blue Cross Blue Shield into the record that was brought to us by Dr. Burgess.

[The information appears at the conclusion of the hearing.]

Mrs. CHRISTENSEN. The Chair now recognizes Dr. Gingrey for 5 minutes.

Mr. GINGREY. Madam Chair, thank you so much. I want to direct my first questioning to my colleague from Georgia, Gainesville, Georgia, and the president of the Medical Association of Georgia. Glad to see you, Dr. Williamson. And I have a series of questions that I would like to ask you. First off, do you support a government-run plan?

Dr. WILLIAMSON. No, the Medical Association of Georgia does not support a public option or a government-run plan in addition to the public plans that already exist, Medicare and Medicaid.

Mr. GINGREY. Right. We are talking about the government option plan that would be competing with the private insurance plans that——

Dr. WILLIAMSON. Right. We do not support a public option.

Mr. GINGREY. What would a government-run health plan that I just described do to your ability and those of your colleagues to treat your patients? What do you fear the most about that type of a government-run option?

Dr. WILLIAMSON. My biggest concern is that it like Medicare will become the only option, and I think over time I think the plan as it is set up in the discussion draft already has the framework for that, for basically all private plans to have to conform to certain rules over time, and my fear, and I think it is a very real concern, is that over time other plans will disappear and the public option will become the only option and we will be left with a single-payer system which I think if you look at what has happened across the planet, single-payer systems basically save money by rationing care and I see that as an inevitable consequence of the creation of a public option, no matter how benign it looks at first glance.

Mr. GINGREY. Well, that was going to be my next question. You pretty much answered my question, which would be, Dr. Williamson, do you support a government-run health care system with the ability to ration care based on cost?

Dr. WILLIAMSON. I absolutely do not support that. I think that care decisions should be made on an individual basis when the patient sits down in the physician's office and I don't think that the government can substitute for the training that a physician has and the opportunity that a physician has to look the patient in the eye and decide what that patient needs.

Mr. GINGREY. Let us see, I am going to skip over number four. My fifth question, fourth actually, we have heard testimony in this committee recently regarding the Massachusetts health care system and the fact that those with public health insurance in the State are twice as likely as those who choose private health insurance to be turned away from a desired physician. As a physician, practicing physician, what are your thoughts on the reasons behind that kind of disparity in access between a public and a private insurance plan?

Dr. WILLIAMSON. Well, public plans in general, and I am speaking in general now, are associated with quite a lot of paperwork. They are associated with the hand of government and, you know, right now in Georgia we are looking at these recovery auditor contractors that are moving across the Nation and coming back and recouping money, saying that you coded something wrong 20 years ago or 10 years ago and coming after those dollars. These sorts of

things that the federal government has the power to do makes dealing with them as a payer a very daunting prospect, and traditionally, government payers have been at the bottom of the barrel in terms of covering costs and so physicians feel like they can't deliver to patients what they have been trained to do and the downsides associated with the government as a payer are daunting, and, you know, I recently had the opportunity to go to the AMA and one of my colleagues from Massachusetts stood and spoke loudly in support of a national public option, but I believe that the folks from Massachusetts probably want a public option nationally so they don't have to pay for their own anymore.

Mr. GINGREY. Well, Doctor, I appreciated that response and the reason I asked you the question is because what we are talking about here is something very, very similar to the Massachusetts model, and we have even heard suggestions from the majority that it may be that physicians who are treating people within this exchange would absolutely have to accept the public option plan or they would be ruled ineligible to participate in Medicare or Medicaid. So they would have their arm twisted behind their back and have no choice, which is pretty frightening.

I have got just a little bit of time left and I wanted to go to Dr. Ulrich and also Dr. Gabow if we have a chance. If time permits, Madam Chair, I hope you will let me get this in. If health reform were to include a requirement that all Americans purchase health insurance, do you think that hospitals would need continued federal funding to offset cases of uncompensated or charity care and why? And basically I am talking about DSH hospitals and the suggestion that we are going to save money by eliminating all DSH payments when we pass this bill.

Dr. ULRICH. Well, my sense is, the answer to that is yes, you would still need to have some supplemental dollars rolling in, simply because the reality is that there still are things as bad debt, you know, people who need care get it and then can't pay for it because of competing priorities of their own pocketbook and plus the fact that, you know, we really haven't gotten to the point of having fair practice expense accountability within the remunerative system yet and that is absolutely critical to any kind of a public plan. If we are going to go that way, then we have to have fair practice expenses covered before we can go forward.

Mr. GINGREY. That would be a pretty painful pay-for for your——

Dr. ULRICH. That is correct.

Mr. GINGREY. Dr. Gabow?

Mr. GABOW. My understanding, Congressman, is that this bill does not cut disproportionate share payments and I think that that will be necessary to be sustained at least in the foreseeable future because we know that many of the patients that we serve, the homeless, the chronically mentally ill, are traditionally difficult to enroll and so I think if we got to full coverage, certainly we may be able to decrease it but I doubt that it will ever go away. So we support the preservation of DSH as outlined in the draft bill.

Mr. GINGREY. You support the elimination of DSH payment? Is that what you said?

Dr. GABOW. We support the maintenance of DSH payments——

Mr. GINGREY. Oh, absolutely, as I expected you would, Dr. Gabow, and as Dr. Ulrich and hospitals all across the 11th Congressional district of Georgia support the continuation of those DSH payments. Thank you for your patience, Madam Chair. I yield back.

Mrs. CHRISTENSEN. Thank you. The Chair now recognizes Congresswoman Baldwin for 5 minutes.

Ms. BALDWIN. Thank you, Madam Chairwoman.

I want to welcome a fellow Wisconsinite, Dr. Ulrich. I am pleased to have you on the panel. I wanted to probe into an area—I stepped out for a little while so I don't know if anyone else has raised this, but in your testimony on page 7, you talk a little bit about care issues at the end of life and make some recommendations, and it is one of those very challenging topics because we certainly hear from much research that much of our health care dollar goes to treat people at that stage of their lives. But that is one thing much more disturbingly that that often doesn't align with the wishes of the person being treated. Could you elaborate a little bit more about both your recommendations to this committee in that arena but also the practices at the Marshfield Clinic, what you have implemented in this regard?

Dr. ULRICH. Yes. Thank you, Congresswoman. I appreciate the question. At Marshfield Clinic, we do have in conjunction with St. Joseph's Hospital, who is our hospital partner, developed palliative care. We have palliative care fellowships where we train young physicians who are interested in that. We work with families, the patient, obviously, et cetera, really try to do two things. One, there is a humanistic process that occurs under palliative care and that is taking care of people in comfortable surroundings in their last few weeks or days of life, and that really is a throwback, if you will, to the way medicine used to be practiced before we were very fancy with technology, et cetera, and it is not something that we should ever forget. It is something that we need to continue. So we are committed to doing that and will, and I think most medical organizations throughout the country would be in sync with that kind of concept.

The question you raise about the cost of care at the end of life is obviously an important one, and if you think about the cost of medical care in our country, there are really two main things we need to understand. One, as you point out, the costs escalate rather dramatically as life is ebbing away from us because it is an emotional decision for families and patients to keep mom or dad or grandma or grandpa alive for a little while longer, et cetera. It is very difficult for families to say it is time to say goodbye to someone. So we continue then to provide medical care under those very difficult circumstances. There is a cost to providing that care. The other thing that I would like the subcommittee to understand is that not all costs within the system are the same so that we know from the Commonwealth Fund, for example, that really it is only about 20 percent of patients that are costing about 75 to 80 percent of care in this country so that if we can manage these chronic illnesses and in particular patients who have more than one or two chronic illnesses concomitantly, that is where the cost savings will come as we get better in managing folks with complicated chronic

illnesses who concurrently are suffering from several of them at the same time.

Ms. BALDWIN. Your testimony specifically points to things that we could do earlier in life to talk about having people think about advanced directives or other documents. I would offer you to elaborate on that, but also I see some other nodding heads and I would open this up to any of the panelists who would like to make a contribution on this point.

Dr. EPPERLY. Thank you. What Dr. Ulrich just described is the value of primary care. It is having that relationship of trust with people over time in which you can have that type of dialog, and I would say that those sorts of decisions are so important, so critical to the family as a whole and many of those decisions can take place outside of a hospital in terms of where those final days and weeks are. In fact, I would submit that most people would like to have a very dignified death in the place where they can be surrounded by most of their loved ones. And so again, we return right squarely back to what primary care brings to the system. It is what Dr. Ulrich said. It used to be part of medicine. That is kind of gone now. We need to re-create that kind of system. It is in that system that savings are made, quality goes up, cost goes down.

Ms. BALDWIN. Please, Dr. Wright.

Dr. WRIGHT. Yes. I just would like to agree that what needs to take place and is often missing is the conversation, which begins with the relationship. So I completely agree and would support recognition of the value of the cognitive services, not to say that folks who do procedures for a living are not thinking them, they certainly are, but the importance—I have seen it over and over in my practice that while someone does indeed benefit from a procedure, what is wrapped around that procedure, the informed consent process, the education about the disease process and right now the aftercare to try to prevent that from ever happening again is incredibly valuable to that individual and that family and our economy at this point.

Ms. BALDWIN. Dr. White, did you have a comment?

Ms. WHITE. Yes, I would just like to add that I think as Congresswoman Capps had mentioned earlier that patient advocate role that nurses provide is absolutely important and I think the emphasis on primary care medical home, nurse practitioners being involved in that who have the skills for those conversations, discussions and the relationships I think would be an important consideration for it all.

Dr. WILLIAMSON. Thank you. I would like to briefly add, I think that resources spent on time with the doctor saves money in the long run. If you look at the percentage of medical expenditures, physicians' services constitute a small fraction of that. By concentrating on that whether it be for primary care or for a specialist, you are going to have money in other areas whether it is the end of life, very sick patients. So funds, resources that are concentrated on giving the patient or the patient's family face time with their doctor is going to save you lots of money across the system.

Mrs. CHRISTENSEN. Thank you. The gentlelady's time has expired, and I now recognize Congresswoman Blackburn for 5 minutes.

Mrs. BLACKBURN. Thank you, Madam Chairman, and thank you to all of you.

I want to do a yes and no and show of hands to get where you all are on some issues, and by the way, thank you for your patience with us today. As you know, we have another hearing that has been going on upstairs. OK. Show of hands, how many of you favor a single-payer system? OK. Nobody on the panel favors a single-payer system. OK. How many of you favor a strategy, putting in place a strategy that would eventually move us to a single-payer system? So nobody favors doing that. That is really interesting because there are some of us that fully believe that this bill that is before us, whether it is the House version, the Senate version or the Kennedy plan would move us to a single-payer system and we make that determination based on experience that we have had from pilot projects and from programs that have taken place in the States, my State of Tennessee being one of those. OK. How many of you favor having government-controlled comparative research? Nobody favors government-controlled comparative research. OK. How many of you—OK. We have got some takers on that one. All right. Just show of hands, the comparative research board that they are talking about having, that this bill would put in place, how many of you want to see that? OK. So we have Epperly, Ulrich, Wright, White and Gabow. OK. And then how many of you favor having that comparative research board make medical decisions for patients? Nobody. OK. All right.

Dr. Epperly, you know, it makes it kind of a head scratcher to me and I appreciate having your views on this because we know that the comparative research results board would end up making a lot of the medical decisions for patients and it would move that away from the doctor-patient relationship. I wanted to ask you, you had mentioned in your testimony that you felt that a public plan would be actuarially sound. What I would like for you to do is cite for me the research upon which you base that assessment and that decision. How did you arrive at that?

Dr. EPPERLY. You know, I would say that I don't—I am not aware of anything I said that said that it would be actuarially sound.

Mrs. BLACKBURN. Well, I think that that is a statement in your testimony.

Dr. EPPERLY. What I will say as you look that up, though, is that we believe that expanding coverage to people and giving them choice is a sound decision for America in regards to helping people get health care coverage. We are in agreement with that. As it presently stands, this would have to be at an enhanced rate above Medicare. That is why we say that, you know, if the model is Medicare, that is not going to work, but anything that starts to promote primary care as being a solution to that, that will work and that——

Mrs. BLACKBURN. OK. Let me interrupt you with that. You say that it would be at an enhanced model above the rate of Medicare. So in other words, it is going to cost more?

Dr. EPPERLY. Yes, but the——

Mrs. BLACKBURN. OK. Now, yesterday, if I may interrupt you again, Secretary Sebelius said that this would be deficit neutral. So

I am trying to figure out, and I asked her yesterday how she could say it was deficit neutral. We have not had one witness out of all the hearings we have done that has said they felt like this would be deficit neutral or would be a money saver. Everybody has said it is going to cost more.

Dr. EPPERLY. I would say that it would be beyond deficit neutral in a positive way because where the savings will come from the system is in regards to reduced hospitalizations, reduced readmissions, more efficient——

Mrs. BLACKBURN. OK. If I may interrupt you again, do you have any kind of model that shows that actually happens because you can look at TennCare in Tennessee, you can look at Massachusetts and you can see that that does not happen.

Dr. EPPERLY. Yes, Community Care of North Carolina proved that. Other international studies have proven that as well. That is why when we talk about the value of primary care, we are saying that there are systems savings from across the existing system that will save the entire system money.

Mrs. BLACKBURN. All right, but I can tell you that in Tennessee we found that did not happen, and so I appreciate your input.

Dr. Williamson, I have got 15 seconds left. Medicare patients, senior citizens are just up in arms. They see that their care is going to be diminished somewhat, that savings from Medicare are going to go to pay for care for younger enrollees in this public plan. My seniors are coming to me and saying we are scared to death. What do I say to them? What is Medicare going to look like after this public plan goes in place?

Dr. WILLIAMSON. I don't see anything in the discussion draft that gives me hope that we are moving in the right direction in terms of payment. I think that private contacting and empowering patients to buy their own health care. I don't think we should ever take away a patient's right to pay for their own health care, and if we do that, we are committing a colossal mistake.

Mrs. BLACKBURN. Thank you. I yield back.

Mrs. CHRISTENSEN. Thank you. The Chair now recognizes Congresswoman Harman for 5 minutes.

Ms. HARMAN. I thank you, Dr. Christensen, and point out that our committee benefits a lot from the fact that many members are medical doctors and nurses and have extensive medical backgrounds. I hope the panel is impressed that we actually, some of us, others here know a great deal about this. In my case, I don't have either of those but I am the daughter of a general practitioner who actually made house calls to three generations of patients before he retired in Los Angeles and I am the sister of an oncologist/hematologist who was the head of that practice at Kaiser in San Rafael, California, before he semi-retired. He is younger than I am, so go figure. But he did win the healer of the year award in Marin County for his compassionate treatment of patients, so I love listening to a bunch of docs and experts who put that on the front burner.

I come from Los Angeles County, as you just heard. We are extremely concerned, if not panicked, about the President's proposed cuts in DSH payments. Listening to this panel and listening to you, is it Dr. Gabow or——

Dr. GABOW. Yes.

Ms. HARMAN. And reading your excellent testimony, I think your bottom line is, you don't want cuts on the front end, you want to see how all this works and phase in cuts later once the efficiencies take hold. Is that what you are saying?

Dr. GABOW. That is correct.

Ms. HARMAN. Thank you. And on this point, Madam Chair, I would like permission to put a letter in the record from the board of supervisors of the county of Los Angeles talking about the DSH——

Mrs. CHRISTENSEN. Without objection, it will be admitted into the record.

[The information appears at the conclusion of the hearing.]

Ms. HARMAN. Thank you. Well, I would just like to invite the panel on this subject to address, and starting with you, Dr. Gabow, and it seems like you may have a bit of laryngitis. Am I right?

Dr. GABOW. Congresswoman, I have a chronic voice problem——

Ms. HARMAN. Oh, my goodness.

Dr. GABOW [continuing]. Spastic dysphonia, and the treatment for it is Botox but it doesn't do anything for my wrinkles.

Ms. HARMAN. As my kids would say, I think that is more information than we need. But I appreciate this. I hope I am not stressing you, but I would really like the record to be more complete on this subject because I think it is an urgent subject for at least our large metropolitan areas and one this committee has to take very seriously, and based on the comments I heard from the minority side, I think everyone here generally agrees about this. Yes?

Dr. GABOW. Congresswoman, I think all of the safety-net institutions would be very concerned if disproportionate share funding were cut at the front end of this process. We rely heavily on disproportionate share funding to cover not only our uninsured patients but also the gap between what Medicaid pays us and our costs. So I think that the timing of this issue is really critical, and as I said earlier, I think what we have learned from expansions in the past with Medicaid and SCHIP is that it takes a long time to enroll certainly highly vulnerable populations. They are vulnerable in so many ways that enrollment is not an easy process so it is going to take a period of time to really get to full coverage even with this bill so I don't think we can cut DSH at the front.

Ms. HARMAN. I realize I only have 48 seconds left, so let me just expand the question in case anyone else wants to answer it as well. One of my personal issues, since I focus on Homeland Security issues generally, is surge capacity in our hospitals in the event of a terror attack or a large natural disaster, and so my question is, what is the relationship between the ability of our level I trauma centers which are located in many of our DSH hospitals, what is the relationship between the ability of our level I trauma centers to be available in the event of terror attack or a natural disaster and the proposed cuts in DSH?

Dr. GABOW. Congresswoman, I think you are right, that these are related in that many of the trauma centers are at the disproportionate share hospitals and also many of the pre-hospital care services and burn units so that much that you would need in disaster are located in these safety-net institutions so they need to

be preserved and you can't destabilize them financially at the beginning of the process and still preserve those critical resources.

Ms. HARMAN. Thank you very much.

Mrs. CHRISTENSEN. Thank you. The Chair now recognizes Mr. Pitts for 5 minutes.

Mr. PITTS. Thank you, Madam Chairman.

Dr. Ulrich, if a large number of private-payer patients were to shift into the public plan and the public plan is paid based on Medicare rates, what would be the effect on your ability to continue to offer the same level of services that you provide today?

Dr. ULRICH. Well, it would be impacted extremely negatively and probably fairly rapidly. It would be beyond my capacity to give you an exact timeframe but it would be disastrous, I think, is a fair word to use.

Mr. PITTS. Now, are you treating a large number of Medicare- or Medicaid-eligible patients in your part of Wisconsin?

Dr. ULRICH. Absolutely. If I can enlarge on that just a second, there already is a problem as you are describing. In certain parts of the service area that we provide, we comprise about 33 percent of the physicians. We are caring, however, for 70 percent of what we call fixed payer, which is Medicare or Medicaid patients. Why? Because other providers are not choosing to take care of those patients. So this is already happening. This is not——

Mr. PITTS. So how are you surviving now if you——

Dr. ULRICH. Well, you know, we try to watch our costs as closely as we can. I found it necessary to try to branch into ancillary revenue streams, try to sell the electronic medical record. We do food safety with Cargill, with Hormel, et cetera because I am not confident that just providing health care is going to be a way to sustain our organization.

Mr. PITTS. Dr. Williamson, each year fewer and fewer physicians are willing to accept Medicare and Medicaid patients. From your perspective as a practicing physician, could you tell us why you think this is?

Dr. WILLIAMSON. I think as has been said, it is becoming more and more impractical to do that. I think inertia plays a large role here. Doctors have done it for a long time. It is becoming less and less practical because the Medicare and the Medicaid payment systems have not kept pace with the cost of providing care, and physicians want to keep taking care of these patients, we want to keep doing that, and so what you are seeing across the Nation are doctors basically doing the very best they can to control costs and keep functioning in this environment, but as I said, it is a house of cards. Some doctors are retiring early. They are getting out of medicine. They are going into other ancillary revenue streams because these payment systems simply are not adequate to cover the costs of providing care and moving more patients onto those types of payment schedules is going to adversely impact everybody's health care in this country, not just those patients that are taking—that are enrolled in the public option.

Mr. PITTS. Now, if we allowed more people to purchase health care services with untaxed dollars instead of relying so heavily on third-party payers for routine health care services, do you think

that we could solve many of our problems faced today by consumers or providers of health care services?

Dr. WILLIAMSON. Congressman, I think you just hit the nail on the head. Right now what we are trying to do is solve a problem for uninsured patients. That is what all this is about. We wouldn't be sitting here if we weren't dealing with this issue. I think that by making it feasible for every person to own and control their own insurance policy is the way to solve this problem, and I know that we can do that with the tax system, with tax credits, tax subsidies. We can put the control back into the hands of the patients so that the government doesn't have to orchestrate this massive machine that we are looking at right now that is going to not attend adequately to the needs of the individual patient. I believe by restructuring the tax system, we can take care of the uninsured patients and we can solve this problem without putting private insurance companies out of business and taking away the ability of individuals to purchase their own health care.

Mr. PITTS. Dr. Wright, if you could respond, polling has suggested that over 95 percent of the American people support the right to know the price of health care services before they go in for treatment. What do you view as the major barriers to the American people getting the price and quality information that they want and they need?

Dr. WRIGHT. I think there has just not been enough transparency in the pricing structures. It is Byzantine at the very least. It is difficult to figure out. Even within a practice often most of us have no idea what an individual patient is paying for a service, so I think the system would clearly benefit from additional transparency.

Mr. PITTS. And how would the patients, the providers, the taxpayers benefit by public disclosure price and risk adjusted quality?

Dr. WRIGHT. Well, I think it lends to the—it is one component of their decision-making process. I would not uncouple pricing information from quality information because cheap care may not necessarily be the best care. On the other hand, the best care can be less expensive than we are delivering it now.

Mr. PITTS. What about the agency that reports price and risk adjusted quality information to be completely separate from the Department of Health and Human Services? Do you see any conflicts of interest with HHS reporting on their own programs?

Dr. WRIGHT. No, I don't.

Mr. PITTS. My time is up. Thank you very much, Madam Chair.

Mrs. CHRISTENSEN. Thank you, Mr. Pitts. The Chair now recognizes Mr. Gordon for 5 minutes.

Mr. GORDON. Thank you, Madam Chair.

Last week the President put forth a challenge to find ways to reduce the number of medical liability suits without capping malpractice awards. I agree with the President. I think if you are going to be able to try to reduce the cost of health care, you have got to get all the inefficiencies out and this is certainly one area. PriceWaterhouseCooper estimates there is $280 billion spent in defensive medicine. We can't wrench all that out but surely there is some savings that can be made there. That is why I am drafting medical malpractice reform alternative legislation responding to

the President's challenge. The bill encourages States to step outside the box and test so-called alternatives like health courts and "I am sorry" methods. Also, I think that this will help lower the cost of defensive medicine and I think it will compensate patients faster and be more fair. In my home State of Tennessee, we enacted a certificate of merit requirement last October that has already proven that there has been a 4 percent reduction in malpractice premiums. Earlier you were all asked about whether you would think that malpractice reform should be a part of the overall reform, and you agreed. So I want to quickly ask you to say why and what savings you think we might be able to achieve. Dr. Epperly, why don't we start with you?

Dr. EPPERLY. First, I applaud you for doing this. I think it is the right step in the right direction.

Mr. GORDON. Don't applaud me. Let us just move on and tell me why it is good.

Dr. EPPERLY. Oh, oK.

Mr. GORDON. No, no, no, no, tell me why. Please tell me why it is good.

Dr. EPPERLY. Oh, oK. I think it is a step in the right direction. If there is not a relationship with patients, the default is to do more to patients, not less so that you cover yourself. That is why the relationship is critical. If we don't get reform in place, then people that don't have that relationship will continue to order every test known to man to try to diagnose the problem.

Dr. WILLIAMSON. I agree completely. I think the costs are hidden but they are very, very real and I think they are gigantic. Physicians order expensive tests to rule out conditions that they don't suspect but might occur randomly in one in several thousand, and if someone gets $10 million from a lawsuit and it occurs in an incidence of one in 10,000, if you don't screen for that you are statistically going to lose money. And so you are exactly on target here. We must have real medical liability reform. I will tell you in Georgia in 2005, we enacted a very effective tort package. The number of suits in Georgia are down by 40 percent now. We only had three professional liability carriers in Georgia. We now have something like in the teens, and we have a cap on non-economic damages, not total damages but only non-economic damages so that economic——

Mr. GORDON. We are not talking about caps here. We are thinking about things less than that.

Dr. Ulrich?

Dr. ULRICH. I would agree with what both gentlemen before me said. The reality is that, you know, having to pay some dollars out in those unfortunate circumstances is an actual cost and without some relief from that we will continue to bear those costs.

Mr. GORDON. Dr. Wright?

Dr. WRIGHT. I also agree. I think the burden of this is quite large and I particularly like the idea that you would test various options, various approaches to controlling the tort problem.

Mr. GORDON. What we want to do is give incentives for States to experiment and let us find out what might work.

Dr. White?

Ms. WHITE. The American Nurses Association does have some concerns about caps. They have a position statement that——

Mr. GORDON. OK. We are not talking about caps. I said practices short of caps.

Ms. WHITE. OK. Well, they have a position statement that they can make available to the committee.

Mr. GORDON. But they would support malpractice reform short of caps? You raised your hand earlier.

Ms. WHITE. Yes. I mean, it——

Mr. GORDON. Dr. Gabow?

Dr. GABOW. As a governmental entity, we have governmental immunity. In the broader discussion, I think that it is very important to do malpractice reform and I think your idea of experimenting with health courts is a very good one.

Mr. GORDON. Mr. Hawkins, earlier you said you weren't personally affected but that is not the question, it is for the system overall.

Mr. HAWKINS. Yes, and as a matter of fact, if I can, one important thing that—a couple of members of the committee here have sponsored legislation to extend the Federal Tort Claims Act, FTCA coverage, that health center clinicians get today to clinicians who volunteer at health centers.

Mr. GORDON. Well, that will be a part of the bill in terms of emergency rooms. I think they should be considered as first responders.

Mr. HAWKINS. Yes, I would just say we know for a fact——

Mr. GORDON. And Mr. Yarwood—oh, I am sorry. OK. You are saying you know for a fact that it helps?

Mr. HAWKINS. That many local physicians and clinicians would volunteer time at a health center if this issue were addressed.

Mr. GORDON. Mr. Roberts?

Mr. ROBERTS. I think from a pharmacy's perspective, it is not as large an issue but still we would be supportive.

Mr. GORDON. Mr. Yarwood?

Mr. YARWOOD. It is a huge issue. We talked about this before.

Mr. GORDON. Ms. Fox?

Ms. FOX. We absolutely agree.

Mr. GORDON. And if I could go back, since I have a little more time, concerning those individuals that have the hospitals. Are you finding it a problem now to get specialists to come into the emergency room because of the medical malpractice problem? Yes, ma'am, go ahead.

Dr. GABOW. Because of medical malpractice, we aren't because we have governmental immunity and our physicians are employed so we have no problem getting coverage and we don't pay extra for that coverage.

Mr. GORDON. But it is because they are already covered? Yes. OK. My time is up and I thank you for your advice.

Mrs. CAPPS [presiding]. The Chair now recognizes Mr. Shadegg for questions.

Mr. SHADEGG. Thank you, Madam Chair.

Dr. Wright, I want to begin with you. I also want to follow up with Dr. Ulrich because he mentioned a word that I think is very important. He talked about the incentives in the current policy or

health care system. Under the tax code in America today, businesses can buy health insurance tax-free. Individuals have to buy it with after-tax dollars, making it at least 30 percent more expensive. You were just asked, and I want to follow up, a question by Mr. Pitts about transparency. I guess my concern about transparency is that until we enable consumers, individual people, to buy health insurance on the same tax-free basis that businesses can do it, I don't see how a consumer has the motivation to look at transparency, that is, to say if my employer provides me with health care and he or she pays for it, I don't see what the motivation is for me to go research the cost of a particular procedure at one hospital versus another or one doctor for another or the quality outcomes. Because I agree with you, I think that both cost and quality are things consumers want to know but only if they are a part of a marketplace where those factors can make a difference to them. Would you agree?

Dr. WRIGHT. I am not a pricing expert. I am barely a quality-of-care expert. I understand your point. I am greatly concerned about the number of people who are not covered at this point in time.

Mr. SHADEGG. Me too.

Dr. WRIGHT. I know you are, and so I guess most of my priority in terms of getting this fixed has been directed at them.

Mr. SHADEGG. Dr. Ulrich, is that one of the incentives that concerns you?

Dr. ULRICH. Yes, certainly, and if I can expand on that just briefly?

Mr. SHADEGG. Please.

Dr. ULRICH. If we look at the quality equation, that is the outcomes of patient care and the patient-physician interaction being the numerator, costs being the denominator, quality being the end product of that, the concern I have is this, is that currently we don't pay for that. We absolutely need to move to that model, but what hinders us now is the fact that patients don't understand necessarily what quality is. We did some market research, and what patients tell us is that look, you guys are all the same. You all went to medical school, you all did residencies so there is really very little to pick between you. When in fact for those of that work in the industry, there are differences, so the question before us, how do we now educate our patients so that they can make fully informed decisions relative to that quality equation.

Mr. SHADEGG. Dr. Williamson, I think if I gather your testimony correctly, you think that is exactly the point. If we empowered or allowed, just permitted people to buy their own health insurance policy and therefore to shop for it and to be involved in the selection of the plan and the selection of the doctor, they would be motivated to use transparency, cost data, quality data, and make the market much more competitive, bringing down costs and causing quality to go up?

Dr. WILLIAMSON. Absolutely, and I think it would raise quality on two levels. It would raise quality on the national level in terms of saving money in the entire system and it would raise the quality that the individual patient perceives. Even though patients may not be able to judge scientific quality, they do vote with their feet, and I think if we had transparency, I think doctors are going to

have to compete with each other, and if we can do what you have suggested which is to empower patients to buy with the same tax advantage that employers have now, their own health insurance policies and control that, they then control their medical decision making and that is the best way to keep costs down and ensure good patient care.

Mr. SHADEGG. The health care policy I have advocated says that we should tell every American that has employer-provided health care that they can keep it and they can keep the exclusion, but every American that doesn't have employer-provided health care would get a tax credit. Those Americans who can't afford to buy their own health care would get a refundable and advancable tax credit to go out in the market and buy what they want. We would then bring consumer choice to the entire health care industry.

I would like every member of the panel to tell me what other thing in our society somebody else buys for us. I mean, I struggle with this question, and I don't understand it. Our employers buy our health care insurance. They don't buy our auto insurance, they don't buy our homeowners insurance, they don't buy our suits. I don't buy my employees lunch. But why in health care do we decide that only employers can buy it? Is there something else that somebody on the panel can remember or can think of that is of that dimension where your employer buys it for you and you are just kind of a pawn in the whole system? Dr. Williamson?

Dr. WILLIAMSON. I can't answer the question but I can tell you where it came from, and it came from the notion of pooling risk. Patients realize that if I get really sick, I am going to need a lot of money, and so they went together and they pooled their money and then what happened is, over time they have lost control of that pool of money and that is where all this is coming from. The patients have turned over to others the ability to make their health care decisions for them by allowing them to pay for it.

Mr. SHADEGG. So if we empower them to be able to buy their own health care if choose it from their employer or out on the market and we empower poor people to do that who can't afford it by giving them a refundable tax credit, we would also need to create new pooling mechanisms, would we not?

Dr. WILLIAMSON. I completely agree with you.

Mr. SHADEGG. Thank you very much.

Mrs. CAPPS. Thank you very much, and we will turn to Mr. Green for his questions, and I will just say probably this is our last series of questions because the vote has been called and your panel can be excused. You really set a record for endurance. I have to thank each of you.

Mr. GREEN. Madam Chairman, some of us were here last night at 7:00. Well, you were too, I think, and we started at 9:30 yesterday morning and finished some time after 7:00.

Mrs. CAPPS. Be thankful you weren't on that last panel.

Mr. GREEN. Yes, you will at least get out before dark.

Mr. Hawkins, you and I have been working with Representative Tim Murphy since we reauthorized community health centers program last year on a bill we introduced, the Family Health Care Accessibility Act of 2009. The bill would extend Federal Tort Claim Act coverage to volunteers by deeming these volunteer practitioners

at health centers as employees of the federal government. These volunteers would have to be licensed physician or licensed clinical psychologists and unpaid in order to qualify. This seems like an easy solution to the lack of primary care physicians in some areas, especially in medically underserved areas where community health centers are located. Yesterday the GAO released a report stating that the lack of Federal Tort Claims Act coverage for volunteer practitioners can be a barrier for volunteers who wish to dedicate their time at a federally qualified health center. Can you elaborate on how the extension of the FTCA coverage to licensed physicians or other licensed practitioners would help increase the number of volunteers at federally qualified health centers?

Mr. HAWKINS. Sure, Mr. Green, and thank you for raising that issue. In fact, just a couple of minutes ago we were discussing the issue of malpractice and I——

Mr. GREEN. I thank my colleague, Congressman Murphy, for bringing it up.

Mr. HAWKINS. That is oK. I specifically alluded to this legislation which you and Mr. Murphy have collaborated on in the past and continue to collaborate on. I can't tell you not only for primary care, Mr. Green, but even for urologists, dermatologists. You know, the biggest frustration that health center clinicians who are virtually all primary care today express is the barriers and difficulty they face getting specialty care, diagnostics, even hospital admits for the 7.5 million uninsured people we serve in particular, not exclusively but in particular. Allowing FTCA coverage to extend to individuals who, as you note, come into the health center and donate their time, do not charge the patient, don't charge the health center, would be a phenomenal benefit and boon and would provide for much more fully integrated care and better health outcomes.

Mr. GREEN. And we discovered this problem in Texas with Hurricane Katrina with all the evacuees. In our federally qualified health centers, we had medical professionals who couldn't volunteer in Texas because they weren't covered, and we realize now that it is a way we can provide for our federally qualified health centers.

The discussion draft also addresses the issue of residency training in offsite locations like FQHCs, but it still allocates the funds to the hospitals and not to the offsite locations. Do you believe the language in the draft should make it easier for federally qualified health centers and other offsite residency training programs to start up and operate residency programs? And again, we have an example in my district of a federally qualified health center has a partnership with Baylor College of Medicine in Houston, and they do it, and what I would like to do is see if we can get a number of medical schools, because I want primary care physicians to know they can make a living at a federally qualified health center in a community-based setting.

Mr. HAWKINS. Not only that, Mr. Green, but I am honored to be part of a panel today that includes Denver Health, a community health center, as well as a public hospital——

Mr. GREEN. Congresswoman DeGette has preached to me for years about Denver Health.

Mr. HAWKINS. And the great work that Dr. Gabow has done. Also, residency training program, Marshfield Clinic, which has a community health center embedded in it, doing residency training and Ted Epperly, Dr. Epperly, whose family medicine residency training program in Boise, Idaho, is also a federally qualified health center. Perfect examples. Now, all are working locally with their medical schools and with teaching hospitals to ensure, because those residents, even family medicine, have to have med-surg residency inpatient based so it can't be done independently. At the same time, the vast bulk of family medicine residency training, pediatric residency training, even general internal medicine residency training can be done in an ambulatory care site. More than 300 health centers today across the country are engaged in residency training programs. They have rotations of residents through them and everyone is willing to step up and do more. All that is needed is the resources to be able to do so.

Mr. GREEN. And if we know we have chronic need for primary care doctors, then this is a way we can do that and hopefully expand it.

One last question in my last 6 seconds. The discussion draft includes additional funding through the Public Health Investment Fund, and as many on the committee know, we have been asking for additional funds for federally qualified health clinics for years. How do you intend to use the new funds when you provide more services like dental and mental health and would it also help build more FQHCs? Because we know we need that in our country.

Mr. HAWKINS. I think there are two or three quick points to make on that. Just last month, the Government Accountability Office, GAO, issued a report that pointed out that almost half of federally designated medically underserved areas in this country have no health centers, not a one. There are 60 million people out there today across this country, some of whom have insurance and yet do not have a regular source of preventive and primary care, no family doctor, no medical or health care home. So the need is great. It runs in tandem with the extension of coverage that this bill would provide but takes it that one step further, turning the promise of coverage into the reality of care through providing a health care home. The expansion of coverage to serve more people as you noted very importantly the expansion of medical care to include oral health and mental health services so crucially important, all of that will be afforded through the new resources in this bill.

Mr. GREEN. Thank you.

Mrs. CAPPS. Thank you again to the panelists, and we are in recess for the next panel to begin after this series of votes. It is eight votes, but after the first one apparently is 2 minutes per vote so it should go fairly quickly hopefully. Thank you very much.

[Recess.]

Mr. PALLONE. The Subcommittee on Health will reconvene, and our next panel is on employer and employee views. Let me introduce the panel, from my left is Kelly Conklin, Mr. Conklin, who is the owner of Foley-Waite Custom Woodworking, Main Street Alliance, and then we have John Arensmeyer, who is founder and CEO of Small Business Majority. We have Gerald M. Shea, who is the assistant to the president of the AFL–CIO, Dennis Rivera, who is

the health care chair for the SEIU, John Castellani, who is president of the Business Roundtable Institute for Corporate Ethics, John Sheils, who is senior vice president for the Lewin Group, and Martin Reiser, who is manager of government policy for Xerox Corporation, I guess representing the National Coalition on Benefits. And you know, we ask you to speak for about 5 minutes, your written testimony becomes part of the record and then we will have questions from the panel.

So I will start with Mr. Conklin. Thank you for being here.

STATEMENTS OF KELLY CONKLIN, OWNER, FOLEY-WAITE CUSTOM WOODWORKING, MAIN STREET ALLIANCE; JOHN ARENSMEYER, FOUNDER AND CEO, SMALL BUSINESS MAJORITY; GERALD M. SHEA, ASSISTANT TO THE PRESIDENT, AFL-CIO; DENNIS RIVERA, HEALTH CARE CHAIR, SEIU; JOHN CASTELLANI, PRESIDENT, BUSINESS ROUNDTABLE; JOHN SHEILS, SENIOR VICE PRESIDENT, THE LEWIN GROUP; AND MARTIN REISER, MANAGER OF GOVERNMENT POLICY, XEROX CORPORATION, NATIONAL COALITION ON BENEFITS

STATEMENT OF KELLY CONKLIN

Mr. CONKLIN. Thank you, Chairman Pallone, Ranking Member Deal and other members of the committee for inviting me to appear today. My name is Kelly Conklin and I co-own with my wife, Kit, an architectural woodworking business in Bloomfield, New Jersey. My purpose today is to explain how the House tri-committee's health reform proposals might affect small companies like ours.

To start, I think the draft legislation is right on target. I believe it will receive broad support in the small business community. Before I go any further, let me provide some background. My wife and I opened Foley-Waite in 1978 in a 700-square foot shop in Montclair, New Jersey. In 1985 we expanded, hired four employees and started offering health insurance. The premiums were about 5 percent of payroll and we paid it all. Today we employ 13 people, occupy 12,000 square feet of space and serve some of the most influential people in the world, and we fork over $5,000 a month in health insurance premiums, close to 10 percent of payroll and one of the largest single expenses in our budget. Practically speaking, we offer coverage to attract and retain skilled employees but like the majority of small companies, we do so because it is the right thing to do for our workers and if we don't offer coverage, we are just passing our obligation and our share of the cost on to someone else.

Cost is by far the single most important driver in making basic decisions regarding health care. That applies whether it is a small firm like mine or the United States Congress, and no system that tends to dance around the cost issue can succeed.

April is the month I dread, not for taxes but for health insurance renewal nightmares. Every year is worse—unpredictable rate hikes, unaffordable premiums, an administrative tangle that is our system. In 3 years, we have had three different insurance companies. Most recently, Horizon Blue Cross Blue Shield raised our rates 25 percent. Now we have Health Net. That means new primary care physicians, and for my wife, who has a chronic illness,

a new doctor who knows nothing of her medical history. It is very frustrating. There are no quality, affordable health care options available for small businesses.

In reading the discussion draft, it is apparent the committee is determined to control cost. Responsible employers understand we will all be better off in a system where employers and individuals contribute a reasonable amount toward assuring our common health and well-being. That is why I support the draft provisions requiring employees and individuals to pay their fair share. For too long, the small business community has paid too much for too little. We sacrifice growth, financial security and the peace of mind of our employees and their families in the name of protecting private insurers from meaningful competition. The private health insurance market has failed to contain costs, enhance efficiency or improve outcomes. It fails to provide coverage to millions. Half measures warmed over, more of the same second chances for the health insurance industry won't fill the yawning gaps in our patchwork coverage. We need a guarantee that individuals and small companies will have real choices and affordable coverage options.

I commend the committee for including a strong public health insurance option in this legislation. With a public option, small businesses will have leverage, real bargaining power and guaranteed backup and greater transparency. Most importantly, by creating genuine competition and restoring vitality to the market dynamic, this proposal will bring about the kind of broad-based changes in the private insurance industry Main Street is clamoring for. For a small business like mine, bringing down health insurance premiums can be the difference between growth and sitting tight. Two years ago we were interested in buying a building. It represented growth potential, financial security and long-term equity. We were looking at around $5,000 a month in mortgage payments as opposed to our rent of around $3,500. If our health insurance premiums had been closer to our rent and not the future mortgage, we might be in that building today. We work in a competitive marketplace. All the time there are new competitors looking to take business away. We find savings, improve efficiency, invest in equipment and personnel. That is how it is for us and that is how it will be for the health insurers if a public option is available.

Transparency is critical. It is time for the insurance companies to come clean and in plain English explain where our premium money goes, to say up front what is covered and what is not. It is time to put a halt to cost containment by denial, copays and hidden charges. The draft discussion addresses this need by creating a health insurance exchange to offer real coverage choices to allow us to actually know where our premium dollars are being spent. We can provide access to both preventive and therapeutic care for everyone. We are encouraged by the provisions reforming common practices in the current insurance market. Ending lifetime and annual benefit limits, discriminatory coverage and rating policies and creation of a basic benefit are all important and necessary parts of a complete reform package. These are full measures designed to provide real relief. If enacted, they will represent a watershed for American health care and a godsend to the small business community.

This committee working with its counterparts to develop the tri-committee proposal has done yeoman's work taking on and meeting an extremely complex set of issues. I will not be alone in supporting this extraordinary effort. I am a member of the New Jersey Main Street Alliance, a coalition of over 450 small businesses working for health reform that will finally give us access to quality health care we can afford. I have canvassed small businesses, and when I say "and we support a public option," they take the pen out of my hand and the New Jersey MSA has a new member. Small businesses have seen your leadership and with this document you have delivered. Now the real fight begins. We need you to enact this proposed legislation and bring about health reform that works for us and our employees this year so we can do our part for economic recovery. Thank you, Mr. Chair.

[The prepared statement of Mr. Conklin follows:]

the alliance

A big vision for small business

Testimony of Kelly Conklin
Foley-Waite Associates, Inc. – Bloomfield, New Jersey

Before the House Energy and Commerce
Subcommittee on Health

Hearing on House Tri-Committee Discussion Draft Proposal
for Health Care Reform

June 25, 2009

Chairman Pallone, Ranking Member Deal, and members of the Subcommittee, thank you for this opportunity to share my experience with and views on our current health care system as it relates to the House Tri-Committee's Health Reform Bill. My name is Kelly Conklin, and I am a co-owner of Foley-Waite Associates, an architectural woodworking company in Bloomfield, New Jersey.

We've been in business for thirty years, and have worked for a wide range of commercial clients including Prudential Insurance, First Fidelity Bank, Shering Plough, Merck, and Citi Bank. For the past 15 years, we've focused on serving a high-end residential customer base in New York City. We have 13 employees, and currently we pay about $5,000 a month in health insurance premiums. Health insurance is close to 10 percent of our payroll at this point, and it's the third largest single expense in our budget. So this is an issue of great concern to me. We attribute about 10% of our payroll to health insurance (I previously misstated the percentage in testimony before the House Ways and Means Committee in April 2009 and apologize for the error).

Small Businesses and Health Insurance: Responsibilities and Challenges
It is often repeated in the public square that small business is the backbone of our economy. It sometimes looks from Main Street, that along with the economic and political well-being of the free world, the small business community is charged with the health and wellness of the American worker. But the skyrocketing costs of health coverage for small businesses are pushing us to the brink.

Why even offer health coverage? First, there's a strong business case: it's a critical benefit to attract and retain the skilled employees we need to succeed as a company. But there's more to it. I do it because I feel it's the right thing to do for my employees. Part of why we started our own business was to create an environment where we ourselves would want to work. I once had a business consultant advise me that I should tell my employees I had to drop their health coverage to ensure their job security, but I just couldn't do it – the ethics seemed questionable. It's also the responsible thing to do because if I didn't offer coverage, I'd just be shifting the cost of my employees' health care onto someone else.

It's counterproductive to try to escape the costs of health care. From my standpoint, it's a fixed cost, an inescapable cost. The way we're doing things now, where responsible employers offer coverage and others don't, that creates an incredibly unlevel playing field. If my employees and I are sharing the costs, then another employer who isn't contributing for health care has a competitive advantage over us. We'd be much better off in a system where all employers are contributing a fair share, instead of this game of cost-shifting we're stuck with now. Small business owners like me are willing to contribute – 73 percent said so in the *Taking the Pulse of Main Street* survey I was a part of last year (see page 6 for more details).

Small businesses who want to offer health coverage face a number of serious challenges. We have no bargaining power with the insurance carriers – it's "take it or leave it." We pay more in administrative costs – 25 percent or more of our premium dollars, compared to around 10 percent for larger groups. Because of our small size, we can't spread risk effectively, and we get penalized for it. Because of rising costs, we're forced to reduce benefits by increasing deductibles and our employees' share of the premiums. And, we must contend with the great lack of transparency in the insurance market. It's so

hard to know what you're buying and impossible to determine whether your dollars are being spent well.

April is a month I dread, not for taxes, but for health care. We struggle every year to find a way to make it work. We've been forced to cap our contributions for employees' coverage, and we've gotten used to switching carriers every year. In three years, we've had three different insurance carriers. Most recently we had Horizon Blue Cross/Blue Shield, but they raised our rates 25 percent, so we have switched to Health Net. That means enrollment forms, discontinuation forms, finding new primary care physicians and, because my wife has a chronic illness, new specialists who know nothing about her health history. It's extremely frustrating, as the person who literally writes and signs the check every month, to know that a lot of that money is not going to provide care for the people I'm paying the benefit for – I pay thousands of dollars for a system that is inefficient and doesn't deliver the promise of decent care or financial security.

Back in '78 if you had told us that one day we would employ 13 people, occupy 12,000 square feet of loft space, serve some of the most influential people in the world and fork over $5,000 a month in health insurance premiums, we would have questioned your sanity. Like thousands of other small company owners we felt our way along, picking up sound business practices by the seat of our pants, usually preceded by a swift kick to the same. To this day I am appalled whenever I read on a health insurance document that if an employee should have a question or problem with their health insurance plan they should "first contact the company health insurance administrator" – that being me. Talk about "in the land of the blind a one-eyed man is king."

Too often the "catastrophe" in catastrophic illness refers not the disease, but to the devastation of medical bankruptcy in the aftermath. The lack of transparency in health insurance policies means that the insurance purchased in this case by your local cabinet maker (me) could be a financial disaster waiting to happen. What are the limits of our policy? How many Americans think they're covered but then find themselves destitute because their employer "shopped" for the cheapest coverage? How many of us actually know our policy limits and how that compares to what we might need? And how much of what I and my employees spend on health insurance goes to make up the system's shortfall because millions of our fellow Americans are too poor to afford any insurance at all and receive their care in the emergency room, where the costs are highest and the outcomes least certain?

The health insurance market has failed to deliver on its promise for small businesses. It fails to provide peace of mind or deliver quality care. It fails to contain costs, enhance efficiency or improve outcomes. It fails to provide coverage to millions of our poorest citizens, to our low-wage workers, to our sole proprietors, to our corner coffee shop owner, our local plumber and car mechanic. Something has got to be done.

Real Solutions for Small Businesses

We need to stop whistling past the graveyard and face this problem full on. There are no cheap or easy solutions. But there are things we can do. I congratulate this committee and the other House committees with which you have collaborated in drafting the legislation we are discussing today. It represents a tremendous step forward in addressing the health insurance problems facing small

businesses, and I hope this committee will act quickly to approve it and encourage its passage by the full House of Representatives.

As this legislation demonstrates, we can promote transparency by having the private insurance companies come clean in plain English about where our premium money goes. We can have the private insurance companies produce policies that clearly explain and comparatively measure regional cost and probabilities so consumers can understand what it is they can expect and how secure they are from medical bankruptcy. We can assure everyone access to health care, preventative and therapeutic, and we can agree that this should be a shared commitment where employers like me, our workers, health providers and the government all contribute to make it so.

The legislation before us today addresses these needs by creating a Health Insurance Exchange that will provide a more competitive, transparent marketplace that will offer real coverage choices for individuals and small businesses. In this 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 explicitly disclosed.

I'm pleased to see that the bill also includes provisions that will significantly reform practices in the insurance market to prohibit discriminatory coverage and rating policies. These changes are long overdue – I wish it wasn't necessary for the federal government to have to pass a law to get insurers to stop these unfair practices, but after the experiences we've had I know we need laws and regulations to keep private insurers honest.

But these reforms, as important as they are, are not sufficient to guarantee that individuals and small businesses will have real choices and truly affordable coverage options. To achieve these goals, I believe we must create a strong public health insurance option – and I commend the committee for including provisions in this bill that will do just that. The choice of a public health insurance plan will finally give small businesses like mine real bargaining power, it will provide a guaranteed backup, and it will promote greater transparency in the system. Perhaps most importantly, by creating genuine competition and restoring vitality to the market dynamic, this will bring about 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 would submit that these are savings we cannot afford to pass up.

I think a public health insurance plan is also critical in encouraging innovation in coverage and affordability in a competitive marketplace. Our business has always sought to serve our customers better, more efficiently, and at lower prices, and we are driven by competition from other businesses. As a purchaser of health insurance coverage, I want my insurer to have to compete as hard for my business as I have to compete for my customers.

The bill phases in the eligibility of all but the smallest businesses to secure coverage through the Exchange, and through the Exchange to gain access to the public health insurance option, with firms employing 10 or fewer workers eligible in year one and businesses with up to 20 employees eligible in

year two. I appreciate the intention of the committee to be cautious and avoid creating unintended consequences by moving too quickly, but from my perspective we need to provide as many businesses as possible access to the Exchange and the public plan option as quickly as possible. I hope the committee will explore ideas for accelerating the phase-in of employer eligibility in the Exchange.

For small businesses like mine, the savings resulting from a public insurance plan and a truly competitive health insurance marketplace could mean the difference between cutbacks or expansion. Two years ago, we were seriously looking into buying our own building. It would have meant more security and more equity for our company. Unfortunately, the mortgage would have been $5,000 a month compared to the $3,500 we are paying in rent. If we could just switch the amount of money we are paying for health coverage with the amount of money we can afford to pay in a rent or mortgage – we would have that building now and our company would have the ability to expand.

With an active Health Insurance Exchange, meaningful reform of insurance coverage and rating policies, and a strong public health insurance plan option, I agree with the committee's proposal to require individuals and employer to pay their fair share to assure that all Americans have access to health care coverage. I support the approach of giving employers the option of providing coverage for their workers or contributing funds on their worker's behalf. I mentioned earlier that my firm pays roughly 10% of our payroll for health insurance costs, so requiring employers to contribute 8% of payroll doesn't seem unreasonable to me. It is a significant improvement over our current options, with greater transparency and protection against unfair coverage and rating practices.

The legislation also suggests that provisions will be included to provide an exemption from the shared responsibility requirement for some categories of small businesses. In order to assure that all Americans have access to affordable, quality health care coverage, it seems fair to me that all individuals and employers should bear a fair share of the responsibility. However, representatives of the Main Street Alliance look forward to continuing to work with you as you assess the interaction of the various small business related provisions in the bill to assure affordability across the full range of employers, whether they directly provide coverage for their workers, contribute to helping employees purchase their own coverage through and Exchange, or provide a targeted exemption for certain small businesses.

A word of caution about some things I believe won't help address the problems we face as small businesses. I don't believe new tax credits are, in themselves, a good solution to this problem. I would rather have real health reform that addresses the cost drivers in health care and bends the cost curve down than a tax credit that won't mean anything in two years after the costs just keep skyrocketing. That said, I support the inclusion of a small business tax credit in this legislation as a way to help those firms whose economic situation makes it difficult for them to contribute to providing health care coverage for their workers. A 50 percent credit will offer important assistance to businesses with 10 or fewer employees whose average annual employee compensation is $20,000 or less.

I'm against capping the employer exclusion for health benefits: this would only push more small businesses over the edge into dropping coverage. We need to create a more stable environment so businesses and employees can afford to contribute, not undermine that stability.

Looking to Congress for Leadership

My challenges with health care and my views on what needs to be done to fix it are by no means unique. Back home in New Jersey, I'm a member of a coalition called the New Jersey Main Street Alliance. We're a coalition of over 450 New Jersey small businesses that are working together to support health reform that works for us. Last year I was surveyed as part of a national small business survey project, where surveyors polled Main Street business owners door to door and asked face to face what we thought about the state of health care.

The results of this survey, reported in "*Taking the Pulse of Main Street: Small Businesses, Health Insurance, and Priorities for Reform*" (full report available at http://mainstreetalliance.org/wordpress/home/publications/), confirm that the views of my fellow business owners across America are quite different than those often attributed to us. The survey results challenge the conventional wisdom on small business and health care in three key areas:

1. Our willingness to contribute: When asked if we were willing to contribute for health coverage for our employees, more than two thirds (73 percent) of small employers said yes. Furthermore, 63 percent indicated a willingness to pay 4-7 percent of payroll (in some cases more) to guarantee effective, affordable coverage for our employees.
2. Our support for real choices, including a public health insurance option: When asked to choose between a proposal with a public insurance option and a proposal with more private options, respondents chose the proposal with a public alternative two to one (59 percent to 26 percent, with 14 percent undecided/other).
3. The role of government in making health care work for us: When asked about public oversight and the role of government, small business owners supported more public oversight of the insurance industry by a margin of almost six to one (75 to 13 percent), and a stronger government role in guaranteeing access to quality, affordable health coverage by a margin of over four to one (70 to 16 percent).

We need Congress to act, and act swiftly, to advance real health reform, this year. In closing, I would like to thank the Chairman and members of the Subcommittee for allowing me to share my experiences as a small business owner. I am certain that if Congress can step back for a moment from the political blood battles that dominate the nightly news and instead keep Main Street in mind, you can craft the legislation we so desperately need to fix health care.

Thank you.

Mr. PALLONE. Thank you, Mr. Conklin.
Mr. Arensmeyer.

STATEMENT OF JOHN ARENSMEYER

Mr. ARENSMEYER. Thank you, Chairman Pallone, Ranking Member Deal and members of the committee. Small Business Majority appreciates this opportunity to present the small business perspective on the House tri-committee draft health care reform plan. We support the effort to move this legislation through Congress expeditiously, and thank you for bringing a proposal forward in such a timely manner.

Small Business Majority is a nonprofit, nonpartisan organization founded and run by small business owners and focused on solving the biggest single problem facing small businesses today, the skyrocketing cost of health care. We represent the 27 million Americans who are self-employed or own businesses of up to 100 employees. Our organization uses scientific research to understand and represent the interests of all small businesses. I have been an entrepreneur for more than 20 years including 12 years owning and managing an Internet communications company. Together with the other senior managers in our organization, we have a total of 70 years running successful small businesses ranging from high tech to food production to retail. We hear stories every day from small business owners who can't get affordable coverage and for whom health care is a scary, unpredictable expense. Louise Hardaway, a would-be entrepreneur in Nashville, Tennessee, had to abandon her business stream after just a few months because she couldn't get decent coverage. One company quoted her a $13,000 monthly premium for her and one other employee. Others such as Larry Pearson, owner of a mail order bakery in Santa Cruz, California, struggle to do the right thing and provide health care coverage. Larry notes that, "The tremendous downside to being uninsured can be instant poverty and bankruptcy, and that is not something my employees deserve." Our polling confirms that controlling health care costs is small business owners' number one concern. Indeed, on average, we pay 18 percent more than big businesses do for health care coverage.

An economic study that we released earlier this month based on research by noted M.I.T. economist Jonathan Gruber found that without reform, health care will cost small businesses $24 trillion over the next 10 years. As such, we are pleased to see that the House bill addresses key cost containment measures such as expanded use of health IT, transparency, prevention, primary care and chronic disease management.

Our polling shows that 80 percent of small business owners believe that the key to controlling costs is a marketplace where there is healthy competition. To this end, there must be an insurance exchange that is well designed and robust. We are very pleased that the committee's bill proposes a national insurance marketplace with the option for state or regional exchanges that adhere to national rules. Moreover, we were encouraged by the committee's proposal that there be standardized benefit packages along with guaranteed coverage without regard to preexisting conditions or health

status, a cap on premiums and out-of-pocket costs and marketplace transparency.

We understand that a balanced set of reforms will require everyone to participate. Sixty-six percent of small business owners in our recent polls in 16 States for which we released preliminary data this week support the idea that the responsibility for financing a health care system should be shared among individuals, employers, providers and government. It should be noted that respondents to our surveys included an average of 17 percent more Republicans at 40 percent than Democrats at 23 percent while 28 percent identified as independent.

According to the results of the economic modeling done for us by Professor Gruber, comprehensive reform that includes even modest cost containment measures and a well-designed structure for employer responsibility will offer vast improvement over the status quo. A system with appropriate levels of tax credits, sliding scales and exclusions will give small businesses the relief they need, potentially saving us as much as $855 billion over the next 10 years, reducing lost wages by up to $339 billion and restoring job losses by up to 72 percent. We are very pleased that the committees have addressed some of the affordability concerns of the smallest businesses. Professor Gruber has modeled specific scenarios described in detail in our report and we look forward to working with you to ensure the best balance between the need to finance the system and our ability to pay.

Finally, another issue of great concern to us is the unfair tax treatment of the 21 million self-employed Americans. Under the current tax code, self-employed individuals are unable to deduct premiums as a business expense and are required to pay an additional 15.3 percent self-employment tax on their health care costs. We encourage that this inequity be rectified in the final bill passed by the House.

In closing, health care premiums have spiraled out of control, placing our economy and the fortunes of small business in peril. Health care reform is not an ideological issue, it is an economic and practical one. We are encouraged by the overall approach of this bill and look forward to working with you to make it a reality this year. Thank you.

[The prepared statement of Mr. Arensmeyer follows:]

STATEMENT BEFORE

HOUSE COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH

ON

COMPREHENSIVE HEALTH REFORM
DISCUSSION DRAFT

JUNE 25, 2009

JOHN ARENSMEYER

FOUNDER & CEO

SMALL BUSINESS MAJORITY

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Good afternoon Chairman Pallone, and Ranking Member Deal, and members of the committee and health subcommittee. Small Business Majority appreciates the opportunity to present the small business perspective on the draft healthcare reform plan being considered by the House Energy and Commerce Committee. We support the effort to move this legislation through Congress expeditiously, and thank you, along with the leadership of both the Ways and Means and Education and Labor committees, for bringing a proposal forward for discussion in such a timely manner.

Small Business Majority is a nonprofit, nonpartisan organization founded and run by small business owners and focused on solving the biggest problem facing small businesses today: the skyrocketing cost of healthcare. We represent the 27 million Americans who are self-employed or own businesses of up to 100 employees. Our organization uses scientific research to understand and represent the interests of all small businesses.

I have been an entrepreneur for more than 20 years, including 12 years owning and managing an Internet communications company specializing in financial services. Together with two other senior managers in our organization, we have a total of 70 years running successful small businesses ranging from high-tech to food production to retail.

We are pleased to be here today to support comprehensive healthcare reform that will reduce the costs of insurance and medical care, while making coverage affordable, fair and accessible. Our research shows that comprehensive health insurance reform is small business owners' number one need, and controlling costs is essential to ensuring our ability to obtain high-quality, affordable healthcare for ourselves, our families and our employees.

My testimony will highlight the issues of most interest to small businesses. I'll discuss what we have learned from our scientific research about both the opinions of small business owners and the projected economic impact of various reform options—and the impact of failing to act. The points I'll be making include:

- Our research shows that small business owners want and need reform now. The high cost of healthcare is killing us.
- Small businesses are willing to be part of the solution.
- A properly designed shared responsibility reform model will significantly help small businesses, according to an economic study we commissioned from M.I.T. economist Jonathan Gruber
- The committees' discussion draft addresses many of the necessary elements in comprehensive reform, particularly controlling costs, creating a robust exchange, instituting insurance market reforms and establishing a workable system of shared responsibility that takes into account the needs of the smallest businesses.
- We look forward to working with the committees to ensure that their recommendations on small business obligations, exemptions and tax credits are most helpful to small businesses and are consistent with our ability to pay.
- The tax rules for purchase of health insurance by the self-employed must be brought in line with those of all other businesses.

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Healthcare Costs are Killing Small Business and Sapping Our Economic Vitality

National surveys of small business owners consistently show that the cost of health insurance is our biggest overall problem. In fact, the crushing costs of healthcare outranked fuel and energy costs and the weak economy for 78% of small business people polled by the Robert Wood Johnson Foundation in 2008.[1]

Small businesses are at a disadvantage in the marketplace largely because our small numbers make rates higher. According to research supported by the Commonwealth Fund, on average we pay 18% more than big businesses for coverage.[2] Small businesses, including the growing legions of the self-employed, need a level playing field to succeed and continue as the job generator for the U.S. economy.

We hear stories every day from small business owners who can't get coverage because they've been sick in the past or the health plans they are offered are outrageously priced. Louise Hardaway, a would-be entrepreneur in the pharmaceutical products industry in Nashville, had to give up on starting her own business after just a few months because she couldn't get decent coverage—one company quoted her a $13,000 monthly premium.

Many other businesses maintain coverage for employees, but the cost is taking a bigger and bigger chunk out of their operating budgets. It's common to hear about double-digit premium increases each year, eating into profits and sometimes forcing staff reductions. These rising bills frequently force business owners to hack away at the insurance benefit to the point where it's little more than catastrophic coverage. That leaves employees with huge out-of-pocket expenses or a share of the premium they can't afford, forcing them to drop coverage. That concerns Larry Pierson, owner of a mail-order bakery in Santa Cruz, California, who says that "the tremendous downside to being uninsured can be instant poverty and bankruptcy, and that's not something my employees deserve."

Small business owners want to offer health coverage, and our surveys show that most of us feel we have a responsibility to do so. With staffs of 5, 10 or even 20 people, we run tight-knit organizations, know our employees well and depend on each employee for our businesses' success. We don't want to see our valuable employees wiped out financially by a health problem, or ignore illnesses because they can't afford to go to the doctor.

Many small businesses are forced to drop coverage altogether. According to the Kaiser Family Foundation, among firms with 3 to 9 workers, the percentage that offers insurance dropped from 57% in 2000 to 49% in 2008.[3]

This makes small business employees a significant portion of the uninsured population. Of the 45 million Americans without health insurance in 2007, nearly 23 million were small

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[1] "Study shows small business owners support health reform," Robert Wood Johnson Foundation, 2008.
[2] J Gabel et al, Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii is Up, Wyoming is Down, *Health Affairs*, May/June 2006.
[3] Kaiser Family Foundation/HRET Employer Health Benefits Annual Survey, 2008

business owners, employees or their dependents, according to Employee Benefit Research Institute estimates.[4]

Our scientific research reinforces what we hear anecdotally every day: High healthcare costs are putting enormous pressure on small business owners. We have just completed a series of telephone surveys of a scientific sample of small business owners in 16 states. The staggering cost of health coverage is reflected in some of the key findings:

- An average of 72% say they are struggling to afford health insurance;
- An average of 69% overall say reform is necessary to save the economy;
- and when asked about the most important goals for healthcare reform, the top choice is most often "control costs."

Finally, if we don't get control of the healthcare crisis facing small businesses, we will impede our overall economic growth. Small businesses under 100 employees employ 42% of American workers.[5] Traditionally, small businesses lead the way out of recessions. Addressing this crisis is essential to our vitality as a nation.

Cost Containment Comes First

We have sponsored research that actually models what would happen to small business without comprehensive reform, contrasted with three different levels of support to small business. The research underlying this report, made public earlier this month, was conducted for Small Business Majority by Jonathan Gruber, noted economist at the Massachusetts Institute of Technology. Dr. Gruber's research found that without reform, the continued rising cost of healthcare coverage will cost small businesses $2.4 trillion over the next ten years.[6]

We need to slow the growth of overall healthcare costs to make coverage affordable and to improve the competitiveness of small businesses. The key to cost containment is to create a marketplace where there is healthy competition among insurers, which would create incentives to lower costs by increasing price competition. Specific actions that are likely to have the most impact include expanded use of health IT, research about what works in medicine, transparency and public reporting of costs and quality, incentives for expanded use of preventive services, primary care and effective management of chronic conditions, malpractice reform, and reduction in waste, fraud and abuse. We are pleased to see that the House discussion draft addresses many of these approaches.

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[4] Employee Benefit Research Institute, Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2008 Current Population

[5] U.S. Bureau of Census, 2006 County Business Patterns

[6] The Economic Impact of Healthcare Reform on Small Business, Small Business Majority; available at www.smallbusinessmajority.org

A Robust Exchange Coupled with Insurance Market Reforms is Essential

We believe that it is essential to have an insurance exchange that is well-designed and robust. A broad, well-functioning marketplace offering consistency, fairness and healthy competition will vastly improve the availability and affordability of coverage to small businesses and the self-employed. Indeed, our recent opinion research shows that 80% of small business owners in those states surveyed support a health insurance pool to create a marketplace where small businesses and individuals choose their coverage.

The current insurance marketplace is broken, particularly for small businesses, which cannot access plans with favorable rates because of their small size. Kaiser Family Foundation research shows that insurers' administrative costs are 18% higher for individual and small business health plans than for large groups. Those costs are passed along in higher premiums.

We are very pleased that the committees' discussion draft would establish a national insurance marketplace for individuals and businesses to comparison shop for coverage. It is good policy for states to establish state or regional exchanges that adhere to the national rules to ensure maximum flexibility and incorporation of particular local needs.

Moreover, we are encouraged by the committees' proposal that there be standardized benefit packages to make it easier to make informed choices on cost and quality, along with guaranteed availability of coverage, no exclusions for preexisting health conditions, health insurance rating rules that prohibit adjustments for health status, a cap on premiums and out-of-pocket spending, marketplace transparency, and affordability credits to ensure that small business employees and others can actually participate without financial hardship.

To be financially successful, the exchange must ensure that it avoids adverse selection. Requirements that individuals and businesses purchase insurance, accompanied by guarantees of affordability, will help provide a wide, diverse base for the exchange. It is vital that the ultimate design of the exchange include as broad a group as possible and potentially include incentives for people to buy into it. To create stability it is important that the exchange can grow in strength as quickly as possible, taking into account the need to ensure a smooth transition.

For small businesses, this kind of exchange will go far in reducing the chaos and decreasing the administrative burden involved in choosing and maintaining health insurance both for business owners and for their employees if they offer coverage.

Healthcare Reform Based on Shared Responsibility Benefits Small Business

Small business owners understand that a balanced set of comprehensive reforms will require everyone to participate. 66% of small business owners responding to our recent state surveys support the idea that the responsibility for financing a more affordable healthcare system should be shared among individuals, employers, insurance companies, providers and

government. It should be noted that respondents to our surveys included an average of 17% more Republicans (40%) than Democrats (23%), while 28% identified as independent.

According to the results of our economic modeling, comprehensive reform that includes even modest cost containment measures and a well-designed structure for employer responsibility will offer a vast improvement over the status quo and spiraling future costs for small businesses. A system requiring an employer contribution, with appropriate levels of tax credits, sliding scales and exclusions, will give small businesses the relief they need, potentially saving as much as $855 billion over the next 10 years, reducing lost wages by up to $339 billion and minimizing job losses by 72%.

The committees' discussion draft proposes an employer requirement to provide health insurance to workers. As shown by our research, this framework is workable, and, if properly designed, can produce substantial benefits for small businesses. Our modeling of the most successful reform scenarios presumes an exemption for the smallest businesses, a sliding scale of obligations based upon the size of payroll or the number of employees up to 6.5% of payroll and tax credits of 50% of health costs for employees earning under $100,000 at businesses with fewer than 50 employees. We are very pleased that the committees have addressed many of the affordability concerns of the smallest businesses, and we look forward to working with you to ensure the best balance between benefit to small businesses and our ability to pay.

Tax Equity for the Self-Employed

Finally, another issue of great concern to us is the unfair tax treatment of the 21 million self-employed people in this country. Under the current tax code, self-employed individuals are unable to deduct premiums as a business expense and are required to pay an additional 15.3% self-employment tax on their healthcare costs. These business owners are at a significant tax disadvantage to larger businesses, which do not pay payroll taxes on the health insurance they provide employees. It is one of many barriers these Americans face in trying to access affordable health insurance for themselves and their families.

The self-employed should be allowed to fully deduct their health insurance premiums for the purposes of their income tax and self-employment tax. We encourage the addition of this provision in the final bill passed by the committees.

Conclusion

Healthcare reform is not an ideological issue—it's an economic one. Small business owners know this, which is why they overwhelmingly support a comprehensive solution to reforming the way we pay for healthcare. We are encouraged by the overall approach of this bill and look forward to working with you to make it a reality this year.

Mr. PALLONE. Thank you, Mr. Arensmeyer.
Mr. Shea.

STATEMENT OF GERALD M. SHEA

Mr. SHEA. Good afternoon, Chairman Pallone and Congresswoman Capps. I really appreciate the opportunity to share the views of the AFL–CIO on this critically important issue.

I want to start by saying a hearty congratulations on producing a very good draft bill. I think you really responded to what the American people have asked for, and we look forward to working with you over the coming weeks to get that bill enacted.

You have decided to build health reform based on the current system, therefore based largely on the employment-based system, since that is the backbone of our health coverage and health financing, and I want to direct my remarks to that today, and I hope that the experience I bring, which is the experience of unions that bargain benefits for 50 million workers each year, will be of some benefit to you. And the main thing I have to say is, if you are going to proceed down this path, and we certainly support it, then job number one is stabilizing employment-based coverage. It has proved remarkably resilient in the face of high cost pressures but it is in fragile shape today. From 2000 to 2007, we lost five full percentage points on the number of 18- to 64-year-old working Americans who were covered, and the underinsured rate, people who have insurance but really can't afford to get care under it, shot up from 16 percent to 25 percent in the last 4 years. So despite the fact that it is still hanging on, employment-based coverage is really eroding very rapidly, and to stabilize that coverage, we would suggest that you focus first of all on cost, secondly on having everyone involved in coverage and in the system, and thirdly, and I don't mean these in rank order, they are really all important, thirdly, reform of the delivery system.

Let me start with participation because in some ways that is the simplest. If you are going to base this on employment-based coverage, we think it makes simple sense, as you have done in your bill, to require that everyone, every individual participate and take responsibility to some extent, certainly responsibility for their own health status, and every employer to participate, and that is included in your bill, and the benefits of this are simple. It helps bring people into the system, it does stabilize the employment-based coverage, it helps reduce the amount of federal tax dollars that you have to spend because everybody who is covered by an employer plan will not be dependent on monies that you have to raise and put into this bill for subsidies. It levels the playing field between employers who now do provide and those who don't. And there really are just three categories of workers in terms of their insurance coverage. The vast majority, as you know, get insurance coverage at work, some 92 percent of the employers of 50 or above workers provide health insurance. There are some employers who don't provide insurance but certainly are well enough off to do that. The example of the Lobby Shop in Washington comes to mind. And then there are a group of low-wage, small employers who really need a lot of help to do this. Our suggestion is that everyone be included in this, no exemptions, because once you start exempting

people, we think you are going to run into distortions in the marketplace as now exist, but we do think it is appropriate, as you have done, to provide tax subsidies for employers with low wage and small numbers of employees and I would emphasize that we don't think there are just small numbers of employees, it actually it is some measure of the financial stability or success of the firm that should be taken into account.

Secondly, in terms of controlling costs, the most important thing we can do is to change the delivery system. If the Institute of Medicine estimate of 30 percent waste in the system is anywhere near correct, we could easily pay for health reform and cover all of the uninsured if we can get a substantial amount, not all of that but a substantial amount of that waste out of the system. So that is the most important thing, and your bill includes a number of good provisions on that. We are working with your staff because we think they could be strengthened in a number of areas but we think you have made a very good start. However, in the short term, that is really not going to do the job. You are going to need to do something else, and there are only two options in our view as to how to do this in the short term. One is to do it by regulation. You could do global budgets or set rates, and the other is to introduce competition into the marketplace that now doesn't exist, and you have chosen the idea of competition through a public health insurance plan and we strongly support that. I would just point out that there is an additional advantage of a public health insurance program in that it can be a leader in reform of the system as Medicare is now. I deal with a lot of employers and a lot of unions who have wanted to change the delivery system for the better over the past few years but it wasn't until Medicare started to change their payment rates that this really started to happen.

And then lastly, looking at the delivery system, I think, as I said, that there is plenty of money in it to pay for reform, but we are not going to get that money back very quickly and some people are talking about having to pay for reform totally out of the current money in the system, which we think is just very unrealistic. We think you have to look outside for additional monies, and if you take the view that you have to look inside, you may well get to the very dangerous territory of the Senate Finance Committee talking about taxation of benefits, which we think would be a disastrous approach. It is unfair to the people involved since they already pay an arm and a leg, many of them, for health coverage, and it is unfair in terms of the inequities built into this, workers who are older, groups that have families, groups that have more retirees will have much higher costs. And then there is the simple political dynamic of this. If you want to throw a monkey wrench into public support to health reform, this would be the perfect way to do it because in the process you would really, really turn the apple cart upside down in employment-based coverage.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Shea follows:]

The Tri-Committee Draft Proposal for Health Care Reform

Testimony Submitted to

House Committee on Energy and Commerce
Subcommittee on Health

By

Gerald M. Shea

Assistant to the President

American Federation of Labor and Congress of Industrial Organizations

June 25, 2009

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 fifty 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 under-insured 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 one year. Our health care costs have exceeded 35 percent of our income for two 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 four to five months of take home pay each year. My insurance bill is split with my employer but equals two 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 "pre-existing 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, three and a half 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 under-insured 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 under-insured 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.

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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.

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.

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.

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[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.

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 five 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.

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[6] Elise Gould. "The Erosion of Employer-Sponsored Health Insurance." Economic Policy Institute. October 2008. Accessed: http://epi.3cdn.net/d1b4356d96c21c91d1_ilm6b5dua.pdf.

"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 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 towards 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

[7] Families USA. "Hidden Health Tax: Americans Pay a Premium." May 2009. Accessed: http://www.familiesusa.org/assets/pdfs/hidden-health-tax.pdf.

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 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

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[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.

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 retirees 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 insures and payers were not making appreciable headway towards 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.

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.

[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.

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 an 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.

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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.

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 pioneered in other U.S. industries—for example, six sigma quality standards and rapid-cycle problem analysis, solution development and testing, and wide-spread 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

[14] Families USA. "Hidden Health Tax: Americans Pay a Premium." May 2009. Accessed: http://www.familiesusa.org/assets/pdfs/hidden-health-tax.pdf.

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 pre-existing 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 two years that the exchange is operational.

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

[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.

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]

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

[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.

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 one 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.

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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.

Mr. PALLONE. Thank you, Mr. Shea.
Mr. Rivera.

STATEMENT OF DENNIS RIVERA

Mr. RIVERA. Thank you. I am chair of SEIU Health Care, the 1.2 million health care workers who are committed to reforming our Nation's broken health care system. We represent members like Pat DeJong of Libby, Montana, who works as a home care aide. Pat and her husband Dan were ranchers but had a hard time finding affordable coverage and were uninsured when he was diagnosed with Hodgkin's lymphoma in the year 2000. The medical bills piled up for Pat and Dan, eventually forcing them to sell the land they loved and that has been in Dan's family for generations. Dan succumbed to cancer and Pat remains uninsured. This is America. We can and we must do better for hardworking families like the DeJongs. Americans are ready to fix health care and they know that this is the year it must happen. Now it is up to you to deliver Pat and the millions who face the consequences of our broken health care system with a real choice of affordable, quality, private and public health care coverage. SEIU's 1.2 million health care workers in hospitals, clinics, nursing homes and in homes in communities are at the bedside every day witnessing high-price families pay for the delay and skip medical treatments. The uninsured are not just a statistic. They are hardworking people, people such as Pat, who despite caring for those who cannot care for themselves, cannot afford health care coverage for herself.

The discussion draft includes many essential elements that would promote coverage and access, cost containment and improve quality and value for American families. A strong public health insurance option is vital to ensuring consumer choice and access. The public plan will drive down the cost of insurance by competing with private insurance and lowering overall costs.

Medicaid expansion—we support increase in Medicaid eligibility for families up to 133 percent of federal poverty. The discussion draft will also improve Medicaid payments to primary care practitioners to address concerns about access to needed services by Medicaid beneficiaries. We caution the committee that safety-net providers and systems must be protected to provide access and support to low-income communities and to maintain a mission that includes trauma care and disaster preparedness. Special payment to these facilities such as the disproportionate share payments must be maintained as coverage expands. In addition, essential community providers must be included in insurance plans that serve Medicaid beneficiaries and individuals eligible for health care credits.

Health care reform needs to work for everyone including the 4 million American citizens who reside in Puerto Rico, and we urge Congress to include Puerto Rico and all the territories in all parts of health care reform. SEIU is pleased to see that the committee has recognized the need to improve the treatment of Puerto Rico and the territories under Medicaid by increasing the caps and federal matching rates. While this is an important step in the right direction, it falls short of resolving the longstanding inequities in federal health care programs that have been hurting the people of Puerto Rico for decades.

Shared responsibility. Employers, individuals and government must all do their part to make sure we have a sustainable and affordable system that covers everybody. For employers that do not provide meaningful coverage to their employees, they must pay into a fund. This pay-or-play requirement is necessary to ensure individuals can meet their responsibility to obtain affordable coverage with special support provisions to provide small businesses with tax credits and access to an insurance exchange to help them purchase coverage for their employees.

Affordability. Individuals' responsibility must be augmented by measures to ensure affordability. We commend the committee for offering federal financial assistance to individuals and families with low and moderate income and those with high health care costs relative to their income to guarantee affordability.

Eliminating disparities—We congratulate the committee for recognizing disparities in access to quality health care. No one should be discriminated for preexisting conditions. No one should be discriminated for being low income, minority, disabled or aged.

Workforce. As coverage grows, so much the health care workforce. Today there are chronic shortages in almost every area of health care from primary care physicians to nurses to long-term-care workers. Health care reform to be effective must include a diverse, well-trained workforce that is working in the appropriate setting across the delivery system and is well distributed in both urban and rural areas.

This is your moment, your moment to ensure that Pat DeJong and millions of other hardworking Americans do not have to wait any longer in America for quality, affordable health care coverage. The time is now. We cannot wait.

[The prepared statement of Mr. Rivera follows:]

Testimony before the House Committee on Energy and Commerce
June 25, 2009

My name is Dennis Rivera, and I am chair of SEIU Healthcare. The Service Employees International Union is the largest union in the United States, and the 1 million caregivers of SEIU are especially committed to reforming our nation's broken healthcare system.. Chairman Waxman and members of the Committee, SEIU applauds you for the discussion draft Tri-Committee bill released on June 19.

Americans are ready to fix healthcare. According to a poll conducted in April by the Kaiser Family Foundation, 6 in 10 Americans say that they or a member of their household have delayed or skipped medical treatment in the past year. A solid majority of the respondents agree that the current economic crisis makes it more important that we reform healthcare now. As a union of more than 1 million healthcare workers—in hospitals, clinics, nursing homes, and in homes and communities—the Service Employees International Union knows these workers, their families, and their communities. While working in the healthcare system, they not only witness the failed system, but also experience it firsthand.

The uninsured are not just statistics. They are hardworking people such as Pat DeJong of Libby, Mont., an SEIU member who works as a home care aide. Pat and her husband Dan were ranchers, but had a hard time finding affordable coverage, and were uninsured when he was diagnosed with Hodgkin's lymphoma in 2000. The medical bills piled up for Pat and Dan, eventually forcing them to sell the land they loved and that had been in Dan's family for generations. Dan succumbed to cancer and Pat remains uninsured. We can and must do better for hardworking families such as the DeJongs.

The importance of reform cannot be overstated. A comprehensive approach to healthcare reform that expands coverage to everyone is the only approach that will slow healthcare costs and preserve coverage for those who have it now. If we allow high medical bills to drive families deeper in debt, and rising healthcare costs to put a drag on our economic recovery, we will not restore consumer confidence and generate the number of good U.S. jobs needed to put our country back on the right track. Reform must eliminate barriers to quality, affordable healthcare by decreasing

costs, eliminating waste, and ensuring consumer choice and access. This is the type of reform that will help people such as Pat and many other Americans who go untreated.

Your discussion draft includes many essential elements that will promote coverage and access, cost containment, and improved quality and value:

The Public Plan: We applaud the Committee for including a public plan option in the discussion draft. A strong public health insurance option is vital to ensuring consumer choice and access. The public plan will drive down the costs of insurance by competing with private insurers and lowering overall costs. A reliable public plan assures consumers they will have continuity and stability in their coverage, while private plan offerings often change year to year, and are often scarce in rural areas. Wide availability of a public plan is a necessary part of a comprehensive cost-containment strategy. The plan will have lower administrative costs and offer less red tape through standardized forms and simpler policies for consumers and providers. According to the Urban Institute, there is increasing consolidation of both hospital systems and insurers, and a public plan can help create competition where it is lacking in consolidated markets, thereby lowering costs and ensuring consumer choice.

Medicaid Expansion: We support the increase in Medicaid eligibility for families up to 133 percent of federal poverty. The discussion draft also would improve Medicaid payments to primary care practitioners to address concerns about access to needed services by Medicaid beneficiaries. We caution the Committee that safety net providers and systems must be protected to provide access and support to low-income communities, and to maintain a mission that includes trauma care and disaster preparedness. Special payments to these facilities, such as disproportionate share payments, must be maintained as coverage expands. In addition, essential community providers must be included in insurance plans that serve Medicaid beneficiaries and individuals eligible for healthcare credits.

SEIU is pleased to see that the Committees recognize the need to improve the treatment of Puerto Rico and the territories under Medicaid by increasing their caps and federal matching rates, and we urge you to retain this provision to address longstanding inequities and strengthen access and coverage.

Shared Responsibility: Employers, individuals and government must all do their part to make sure we have a sustainable and affordable system that covers everybody. The journal *Health Affairs* recently published a paper by Bob Blendon and colleagues showing stronger public support for a shared responsibility approach to reform compared to an approach that relies solely on individual responsibility[1]. For employers that do not provide meaningful coverage to their employees, they must pay into a fund. This "pay or play" requirement is necessary to ensure individuals can meet their responsibility to obtain affordable coverage. We especially support provisions to provide small businesses with tax credits and access to an insurance exchange to help them purchase coverage for their employees.

Affordability: Individual responsibility must be augmented by measures to ensure affordability. We commend the Committee for offering federal financial assistance to individuals and families with low and moderate incomes, and those with high healthcare costs relative to their incomes, to guarantee affordability. Affordability credits for families between 133 percent and 400 percent of the federal poverty line, the Medicaid expansion, and the cap on premium contributions and out-of-pocket expenses will make healthcare more affordable, and thereby more accessible, for millions of working families.

Eliminating Disparities: We congratulate the Committee for recognizing disparities in access to quality healthcare. No one should be discriminated for pre-existing conditions. No one should be discriminated for being low-income, minority, disabled or aged. Everyone deserves quality care. To that end, healthcare inequities must be addressed. We fully support the Committee's inclusion of a provision to collect data on healthcare access and quality disparities.

Workforce: As coverage grows, so must the healthcare workforce. Today there are chronic shortages in almost every area of healthcare from primary care physicians to nurses to long term care workers. Healthcare reform, to be effective, must include a diverse, well-trained workforce that is working in the appropriate settings across the delivery system, and is well-distributed in both urban and rural areas. We applaud the Committee for including provisions to improve

[1] Tara Sussman, Robert J. Blendon, Andrea L. Campbell, "Will Americans Support the Individual Mandate?", *Health Affairs*, May/June 2009.

payment systems for primary care physicians, expanding the pipeline of individuals going into health professions, increasing support for workforce diversity and expanding financial assistance for individuals in needed professions and shortage areas. A larger, stronger, diverse, cultural competent workforce is crucial to building a healthcare system that works for everyone.

We Must Seize this Moment: Each year we fail to address the growing healthcare crisis, we fail Americans such as Sarah Posekany of Cedar Falls, Iowa. In 2009, we have a historic opportunity to give Sarah the chance to live the American Dream by enacting comprehensive healthcare reform. Sarah is a young adult who has been living with Crohn's disease since she was 15 years old. The disease made it difficult for her to begin college, so she lost eligibility and was dropped from her parents' health insurance plan. Sarah's condition caused her to incur hundreds of thousands of dollars in medical bills as she had multiple surgeries; and she was forced to declare bankruptcy. Sarah is working now, but her plan won't cover her ongoing costs related to treating Crohn's disease for an entire year; and her specialist is not in the plan's network. Sarah wants to enroll in a community college but her poor credit rating disqualifies her from student loans.

Pat DeJong, Sarah Posekany and millions of other hardworking Americans shouldn't have to wait any longer in America for quality, affordable healthcare coverage.

Mr. PALLONE. Thank you, Mr. Rivera.

I wanted to apologize to Mr. Castellani because I said that you represented the Business Roundtable Institute for Corporate Ethics, and apparently it is just the Business Roundtable.

Mr. CASTELLANI. I am president of the Business Roundtable. I am a member of the board of directors of the Business Roundtable Institute for Corporate Ethics. That is probably——

Mr. PALLONE. Oh, I see. OK. Well, thanks for clarifying that.

STATEMENT OF JOHN CASTELLANI

Mr. CASTELLANI. Thank you, Mr. Chairman. I am here on behalf of the members of the Business Roundtable who are the chief executive officers of America's leading corporations. Collectively, they count for more than $5 trillion in annual revenues and 10 million employees but most importantly they provide health care for 35 million Americans. I appreciate the invitation to testify and I share the urgency of this committee and the fellow panelists that health care reform must be addressed now.

Today I want to focus on key three messages. First, we need to get health care costs under control. Second, we must preserve the coverage for those 132 million Americans who receive that coverage from their employer. And third, we need a reformed insurance marketplace so that individuals and small employers can afford and find affordable coverage.

Let me address the draft legislation that you have before the committee. First, let me thank you and the committee of moving forward on health care reform. We view that as very positive and necessary and we want to be constructive in what we believe will work and what we believe will not. We support the provisions that reform the insurance market so that there are more affordable coverage options. The bill also includes a requirement that all Americans get health insurance coverage and includes auto-enrolling for individuals into SCHIP or Medicaid if indeed they are eligible. We support both of those provisions and also support offering subsidies to low-income Americans who cannot afford coverage. The changes that you have included in the Medicare programs and other efforts to make our health care system more efficient are very positive. Medicare payments do need to be adjusted and we will provide the committee with comments on these and other issues.

We do, however, have significant concerns about two major issues in the draft legislation and hope that the committee will consider some revisions. First, ERISA should not be changed if reforms are to be built on the employer-based system. The proposal before you would change some of the ERISA rules. For example, it would impose minimum benefit packages on our employees. Large employers design innovative plans including wellness and prevention initiatives that have been tremendously successful in helping employees take greater control over their own health and yet such programs which we believe are critical to the success of health care reform would be jeopardized by a new federally mandated benefit law.

Second, we are very concerned about public plan proposals that would compete in the private marketplace. As large employers, we are concerned that our employees will suffer from additional cost

shifting that come from inadequate government repayment to the providers. For that reason, we are concerned that the kind of cost shifting that we are dealing with now would be exacerbated. Further, the government plan could erode existing worker coverage if employees seek subsidized lower priced public option that would diminish the people in our plans and would leave employer-sponsored coverage with more expenses, most cost for both employers and employees.

Innovation, which we think is the key to modernizing our health care system and getting our costs under control, benefits improvements and how best to care for patients, we believe come best from the private marketplace. We need to preserve the energy and the commitment to improve our health care market and we are concerned that government plans cannot do that as well as the private sector. We urge the committee to instead create even stronger rules to make the private insurance marketplace more competitive and we want to help in that effort.

Business Roundtable believes that the search for bipartisan consensus can begin by honoring the principles that we have outlined in our written testimony and by crafting reform that is consistent with the uniquely American principles that drive our economy: competition, innovation, choice and a marketplace that serves everyone. On behalf of our members, we pledge to work with you and all the members of the committee to find workable solutions that let people keep what they have today in a reformed health care system that works better for everyone. Thank you.

[The prepared statement of Mr. Castellani follows:]

Business Roundtable

Testimony to

the House Energy and Commerce Committee,

Subcommittee on Health

John J. Castellani

President

Business Roundtable

Thursday, June 25, 2009

I am John J. Castellani, President of Business Roundtable. Chairman Pallone, Chairman Waxman, Congressman Deal, Congressman Barton: I appreciate your invitation to testify before the committee and I look forward to working with you on health care reform legislation that can win bipartisan support in Congress and broad approval among the American people. Business Roundtable believes health care reform should be addressed now as we work our way through these difficult financial times.

Business Roundtable represents the chief executive officers of leading U.S. companies with $4.5 trillion in annual revenues and almost 10 million employees. Member companies account for nearly one-third of the total value of U.S. stock markets and pay over 40 percent of all corporate income taxes to the federal government. More to the point of today's hearing, Business Roundtable companies provide health care coverage to nearly 35 million American workers, retirees and their families.

Health care reform is an enormously complex issue that touches millions of Americans – from the 177 million Americans who receive employer-provided health insurance to the 45 million who lack insurance and must be covered. American business is a critical stakeholder in this debate.

Health Care Reform — An Economic Imperative

Simple mathematics dictates that effective health care reform must start with reducing the rate of increase in health care costs. Virtually all (99 percent[i]) large employers with 200 or more employees offer health benefit coverage. But the cost pressures are tremendous.

Between 1999 and 2008, the cost of health insurance premiums increased by 119 percent – far outstripping the 29 percent rise in inflation.[ii] According to Hewitt Associates, since 2001 alone, health care costs for large employers – such as Business Roundtable members – have more than doubled and are expected to reach $8,863 per employee in 2009, with some employers paying more than $13,000 annually for every employee they cover.[iii] Across the nation, total spending in 2007 was $2.3 trillion or $7,600 for every man, woman and child in America – 16 percent of U.S. gross domestic product (GDP). Unless we take action now to

rein in runaway costs, by 2016 health care spending will consume an estimated $4.2 trillion or a staggering 20 percent of GDP.

To track the impact of the U.S. health care system on our ability to compete worldwide, Business Roundtable recently released our first annual Health Care Value Index. This Index clearly illustrates the disadvantage American companies carry due to our inefficient and costly health care system. If global economic competition were a 100-meter race, the United States would be giving a 23-meter head start to our major economic competitors (Canada, Japan, Germany, France, the United Kingdom) and a 46-meter head start to the three rising economic powers (Brazil, India, China). This is just one of the many ways in which U.S. business is straining to compete globally under the costs of this system.

Domestically, more than 177 million Americans receive health insurance through their employers; so it seems self-evident that any reform effort must build upon the foundation of employer-provided health care. Finding ways to lower costs and expand health coverage—while balancing the impact of any reforms on those who *have* coverage—is challenging.

Most of the 177 million Americans who have employer-based coverage say they are happy with the coverage they receive. Given the limited resources of a tight economy, we must find ways to enact further health care reforms that do not disrupt the coverage of the employed, or place further strain on an already strained federal budget.

To expand coverage for the uninsured while protecting the Americans covered through their employers Business Roundtable believes broad health care reform must be based on four key principles:

1. Creating greater consumer value and efficiency in the health care marketplace;
2. Providing more affordable health insurance options for all Americans;
3. Placing an obligation on all Americans to have health insurance coverage and encouraging all Americans to participate in prevention and chronic care programs; and
4. Offering assistance to uninsured, low-income families to meet their obligation.

In September of 2008, Business Roundtable released its health care reform plan based on these four principles. Let me briefly discuss each one individually and outline how Business Roundtable CEOs believe they would contribute toward creating the kind of bipartisan health care reform legislation this committee desires.

1. Creating Greater Consumer Value and Efficiency in the Health Care Marketplace.

There are many common sense health care reforms that enjoy strong, bipartisan support and would go a long way toward improving the efficiency of our health care system and delivering more value to health care consumers. These include:

- **Promoting the adoption of a uniform, interoperable health information technology (health IT) network**. Every Business Roundtable member has utilized information technology to become more efficient, more productive and more responsive to customers. Replacing the antiquated, pen-and-paper records still widely used in the health care sector with a modern, 21st Century health IT system would save an estimated $81 billion annually and cut down substantially on the 100,000 U.S. deaths every year attributable to preventable medical errors. Congress can enable a national health IT network by creating the standards and incentives necessary to ensure its widespread adoption. Great progress has been made with the passage of the stimulus bill.
- **Ensuring the dissemination of consumer information on the cost and quality of health care, including information that allows consumers to compare the effectiveness of health care services.** Americans today enjoy unprecedented access through the click of a mouse to a wealth of sophisticated information, from which car to buy to how to plan for retirement to which auto insurance plan will save them the most. Yet they remain in the dark when it comes to comparing the effectiveness of doctors, hospitals and medical treatments. This must change.

- **Rationalizing the payment system for both public and private consumers,** including Medicare, to reward the value of services delivered, not simply the volume of care provided.

Empowering consumers with better information that highlights the best providers and treatments through health IT; creating incentives that encourage healthier behavior; and revising the payment structure to reward value of care over volume: these are the essential building blocks of a modern, 21st Century American health care system. Harvard University economics professor David Cutler recently estimated that these and other steps to modernize our health care system would save $9 trillion over the next 25 years – more than enough to cover the cost of providing coverage to the uninsured.[iv]

2. Providing More Affordable Health Insurance Options for All Americans

Out of the 177 million Americans who receive coverage through their employers, 132 million are insured by private companies. Almost all U.S. private employers offer health plans that are governed by the federal Employee Retirement Income Security Act, or ERISA. This law establishes fiduciary requirements, administrative requirements, and procedures to resolve problems in the plans. Tampering with ERISA could well endanger coverage for the 132 million Americans who receive health benefits from private employers. Indeed, it could cause the end of employer-provided care as we know it today.

It makes absolutely no sense to begin health care reform by threatening to disrupt coverage for 132 million Americans. Instead, we encourage the committee to preserve ERISA – the bedrock of employer-provided coverage. The federal ERISA statute gives employers the flexibility to design and finance plans that meet their employees' needs — a system that has proven successful in making coverage widely available to workers.

Americans who do not have access to employer-sponsored coverage must rely on the health insurance marketplace for their coverage. The structure of the market itself is state-by-

state. This marketplace has become inflexible, highly segmented, overly prescriptive, and is afflicted with dueling mandates, rules and regulations.

Business Roundtable believes there should be national rules governing the insurance marketplace that could be enforced by the states. Certain state rules, such as state solvency requirements and consumer protections, would continue to apply. This would allow for greater consistency in applying other rules, such as rate setting, guaranteed issue requirements, and risk adjustments and reinsurance issues would need to be explored.

3. Placing an Obligation on All Americans to Have Health Insurance Coverage

When it comes to heath care reform, ERISA isn't broken and does not need fixing. What is broken is a system that allows 45 million Americans to fall through the cracks, with no insurance coverage. Any attempt to provide health benefits to these 45 million people must start with an understanding of exactly who they are and why they lack coverage. Of the 45 million Americans who have no health coverage:

- 4.7 million are college students;
- Slightly fewer than 10 million are non-citizens;
- About 11 million are currently eligible for public programs, such as Medicaid and SCHIP, but they have not enrolled; and
- More than 9 million have household incomes over $75,000, but do not purchase or elect employer-sponsored coverage.

Clearly a "one-size-fits-all" solution will not address the problems of a 45 million-person group that is hardly monolithic. For many of these Americans, obtaining coverage isn't so much financial, as it is structural. To reduce the ranks of the uninsured, we need a competitive system that provides Americans with affordable options that are suitable for their families. As part of that compact, Business Roundtable believes that all Americans have

an obligation to obtain insurance coverage — through auto-enrollment or some other mechanism.

Many large employers already auto-enroll their employees into employer-sponsored health insurance coverage. This concept could be expanded to ensure broader coverage for the millions of American who, for one reason or another, are electing *not* to be insured. Many health care reform proponents have proposed creating a penalty for those who can afford insurance but do not elect coverage. Business Roundtable is open to this idea and to other suggestions aimed at achieving broader coverage.

As I discussed earlier, Business Roundtable also supports encouraging all Americans to participate in employer- and community-based prevention and chronic care programs. More needs to be done to educate and encourage participation.

4. Offering Health Coverage and Assistance to Low-Income, Uninsured Individuals and Families

For some low-income uninsured families, health care coverage is unaffordable. We believe that the government should provide financial assistance so that low-income individuals and families can purchase coverage from the private market. These targeted subsidies would be funded from the cost efficiencies gained by improving the healthcare marketplace. We want this assistance to be used either in the newly established health insurance marketplace or by paying the individual's portion of the premium if they are eligible for employer-sponsored health insurance coverage.

Positive Aspects of the Tri-Committee Bill

Some aspects of the draft Tri-Committee bill create an important foundation for health care reform. First, it recognizes that we need insurance market reforms to enable more affordable coverage options. It supports greater efforts to get Americans enrolled in programs for which they are eligible. For example, the bill would auto-enroll individuals into CHIP or

Medicaid if they are eligible. It would also offer coverage to low-income Americans who cannot afford coverage. Finally, the Tri-Committee approach places an obligation on all eligible Americans to have health insurance coverage. Such coverage, of course, must be affordable.

In addition, it is necessary to enact many of the bill's changes to the Medicare program and other efforts to make our health care more efficient. Business Roundtable supports changes that will improve the health care system. Medicare payments need to be adjusted. We will be providing the Committees with comments on these and other issues.

Health Care Reform Cautions

While there are many positive aspects of the Tri-Committee health care reform proposal, we have significant concerns with two major issues in the draft legislation and hope that you will consider some revisions.

First, preservation of ERISA is critical if reforms are to be built on the employer-based system. The Tri-Committee health care reform proposal would erode the flexibility in ERISA by requiring all health insurance coverage to ultimately meet similar requirements with which insurers must comply. It would also impose minimum benefit packages on our employees. Large employers have already designed innovative plans – including wellness and prevention initiatives– that have been tremendously successful at helping employees take greater control over their health. This approach has real potential to reduce national health care costs. And yet such programs – critical to the success of health care reform – would be jeopardized by new federally mandated benefit laws.

Second, we are very concerned about "public plan" proposals that would undermine the private marketplace. Government will never have the same cost structure as a private company, so there can never be a level playing field. There is a danger that many employees will abandon employer-provided plans, leaving our risk pools unsustainable and threatening coverage for all our employees that are happy with their current plan. Moreover, we are concerned that inadequate government payments to providers will shift additional costs to our employees. Finally, "public plans" have less incentive to innovate and capture more efficient

ways to deliver care. Instead, we urge the Committee to create even stronger rules to make the private insurance market more competitive and affordable, and we pledge to support that effort.

Conclusion

Business Roundtable understands that effective legislation will require individuals, employers, providers, insurers, and the government to work together to find the right balance to preserve what is working with our current health care system – such as employer-provided coverage enabled by ERISA – while fixing what is wrong – such as ensuring all Americans have access to affordable, quality coverage and reining in soaring health care costs.

Given the scope, complexity and cost of health care reform, bipartisan support is necessary for any legislation that will win the lasting endorsement of the American people and endure past the current political season. Health care reform is simply too important to pass on a narrow, partisan basis. Business Roundtable believes that the search for bipartisan consensus can begin by honoring the principles we have outlined and by crafting reform that is consistent with the uniquely American principles that drive our economy: competition, innovation, choice and a marketplace that serves everybody.

On behalf of Business Roundtable Members, I pledge to work with you, and all Members of this Committee, to find realistic solutions to this national problem. Thank you again for the opportunity to testify today.

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[i] Kaiser Family Foundation from Kenneth L. Sperling, Hewitt Associates, testimony before Senate Finance Committee, 5/5/09.
[ii] Henry J. Kaiser Family Foundation, *Health Care Costs: A Primer*, 2009.
[iii] Kenneth L. Sperling, Hewitt Associates, testimony before Senate Finance Committee, 5/5/09.
[iv] David M. Cutler, Center for American Progress, *Health System Modernization Will Reduce The Deficit*.

Mr. PALLONE. Thank you.
Mr. Sheils.

STATEMENT OF JOHN SHEILS

Mr. SHEILS. Hello. Good afternoon, Mr. Chairman. My name is John Sheils. I am with the Lewin Group, and I have specialized over the years in estimating the financial impact of health reform proposals. We got your bill on Friday and immediately went about doing some preliminary estimates on coverage and the impact on provider incomes. Allison is going to help me with some slides.

[Slide.]

The first slide, the system that the bill would establish begins with, we have new health insurance exchange. The exchange would provide a selection of coverage opportunities. Most of them are private coverage that we are familiar with but it would also offer a new public plan. The impact that this program will have on coverage is going to be drive by the groups that you are permitted to enroll. The program would allow individuals, self-employed and small firms, at least in the first year, to go through the exchange to obtain their coverage. In the third year, the newly established commissioner would have the authority to open the exchange to firms of all sizes. The new public plan, we predict, will attract a great many people because the premiums in the public plan will be much lower than for private insurance, and because of that, we think that a great many people are going to be attracted to it. Let us discuss that a little bit.

[Slide.]

On the next slide, we summarize some of the payment rates on the left side. You are using the Medicare hospital reimbursement methodology, and under Medicare, payments are equal to about 68 percent of what private payers have to pay for the same services. For physicians' care, you pay about—well, Medicare pays about 81 percent of what private insurance pays. You are going to be adding another 5 percent to that, so we are looking at about 85 percent of private payers. And we also have some information here on what happens to insurance administrative costs in the exchange. The public plan will not have to worry—need an allowance for profits and it will not pay commissions for brokers and agents.

[Slide.]

The next chart shows what happens to premiums. For family coverage for the enhanced benefits package described in your legislation, in the private sector it would cost about $917 per family per month. Under the public plan, it would cost about $738 per family per month. That is savings of about $2,200 a year, and we think that is going to draw a lot of people into the public plan. Next page.

[Slide.]

On the right-hand side, we illustrate what happens to coverage when the plan is open to all firms. The program would reduce the number of uninsured by about 25 million people. There would be an increase in Medicaid enrollment of about 16 million people but we find 123 million people going into the public plan. That is a reduction in private coverage of about 113.5 million people. That is about 66 percent of all privately insured persons. This of course is if and when the plan is opened up to firms of all sizes. If it is lim-

ited to just firms less than 10 workers as in the first year, you still get a reduction of about 25 million people uninsured, still 16 million people with Medicaid coverage but private coverage would drop by about 20 million people. The public plan coverage would be 29 million people. Next chart, please.

[Slide.]

This chart summarizes what happens to provider incomes under the plan. On the right-hand side, we have the scenario where all firms are eligible to participate in the program. Hospital margin, which is hospital profit, net income basically, would be reduced by about $31 billion because of that. That is about a 70 percent reduction in hospital margin. Physician net income would go down by about $11 billion. That comes to, in terms of net income, that is an average of about $16,000 per year reduction in net income per physician. On the left-hand side, we show what is happening in the small firms, and this is really interesting because under this scenario provider incomes actually go up. For instance, hospital margin goes up by about $17 billion. Much of this has to do with the fact that we will have reduced uncompensated care and they will be paid for services they were providing for free before, and there will be new services they will provide to newly insured people. The physician net income would go up by about $10 billion, and the increase in income there is largely driven by the fact that you are going to increase payments for primary care under the Medicaid program.

That sums it up, and I am out of time so I will turn it over to my colleague here.

[The prepared statement of Mr. Sheils follows:]

The Impact of the House Health Reform Legislation on Coverage and Provider Incomes

Testimony before the Energy and Commerce Committee,
U.S. House of Representatives

John Sheils

Vice President

The Lewin Group

Thursday June 25, 2009

The LEWIN GROUP
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About The Lewin Group

The Lewin Group is a health care and human services policy research and management consulting firm. We have over 25 years of experience in estimating the impact of major health reform proposals. The Lewin Group is committed to providing independent, objective and non-partisan analyses of policy options. In keeping with our tradition of objectivity, The Lewin Group is not an advocate for or against any legislation. The Lewin Group is part of Ingenix, Inc., which is a wholly owned subsidiary of the UnitedHealth Group. To assure the independence of its work, The Lewin Group has editorial control over all of its work products.

Summary and Introduction

The House bill includes a public plan as part of a broad health reform proposal that would expand health insurance coverage. The program expands increases Medicaid eligibility to 133 percent of the federal poverty level (FPL) and provides individual subsidies for the purchase of insurance for people between 133 percent and 400 percent of the FPL. Tax credits are available to small employers who purchase coverage, while larger employers are also required to contribute to the cost of coverage for workers. Individuals who do not have coverage would be fined 2.0 percent of their income up to the national average premium amount.

The bill would permit individuals and employers to purchase health insurance from a newly created "public plan" modeled on Medicare. The public plan would compete for enrollment with private insurers in a newly formed network of "exchanges" that present a selection of competing health plans to consumers. The public plan would be required to follow the same rules concerning pre-existing conditions and premium rating practices that apply to private plans.

We estimate that the public plan under the House bill would have premiums that are 20 percent to 25 percent less than for comparable private coverage. The bill specifies that the program would pay providers at Medicare levels, which are 20 percent to 30 percent less than what private plans pay for the same services. The bill would pay physicians at Medicare levels plus 5 percent if the provider agrees to serve both Medicare and public plan participants. Also, the public plan does not require an allowance for profits and there would be no broker/agent commissions.

We estimate that the bill would cover about 24.0 million of the 48.9 million people that we estimate will be uninsured in 2010 (***Figure ES-1***). Medicaid enrollment would increase by 16.0 million people. If the plan is implemented without a public plan option, the number of people with private insurance coverage would increase by 8.0 million people.

The public plan under the House bill would result in a substantial decline in the number of people with private insurance coverage, even in the early years of the program. In the first year of the program, individuals and firms with fewer than 10 workers are eligible to enroll in the public plan. We estimate that enrollment in the public plan would be 29,300 people in that year, with a reduction in private coverage of 20,600 people. In the second year, the bill extends eligibility to firms with fewer than 20 workers as well. Thus, in the second year, private insurance coverage would decline by 30.8 million people.

Beginning in the third year, the newly established "Health Choices Commissioner" would be permitted to extend eligibility to include all employers. If the plan is opened to individuals and all employers, the number of people in the public plan would rise to 122.9 million people. Private coverage would decline by about 113.5 million people.[1]

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[1] In an earlier analysis, we estimated that a public plan open to individuals and all employers using Medicare payment levels would reduce the number of people with private coverage. The reduction in coverage is smaller under the House bill because it pays physicians and other professionals Medicare payment levels plus 5 percent.

Figure ES-1
Changes in Hospital and Physician Net-Income under Alternative Public Plan Scenarios [a/]

		Groups Eligible for the Public Plan		
	No Public Plan	Year 1: Individuals and Firms with Fewer than 10 Workers	Year 2: Individuals and Firms with Fewer than 20 Workers	Year 3: Individuals and All Firms
Coverage Effects (millions)				
Public Plan Enrollment	n/a	29.3	39.8	122.9
Change in Medicaid	16.0	16.0	16.0	15.8
Change in Private Coverage	8.0	-20.6	-30.8	-113.5
Change in Uninsured	-24.0	-24.7	-25.0	-25.2
Physician Impacts				
Change in Net-income (billions)	$14.2	$10.9	$7.3	-$11.5
Percentage Change in Net-income	6.6%	5.0%	3.3%	-5.4%
Change in Net-income Per Physician in 2010	$19,795	$15,237	$10,141	-$16,207
Hospital Impacts				
Change in Net-income (billions)	$22.0	$17.5	$12.2	-$11.5
Percent Change in Net-income	44%	35%	24%	-63%
Total Hospital Margin (Currently 6.0 Percent)	8.6%	8.1%	7.4%	2.2%

a/ All scenarios assume an expansion in health insurance coverage modeled on the description of the draft House bill as of June 19, 2009.
Source: The Lewin Group estimates.

In the first year of the program, physician income would increase by $10.9 billion. This reflects the reduction in uncompensated care for uninsured people as well as increased health services utilization for newly insured people. It also reflects the House bill provisions that would increase Medicaid reimbursement for primary care services to Medicare payment levels. Thus, the reductions in payment for people who shift to the public plan are outweighed by increases in reimbursement for Medicaid, reductions in uncompensated care and revenues from increased service use for newly insured people. Average net-income per physician would increase by $15,237 in 2010 under this scenario.

Physicians would see an $11.5 billion reduction in net-income if the public plan is opened to individuals and firms of all sizes. Here, the reductions in payments for people shifting to the public plan would be greater than the increases in net income due to increased Medicaid payment levels and new service utilization for newly insured people. The loss of net-income would average $16,200 per physician.

Hospital net income would increase by $17.5 billion in the first year of the program. This reflects reductions in uncompensated care and increased service utilization for newly insured people. However, if the public plan is opened to individuals and all employers, hospital net-income

would fall by $11.5 billion. This reflects reductions in reimbursement for services provided to those who shift from the private coverage to the public plan.

In this study, we present estimates of the effect of the House bill on coverage and provider revenues under several variations on the design of the public plan. Our analysis is presented in the following sections:

- Health reform and the public plan;
- Premiums in the public plan;
- Coverage effects; and
- Provider impacts.

A. Health Reform and the Public Plan

The House bill includes a public plan as part of a broad health reform proposal to expand health insurance coverage. The program expands Medicaid eligibility to 133 percent of the federal poverty level (FPL) and provides individual subsidies for the purchase of insurance for people between 133 percent and 400 percent of the FPL. Tax credits are available to small employers who purchase coverage, while larger employers are also required to contribute to the cost of coverage for workers. The key features of his campaign proposal include:[2]

- Once fully implemented, all individuals are required to have coverage except in hardship cases, which we define to be people who are unable to obtain coverage for less than 10 percent of their income. Uninsured pay a penalty equal to 2.0 percent of income up to the national average premium amount;
- Medicaid eligibility is expanded to include all individuals living below 133 percent of the Federal Poverty Level (FPL), including able-bodied adults without custodial responsibilities for children;
- Sliding scale affordability tax credits are provided to people purchasing private insurance who live between 133 percent and 400 percent of the FPL;
- Medical underwriting and health status rating is eliminated in all insurance markets, and caps rate variation by age to a 2:1 rating band;
- Medium and large employers are required to offer insurance or pay a payroll tax (assumed to be 8.0 percent); and
- Tax credits are provided to small employers who purchase coverage.

The House bill would create an "insurance exchange" in each area of the country. The exchange would provide a selection of private health plans competing on the basis of price and quality, including HMOs and private fee-for-service plans such as Preferred Provider Organizations (PPOs). All individuals and self-employed people would be permitted to purchase coverage through the exchange. In addition, it would be open to employers as follows:

- Year 1: Individuals and employers with 10 or fewer workers;
- Year 2: Individuals and employers with 20 or fewer workers; and
- Year 3: Individuals and employers of any size allowed by a newly established "Health Choices Commissioner."

One of the coverage options offered through the exchange would be a new public plan, modeled on Medicare. People would pay actuarially determined premiums set to be sufficient to fully fund coverage provided through the public program. The health insurance affordability tax credit for individuals created under the program could be used to help pay the premium. Because Medicare and other government programs pay providers substantially less than private insurers, premiums for the public plan could be substantially less than comparable coverage in a private plan.

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2 "McCain and Obama Health Care Policies: Cost and Coverage Compared," The Lewin Group, October 8, 2008.

The House proposal would rely upon a newly formed Health Benefits Advisory Committee to specify a new essential benefits package. This new essential benefit package will serve as the basic benefit package for coverage in the exchange and over time will become the quality standard for employer plans. It includes preventive service at no cost sharing, mental health services, dental and vision for children, and caps the amount of money a person or family spends on covered services in a year. There would be four benefits levels:

- Essential/Basic: 70 percent actuarial value;
- Enhanced: 85 percent actuarial value;
- Premium: 95 percent actuarial value; and
- Premium Plus: Includes additional benefits (e.g., adult dental and vision).

In this analysis, we estimate the impact of the House bill on coverage and provider incomes under five alternative public plan designs including:

- Coverage expansion without a public plan;
- Year 1: A public plan open to individuals and firms with 10 or fewer workers;
- Year 2: A public plan open to individuals and firms with under 20 workers;
- Year 3: A public plan open to individuals and all employers.

The legislation specifies that payment levels in the public plan would be based upon Medicare payment levels. Physicians and other health professionals would receive an extra 5 percent if they agree to participate in both Medicare and the public plan. Also, Medicaid payment levels would be increased to Medicare levels for primary care providers under the Medicaid program.

We used The Lewin Group Health Benefits Simulation Model (HBSM) to simulate the effect of these variations assuming that each scenario is fully implemented in 2010.[3]

B. Premiums in the Public Plan

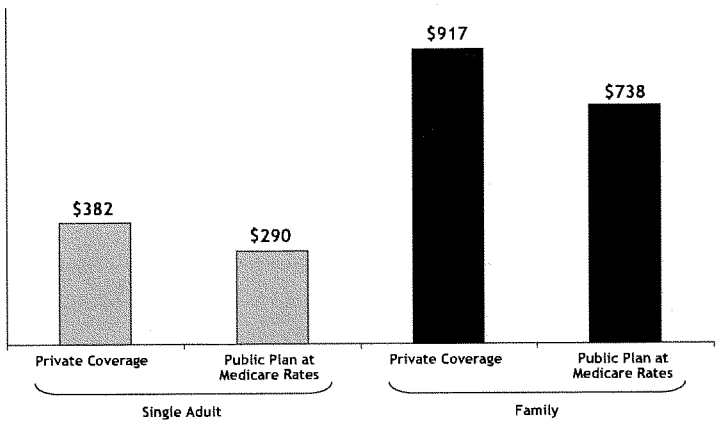
We estimated the premium for private health plans and the public plan under each of the four scenarios described above for the various benefits packages. These estimates are based upon the demographic and health characteristics of the population eligible to enroll in the exchange. They also reflect differences in administrative costs and the levels of benefit management under plan alternatives. However, the most important driver of premiums in the public plan will be provider payment levels.

For illustrative purposes, we provide in this section a detailed description of how we estimated premiums for insurance in the exchange assuming that all firms are eligible to participate in the exchange. To assure comparability, both premiums were estimated using an identical benefits package for a uniform population with identical characteristics. These include all people now covered under private insurance. For illustrative purposes, we present our estimates of

[3] "The Health Benefits Simulation Model (HBSM): Methodology and Assumptions," The Lewin Group, February 19, 2009.

premiums for the "Enhanced" benefits package under the House bill. The average premium per privately insured family in 2010 would be $917 per month for private coverage compared to $738 per month under the public plan (*Figure 1*).

Figure 1
Cost of the "Enhanced" Benefits Package under Private Coverage and the Public Plan under the House Bill [a/]



a/ Premiums are estimated for people with private coverage under current law. Family coverage includes families, couples and single parent households.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Thus, premiums for the public plan would be 20 percent to 25 percent less than less than for comparable private coverage. For some individuals and small employers, savings would be 30 percent or more. These savings derive primarily from the fact that provider payment levels under Medicare are substantially lower than for private payers. Also, the public plan would not include an allowance for profit or broker commissions, further reducing the public plan premium.

The premiums for each of the three public plan scenarios were estimated for the populations eligible to participate under each option (e.g., small firms, large firms etc.) For illustrative purposes, we present in a detailed description of the approach used to estimate premiums per policy holder (i.e., average across individual and family policies) using payment levels (*Figure 2*). In addition to payment levels and administrative costs, these estimates reflect the impact cost-shifting, risk selection and differences in utilization review practices.

Figure 2
Monthly Premiums per Policy Holder under Private Insurance and the Public Plan for the "Enhanced" Benefits Package under the House Bill in 2010 [a/]

	Premiums in Public Plan per Policy Holder			Private Plan Premiums per Policy Holder		
	Benefits Costs	Administration	Total	Benefits Costs	Administration	Total
Public Plan Available to individuals and all Employers						
Current Law Premiums: All Firms	$565.36	$77.45	$642.81	$565.36	$77.45	$642.81
Changes in Premiums						
Payment Level Adjustment [b/]	-$123.52	$0.00	-$123.52	$0.00	$0.00	$0.00
Administrative Savings	$0.00	-$37.89	-$37.89	$0.00	$0.00	$0.00
Selection Effects	$32.99	$0.00	$32.99	-$29.60	$0.00	-$29.60
Reduced Utilization Review	$26.90	-$2.96	$23.94	$0.00	$0.00	$0.00
Cost Shift	$0.00	$0.00	$0.00	$54.12	$0.00	$54.12
Total Premiums Under Public Plan for Individuals and all Employers						
Total	$501.75	$36.6	$538.35	$589.88	$77.45	$667.33

a/ Premiums for policy holders with private coverage under current law. Premiums are an average across family and individual policies.
b/ Assumes provider payment levels are set at Medicare payment levels, with physicians and other professionals receiving an additional 5 percent if they accept patients from both the public plan and Medicare.
Source: Lewin Group Estimates Using the Health Benefits Simulation Model (HBSM)

We estimated these premiums in several steps described in the following sections:

- Provider Payment levels;
- Public plan administrative costs;
- Elimination of utilization review;
- Cost-shifting; and
- Enrollment and risk selection.

1. Provider Payment Levels

Provider payment levels for hospital services under Medicare are equal to only about 68.0 percent of what is paid by private health plans for the same services (***Figure 3***). In fact, Medicare payments to hospitals are equal to only about 91 percent of the actual cost of the services provided.[4,5] For physician services, Medicare pays only about 81.0 percent of what is paid by private health plans for the same services.[6]

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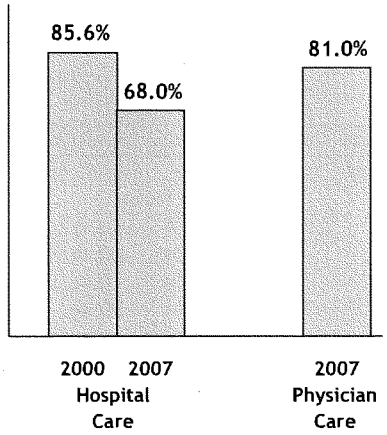
4 American Hospital Association, "Trends Affecting Hospitals and Health Systems," TrendWatch Chartbook, April 2008.

Figure 3
Medicare Provider Payments as a Percent of Private Payer Rates



Source: American Hospital Association, "Trends Affecting Hospitals and Health Systems," TrendWatch Chartbook April 2008; "Report to Congress: Medicare Payment Policy," Medicare Payment Advisory Commission (MedPAC), March 2008; and State Health Facts, The Kaiser Family Foundations (KFF), 2003 report.

For illustrative purposes, we assume that all physicians and other professionals would agree to see both public plan and Medicare patients. Based upon these figures, we estimate that average payments for hospitals and other providers under a public plan using Medicare payment rates would be roughly 25 percent less than under private health plans.

As shown in ***Figure 3***, the disparity between public and private payments for hospitals has grown in recent years. Medicare payment rates for hospitals have fallen from 85.6 percent of private sector payments in 2000 to 68.0 percent in 2007. This disparity could continue to grow into the next decade, suggesting that our use of payment differentials in 2007 may understate our estimate of the impact on provider incomes for 2010.

2. Administrative Costs

Administrative costs are also expected to be lower in the exchange than in the private market. We estimate that administrative costs for individuals and small firms under current law equal 26.8 percent of benefits costs (i.e., claims costs). We estimate that administrative costs in the exchange for individuals and small firms would be equal to 17.9 percent of benefits costs

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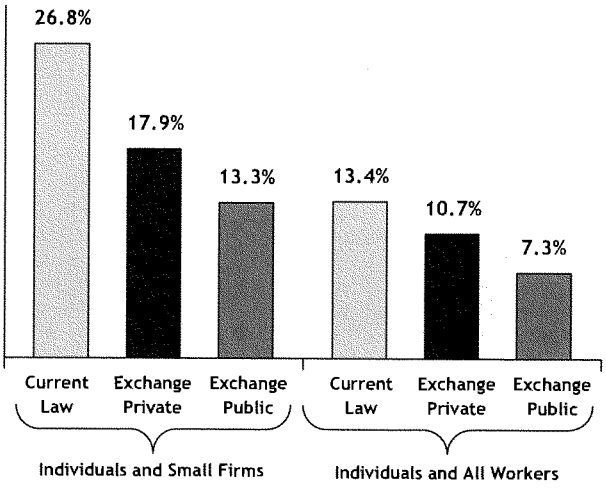
[5] Lewin Group estimates that Medicare allowable costs were 7 percent to 8 percent less than hospital's reported costs in 2007. Unlike the AHA data used here, this estimate does not include the Medicare non-allowable costs (e.g., advertizing, entertainment, penalties, gifts, donations, employee education, etc.).

[6] State Health Facts, The Kaiser Family Foundations (KFF), 2003 report

(***Figure 4***). This is based upon actuarial estimates of how administrative costs are reduced through economies of scale in insurance pools.[7]

Figure 4
Administrative Costs as a Percent of Claims Cost



Source: The Lewin Group estimates. See administrative cost section below.

We assume that administrative costs in the public plan would be the same as for other plans in the exchange, with the exception that the public plan would not include an allowance for insurer profit and insurance agent and broker commissions and fees. Administrative costs for individuals and small employers in the public plan would be about 13.3 percent of benefits costs. If extended to employers of all sizes, administrative costs in the public plan would average about 7.3 percent of claims costs.

Thus, our administrative cost estimates are based upon costs for private health plans rather than Medicare, which we adjusted for the elimination of profits and agent/broker commissions. We chose this approach because the Medicare administrative cost figures for the existing Medicare program do not reflect the cost of administering changes in coverage over time as people change jobs.

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[7] Hay/Huggins data as appeared in: "Cost and Effects of Extending Health Insurance Coverage," The Congressional Research Service, 1989.

3. *Utilization Review and Costs*

Premiums in the public plan would also differ from private plans due to differences in the level of utilization management. Private insurers typically employ utilization management programs designed to avoid unnecessary utilization of health services. These include pre-certification for high-cost procedures, disease management, concurrent utilization review and discharge planning. These approaches are also emphasized in integrated delivery systems such as HMOs to keep patients healthy and to improve efficiency. While the Medicare program does have some pre-certification requirements, they are less extensive than those used in most private plans. Therefore, we adjusted the public plan premiums to reflect that these utilization review processes are less widely used in Medicare.

At the beginning of Title XVIII of the Social Security Act, it reads:

> *Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.*

The language essentially precludes the Centers for Medicare & Medicaid Services (CMS) from administering prior authorization procedures in the Medicare FFS program. In fact, the Government Accounting Office (GAO) recently recommended that CMS consider a front-end payment safeguard mechanism such as prior authorization in response to the rising utilization of advanced imaging procedures.[8] We have even seen prior authorization for imaging services as a recommendation in President Obama's budget projections and scored by the Congressional Budget Office, but at this point CMS is basically limited to setting coverage limits and retrospective medical necessity payment reviews and has acknowledged that prior authorization may not be applicable in the Medicare FFS program.[9] For this reason, the Medicare program does not utilize as many payment safeguard mechanisms as can be utilized in the private insurance sector.

Studies of private utilization management programs have shown that these programs reduce health spending. A study by Feldstein et al. showed that these utilization review methodologies reduced plan costs by 8.4 percent.[10] They found that these programs saved plans eight dollars for every dollar spent by the insurer to administer them. A study by Wickizer showed savings of six

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[8] Government Accounting Office. June 2008. *Medicare Part B Imaging Services: Rapid Spending Growth and Shift to Physician Offices Indicate Need for CMS to Consider Additional Management Practices.* GAO-08-452 <Available as of June 22, 2009 at http://www.gao.gov/new.items/d08452.pdf>.

[9] Congressional Budget Office. December 2008. *Budget Options Voulme 1: Health Care;* Government Accounting Office. June 2008. *Medicare Part B Imaging Services: Rapid Spending Growth and Shift to Physician Offices Indicate Need for CMS to Consider Additional Management Practices.* GAO-08-452 <Available as of June 22, 2009 at http://www.gao.gov/new.items/d08452.pdf>.

[10] Feldstein, P., Wickizer, T. and Wheeler, J., "The Effects of Utilization Review of Health Care Use and Expenditures," ***NEJM***, 1988; 318:1319-4, Volume 3

percent.[11] Another more recent study showed savings of about four percent in PPOs and eight percent in HMOs.[12] These estimates do not include the provider's cost of complying with utilization review.

In this study, we assumed that Medicare engages in about one-third of the utilization review used in private health plans. This resulted in an average increase in costs once enrolled in the public plan of 5.4 percent. We assumed that administrative costs in the public plan are reduced by 0.5 percent of benefits costs to reflect administrative savings from less extensive utilization review programs.

4. Cost-Shifting under Public Plan

The coverage expansions and the public plan would affect provider payments for private coverage through the "cost-shift." In today's system, hospitals and physicians provide a substantial amount of free care to uninsured people called "uncompensated care." Also, payments for Medicare and Medicaid are usually less than the cost of the services provided resulting in payment shortfalls. Hospitals and physicians cover the cost of uncompensated care and payment shortfalls under public programs by increasing charges for private health plans in a process known as cost-shifting.

In this analysis, we assumed that a portion of the reductions in uncompensated care resulting from an expansion in coverage would be passed back to privately insured people as a reduction in the cost-shift. This would take the form of a reduction in the rate of growth in provider charges. However, a public plan that pays providers at Medicare levels would increase shortfalls in reimbursement, resulting in increased cost-shifting to private payers. The net effect on provider incomes will depend upon the amount of the payment shortfall relative to the savings in uncompensated care.

The available research shows that not all of uncompensated care and government payment shortfalls are passed on to private payers as higher charges. There are two separate studies indicating that about one-half of hospital payment shortfalls are passed on to private payers in the form of higher charges.[13] However, two other studies showed considerably less evidence of hospital cost-shifting, although they did not rule out a partial cost-shift.[14] One study of physician pricing by Thomas Rice et al., showed that for each one percent reduction in physician payments under public programs, private sector prices increased by 0.2 percent.[15] Our own analysis of hospital data indicates that about 40 percent of the increase in hospital payment shortfalls (i.e.,

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[11] Wickizer, Thomas, "The Effects of Utilization Review on Hospital Use and Expenditures: A Covariance Analysis," *Health Services Research*, May 16, 1991.

[12] Stapleton, D., "New Evidence on Savings from Network Models of Managed Care," (a report to the Healthcare Leadership Council), The Lewin Group, Washington, DC, May 1994

[13] Dranove, David, "Pricing by Non-Profit Institutions: The Case of Hospital Cost Shifting," *Journal of Health Economics*, Vol. 7, No. 1 (March 1998); and Sloan, Frank and Becker, Edward, "Cross-Subsidies and Payment for Hospital Care," *Journal of Health Politics, Policy and Law*, vol. 8., No. 4 (Winter 1984)

[14] Zuckerman, Stephen, "Commercial Insurers and All-Payer Regulation," *Journal of Health Economics*, Vol. 6. No. 2 (September 1987); and Hadley, Jack and Feder, Judy, "Hospital Cost Shifting and Care for the Uninsured," *Health Affairs*, Vol. 4 No. 3 (Fall 1985)

[15] Rice, Thomas, et al., "Physician Response to Medicare Payment Reductions: Impacts on public and Private Sectors," Robert Wood Johnson Grant No. 20038, September 1994.

revenues minus costs) in public programs were passed-on to private-payers in the form of the cost-shift during the years studied.[16] Based upon this research, we assume that 40.0 percent of changes in uncompensated care and payment shortfalls are passed on to private payers in the form of reduced charges.

We estimate that premiums for privately insured people would increase by about $460 per privately insured person under a public plan available to all individuals and employers using Medicare payment rates. This reflects the shortfalls in payments under the new public plan which is partially offset by the reduction in uncompensated care resulting from expanded coverage and increases in Medicaid reimbursement for primary care services under Medicaid.

5. *Enrollment and Risk-Selection*

In this step, we use HBSM, a micro-simulation model of the US health care system, to identify privately insured individuals and employers who would be eligible to purchase coverage at a lower cost through the public plan. We then simulate their decision to shift to the public plan based upon studies of how people respond to changes in the relative price of insurance within employer groups offering a choice of health plans.[17] We simulate these shifts in a two step process that allocates affected people into one of the following three groups:

- People who remain with their current private health plan rather than shifting to the public plan;
- People who drop private coverage to enroll in the public plan due to the lower premiums; and
- People who leave the public plan to enroll in a lower cost HMOs.

In the first step, we model the shift of privately insured individuals to the lower cost public plan. We do this using "plan change price elasticity" estimates developed by Strombom et al., showing that on average, a 1.0 percent decrease in the price of an alternative source of coverage is associated with a 2.47 percent migration of enrollees to the lower cost health plan.

The study shows that younger and healthier people are more likely to change plans in response to a change in premiums. This is consistent with the idea that older and sicker people are more likely to resist changing plans if it means their physician is not in the plan's provider network. These estimates are consistent with other studies showing that people leaving fee-for-service (FFS) health plans for HMOs and other managed care plans tend to have lower costs than those who remain with FFS plans.[18]

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[16] Sheils, J., Claxton, G., "Potential Cost Shifting Under Proposed Funding Reductions for Medicare and Medicaid: The Budget Reconciliation Act of 1995," (Report to the National Coalition on Health Care), The Lewin Group, December 6, 1995

[17] Strombom, B., Buchmueller, T., Feldstein, P. "Switching Costs, Price Sensitivity and Health Plan Choice," *Journal of Health Economics*, 21 (2002), 89-116.

[18] David M. Cutler and Richard J. Zeckhauser, "Adverse Selection in Health Insurance," National Bureau of Economic Research, working paper 6107, July 1997; and Paolo Belli, "How Adverse Selection Affects the Health Insurance Market," Harvard School of Public Health.

In the second step we model risk selection against the public plan. Some managed care plans would develop products that tend to attract younger and healthier people through benefit designs or marketing practice. This would tend to leave the public plan with higher cost individuals. We simulate this by assuming that private HMOs are able to offer a product that is four percent less costly than the premium for the public plan. This assumption is based upon research showing that utilization of health services in HMOs is about four percent less than in PPO and other FFS plans.

Using this approach, we estimate that the public plan would experience adverse selection of about 7.1 percent. This would be met with favorable selection of about 5.0 percent in the remaining private insurance markets (including private plans in the exchange). This is a differential of about 12.7 percent between the two groups, over and above what is corrected for with age rating. In this scenario, we have assumed the use of age-rating with a 2 to 1 ratio between the highest and lowest cost age groups, with no premium adjustment for health status.

The Strombom results were within the range of the available estimates of the price response due to changes in the relative prices of insurance. Several estimates of price elasticity of demand from previous research have ranged from -0.8 to -6.175 depending on the types of plans analyzed, as well as variations in the models used to estimate the price elasticity.[19] We selected the work of Strombom et al. because it allows us to show how the price response varies with age and health status.

B. Coverage Effects

We estimate that there will be about 48.9 million uninsured people in 2010. If the House bill were implemented without a public plan, about 24.0 million of these uninsured would become covered (***Figure 6***). Medicaid enrollment would increase by 16.0 million people. There would be a net reduction in the number of people with employer coverage of about 3.6 million people, despite the "pay-or-play" mandate. This is because many employer groups will find it less costly for workers to purchase non-group coverage with the assistance of the new subsidies, than it is to continue to provide insurance. The number of people with non-group coverage would increase by 11.6 million people, largely due to the affordability tax credits provided for the purchase of private coverage for those not eligible for employer insurance.

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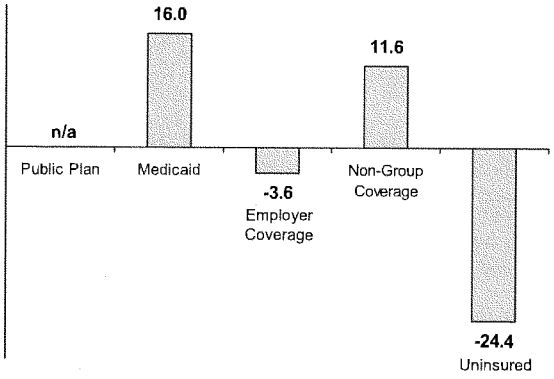
[19] Royalty AB and Solomon N. 1999. "Health Plan Choice: Price Elasticities in a Managed Competition Setting," *The Journal of Human Resources*, 34(1): 1-41; Buchmueller TC and Feldstein PJ. 1996. "The Effect of Price on Switching Among Health Plans," 16(1997): 231-247. Cutler DM, Reber S. 1996. "Paying for Health Insurance. The Tradeoff between Competition and Adverse Selection," *NBER Working Paper #5796*.

Figure 6
Change in Sources of Coverage under The House Bill Assuming no Public Plan



Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

These shifts in coverage would differ depending upon the groups of firms that would be eligible to enroll. In the first year, the public plan would be open to individuals and firms with fewer than 10 workers. Under this scenario, 29.3 million people would be enrolled in the public plan (***Figure7***) if fully implemented in 2010. The number of people with private coverage would fall by about 20.6 million people. The plan would cover a slightly larger number of the uninsured because a public plan using Medicare rates reduces the cost of insurance for eligible people.

In the second year of the program, the exchange and public plan become available to individuals and firms with fewer than 20 workers. If fully implemented in 2010, public plan enrollment would reach 39.8 million people, with the number of people covered under private coverage declining by 30.8 million people.

As discussed above, the bill leaves it to the Commissioner to specify the groups of firms that would be permitted to enroll in the public plan beginning in the third year of the program. To illustrate its potential impact, we estimated the effect on coverage in the third year of the program assuming the public plan is opened to individuals and all firms, the public plan would enroll about 122.9 million people (includes some uninsured who take coverage). The number of people with private health insurance would decline by about 113.5 million people (***Figure 7***). This is equal to about 66 percent of all people currently covered under private health insurance (excludes supplemental coverage for Medicare beneficiaries).[20]

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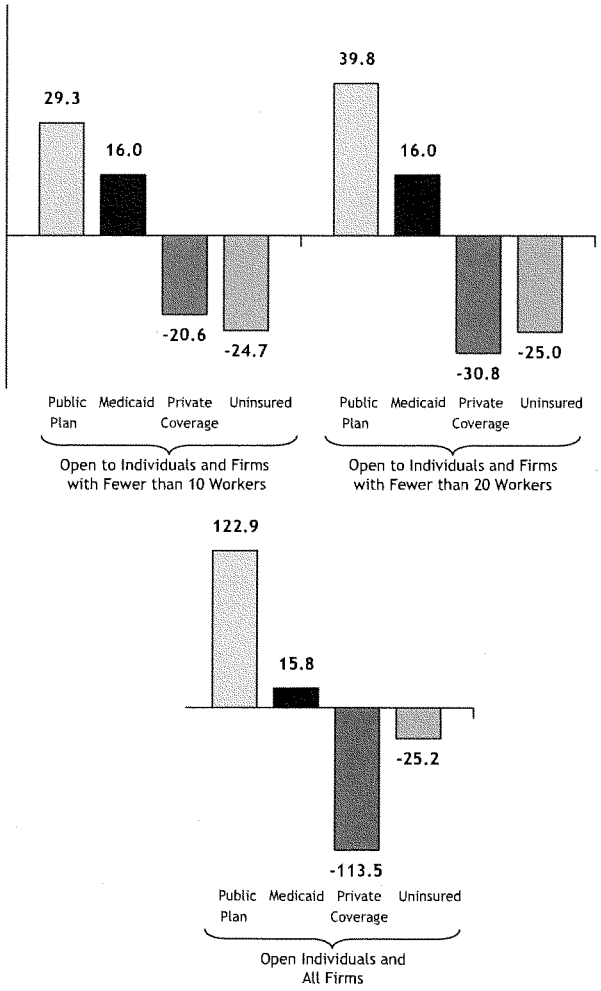
[20] In a recent study, we estimated that a public plan using Medicare payment rates would enroll about 131.0 million people with a reduction in private coverage of 119.1 million people. We estimate smaller public plan enrollment under the house bill because physician payment would be 5 percent higher than Medicare levels.

Figure 7
Changes in Sources of Coverage under the House Bill with Alternative Public Plan Eligibility Levels in 2010 (millions)

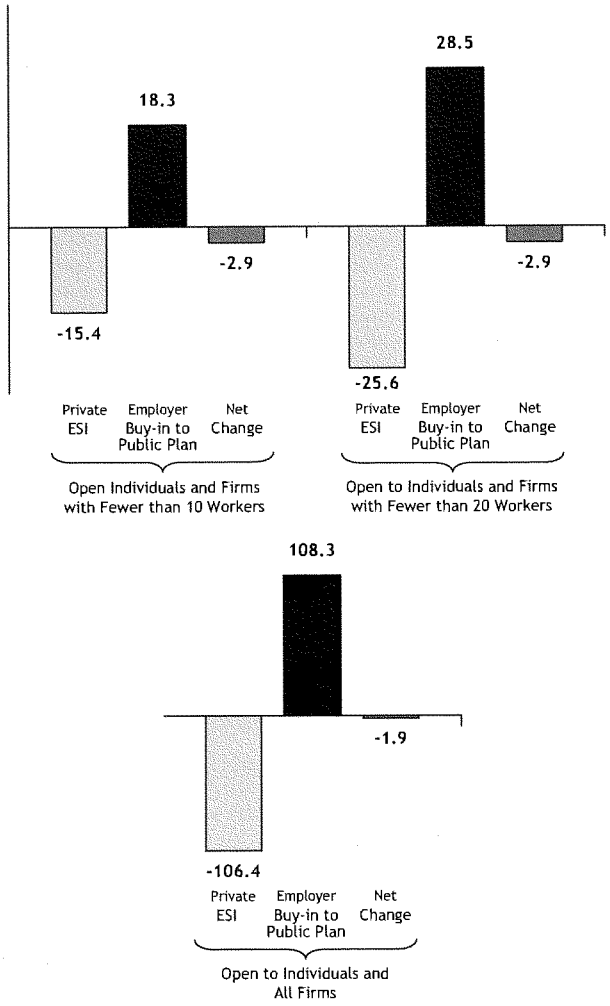


Source: Lewin Group Estimates.

Figure 8 presents the changes in employer coverage under alternative specifications of the public plan at various levels of provider payment. For example, under the scenario where the public plan is open to individuals and all employers, the number of people with private employer sponsored coverage would decline by 106.4 million people. However, employers would cover about 108.3 million workers and dependents under the public plan.

Thus the number of people in plans where the employer contributes to the cost of coverage would decrease by 1.9 million people. This reflects a net increase in the number of employers who sponsor coverage due to the employer pay-or-play requirements under the House bill proposal.

Figure 8
Changes in Employer Coverage under the House Bill with Alternative Public Plan Models in 2010
(millions)



Source: The Lewin Group estimates.

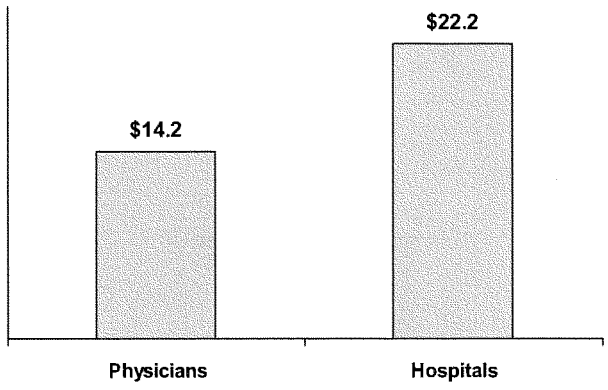
C. Provider Impacts

A health reform plan with a public plan would have a significant impact on provider net-incomes. Expanding coverage would reduce uncompensated care for uninsured people and increase health services utilization for the newly insured, all of which would represent new revenues to providers. Also, the House bill increases reimbursement for primary care providers under Medicaid, which would also increase provider income. However, these increases in revenues could be largely offset by reductions in payment levels for people who shift from private insurance to the public plan.

1. Net-income effects of Public Plan on Providers

If the House bill were to be implemented without a public plan, there would be a significant increase in provider revenues. Hospital net-income would increase by $22.4 billion and physician net-income would increase by $14.2 billion (***Figure 9***). This reflects that provider net income would generally increase due to: reduced uncompensated care; increased reimbursement under Medicaid for physicians ($8.4 billion); and increased utilization of services for newly insured people. The change in net-income to providers would be similar if a public plan is used that pays providers at private payer levels.

Figure 9
Changes in Provider Net-Income under the House Bill without a Public Plan



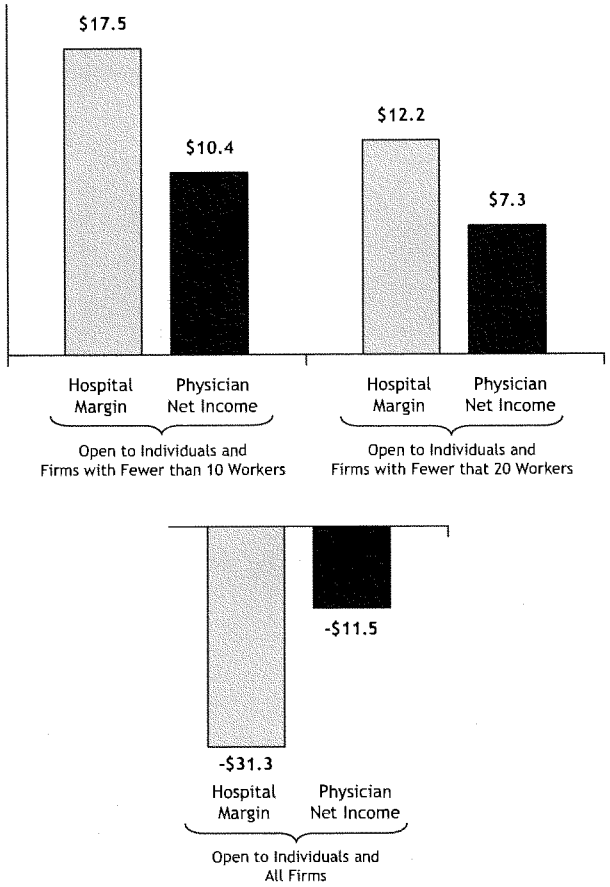
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

The impact of the public plan on providers will vary depending upon the groups who become eligible to participate. In the first year, the plan would be open to individuals and firms with fewer than 10 workers. Under this scenario, hospital net income (also known as margin) increases by $17.5 billion and physician net income increases by $10.4 billion (***Figure 10***). In the

second year, where firms with fewer than 20 workers become eligible, hospital margin would increase by $12.2 billion while physician income would increase by $7.3 billion.

Provider incomes would decline if the public plan is opened to all firms in the third year of the program due to higher enrollment in the public plan. Under this scenario, hospital net-income would fall by $31.3 billion in 2010 (***Figure 10***). Physician and other health professionals' net-income would fall by about $11.5 billion under this scenario.

Figure 10
Impact of Public Plan on Provider Income under Alternative Public Plan Models in 2010 (billions) [a/]



a/Includes changes in provider net-income due to increased utilization and reduced uncompensated care, payment level changes under the Medicaid expansion and changes in revenues due to the shift to the public plan.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

The effect on provider income is substantially smaller under a scenario where large firms are excluded from participation in the public plan. For example, even if Medicare Payment rates are used in the public plan, hospital margin would actually increase by $17.5 billion in 2010 as long as eligibility is limited only to individuals and small firms with fewer than 10 workers. Thus, the increased revenues for newly insured people (including reduced uncompensated care) are greater than the loss of revenues for people who shift from private coverage to the public plan. Physician income net of practice expenses would also increase by $10.4 billion under this scenario.

2. *Detailed Physician Impacts Estimates*

We estimated the changes in physician revenues resulting from the five scenarios described above. Our estimates reflect reductions in uncompensated care resulting from expanded health insurance coverage, which represent a net increase in income to providers. We then estimated increases in revenues for new health services utilization for the newly insured at the provider payment levels used under affected programs including Medicaid, private insurance and self-pay. Finally, we adjusted revenues from private insurers to simulate the effect of shifts in enrollment to the public plan at various provider payment levels for the four scenarios (***Figure 11***).

In addition, we estimated increases in practice expense associated with providing services to the newly insured. We assumed that the marginal cost of providing these services is equal to 80 percent of average costs.[21] The resulting data show the net change in physician revenues and net income under each of the public plan scenarios considered in this study.

Based upon data obtained from the American Medical Association, we estimate that average revenues per physician under current law will be $766,500 in 2010. Of this, about 61 percent would be attributed to medical practice costs. Net income per patient care physician (excluding hospital employees) will be $299,700 in that year.[22,23,24]

Physician net income would increase by an average of $19,795 per physician if the House bill is implemented without a public plan (***Figure 11***). This includes increased net-income for services provided to newly insured people (i.e., increased revenues less additional practice expenses for newly covered). It also reflects payments received for care that would have been provided free to uninsured people under current law and the improvement in Medicaid payment rates for primary care providers under the bill.

If the public plan is open to individuals and all employers using Medicare payment levels plus 5 percent, physician revenues would fall by 1.0 percent (***Figure 11***). While physician revenues would decline, physician practice expenses would increase due to the cost of increased utilization for newly insured people. Thus, physician net income would fall by 5.4 percent. The

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21 This is the assumption used by the Center for Medicare and Medicaid Services (CMS) in calculating outlier payments.

22 "Physician Characteristics in the US: 2007 Edition," American Medical Association

23 "Physician Socioeconomic Statistics: 2000-2002 Edition," American Medical Association

24 "Cost Survey for Multispecialty Practices: 2006 Report," Medical Group Management Association

loss of net-income under this scenario would average about $16,207 per physician assuming the program is fully implemented in 2010.

Figure 11
Impact of Public Plan on Physician Revenues, Expenses and Net Income under the House Bill by Public Plan Eligibility Group in 2010

		Groups Eligible for the Public Plan		
	No Public Plan	Year 1: Individuals and Firms with Fewer than 10 Workers	Year 2: Individuals and Firms with Fewer than 20 Workers	Year 3 Individuals and All Firms
Physician Revenue Effects (billions)				
Newly Utilization	$11.0	$11.3	$11.5	$11.6
Reduced Uncompensated Care	$2.5	$2.6	$2.7	$2.9
Increased Payments for Primary Care Under Medicaid	$8.4	$8.4	$8.4	$8.4
Payment Level Adjustment	-$1.9 [a/]	-$5.5	-$9.3	-$28.3
Net Change	$20.0	$16.8	$13.3	-$5.4
Physician Costs for New Health Services Utilization (billions)				
Costs for Newly Insured	$5.8	$5.9	$6.0	$6.1
Changes in Physician Net Income (billion)				
Change in Net Income	$14.2	$10.9	$7.3	-$11.5
Summary Impacts				
Percentage change in revenues	3.7%	3.1%	2.4%	-1.0%
Percentage change in net income	6.6%	5.0%	3.3%	-5.4%
Change in net income per physician in 2010	$19,795	$15,237	$10,141	-$16,207

a/ Reflects changes in payment levels for people moving to the public plan and currently insured people and includes changes resulting from privately insured people who shift to the expanded Medicaid program.
Source: The Lewin Group analysis using the Health Benefits Simulation Model (HBSM).

3. *Detailed Hospital Impacts Analysis*

We estimated the impact of the four alternative scenarios that we modeled on hospital net-income under the House bill. We used data primarily from the Medicare Hospital Cost Reports for federal fiscal year 2006. These data provide information on total hospital net patient revenues, other income, total operating expenses and other expenses for each U.S. hospital. The Medicare Hospital Cost Report data also includes information on revenues and expenses related to Medicare patients, uncompensated care expenses and inpatient utilization for Medicare, Medicaid and all other payers. All hospital payments and revenues were controlled

to match hospital totals from the National Health Expenditure data by payer category and inflated to 2010. [25,26]

We used these data to estimate the change in hospital revenues resulting from the various health reform options. These reflect reductions in uncompensated care resulting from expanded health insurance coverage, which represent a net increase in revenues to hospitals. We then estimated increases in revenues for new health services utilization for the newly insured at the provider payment levels used under affected programs including Medicaid, private insurance and self-pay. Finally, we adjusted revenues from private insurers to simulate the effect of shifts in enrollment to the public plan at various provider payment levels (***Figure 12***).

Figure 12
Impact of Public Plan on Hospital Revenues and Expenses under the House Bill by Public Plan Eligibility Group in 2010

		Groups Eligible for the Public Plan		
	No Public Plan	Year 1: Individuals and Firms with Fewer than 10 Workers	Year 2: Individuals and Firms with Fewer than 20 Workers	Year 3 Individuals and All Firms
Hospital Revenue Effects (billions)				
Newly Utilization	$12.5	$12.8	$13.1	$13.2
Reduced Uncompensated Care	$20.7	$21.2	$21.7	$21.8
Payment Level Adjustment [a/]	-$1.2	-$11.3	-$15.2	-$62.5
Net Change	$32.0	$27.8	$23.7	-$20.8
Hospital Costs for New Health Services Utilization (billions)				
Costs for Newly Insured	$10.0	$10.3	$11.5	$10.5
Changes in Hospital Net Income (billion)				
Change in Net income	$22.0	$17.5	$12.2	-$11.5
Summary Impacts				
Percent Change in Net Income in 2010	44%	35%	24%	-63%
Total Hospital Margins in 2010 Under the Proposal (Estimated margin under current law = 6.0%)	8.6%	8.1%	7.4%	2.2%

a/ Reflects changes in payment levels for people moving to the public plan and currently insured people and includes changes privately insured people who shift to the expanded Medicaid program.
Source: The Lewin Group analysis using the Health Benefits Simulation Model (HBSM).

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[25] Centers for Medicare & Medicaid Services, June 11, 2009 at http://www.cms.hhs.gov/nationalhealthexpenddata/
[26] American Hospital Association, "Trendwatch Chartbook 2009"

In addition, we estimated increases in operating expense associated with providing services to the newly insured. We assumed that the marginal cost of providing these services is equal to 80 percent of average costs. The resulting data show the change in hospital net income under five public plan design scenarios.

We estimate that total hospital net income will be about $49.9 billion in 2010 under current law. This is an average hospital margin of 6.0 percent. If the public plan is open to individuals and all employers using Medicare payment levels, hospital net income would fall by $31.3 billion, which is a 63 percent reduction from what margin would be under current law (***Figure 12***). Total hospital margin would fall from 6.0 percent under current law to 2.2 percent.

STATEMENT OF MARTIN REISER

Mr. REISER. Mr. Chairman and members of the committee, I want to thank you for the opportunity to testify about proposals to reform the U.S. health care system. I am here today on behalf of the National Coalition on Benefits, a coalition of 185 business trade associations and employers that have joined together to work with Congress to strengthen the employment-based system.

The NCB supports health care reform that improves health care quality and reduces costs. The NCB recently wrote President Obama applauding his commitment to comprehensive, bipartisan health care reform. We expressed our shared view that a strategy to control costs must be the foundation of any effort to improve the health care system. I have included that letter in my written testimony.

For many years, the American people have sent two clear messages to elected officials. First, Americans want to see change and improvements in both cost and access to health care, and second, Americans like the health benefits they receive through their employer. The NCB believes the American people are right on both points. We do need change, however, such change should not erode the part of the health care system that is working. The employer-sponsored model works well because it allows the pooling of risks and because group purchasing lowers health care costs, enabling those who are less healthy to secure affordable coverage for themselves and their families. ERISA and its federal framework allows employers to offer equal, affordable and manageable benefits regardless of where the employees live and work and without being subject to the confusing patchwork of mandates, restrictions and rules that vary from State to State.

Yet as good as it is, the system is increasingly at great risk. As President Obama has said, soaring health care costs make our current course unsustainable. The National Coalition on Benefits completely agrees. Unfortunately, we are concerned that the legislative proposal released last week does not provide meaningful cost savings for the overall system. In an effort to expand coverage, cost containment has not received the priority it demands. For several years, employers have worked to make clear the issues that health care reform must properly address to preserve the employment-based system, control costs and lead to our support. To date, we have not seen legislative proposals where each of these core issues have been adequately resolved. I will briefly discuss our concerns on ERISA, the employer mandate and the public plan.

If the objective is to build upon the employer-based system that successfully covers more than 170 million Americans, then employers must have the ability to determine how best to meet the needs of their employees. Legislation should not include changes to ERISA or other laws that would risk hurting those who are highly satisfied with the health care coverage they currently receive. The NCB opposes provisions that alter the federal ERISA law remedy regime. The existing structure encourages early out-of-court resolution of disputes and provides a national uniform legal framework to provide both employers and employees with consistency and certainty. The draft of the legislation would replace the successful structure with differing remedy regimes depending on where the

employers and employees attain health coverage. All these differing bodies of law are likely to result in contradictory decisions about plan determination and would expose employers who obtain coverage to the exchange to unlimited state law liability. In other words, these legislative provisions would weaken the employer-based system.

We are also concerned about proposals that would limit the flexibility of employers at a time when our country needs employers to create jobs and invest in future growth. Employer mandates including requirements to pay or play are not the answer to the health care problem because they undermine our ability to address 2 key goals of health care reform, coverage and affordability. On the public plan, we do not believe a public plan can operate on a level playing field and compete fairly if it acts as both a payer and a regulator. A public plan that would use government-mandated prices would result directly in a cost shift to other payers and thus would do nothing to address the underlying problems that make health coverage unaffordable for many. We already experience that cost shift today as Medicare, the largest payer in the United States, consistently underpays providers.

In summary, we remain concerned about any provisions that would make health care more costly for employers and employees, to stabilize our employer-based system of health coverage or restrict the flexibility of employers to provide innovative health plans that meet the needs of their employees. As Congress moves forward to formal consideration of the legislation, we want to continue to work with all members of Congress to enact reforms that not only allow Americans to keep the coverage they have today if they like it, and for most Americans that means their employer-based coverage, but make it possible for them to count on it being there tomorrow when they need it.

[The prepared statement of Mr. Reiser follows:]

National Coalition on **BENEFITS**

Testimony
Martin G Reiser
Manager, Government Policy
Xerox Corporation
And
Chairman, National Coalition on Benefits

Before

The U.S. House of Representatives
Energy and Commerce Committee
Subcommittee on Health
June 25th, 2009

Testimony
Martin G Reiser
Manager, Government Policy
Xerox Corporation
And
Chairman, National Coalition on Benefits

Before

The U.S. House of Representatives
Energy and Commerce Committee
Subcommittee on Health
June 25th, 2009

Mr. Chairman, and Members of the Committee, I want to thank you for the opportunity to testify about proposals to reform the U.S. health care system. I am here today on behalf of the National Coalition on Benefits, a coalition of 185 business trade associations and employers that joined together to work with Congress to facilitate the ability of employers to voluntarily maintain uniform health and retirement benefits for employees and retirees across states and localities.

The National Coalition on Benefits (NCB) was formed almost two years ago because we support health care reform that improves health care quality and reduces costs. We believe that individuals should have the responsibility to obtain health insurance and the health care delivery system should be improved through measures such as value purchasing, wellness and prevention, health information technology, and comparative effectiveness research that does not result in rationed care.

The National Coalition on Benefits along with over 190 companies and associations recently wrote to President Obama applauding his commitment to comprehensive, bipartisan health care reform for all Americans and access to affordable health care coverage. [1] We expressed our shared view that "a strategy to control costs must be the foundation of any effort to improve the health care system." I have included that letter in my written testimony.

For many years, the American people have sent two clear messages to elected officials about America's healthcare system. First, Americans want to see change and improvements in both the cost and access to health care. And, second, Americans like the health benefits they receive through their employer. The NCB believes the American people are right about both points: We do need change. However, such change should not erode the part of the health care system that is working.

[1] Letter to President Obama, April 1, 2009, attached to testimony

We believe the employer-sponsored model works well because it allows the pooling of risks and because group purchasing lowers health care costs, enabling those who are less healthy to secure affordable coverage for themselves and their families. ERISA and its federal framework allows employers to offer equal, affordable and manageable benefits regardless of where their employees and retirees live and work. The members of NCB believe that the federal standard of ERISA (also known as the "preemption" standard) is a critical cornerstone to our health care system because it allows employers to offer uniform benefits to their employees, retirees and families without being subject to the confusing patchwork of mandates, restrictions and costly rules that vary from state to state. Equally important, the federal ERISA framework makes it possible for employers to adopt and consistently apply leading edge, innovative practices to improve their employees' wellness, address chronic diseases, reward high performance health care providers and implement numerous other vitally important strategies that directly translate into better health care for employees and families.

Employer-based plans typically waive pre-existing conditions and cannot increase premiums or limit coverage based on individual health status. HIPAA regulations ensure that people can move from job to job without concern for being denied coverage due to health status. More importantly, employers have a vested interest in the health and productivity of their workforce, and the employer-based system has consistently produced innovative health care solutions that improve productivity, reduce absence from work, and lower disability costs.

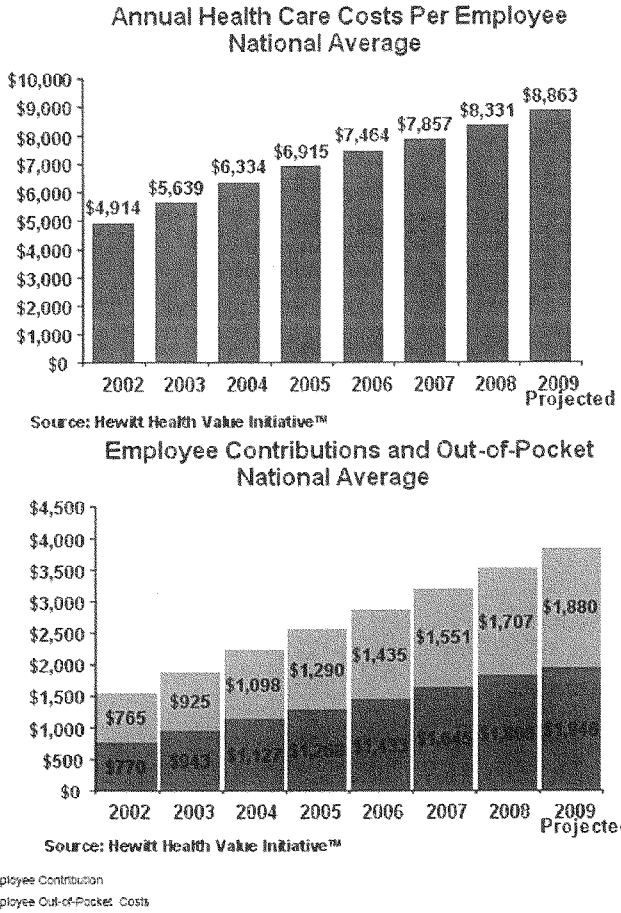
As good as it is, this system is increasingly at great risk, given the combination of cumulative increases in health care costs and the current severe economic downturn. Despite the positive actions of many employers, there are many problems to solve in the current U.S. health care system.

For decades, employers have provided health benefits for solid business reasons. However, our health care system is on a financially unsustainable path with costs rising at rates that far exceed economic growth. In particular, according to government estimates, over the period 2008-2018, average annual health spending growth (6.2%) is anticipated to outpace average annual growth in the overall economy (4.1%). By 2018, national health spending is expected to reach $4.4 trillion and comprise over one-fifth (20.3%) of GDP. The increase in overall health spending has a direct impact on health insurance premiums because premiums generally track the underlying growth of health services. Consequently, if we fail to address these underlying costs and improve our health care system, rising health care costs will threaten the viability of U.S. businesses of all sizes and put job security, pay increases and other vital employee benefits at risk for millions of American workers.

According to Hewitt Associates LLC data shown in Exhibit 1, annual large-employer health care costs (i.e., total costs for all health plan participants

divided by the number of enrolled employees) have more than doubled since 2001 and are projected to reach $8,863 in 2009. Over the same period, annual employee contributions and out-of-pocket costs are expected to increase by 190 percent to $3,826.

Exhibit 1:



As President Obama has said, "Soaring health care costs make our current course unsustainable." The National Coalition on Benefits completely agrees. Unfortunately, we are concerned that the legislative proposal released last week does not provide meaningful cost savings for the overall health care system, especially in the near term. In an effort to expand coverage, cost containment has not received the priority it demands.

Over the course of the past two years, employers have worked to make clear the five fundamental issues that health care reform must properly address to preserve the employment-based system, control costs and lead to our support. To date, we have not seen legislative proposals where each of these core issues has been adequately resolved.

ERISA

We continue to strongly support the flexibility that ERISA provides in the offering of employer-sponsored health insurance coverage. If the objective is to build upon the employer-based system that successfully covers more than 170 million Americans, then employers must have the ability to determine how best to meet the needs of their employees and retirees. Additionally, allowing states or localities to require employers to comply with various mandates would further raise employer costs, stifle innovation in employer-sponsored coverage and result in unequal benefits for employees.

But simply retaining the federal framework is not sufficient if onerous or impractical requirements are added to ERISA itself. Since a fundamental tenet of health care reform is to allow Americans to keep the coverage with which they are satisfied, legislation should not include changes to ERISA or other laws that would risk hurting those who are highly satisfied with the health care coverage that they currently receive.

The National Coalition on Benefits strongly opposes provisions that alter the federal ERISA law remedy regime. The existing structure encourages early, out-of-court resolution of disputes, and provides a national uniform legal framework to provide both employers and employees with consistency and certainty. The current draft of the legislation would replace this successful structure with differing remedy regimes depending on where employers and employees obtain health coverage. The House bill would create three differing enforcement regimes: state law for coverage obtained INSIDE an exchange, ERISA's federal law regime for coverage obtained OUTSIDE an exchange, and Medicare's federal law regime for coverage obtained from the public plan option.

All these differing bodies of law are likely to result in differing decisions about plan determinations and would expose employers who obtain coverage through the exchanges to unlimited state law liability. Employers would be faced with understanding and administering plans to comply with 50 distinct remedies regimes. Instead of relying on the precedents of one federal regime, employers would need to become experts on the remedies laws, and the resulting court decisions, in every state where they employ workers.

Additionally, if the legislation exposes employers to state-based remedies law, the result will be a severe increase in their potential financial liability stemming

from providing employees with health insurance and will discourage employers from offering generous and innovative health plans to their employees.

In other words, these legislative provisions would weaken the employment-based system. Some employers would likely determine that they could not expose their shareholders to the increased liability and would chose to drop coverage. More would conclude that one of the great strengths of the employment-based system – the freedom to innovate with plan design – would now become a potential liability, and the result would be greater rigidity and higher costs.

Now is the time where employers and employees are looking to Congress for real solutions that will put the nation on a sustainable path to controlling health care costs. Rather than subjecting employers to expensive and time-consuming litigation and differing enforcement regimes under both federal and state laws, we urge that you retain the ability for employers to offer highly valued health benefits to their employees under ERISA's uniform regulatory and enforcement framework.

Employer Mandate

Faced with a severe and continuing economic crisis, employers simply cannot absorb new burdens, such as specific coverage levels or payment requirements, no matter how well intentioned.

We are gravely concerned about proposals that would limit the flexibility of employers at a time when our country needs employers to create jobs and invest in future growth. Employer mandates of any kind, including requirements to "pay or play" are not the answer to the healthcare problem because they undermine our ability to address two key goals of health reform: coverage and affordability. In fact, mandates limit the flexibility and innovation that serves as the foundation of voluntary employer provided health care.

This voluntary and flexible system has worked for over six decades and today provides the backbone of the coverage model for over 170 million Americans. Weakening this system would undermine the very goal we are trying to accomplish - making insurance more accessible and affordable for those who do not have health insurance. Most significantly to employers - mandates fail to address the shared problem facing all employers – the soaring cost of health care.

Mandated Minimum Benefit

Any minimum standards for benefits need to be affordable for individuals and taxpayers. Individuals should be able to determine the level of benefits they need and can afford for their family. Employers must also be able to continue to

design the benefit plans that make sense for their workforce and consider the full range of health plan options available in a reformed health care market.

The Public Plan

A public plan, particularly combined with the impact of Medicare, Medicaid, and other public plans, cannot operate on a level playing field and compete fairly if it acts as both a payer and a regulator. The public plan's unfair competitive position, both by its size and regulatory authority, will merely shift additional costs to the private sector and employees covered by private plans.

A public plan that would use government mandated prices would directly result in a cost-shift to other payers and thus would do nothing to address the underlying problems that make health coverage unaffordable for many. Improving the cost, quality and the efficiency of health delivery are key imperatives for reform.

We already experience that cost-shift today as Medicare, the largest payer in the United States, consistently underpays providers. Employers and our covered employees and families also see higher price tags in their medical plans because Medicare and Medicaid payment rates are set by law and are comparatively lower than rates for employer-sponsored group health plans. It is no secret that providers receive much higher payments from private insurance plans than from public plans.

Economists vary in their views about how much of the difference between employer-sponsored and public payments truly represents "cost shifting" from public to private plans. But, the fact remains that Medicare and Medicaid reimburse providers at much lower levels than commercial payers. For example, according to a 2008 Milliman actuarial study,[2] Medicare reimburses hospitals at an average of 70% of private plan reimbursements and pays physicians 78% of what they receive from private plans. Medicaid reimburses hospitals at an average of 67% of private plan rates and pays physicians at an average of 53% of private plan rates.

Medicare's underpayment results in private payers and the people covered by these plans making up the shortfall – and increases the cost to employers of providing quality health care coverage. A "public plan" option administered by the federal government is inherently destabilizing to the employed-based health insurance benefit.

Employer plans continually innovate though technology, new programs that drive value and improve quality, while the Medicare system tends to rely primarily on

[2] Milliman, *Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid & Commercial Payers* study, December 2008.

the fee-for-service, volume based payment systems without a focus on care management and care coordination.

Tax Exclusion

Changes to the taxation of employer-provided health care are also not the answer to health care reform. These policies would increase employer and employee costs and could have a chilling impact on the part of our health care system that provides coverage to all-comers at a community rated premium irrespective of health risk or preexisting conditions. Moreover, it is important to recognize that employers and employees are already paying the largest share of health care costs in this country. As a result, we believe that savings achieved by lowering health care costs and improving quality should continue to be the first and foremost sources of financing for health care reform.

Conclusion

In summary, we remain concerned about any provisions that would make health care more costly for employers and employees, destabilize our employer-based system of health coverage, or restrict the flexibility of employers to provide innovative health plans that meet the needs of their employees.

As Congress moves to formal consideration of legislation, we want to continue to work with all Members of Congress to enact reforms that not only allow Americans to keep the coverage they have today if they like it – and for most Americans, that means their employer-based coverage -- but make it possible for them to count on it being there tomorrow when they need it. Therefore comprehensive health care reform must start by first addressing the very real issues that drive up cost, preventing more employers from participating and more individuals from taking advantage of the public and private health care programs available to them.

April 1, 2009

The President
The White House
Washington, D. C. 20500

Dear Mr. President:

The undersigned companies and associations applaud your commitment to comprehensive, bipartisan health care reform, and share your belief that all Americans should have access to affordable health care coverage. As voluntary providers of health care to more than 170 million Americans, employers are leading the way in helping to improve our health care system. While firmly committed to helping workers and their families meet their health care needs, employers are also struggling with health care costs.

We have a direct and real stake in the outcome of health reform efforts. For decades, employers have provided health benefits for solid business reasons. Since 1999, however, employment-based health insurance premiums have increased 120 percent, compared to cumulative inflation of 44 percent and cumulative wage growth of 29 percent during the same period. If we fail to improve our health care system, rising health care costs will threaten the viability of U.S. businesses of all sizes and put job security, pay increases and other vital employee benefits at risk for millions of American workers.

A strategy to control costs must be the foundation of any effort to improve the health care system. Controlling spiraling health care costs benefits every American seeking access to quality, affordable care and makes it possible for employers to continue their role as voluntary sponsors of health plans for their employees. Faced with a severe and continuing economic crisis, employers simply cannot absorb new burdens, such as specific coverage levels or payment requirements, no matter how well intentioned.

Fortunately, many of the proposals to control costs can also improve quality and value. Health IT is one example, but there are many others. Employers have led the way in driving for a higher quality, evidence-based health care system and have an urgent interest in finding solutions that foster continuous quality improvement.

Any successful reform effort must build on the strengths of America's voluntary employer-based system while ensuring there is a greater variety of affordable

private health plan options in the marketplace for all. By making it easier, not harder, for employers to provide quality health coverage for workers and their families we can not only strengthen health security, we can strengthen our nation's economic security.

We are eager to work with you to find solutions for this urgent national priority.

Sincerely,

Acry Fab, Inc.
Aetna
Alcoa Inc.
Allegiance Benefit Plan Management, Inc.
American Administration Services Co.
American Airlines
American Bakers Association
American Benefits Council
American Boiler Manufacturers Association
American Farm Bureau Federation
American Hotel & Lodging Association
American Rental Association
American Society of Home Inspectors
American Staffing Association
American Veterinary Medical Association
AmeriGas Propane, Inc.
Aon Corp.
Arizona Chamber of Commerce
Associated Builders and Contractors, Inc.
Associated Industries of Massachusetts
Association of Equipment Manufacturers
Association of Ship Brokers & Agents
Assurant, Inc.
AT&T
Auntie Anne's, Inc.
Automotive Aftermarket Industry Association
Avaya Inc.
Ball Corporation
Battery Council International
Best Buy Co., Inc.
Birmingham (AL) Regional Chamber of Commerce
Bison Gear & Engineering
Boeing
BTE Technologies, Inc.
Buck Consultants, LLC.

Buffalo Wild Wings, Inc.
Business Roundtable
Case New Holland
Caterpillar Inc.
Chevron Corporation
Chicopee Chamber of Commerce (MA)
Chrysler LLC
CIGNA
Clark & Associates of Nevada, Inc.
Computing Technology Industry Association (CompTIA)
Corporate Healthcare Coalition
Darden Restaurants Inc.
Deere & Company
Delta Airlines
Deseret Mutual
Dollar General Corporation
DTE Energy
Eastman Kodak Company
EBS Advisors, Inc.
El Paso Corporation
Employers Council on Flexible Compensation
Exelon Corporation
Express Employment Professionals
F.C. Brengman & Associates
FMC Corporation
Food Marketing Institute
Ford
Fox Entertainment Group
Gap Inc.
Gateway Regional Chamber of Commerce (NJ)
General Mills
General Motors Corporation
Goodrich Corporation
Great Plains Energy Incorporated
Greater New Haven Chamber of Commerce
Harris Corp.
HealthCare 21 Business Coalition
Healthways
Honeywell
HR Policy Association
Independent Electrical Contractors
Independent Office Products & Furniture Dealers Association
Ingram Industries Inc.
Institute of Electrical and Electronics Engineers - United States of America
International Foodservice Distributors Association
International Franchise Association

International Housewares Association
JELD-WEN, Inc.
Jostens, Inc.
Koller Enterprises Inc.
Kraft Foods Inc.
Lamiglas, Inc.
Los Angeles (CA) Chamber of Commerce
Louisiana Business Group on Health
Lowe's Companies, Inc.
Manhattan Chamber of Commerce
Maryland Chamber of Commerce
MassMutual Financial Groups
Medco
Meridian Health
MetLife
Miles Fiberglass & Composites, Inc.
Mobile (AL) Area Chamber of Commerce
Monsanto Company
Montana Chamber of Commerce
Motor & Equipment Manufacturers Association
Motorola, Inc.
Mutual of Omaha
National Association of Computer Consultant Businesses
National Association of Convenience Stores
National Association of Health Underwriters
National Association of Home Builders
National Association of Manufacturers
National Association of Theatre Owners
National Association of Wholesaler-Distributors
National Burglar and Fire Alarm Association
National Business Group on Health
National Coalition on Benefits
National Federation of Independent Business
National Funeral Directors Association
National Lumber and Building Material Dealers Association
National Restaurant Association
National Retail Federation
National Roofing Contractors Association
National Rural Electric Cooperative Association
National Tooling and Machining Association
New Jersey Chamber of Commerce
Northeastern Retail Lumber Association
Northwestern Mutual
Palm Desert (CA) Chamber of Commerce
Paul, Hastings, Janofsky & Walker LLP
Pharmaceutical Care Management Association

Phoenix Electric Mfg. Co.
Pietzsch, Bonnett & Womack, PA
PPG Industries
Precision Metalforming Association
Principal Financial Group
Printing Industries of America
Professional Golfers' Association of America
Quality Float Works, Inc.
Raytheon Company
Red Bud Industries, Inc.
Reno Sparks (NV) Chamber of Commerce
Retail Industry Leaders Association
Rochester Business Alliance (NY)
Ryder System, Inc.
Santa Clara (CA) Chamber of Commerce
Scottsdale (AZ) Chamber of Commerce
Sears Holdings Corporation
Sebago Lakes Region Chamber of Commerce (ME)
Self-Insurance Institute of America
Small Business & Entrepreneurship Council
Snyder's of Hanover
Society for Human Resource Management
Society of American Florists
Society of the Plastics Industry
South Carolina Business Coalition on Health
Specialty Equipment Market Association
Spring Consulting Group LLC
Stuart/Martin County (FL) Chamber of Commerce
SUPERVALU INC.
TechAmerica
Tempe (AZ) Chamber of Commerce
Textile Rental Services Association of America
The Adhesive and Sealant Council, Inc.
The Association for Suppliers of Printing, Publishing and Converting Technologies
The Black & Decker Corporation
The Council of Insurance Agents & Brokers
The Dow Chemical Company
The ERISA Industry Committee
The Financial Services Roundtable
The New Jersey Business and Industry Association
The Savitz Organization, Inc.
Timesavers, Inc.
Tire Industry Association
Tyco Electronics
U.S. Chamber of Commerce
U.S. Foodservice, Inc.

Union Pacific Corporation
United States Steel Corporation
Unum
UPS
Verizon Communications
Visant Corporation
Volvo Group North America
Waste Management
Wedding and Event Videographers Association International
WellPoint, Inc.
Western Growers
WillisHRH
Xerox Corporation
Yazaki North America Inc.

cc: Members of the U.S. House of Representatives
Members of the United States Senate

Mr. PALLONE. Thank you, and thank you all. I am going to start, and I am going to try to get a lot in in my 5 minutes here so bear with me if you don't mind. Mr. Shea, you expressed concern about taxing health care benefits. And you know, and you acknowledge in your testimony, this came from the Senate, not from the President, not from the House, needless to say. My concern is that, you know, a stated purpose of this reform is to let people keep what they have, and of course that implies employer, not only for employer benefits, but whoever has an insurance policy that they have. So I mean if you just want to tell me briefly what the consequences would be. I mean I know everything is on the table, but this is something that I am concerned about. Just briefly.

Mr. SHEA. What was it that somebody said about some things are moving off the table, but we hope this is in that category. The main thing that would happen is destabilized employment coverage which, as I said, is exactly the opposite direction for where we need to go because it would change the relationship between employees and employers around this very important part of their compensation. Some employees who are younger might say, well, gee, I really don't need to be part of the group plan. I am going to go off since it is now taxed money. Secondly, it would penalize certain groups of workers because of their health status essentially. We looked at health funds——

Mr. PALLONE. I am going to stop you because, you know, I appreciate what you are saying but I have got to ask Mr. Rivera a question. He stressed the pay to play requirements for businesses and, of course, we get criticisms of this, and, you know, a suggestion that, you know, it is going to hurt business. Why do you think the pay to play requirement is necessary for, you know—why do you think it is a good idea basically?

Mr. RIVERA. Because we believe at this moment some of the employers—the employers who basically are providing health care are basically subsidizing those who are not providing health care. For example, on average health insurance is about between $1,300 to $1,500 more for the cost of a family insurance, and those who don't provide health care coverage to their employees are basically on the free ride here. That is basically it.

Mr. PALLONE. OK. And what about the public option? You know, you said you are supportive of it. Obviously, it is in the discussion draft. Are insurance market performance enough to drive down costs and ensure coverage for all or do you think the public option is an essential piece of the reform?

Mr. RIVERA. We believe that it is an essential part of the reform, sir, and we believe that it will be a very important contribution to lowering the cost of health care. And basically this is America where we all can compete and this is another way of competing to lower the cost, sir.

Mr. PALLONE. OK. Mr. Sheils, I am going to you last here. I have about 2 minutes left. You criticize the public option and just for purposes of full disclosure the study you mentioned, my understanding, and tell me if I am wrong, is it was completely funded by an insurance company. You said in your written testimony you are the senior vice president of the Lewin Group and your group is—my understanding is your group is 100 percent funded by

United Health Group, one of the largest insurance companies in the country. Is that accurate?

Mr. SHEILS. We are owned by United Health. We have a 36-year tradition of doing——

Mr. PALLONE. But it is 100 percent owned by United Health.

Mr. SHEILS. I would like to finish.

Mr. PALLONE. Well, let me get to the next thing and you probably can respond to it——

Mr. SHEILS. Anyway, about 2 years ago and at that point we were—but our work is completely independent. We have complete editorial control over our work.

Mr. PALLONE. But I mean the group is 100 percent funded by United Health, right?

Mr. SHEILS. Well, we are a consulting firm. We are funded by the work we negotiate with the clients, so I work for the Commonwealth Fund, I work for Families, USA, I work for Blue Cross/Blue Shield.

Mr. PALLONE. Well, what about this study?

Mr. SHEILS. This study?

Mr. PALLONE. Yes.

Mr. SHEILS. This study was done on our own nickel.

Mr. PALLONE. But who funded it?

Mr. SHEILS. Well, we just did our own nickel. We did it out of our firm's overhead.

Mr. PALLONE. Did United Health directly or indirectly pay for it because they are funding you? I am just trying to get an answer to that.

Mr. SHEILS. You could say it that way but United Health did not review any of our materials.

Mr. PALLONE. OK. The only reason I mentioned it is our committee conducted an investigation of United Health and we found that the company had incredible profitability. In 2004 their net income was $2.6 billion, 2005 it grew to $3.3 billion, 2007 it went up to $4.7 billion. Even last year at the height of the financial collapse, the company's net income was $3 billion. And then in 2005 the CEO of United Health, William McGuire, was the third highest paid CEO in the country according to Forbes magazine. He resigned in 2006 after the SEC launched an investigation involving the back dating of stock options, but United Health gave him a severance pay of $1.1 billion, which was stunning to me. I mean do you think it is appropriate for United Health to pay the CEO more than a billion dollars severance?

Mr. SHEILS. I don't have—if I were at the pay level where I would even know this stuff, it would be a much different spot. We were a firm that was bought by Genex which is owned by United Health. We don't get involved in anything like that and there is nobody in our firm who ever sees income of that type. You can only imagine how surprised we were when 2 years ago we were bought. They quickly assured us that they wanted us to maintain editorial control of our work to continue our 36-year tradition of non-biased, objective, non-partisan work.

Mr. PALLONE. All right. Thank you.

Mr. SHEILS. That is all I am about.

Mr. PALLONE. I appreciate that. Thank you. Mr. Whitfield.

Mr. WHITFIELD. Thank you, Mr. Chairman. And I want to thank all of you on the witness panel for being with us today. We genuinely appreciate your testimony as all of us attempt to get through this legislation and understand as best we can what the ramifications and implications of the legislation will be. We hear a lot of discussion about the public plan, the public option, and I know some of you are opposed to it, some of you support it. What I hear most of all from members of the committee the concern is that if you have a public plan many people will leave the private plan, their employer plan, and go join that plan because the costs are lower, which is certainly understandable. But eventually you can basically destroy the employer plans because everyone is going to leave and then you will end up with one big government plan.

And maybe that is OK except the Medicare system can be criticized in many ways, particularly because of the cost escalations and I am saying that because Medicare is basically a U.S. government plan and if this public option goes the way some people will say that is going to be a big government plan. And I will make one comment. In 1965 when they started the Medicare program the Congressional Budget Office did a forecast that in 1990 that plan would cost $9 billion. It turned out to be almost $200 billion by 1990, so that is an astronomical miscalculation. So, Mr. Shea, you represent the AFL-CIO?

Mr. SHEA. Yes, sir.

Mr. WHITFIELD. OK. Well, tell me, the argument that I made that if it is less expensive more people are going to move over there and it is going to weaken the private system. Does that concern you or do you think that that argument has merit?

Mr. SHEA. Well, as I said, Congressman, we start out saying that we need to address cost containment just like others on the panel said that is job number 1. If we don't control these costs nothing else is going to be done in health care. So how do you do that? Well, there is several ways to do it but the public health insurance plan is one. You can calibrate the rates in the public insurance plan. This plan proposes Medicare rates. You could do Medicare plus 10 percent or you could do halfway between private. That would all affect this. But the notion is to put some competition in the insurance market that now doesn't display any competition. What we have are really close relationships in my view between insurers and providers, and that is the problem that we have to change. It was what Mr. Conklin was talking about. We are just trapped by this. So there are other ways to do it but this is what the competitive model is——

Mr. WHITFIELD. OK. Thank you. There are other ways to do it. Mr. Reiser, will you make a comment on the argument that I put out there that people are making?

Mr. REISER. The concern that we have about the public plan option is Medicare currently underpays, and there is a significant cost shift onto the private employers which is a big problem in the current system. A public plan option, we believe, would exacerbate that, particularly a public plan option as outlined in the proposal that would pay Medicare rates so that would just exacerbate the system. The second problem that we see with it is if people do leave the employer pool, that is going to weaken our risk pool and

lead to higher costs for the remaining employees, and over time will weaken and potentially destroy the employment-based system.

Mr. WHITFIELD. Yes, sir, Mr. Rivera.

Mr. RIVERA. One of the things that we have in New York State is a health care plan which provides health care for health care workers in the greater New York metropolitan area, and we pay about $8,500 for family insurance. Upstate New York where only one of the insurance companies basically dominates the market, we pay close to $17,000 so basically the idea of the public plan is to come into markets where basically are concentrated by only one insurance company, and there is a case of Maine, New Hampshire, and you can see high cost areas where basically the lack of competition that basically insurance companies don't come into those areas and the cost of health care goes up.

Mr. WHITFIELD. Mr. Castellani, I know the Business Roundtable is comprised of very large companies but what are your views on the pay or play provisions of this bill?

Mr. CASTELLANI. Well, pay or play is almost an academic issue for us because indeed on the surface all of our members provide health care, and we want to continue providing it. The problem that we see with the concept of pay or play is that we need to bring into the healthcare system all those people who are currently not covered or can't afford to be covered because we are paying for them through the kind of cross subsidies that Mr. Reiser referred to. We do not see the merit of forcing companies to buy something that they cannot afford, particularly the small businesses. And so pay or play we think can be dealt with if we provide the kind of competition that both Mr. Rivera and I think all of us would agree on but we think it is best provided through reforms in the insurance market because in addition to what Mr. Reiser said, that is, the public option plan exacerbates the cost shift. It potentially erodes our risk pool and causes younger, healthier people to leave, quite frankly, and get a lower premium.

But it also does something else that hurts what we all want and we all talk about, and that is we see much more innovation in terms of delivery, in terms of wellness, in terms of prevention, in terms of quality, in terms of information technology, the kinds of things that will reduce costs and increase quality coming out of the private sector. We are concerned that a government run program as we see now in Medicare and Medicaid just doesn't have the ability to innovate, so we also lose out on the ability to gain from those innovations.

Mr. WHITFIELD. Thank you. I think my time has expired.

Mr. PALLONE. Mrs. Capps, our vice chair.

Mrs. CAPPS. Thank each of you for your presentations. It has been a good panel. You waited a long time, many of you, because it has been a very long day of presentation and different panels on this topic of health care reform. I have questions for two of you because there is not enough time, only 5 minutes, and my first question will be for Mr. Rivera with SEIU. In your testimony, Mr. Rivera, you expressed that individual responsibility must be augmented by measures to ensure affordability. It seems fair to think that our health care system should meet hard-working Americans halfway. For this reason, SCIU supports affordability credit for

families between 133 percent and 400 percent of the federal poverty line. Why do you believe it is necessary to offer these credits for families up to 400 percent of the poverty level?

Mr. RIVERA. Part of the problem that we have is the incredible cost of health care these days. For example, in the case of SEIU almost 50 percent of the members of our union basically live on very meager means, less than $35,000, so when you take into account on one hand the high cost of health care and the disposable income you can see that basically in order to make it meaningful you have to have subsidies.

Mrs. CAPPS. So you are talking about your work force, hard-working men and women with raising a family and trying to have a quality of life in this country, not at all luxurious, but still they are doing essential work in their communities and they should have a decent health care system, and so you are wanting to provide——

Mr. RIVERA. As a matter of fact, the overwhelming majority of Americans who don't have health care coverage are working people who make more money than to qualify for Medicaid and are not enough to qualify for Medicare and then the question that they have——

Mrs. CAPPS. Which shows you one of the disparities that the premiums are so expensive that you really—if you are going to have your own private insurance plan, self-employed or whatever, you have to be upper middle class or wealthy in order to pay for it, and that is one of the major challenges that we face in this country right now. I am sure you would say that. Are there some other protections? We are talking about middle class, right, or at least what we want to consider as the middle class, the working class, the hard-working people who keep this country going whether in small businesses or in large companies providing labor or providing management. What other projections do you believe are necessary to make health care more affordable for the middle class? This is a big question, but I want to also move on to another subject.

Mr. RIVERA. I think the fundamental question that we have is that we are spending 17½ percent of our gross domestic product on health care, and if we do not—and I think my colleague, Mr. Shea, was talking about it, if we don't resolve the problem of the cost controls we are not going——

Mrs. CAPPS. I see other people nodding your heads. Is this sort of a given that this is one of the major challenges that—and one of the reasons that you are participating is because we need reform to deal with this in some aspect. I appreciate that. You are a very diverse group, I might add. I think there is quite a cross section here. That is interesting. I would like to now turn for the last couple minutes to you, Mr. Sheils, just some particular questions about what you were talking about. Your analysis suggested a public option can get lower premiums than private plans. Some of our colleagues are making the—come to the conclusion that this disparity—that a private plan is not even going to be able to compete with the public option. Does your model assume that private insurers and large employer purchases are simply price takers with no ability to add value or change behavior in a competitive market?

In other words, it is so monolithic in that private world that there is no ability to compete?

Mr. SHEILS. Well, we don't conclude that they cannot compete. We conclude that there are only certain types of plans that could survive, and those would be integrated delivery systems like some of the better HMO type models. I would like to explain that though because there are some key issues here. Right now a lot of the insurers get price discounts with providers.

Mrs. CAPPS. Right.

Mr. SHEILS. Having to do with the fact that they make volume discounts. They say to a hospital I will bring you all 100,000 of my people for their hospital care if you will give me a break. Now if everybody goes to the public plan and the private health plan only has 10,000 people left in it——

Mrs. CAPPS. The public plan is not going to be able to offer that, is it? That is pretty competitive.

Mr. SHEILS. I wanted to finish my—my point is if there is only 10,000 people left in the private insurance plan then they are not going to be able to negotiate discounts that are as deep as what they can get today.

Mrs. CAPPS. And that is the only way they can be competitive.

Mr. SHEILS. Right.

Mrs. CAPPS. I would hope that there would be a lot more creativity within the private sector. I will get to you but—but you said I could have a little more time because of that terribly disruptive moment there. Anyway, maybe you or someone else would comment about some of the larger markets like Los Angeles, New York City, private plans sitting below Medicare fee for service levels. How do you factor that into it and then I will open it up if there is time?

Mr. SHEILS. Well, there are places where there are smaller disparities between Medicare and private, and then there are places where there is much larger disparity. In those areas where you have large disparities, we get quite a bit of shake up. In areas where there is little disparity it doesn't really show us very much of a change.

Mrs. CAPPS. Another comment on this with the other——

Mr. SHEA. Just on the whole dynamic. I think what is important to bear in mind about the Lewin analysis is that it is based on the prices. Your point is just price taking. Employers, and you could ask people on this panel, employers make decisions based on more than price in health care. This is a very——

Mrs. CAPPS. Is that a valid point? May I ask for corroboration?

Mr. PALLONE. One more and then I think we got to move on.

Mrs. CAPPS. OK. I would hope so because I would hope that we would have a little more creativity in the private market. We actually need that competition because this is too big for anyone's response. Many of us feel that way, and I think that is a feature of the public option is that it will be competition and it will be a competitive market place. In my congressional district it isn't competitive at all. It is rural and there is only one private provider. So, you know, this is a thoroughly needed situation. I will yield back, Mr. Chairman.

Mr. PALLONE. Mr. Gingrey.

Mr. GINGREY. Mr. Chairman, thank you. Let me direct my question to Mr. Castellani of the Business Roundtable. Mr. Castellani, could you explain to us how the public plan proposals would undermine the private insurance industry that many Americans are very happy with, and I am not—quite honestly, I have read some of your testimony, and I am not sure where you are on this public plan proposal. In the interest of full disclosure, I am concerned about it so that is the reason for my question.

Mr. CASTELLANI. Yes, sir. What we are concerned about is not that it would undermine although it would the private insurance but it would undermine our ability as employers to provide health care for our employees through the private insurance market. And it is for the reasons that we have discussed here and it is primarily three. We do agree with competition. What Congresswoman Capps was addressing is what we think is part of the solution. We need greater competition, but that competition has to be on a level playing field. If a government plan exists and it has all the elements of a private plan except it is not required to pay its investors back a fair return on their investment, the taxpayers in this case, then it can and will by definition have a lower premium cost. So the first effect is we would lose people who could qualify and would move to that lower premium from our plan.

As a result of that, they will tend to be younger and tend to be healthier employees. Our costs go up because we would lose that spectrum of our risk pool that allows us to provide an affordable product for all of our employees.

Mr. GINGREY. Now, Mr. Castellani, you are speaking from the perspective of the Business Roundtable?

Mr. CASTELLANI. From the payers, yes.

Mr. GINGREY. From the Business Roundtable?

Mr. CASTELLANI. Correct.

Mr. GINGREY. And we are talking about the payers and there are probably 270 million lives covered through employer-provided health insurance. My numbers here say most of the 177 million Americans who have employer-based coverage say they are happy with the coverage they receive. President Obama, God bless him, has promised to ensure that those folks can keep what they have. I think that is almost a quote. He likes the word folks. Those folks can keep what they have. I have heard him say it many times. Do you think that the public plan could lead to Americans losing their current coverage because of an unfair playing field that would be established by a public plan?

Mr. CASTELLANI. Yes, I think it runs that risk.

Mr. GINGREY. All right. Well, I tend to agree with you. Now describe for the committee and for everyone in the room what are some of the unfair aspects that could be attributed to a public plan that we are concerned about, that you are concerned about, that the Business Roundtable is concerned about?

Mr. CASTELLANI. Well, as I had answered previously, a lower premium cost would be attractive to some of our own employees for which we provide coverage now. If they leave the system, we have a reduced risk pool and the nature of that risk pool, the nature of our employees could leave us with a more costly and fewer number of lives to cover. The second thing that it does is by its design in

this draft legislation it does not fully reimburse for cost, so another large player in addition to Medicare and Medicaid that does not fully reimburse for cost because it is a situation, for example, you are a hospital. The government is not going to pay any more, Medicare and Medicaid is not going to pay any more, the uninsured can't pay any more. There is only one person left paying and that is the employers, so it exacerbates the cost shift, makes our cost potentially greater rather than what we are all trying to achieve which is more affordable health care at lower cost trajectories than we have now.

The third thing it does is it hurts us in the long term and that is that fundamentally government programs are not able to innovate at the kind of rates and with the kind of creativity that we see in the private sector with competition, and we need that kind of innovation to bring down the trajectory of cost so it hits us 3 ways in raising our——

Mr. GINGREY. I had one more, Mr. Chairman. I can't see the clock.

Mr. PALLONE. It keeps going off. Go ahead.

Mr. GINGREY. OK. Thank you, Mr. Chairman. I appreciate your indulgence. Just one more question, Mr. Castellani. Under this draft proposal, a tri-committee draft proposal, did you see anywhere that describes what would happen if the public plan did not set the premiums and the cost-sharing high enough to cover its cost? Was there a provision that described what happens if the public plan—if their reserves are not high enough, for example, and indeed was there anything in the draft that describes where those reserves would come from and how they would compare with the reserves that were required of the private insurance, health insurance plans, that they are competing with.

Mr. CASTELLANI. I don't believe they were—at least in my reading of it and analysis of it, they weren't specified. They say there are reserves. Reserves would be provided for. But the one thing that is missing even whatever levels they would be provided at and the networks would be provided at in the public plan the one thing that is missing is a fair return on the people who invest in the capital that allows that public option to exist. If you don't have that, you always have accost advantage.

Mr. GINGREY. Well, I thank you very much, and I am sure my time has probably already expired. Mr. Chairman, thank you for your indulgence. I appreciate it, and I yield back.

Mr. PALLONE. Thank you. I think that is the end of our questions. Thank you very much. We appreciate it. I know it keeps getting later. We have one more panel. You may get, as I think you know, you may get some additional written questions within the next 10 days and we would ask you to get back to us on those. Thank you very much. And we will ask the next panel to come forward. I think our panel is seated. And I know the hour is late, but we do appreciate you being here, and I am told we may also have another vote so we will see. We will try to get through your testimony. This is the panel on insurer views. And beginning on my left is Howard A. Kahn, who is Chief Executive Officer for L.A., I assume that is Los Angeles, Care Health Plan. L.A. OK. Karen L. Pollitz, who is Project Director for the Health Policy Institute at

Georgetown Public Policy Institute, Karen Ignagni, who is President and CEO of America's Health Insurance Plans, and Janet Trautwein, who is Executive Vice President and CEO of the National Association of Health Underwriters. I don't think I have to tell anyone here that we try to keep it to 5 minutes, and your written testimony will be included complete in the record. I will start with Mr. Kahn.

STATEMENTS OF HOWARD A. KAHN, CHIEF EXECUTIVE OFFICER, L.A. CARE HEALH PLAN; KAREN L. POLLITZ, PROJECT DIRECTOR, HEALTH POLICY INSTITUTE, GEORGETOWN PUBLIC POLICY INSTITUTE; KAREN IGNAGNI, PRESIDENT AND CEO, AMERICA'S HEALTH INSURANCE PLANS; AND JANET TRAUTWEIN, EXECUTIVE VICE PRESIDENT AND CEO, NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS

STATEMENT OF HOWARD A. KAHN

Mr. KAHN. Thank you, Chairman Pallone, members of the committee. Thank you. The need for national health care reform has never been greater. As the CEO of L.A. Care Health Plan, America's largest public health plan, I am here to provide information about our model and how a public health option has worked in California for more than a decade. L.A. Care is a local public agency and health plan that provides Medicaid managed care services. We opened our doors in 1997 as the local public plan competing against a private health plan, Health Net of California, Inc. L.A. Care strongly supports the concept that public plans can provide choice, transparency, quality, and competition. L.A. Care competes on a level playing field against our private competitor. Plans must have enough funding to endure provider payments and operate under the same set of rules.

L.A. Care has always been financially self-sustaining and has never received any government bailout or special subsidy. L.A. Care serves over 750,000 Medicaid beneficiaries and has 64 percent of the Medicaid market share in Los Angeles. The competition between L.A. Care and Health Net has resulted in better quality and system efficiencies. For example, as part of our efforts to distinguish ourselves in the market place, L.A. Care attained an excellent accreditation from NCQA, validation that it is possible to provide quality care to the poorest and most vulnerable in our communities. There are 7 other public plans like L.A. Care in California providing health coverage to Medicaid beneficiaries. In all of these counties, the public plans compete against private competitors.

Two and a half million Medicaid beneficiaries are provided health services through this model. California has other public plan models as well. Congresswoman Eshoo, a member of this subcommittee, is very familiar with the enormously successful county organized health system which she and I helped create within her district. Our provider network includes private and public hospitals and physician groups, non-profits, for-profits, federally qualified health centers, and community clinics. Our subcontracted health plan partners include some of the biggest private health plans, Anthem Blue Cross and Kaiser Permanente, as well as smaller local plans. In addition to Medicaid, L.A. Care operates a CHIP pro-

gram, Medicare Advantage special needs program, and a subsidized product for low income children.

What makes L.A. Care, a public health plan, different? L.A. Care conducts business transparently. We are subject to California's public meeting laws so all board and committee meetings are open to the public. L.A. Care answers to stakeholders, not stockholders. Its 13-member board includes public and private hospitals, community clinics, FQHCs, private doctors, Los Angeles County officials and enrollees. Our enrollees actually elect 2 of our board members resulting in a strong consumer voice. Part of our mission is to protect the safety net. When Medicaid managed care began there was fear that FQHCs and public hospitals would lose out. Through several strategies over 20 percent of L.A. Care's enrollees have safety net providers as their primary care home. In Los Angeles large numbers of people will remain uninsured under even the most ambitious health care reform proposals, and the safety net will continue to need our support.

Local public plans like L.A. Care protect consumer choice. Since we started, 3 private health plans serving this population in Los Angeles have gone out of business. L.A. Care's stability has ensured that Medicaid beneficiaries continue to have continuity and choice. Local public plans raise the bar on performance and quality in their local communities. L.A. Care offers a steady calendar of provider education, opportunities that improve provider practices and the quality of care. Our family resource center serves over 1,200 people, most of whom are not our plan members. While defining a public plan option is still underway, we recommend against creating a monolithic national public plan. Health care is, and will continue to be, delivered to local markets which vary in terms of population and competition, infrastructure, community need, and medical culture.

California recognized years ago the need to lower cost and improve quality and develop local plan options for Medicaid that have been supported by each successive Administration, both Democrat and Republican. With regard to the health insurance exchange, L.A. Care supports allowing states to create their own exchange. We appreciate the recognition that Medicaid beneficiaries have special needs and so are not included at first. However, we strongly recommend excluding Medicaid beneficiaries completely as they are among the most vulnerable to care for and present unique challenges. California's local public plans are successful local models that should be considered. Let us build on what is working in health care and focus on fixing what is broken. Thank you.

[The prepared statement of Mr. Kahn follows:]

TESTIMONY
BEFORE THE
UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITEE ON HEALTH

TESTIMONY OF
HOWARD A. KAHN
CEO, L.A. CARE HEALTH PLAN
REGARDING
"LEGISLATIVE HEARING ON DRAFT HEALTH CARE REFORM
LEGISLATION AND THE PUBLIC PLAN OPTION"
WASHINGTON, D.C.
JUNE 25, 2009

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telephone 213.694.1250 • facsimile 213.694.1246 • www.lacare.org
Accreditation of Medi-Cal, Healthy Kids and Healthy Families Program.

For a Healthy Life

Chairman Pallone, ranking member Deal, members of the committee, as the CEO of L.A. Care Health Plan, America's largest public health plan, I am here to provide information about L.A. Care's model and how our public plan option has worked locally in California for more than a decade.

The need for national health care reform has never been greater. Recently, the public plan option has garnered much of the attention in the health care reform debate with concern from many parties – those concerned that without a public plan option reform won't work and those concerned that a public plan option is a clear path to a government take-over of our health care system. California's experience with public plans can offer insight into how a public health plan option can be cost-effective, preserve choice and competition, and improve quality.

L.A. Care is a fully independent, local public agency and health plan established through enabling legislation by the State of California, and created by the County of Los Angeles to provide Medicaid managed care services to the Temporary Aid for Needy Families (TANF) population. At that time, as now, health care costs were rising steadily, and there were serious budget shortfalls. The expansion of mandatory managed care for this Medicaid population was an effective way to control rising costs, improve quality and access to care for beneficiaries and reduce waste and fraud. L.A. Care opened its doors in 1997, as the local public plan option competing against a private health plan, Health Net of California, Inc.

As included in the discussion draft, L.A. Care strongly supports the concept that public plans can provide choice, transparency, quality and competition. L.A. Care competes locally on a level playing field against our private competitor. In the Medicaid managed care program, the State uses the same formula to set plan rates; plans have the same financial reserve requirements, and operate under the same set of licensing requirements and regulations. Since its inception twelve years ago, L.A. Care has been financially self-sustaining, and has never received any government bailout or special subsidy.

Currently, L.A. Care is serving over 750,000 Medicaid beneficiaries, and has 64 percent of the Medicaid managed care market share in Los Angeles County. The competition between L.A. Care and its competitor Health Net has resulted in better quality care and system efficiencies. For example, as part of efforts to distinguish ourselves in the marketplace, L.A. Care attained an "Excellent" Accreditation from the National Committee for Quality Assurance (NCQA), validation that it is possible to provide quality care to the poorest and most vulnerable in our communities. In addition, childhood immunizations among L.A. Care enrollees have improved from 33% in 1999 to 85% in 2008.

There are seven other public plans like L.A. Care in California that provide comprehensive health care coverage to Medicaid beneficiaries in nine counties, called Two-Plan model counties. In all of these counties, the public plans compete in exactly the same way against private plan competitors. In total, 2.5 million Medicaid beneficiaries are provided health, dental, and vision care services throughout California via the Two-Plan model.

California has other public plan models. Rep. Eshoo is very familiar with another public plan structure, the County Organized Health System, as she served on the San Mateo County Board

of Supervisors and the Plan's Board when we started that health plan in the 80's. This type has been enormously successful in San Mateo County. However, it is not a competitive public plan model.

L.A. Care's provider network includes over 3,500 primary care physicians, 7,000 specialists, 1,800 pharmacies, and 55 hospitals that we contract with directly and through other health plans. This includes private and public hospitals and physician groups, non-profits, for-profits, federally qualified health centers and community clinics. Our subcontracted health plan partners include some of the biggest private health plans – Anthem Blue Cross and Kaiser Permanente – as well as Care 1st and Los Angeles County's Community Health Plan. In addition to Medicaid, L.A. Care operates a CHIP program, a Special Needs Plan for Medicare enrollees, and a subsidized product for low-income children that do not qualify for Medicaid or CHIP.

What makes L.A. Care, a public health plan, different?

- L.A. Care has a local Board of Governors that is focused on the needs of community health, not profits. L.A. Care answers to stakeholders, not stockholders. Its 13-member Board is comprised of representatives from public and private hospitals, federally-qualified health centers (FQHC) and community clinics, private doctors, Los Angeles County, and enrollees. In fact, our enrollees elect two members to the Board of Governors, resulting in a strong consumer voice in our governance.

- L.A. Care conducts business in an open and transparent way. As a public agency, we are subject to California's public meeting laws, which mean that all Board and committee meetings are open to the public. The public must be notified in advance, and must have the opportunity to provide comment. This makes L.A. Care accountable to our enrollees and stakeholders.

- This accountability extends deep into the community. We have a robust system of committees designed to solicit and receive feedback from across L.A. County. This includes 11 committees made up of enrollees, over 350 people, who advocate for their communities, bring problems and barriers to our attention, and promote health education and information to their friends, families, and neighbors.

- L.A. Care's enabling legislation mandates that part of L.A. Care's mission is to protect and strengthen the safety net. When Medicaid managed care was introduced in California there was a concern that the FQHCs, safety net clinics and public hospitals would lose their only patients with health coverage. Through several strategies, including investing in the safety net and helping clinics with better marketing and customer service programs, over 20 percent of L.A. Care's enrollees are enrolled with federally-qualified health centers, community or county clinics as their primary care home. In Los Angeles County, large numbers of uninsured will remain so even with the most ambitious health care reform proposals. The safety net will continue to be a vital part of the health care system and will continue to need support.

- Public plans like L.A. Care protect consumer choice. Since L.A. Care has been in existence, two for-profit private health plans and one non-profit private health plan serving this population in Los Angeles have gone out of business; L.A. Care's stability has ensured that Medicaid beneficiaries throughout Los Angeles County continue to have continuity and a choice in doctors and health plans.

- Public plans raise the bar on performance and quality in their local markets. L.A. Care was the first California health plan without a hospital affiliation to be accredited as a Continuing Medical Education provider. As a result, we offer a steady calendar of provider education opportunities in childhood obesity, asthma, and mental health that have improved provider practices and quality of care. Currently, our Family Resource Center offers culturally-sensitive health education classes and services to over 1200 people a month, of which 85% are not L.A. Care enrollees, but community members.

While a working definition of a public plan option is still being developed, I recommend that the creation of a monolithic national public plan be avoided. Health care is at its core local. As we already know, bigger plans do not necessarily save on costs any more effectively than local or regional plans, nor should a large national public plan expect to. The costs of private health insurance and Medicare have continued to rise, despite the fact that large, national health insurers and employers have significant bargaining power.

In addition, under all current reform proposals in Congress, health care will continue to be delivered through local markets, which vary in terms of population, competition, infrastructure, community need and medical culture. These needs can be incredibly complex. For example, L.A. Care's Call Center can help enrollees in up to 32 languages; our member materials are available in ten languages, Braille, Audio CD, and Large Print. We offer provider directories to our enrollees that have information on language and disability access. This is necessary to deliver quality care for our low-income enrollees amidst L.A.'s diversity.

California recognized years ago the need to lower costs and improve quality, and developed local public plan options for Medicaid that have been supported by each successive administration, both Republican and Democrat.

With regards to the Health Insurance Exchange, L.A. Care supports the proposal that allows states to create their own exchange in lieu of a national insurance exchange. L.A. Care appreciates the recognition that Medicaid beneficiaries have special needs, and so are not included in the Exchange for the first four years of operation. However, L.A. Care would strongly recommend excluding Medicaid completely from the Health Insurance Exchange. The federal and state governments pay the entire bill for Medicaid and need to retain the oversight and control of the services for a variety of medical and social reasons. Medicaid beneficiaries are among the most vulnerable populations to care for and present unique challenges in care coordination and require a different set of benefits than is customarily offered in commercial plans. Those challenges, which go beyond health care, will make guaranteeing access and

quality care next to impossible, if included in the Exchange, with regards to social services coordination and support.

Finally, I know I speak for Medicaid plans across the country when I say, we also appreciate that the draft includes section 1843, equalizing drug rebates in Medicaid. This provision will help ensure that health plans can continue providing comprehensive, coordinated care services for our enrollees and we applaud your leadership on this issue.

To conclude, we support those ideas that build on California's over twenty years of experience in improving quality while containing costs through competitive public plans, namely:

- State, regional, or local public plans that meet the same criteria as private plans and compete equally;
- Public plans or similar entities that have transparent governance, and respond to their stakeholders and local communities;
- Public plans or similar entities that support the public and private safety net, and reinvest their margins back into the community.

California's local public plans are a successful model that should be considered. Let's build on what's working in health care and focus on fixing what's broken.

Mr. PALLONE. Thank you. Now let me mention that we do have votes, but I would at least like to get one or possibly two of the testimony in, so let us see how it goes. Ms. Pollitz next.

STATEMENT OF KAREN L. POLLITZ

Ms. POLLITZ. All right. Thank you, Mr. Chairman, members of the committee. First, I would like to congratulate you on the tri-committee draft proposal. It contains the key elements necessary for effective health care reform and at this time I am sure you are going to get the job done. The proposal establishes strong new market reforms for private health insurance with important consumer protections, a minimum benefit package, guaranteed issue, modified community rating, elimination of pre-existing condition exclusion periods. These rules apply to all qualified health benefit plans including those purchased by mid-size employers with more than 50 employees. Today, mid-size firms have virtually no protection against discrimination. When a group member gets sick premiums can be hiked dramatically at renewal forcing them to drop coverage and with no guaranteed issue protection finding new coverage is not an option.

I commend you for not including in the bill exceptions to the employer non-discrimination rule that would allow employers and insurers to substantially vary premiums and benefits for workers through the use of so-called wellness programs. Clearly, wellness is an important goal but ill-advised regulations issued by the Bush Administration cynically hid behind it to allow discrimination against employees who are sick through the use of non-bona fide wellness programs that penalize sick people but do nothing else to promote good health. Another good feature of the tri-committee bill is the requirement of minimum loss ratios of 85 percent, which will promote better value in health insurance. The bill grants broad authority to regulators to demand data from health plans in order to monitor and enforce compliance with the rule, and it creates a health insurance ombudsman that will help consumers with complaints and report annually to the Congress and insurance regulators on those complaints.

Another key feature in the bill is the creation of a health insurance exchange and organized insurance market with critical support services for consumers. The exchange will provide comparative information about plan choices and help with enrollment appeals and applications for subsidies. The exchange will negotiate with insurers over premiums to get the best possible bargain and importantly consumers and employers who buy coverage in the exchange will also have that choice of a new public plan option. I know you have talked today about the cost containment potential of such an option. It is all important that a public option would offer consumers an alternative to private health plans that for years have competed on the basis of discrimination against people when they are sick. Just last week, your committee held a hearing on health insurance rescissions that discussed people who lost their coverage just as they started to make claims.

At the Senate Commerce Committee hearing yesterday, a former officer of Cigna Insurance Company testified on common industry practices of purging employer groups from enrollment when claims

costs get too high. I would like to submit his testimony for your hearing record today. When consumers are required to buy coverage having a public option that doesn't have a track record of behaving in this way will give many peace of mind. And I left the rest of my statement in the folder. Isn't that terrible? There we are. I got it. I got it. I am so sorry. Second, a public plan will promote transparency in health insurance market practices. In addition to data reporting requirements on all plans, with a public plan option you will be able to see directly and in complete detail how one plan operates, and if private insurers continue to dump risk after reform it will be much easier to detect and sick people will have a secure coverage option while corrective action is taken.

Mr. Chairman, in my written statement I offer several recommendations regarding the draft bill and will briefly describe just a few of them for you now. First, the benefit package, the benefit standard in your bill does not require a cap on patient cost sharing for care that is received out of network and it really needs one. Also, the benefit standard does not specifically reference as a benchmark that Blue Cross/Blue Shield's plan that most members of Congress enjoy. Many have called on health reform to give all Americans coverage at least as good as what you have. It is not clear whether your essential benefits package meets that standard but if it doesn't, it should, and if that raises the cost of your reform bill, it will be a worthwhile investment to raise that 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. The stakes are high and it is important to get this right. The second rules governing health insurance must be applied equally to all health insurance. As drafted in your bill, some of the rules that will apply in the exchange might not apply outside of the exchange. Further, there is no requirement that insurers who sell both in and out of the exchange to offer identical products at identical prices. If the rules aren't parallel risk segmentation can continue. As an extra measure of protection, the tri-committee bill provides for added sanction on employers if they dump risks into the exchange and similar added sanctions should apply to insurers.

Another problem with non-parallel rules is the exemption for non-qualified health benefit plans and limited benefit policies called accepted benefits. Health care reform is your opportunity to end the sale of junk health insurance and you should do it. And, finally, Mr. Chairman, with regard to subsidies, the bill creates sliding scale assistance so that middle income Americans with incomes up to 400 percent of the poverty level won't have to pay more than 10 percent of income towards their premiums. But as charts in my written statements show, some consumers with income above that level could still face affordability problems, especially those who buy family coverage and baby boomers who would face much higher premiums under the 2 to 1 A trading. I hope you will consider phasing out the A trading and also setting affordability premium cap so that no one has to spend more than 10 percent of income on health insurance. Thank you.

[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 Energy and Commerce

June 25, 2009

Good afternoon, 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.

Mr. PALLONE. Thank you. I don't want to cut you short, Ms. Ignagni, so you can all wait until we come back. Hopefully, we won't be too long. I would say 20 minutes or so. Thank you.

[Recess.]

Mr. PALLONE. The hearing will reconvene, and we left off with Ms. Ignagni. Thank you for waiting.

STATEMENT OF KAREN IGNAGNI

Ms. IGNAGNI. Thank you, Mr. Chairman, members of the committee. It is a pleasure to be here, and having watched the hearing all day I just want to congratulate you. It is a wonderfully diverse group of people that you have assembled and you all should be congratulated. It was terrific to watch it. I think in the interest of time recognizing you have been here all day, I want to make just a couple of points. First, on behalf of our industry, we believe that the nation needs to pass health reform this year. We don't believe that the passionate debate on which direction or form that should take in any way should deter getting this done. It needs to happen. And to that end, I think it is somewhat disappointing that the focus generally in the press and here in Washington had been almost exclusively on the question of whether to have a government-sponsored plan or not. And I think in many ways one could say that it is obscuring the broad consensus that exists and indeed that I believe you built on in the legislation in several important areas.

First, we see several important areas. First, we see a consensus on improving the safety net and making it stronger. Second, providing a helping hand for working families. Third, a complete overhaul of the market rules. We have proposed an overhaul. You have imbedded it in this legislation. We firmly support it and congratulations for it. We think it is time to move in a new direction and we are delighted you are doing that. Next, a responsibility to have coverage. We think that is very important because, in fact, the market and many of the questions today about how the market works today really can be answered because until Massachusetts passed legislation requiring everybody to participate the industry grew up with the rules that are no longer satisfactory to the American people, and the opportunity to get everyone in and participating is an opportunity to charge a new course.

Next, the concept of one-stop shopping for individuals and small employers. Next, investments in prevention and chronic care coordination. Next, addressing disparities. Bending the cost curve. A number of the witnesses have talked about that today. We believe it is integral to moving forward. And, finally, improving the work force creating new opportunities and looking at where we have deficits and attending to them. The committee's draft contains many and all—actually all of these elements, and we commend you for it. Moreover, we feel that we have to seize the moment as a country and build on this consensus that will accomplish what has eluded the nation for more than 100 years and that is to pass health care reform.

The government-sponsored plan shouldn't be a roadblock to reform, and the key concept of introducing a government-run plan is that it would compete on a level playing field, but that is not what would happen. And, Mr. Chairman, as I sat here today, I thought

of an analogy, and just to reduce it to a clear and hopefully very direct way to explain our concerns, I want to make an analogy to a race between 2 people, one that makes the rules and at the same time says to the other competitor this is my 50-pound backpack and I want you to carry it. Cost-shifting for Medicare and Medicaid is that backpack for our health plans and we can't take it off in this race. The government plan will run without that encumbrance. Moreover, it will add weight to the backpack. We now pay hospitals 132 percent on average nationally of costs about 46 percent above Medicare rates. That has implications for preserving the employer-based system. We believe you cannot under those circumstances implications for hospitals and physicians who have long expressed concerns about Medicare rates and the adequacy or not adequacy—not being adequate, and the implications for the deficit which are not being taken into account.

We believe that the most important message we can convey is that we have tools and skills to provide. Indeed, we have pioneered disease management and care coordination. We pioneered opportunities for individuals to be encouraged when their physician finds it acceptable to substitute generic drugs. We are recognizing high quality performance in hospitals and physicians, and we are moving down a path of showing results. Imbedded in our testimony are some of those results, which are very specific and very measurable about what we are doing and how we are doing a better job. We can help with traditional Medicare. We can bring more of those tools, but we hope that you will recognize the 50-pound backpack and the weight as we explain our concerns with a government-sponsored program.

The most important message I can convey to you today is not to let what people disagree on threaten the ability to pass reform this year. Our members have proposed and are committed to a comprehensive overhaul of the current system. We have appreciated the opportunity to discuss key features of the bill with your staff, and we pledge our support to work to achieve legislation that protects consumers and provides health security to patients. Thank you very much.

[The prepared statement of Ms. Ignagni follows:]

Testimony on Comprehensive Health Care Reform

by

Karen Ignagni
President and CEO
America's Health Insurance Plans

for the
House Energy and Commerce Committee, Subcommittee on Health

June 25, 2009

I. Introduction

Chairman Pallone, Ranking Member Deal, and members of the subcommittee, I am Karen Ignagni, President and CEO of America's Health Insurance Plans (AHIP), which is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. Our members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

We appreciate this opportunity to testify on comprehensive health care reform and the draft legislation that has been developed by the House committees. We believe that health reform needs to be enacted and signed into law this year, and we are strongly committed to playing a constructive role in this debate.

For more than three years, AHIP's members have been working to develop workable solutions to the health care challenges facing the nation. The end result of these extensive deliberations is that AHIP's Board has endorsed comprehensive proposals for significant restructuring of the health care system with three cornerstone goals: achieving universal coverage; reducing the future growth rate of health care costs; and improving quality of care.

These proposals would reform the U.S. health care system with a broad-based strategy for ensuring that no one falls through the cracks, while also promoting quality improvements and providing greater value for the dollars our nation spends on health care. While building upon the strengths of the current system, our plan includes major insurance market reforms that would fundamentally transform our members' business practices and, in so doing, provide peace of mind to all Americans, regardless of their health status or medical history.

Our testimony today focuses on the following topics:

- proposals AHIP's Board of Directors has endorsed for advancing a high quality, affordable, patient-centered health care system;

- our work with other stakeholders to contain health care costs and enhance value throughout the system;

- the consensus that already exists for enacting bold reforms to meet the health care needs of the American people;

- comments on the House draft health care reform bill; and

- the importance of strengthening Medicare and Medicaid to maintain a health care safety net for our nation's most vulnerable citizens.

II. AHIP's Comprehensive Proposals for Health Care Reform

To achieve comprehensive health care reform, AHIP has proposed a plan that provides universal coverage, cost containment, and quality improvement. Our plan focuses on ensuring that no one falls through the cracks of the health care system, providing all individuals with portability of coverage and continuity of care, fundamentally overhauling regulation in the marketplace, improving information and transparency for consumers, taking bold steps to ensure that coverage is affordable, and clearing obstacles to the next generation of quality improvement innovations. As discussed below, this strategy would achieve universal coverage *without* jeopardizing quality improvement initiatives that are working in the system today, *without* exacerbating cost shifting already occurring, and *without* undermining employer-based coverage.

Insurance Market Reforms

We are proposing to combine guarantee-issue coverage with an enforceable individual health insurance requirement and premium assistance to make coverage affordable, while eliminating preexisting condition exclusions and eliminating rating based on health status in the individual market.

We envision a rating system based on the following demographic factors: geography, age, and product type, and we note that the legislation proposes an approach built on these factors. Given the need to improve health status and encourage prevention, we also encourage Congress to provide flexibility for plans to offer premium discounts to individuals who make healthy choices, such as not smoking, participating in wellness programs, and adhering to treatment programs for chronic conditions.

Another key element of our proposal calls for premium assistance to ensure that coverage is affordable for lower-income individuals and working families. We are proposing refundable, advanceable tax credits that would be available on a sliding scale basis for those earning less than 400 percent of the Federal Poverty Level. Additional steps are needed to promote tax equity for individuals purchasing health insurance on their own.

Helping Small Business

Small business owners find themselves in an increasingly difficult marketplace for health insurance because of rapidly rising health care costs and the limited ability of most small businesses to bear risks, contribute a substantial share of costs, or support administrative functions. A policy statement approved by AHIP's Board of Directors in March 2009 outlines solutions, some of which also apply to individuals, for helping small businesses:

- **Essential Benefits Plan:** We propose the creation of new health plan options for small employers and their employees, as well as individuals. These "essential benefits plans" would be available nationwide and would include coverage for primary care, preventive care, chronic care, acute episodic care, and emergency room and hospital services. Alternatively, "essential benefits plans" should include coverage that meets an actuarial equivalence standard, along with the opportunity to include enhancements such as wellness programs, preventive care, and disease management. To maintain affordability, the essential benefits plan should not be subject to state benefit mandates that do not apply to the generally larger employers that enter into self-funded health care coverage arrangements.

- **Tax Credits or Other Incentives to Assist Small Business:** We support the establishment of tax code incentives or other types of assistance that encourage both small business owners to offer coverage to their employees and employees to take up coverage. We recognize the special challenges, both administrative and financial, that small businesses face in offering contributions toward their employees' coverage. Providing assistance can encourage these contributions and help enable employees to take up coverage which improves predictability and stability in the small group market.

- **Improving Coordination of Private and Public Programs Strengthens Small Group Coverage:** Premium or other assistance offered to low-income individuals and working

families can be applied to and work with employer-sponsored coverage. This is important whether the assistance is provided through Medicaid, the Children's Health Insurance Program (CHIP), or other expanded programs designed to help individuals and families obtain coverage. Improved coordination allows workers to take up coverage offered by small businesses by leveraging both public and private sources of assistance, and benefits the firms' employees as a whole by increasing rates of participation in the small group plan.

- **Micro-firms:** "Micro-firms" (those with fewer than 10 employees) face special challenges in offering coverage. Statistics show that only about one-third of these firms offer coverage. This reflects the administrative, financial, and logistical challenges many micro-firms face in setting up and establishing plans and offering and contributing to their employees' coverage. To help these firms meet these challenges, enhanced tools could be developed that would allow those micro-firms that have found it impractical to offer coverage, to contribute to coverage purchased on a pre-tax basis by individual employees. As part of comprehensive health care reform, employees could then use these contributions to help purchase coverage in a reshaped health care system that combines an individual requirement to obtain coverage with reforms in the individual market.

- **One-stop information source:** All small firms will benefit from collaborative efforts between health plans and the public sector (e.g., insurance commissioners) to ensure that small employers and individuals have one-stop access to clear, organized information that allows them to compare coverage options. This "one-stop shop" also could allow individuals to confirm eligibility for tax credits or other assistance and even provide a mechanism to aggregate premium contributions from multiple sources. By providing a mechanism to combine even modest contributions from multiple sources (public and private), this new one-stop shop could be especially helpful to employees who may hold multiple jobs.

Strengthening the Employer Group Market

We support building upon the existing employer-based system, which currently covers 177 million Americans according to the U.S. Census Bureau. It is a key part of our economic fabric. Although the employer-based system faces challenges, more than 90 percent of employers report that offering high-quality coverage is important to their ability to recruit and retain valuable workers and enhance employee well-being. Thus, as a first priority, the nation's reform agenda should be committed to a policy that "first does no harm" to that system and limits strategies that

would reduce employer coverage. Focus should be placed on retaining a national structure for the employer group market that continues to promote uniformity and ensures the smooth functioning of the employer-based system.

At the same time, the nation's economic uncertainties and job losses underscore the need for new strategies to assist individuals who become unemployed or are transitioning from job to job. While a Congressional Budget Office (CBO) study found that nearly 50 percent of the uninsured go without coverage for four months or less, additional protections are still needed. We propose ensuring that tax credits are available to individuals on an advanceable basis to help them through job transitions along with access during these times to more affordable coverage options consistent with our proposal for a basic benefits plan.

III. Containing Health Care Costs and Enhancing Value

The success of health care reform will be closely linked to the implementation of strategies that contain costs and enhance value, in addition to expanding coverage.

Recognizing the importance of cost containment, AHIP recently joined other stakeholder groups in sending a letter to President Obama, outlining our collective proposals for achieving cost savings as part of the broader health care reform effort. This letter was signed by AHIP, the American Hospital Association (AHA), the American Medical Association (AMA), the Pharmaceutical Research and Manufacturers of America (PhRMA), the Service Employees International Union (SEIU), and the Advanced Medical Technology Association (AdvaMed).

The joint letter addressed to the President was accompanied by recommendations from each stakeholder organization for containing costs. AHIP's submission outlined a series of policy proposals and current initiatives to promote administrative simplification, advance health information technology, reward quality and value, and empower patients to more effectively engage in the health care system.

Our administrative simplification efforts are focusing on two particularly important priorities:

- Our members have committed to a comprehensive overhaul of administrative processes to standardize and automate five key functions: claims submissions, eligibility, claims status, payment, and remittance. The move to fully automate and standardize these administrative transactions will allow physicians, hospitals, and other health care providers to reduce their administrative costs substantially. This is a critically important component of our nation's overall strategy for containing costs and freeing up funds to achieve universal coverage. We are committed to this initiative, and we appreciate that the House bill addresses the need for investments in these priorities.

- We are preparing to launch a major effort that will make common administrative tasks in physician offices simpler, more efficient, and less expensive. Beginning with pilot tests in Ohio and New Jersey that will inform a national strategy, our community is establishing a web-based system that will allow physicians to conduct business with insurers throughout a region or state at one website, reducing the need to visit multiple websites and/or spend hours on the phone. Common web portals will virtually eliminate paperwork, improve efficiency through the system, and yield significant savings.

In addition to this industry-wide effort, our members are implementing a wide range of plan-specific initiatives to realign payment incentives to reward value and outcomes, rather than reward the volume of services delivered. A recent monograph released by AHIP, entitled "Innovations in Recognizing and Rewarding Quality," highlights key private sector initiatives that have been implemented throughout the nation to move the system toward a value-based structure. This publication demonstrates that innovative care coordination programs that enhance outcomes and reform payment incentives are being implemented in the private market with an infrastructure, which is often lacking in public programs, that will be valuable in reforming the health care system.

One notable example is California's pay-for-performance program, sponsored by the Integrated Healthcare Association (IHA). This program involves 235 physician groups representing approximately 40,000 doctors who provide care for 11 million commercial HMO patients in California. Since 2004, participating plans have awarded more than $265 million in payment incentives based on the performance of physician groups with respect to clinical quality and patient experience measures and the adoption of information technology to support systematic, evidence-based care. A recent survey of participating physician groups revealed that this

program has increased accountability for quality, accelerated the adoption of health information technology, improved data collection for quality management, and created greater focus and support for quality improvement initiatives.

This model demonstrates the innovation that is possible when stakeholders come together to collaborate and agree on performance measures, and shows that quality improvement and cost containment are compatible goals. Moreover, the IHA's success underscores that payment reform is achievable in the near-term and should be implemented as quickly as feasible.

Health plans are pursuing or recommending additional payment reforms in the following areas:

- establishing prospective payment for defined services that better coordinate care and achieve results through medical homes and similar models which utilize team-based medical care and non-physician practitioners;

- revising scope of practice rules that inhibit the use of non-physician health practitioners;

- recalibrating the Medicare physician fee schedule to eliminate incentives that favor specialty care over primary care, with a transparent public process for determining rates;

- moving from single provider payments to "bundled" payments;

- implementing computerized drug order entry systems and electronic prescribing; and

- eliminating reimbursements for preventable hospital readmissions and for "never events" (i.e., involving preventable medical errors).

These fundamental reforms address the reality that the rising cost of health care in the United States is unsustainable, that the quality of care varies greatly, and that millions of Americans lack access to quality, affordable care. Implementation of these initiatives will represent an important step toward advancing a patient-centered health care system in which care is safe, timely, efficient, effective, and equitable – while at the same time constraining costs to advance the broader goal of achieving universal coverage for all Americans.

IV. Consensus on Framework for Reform

Despite the strong disagreements that exist on certain issues in the health care reform debate, we believe it is important to recognize that there is a widespread consensus among policymakers and stakeholders about the need for bold legislative action in many key areas.

For example, there is a shared agreement for moving forward immediately with sweeping insurance market reforms and new consumer protections, bringing everyone into the system through an individual coverage requirement, providing premium assistance to make coverage affordable, strengthening the Medicaid safety net, reducing health disparities, taking strong measures to promote wellness and prevention, using health information technology to improve health outcomes and achieve greater cost efficiencies, and employing innovative strategies to meet the needs of patients with chronic conditions.

We applaud the House committees for developing a bill that addresses these important priorities, particularly the basic structure of combining insurance market reforms with an individual coverage requirement and premium assistance to make coverage affordable. These provisions could serve as the building blocks for consensus legislation that would be widely supported by Congress, by the American public, and by a wide range of stakeholders. Recognizing the potential that exists for major legislative accomplishments on these critical issues, we believe the uncertainty surrounding other issues – including a government-run health insurance plan, which we discuss below – should not be allowed to delay congressional action on key reforms that could be enacted with widespread support in the immediate future.

V. Comments on the House Draft

While we agree with many elements of the House bill, we believe that there are some fundamental problems in this legislation that would work against the objective of ensuring that those who like their existing coverage are allowed to keep this coverage under a reformed health care system. We are concerned that some of the bill's provisions – most notably, the creation of a government-run health insurance plan – would undermine this important goal and disrupt a

system in which, according to a recent *New York Times* survey, 77 percent of Americans are satisfied with their existing health insurance coverage.

We have three major concerns about a government-run plan: that it would hamper the development of the best-quality delivery system for consumers; that it would undermine the current health care financing system, including increasing rather than lowering costs for consumers; and finally that it would not deliver the necessary value to consumers in terms of preventive measures.

Government-Run Health Insurance Plan Thwarting the Creation of the Highest-Quality Delivery System

We share the concerns that employers, providers, and patients have raised about the significant unintended consequences of a new government-run health insurance plan. A government-run plan using Medicare reimbursement rates would erode the employer-based system, significantly increase costs for those who remain in private coverage, and add additional liabilities to the federal budget. Alternatively, strong market rules and consumer protections will ensure that nobody falls through the cracks and will do so without disrupting the coverage of tens of millions of Americans who like and want to keep their current health plans.

We are particularly concerned that a government-run plan would undermine efforts to transition to a high quality health care delivery system. Recognizing that the traditional Medicare program has made very little progress in developing innovative care management programs, we are concerned that creating a government-run health insurance plan for the broader population would result in tens of millions of Americans being enrolled in a new coverage option that lacks a meaningful commitment to care coordination, disease management, health promotion, and other pro-active initiatives that have been successfully implemented by private sector health plans.

Government-Run Plan Undermining the Current Health Care Financing System and Ultimately Increasing Costs

While we have many serious concerns about establishing a government-run plan, there is one issue that deserves particularly close scrutiny. Specifically, we are concerned that a government-run plan would exacerbate the cost-shifting that already occurs, from public programs to private payers, as a result of the inadequate reimbursement rates that Medicare and Medicaid pay to hospitals and physicians. According to a recent Milliman study, an average family of four already pays a hidden tax of more than $1,700 annually on their premiums because Medicare and

Medicaid significantly underpay hospitals and physicians, compared to their actual costs of delivering medical care. To offset these inadequate payments, providers pass on higher costs to individuals, families and employers in the private sector.

If Congress establishes a new government-run health plan, this hidden tax on consumers could add billions of dollars to the federal budget. Because of lower payment rates, the insured population would migrate from employer coverage to the new government-run plan and providers would have a declining base to shift costs to in the remaining commercial market. Eventually, this dynamic would accelerate with rising costs in the private market because of the exacerbating cost shift, causing further declines in private coverage and leaving significant costs to be covered by the federal budget.

To better understand the severity of this problem, it is helpful to examine real world data on the impact a government-run health insurance plan, using Medicare reimbursement rates, would have on specific hospitals. In recent months, AHIP's Center for Policy and Research has conducted a research project analyzing data from California to demonstrate how a switch to Medicare fee-for-service reimbursement rates would affect the revenues and net income margins of 381 hospitals in California.

The findings of our study are very revealing. They show, for example, that California's acute care hospitals would collectively experience a net revenue loss of $3.5 billion annually if 50 percent of individuals who currently are privately insured are moved into a government-run plan that pays hospitals using Medicare rates. (This projection assumes that a reformed system would achieve universal coverage, providing relief to hospitals from the costs of uncompensated care.)

The findings for specific hospitals are equally alarming. Cedars-Sinai Medical Center, which was reimbursed by Medicare at 72 percent of its actual costs in 2007, would lose $268 million annually if even 50 percent of its patients moved from private coverage to a government plan paying Medicare reimbursement rates. Stanford University Hospital, which was reimbursed by Medicare at 82 percent of its actual costs in 2007, would lose $160 million annually under the same scenario. Hundreds of other hospitals throughout the state, and thousands throughout the nation, would be driven into financial crisis by shortfalls of this magnitude.

The economic realities surrounding this issue are directly related to the ability of a government-run plan to set reimbursement rates below the actual cost of delivering care and below the rates

paid by private plans. The assumed consequence of lower reimbursement rates is lower premiums and cost-sharing in the government-run program, attracting those with private coverage to the government-run option.

Ultimately, with the loss of cross-subsidization by the private sector, we estimate that public programs would face hundreds of billions of dollars in additional costs that are not accompanied by a commensurate revenue offset. This is in addition to the existing Medicare trust fund deficit.

Value-Based Competition

Despite the serious concerns we have raised about a government-run plan, we want to emphasize that private health plans would outperform a government plan if the competition was based solely on value, and not on the ability to impose government-administered reimbursement rates. To illustrate this reality, we call attention to two other AHIP analyses that compare the performance of Medicare Advantage plans and the Medicare fee-for-service program in keeping beneficiaries healthy and avoiding unnecessarily hospitalizations and emergency room visits. The tables below show that, by taking a pro-active approach to coordinating patient care, Medicare Advantage plans have been highly successful in reducing hospital admissions, readmissions, and emergency room visits for diabetes patients and heart disease patients, as well as the broader population of Medicare Advantage enrollees. By reducing the need for hospitalizations and emergency room care, private plans are not only improving the health and well-being of Medicare beneficiaries – but also achieving greater efficiencies and cost savings.

California Data from AHRQ on Hospital Discharges

Data from 2006	All Hospitals, Patient Age 65-69	Diabetes Patients	Heart Disease Patients
MA Rate vs. FFS Rate (Per Risk Score Value)			
Inpatient Hospital Days	-34%	-40%	-34%
Re-Admissions, Same Quarter, Same DRG	-17%	-23%	-16%
13 "Potentially Avoidable" Admissions (AHRQ definitions)	-4%	-9%	-3%
Source: AHIP analysis of AHRQ data for discharges from all hospitals in California in 2006.			

Seven MA HMOs vs. FFS in Same Counties Adjusted for Risk Scores, Simple Averages

Data from 2005 and 2006 (pooled)	All Enrollees	Diabetes Patients	Heart Disease Patients
MA Rate vs. FFS Rate (Per Risk Score Value)			
Hospital Days	-18%	-21%	-14%
Hospital Admissions	-10%	-13%	-7%
ER Visits	-32%	-35%	-31%
Re-Admissions, Same Quarter, Same DRG	-41%	-45%	-37%
13 "Potentially Avoidable" Admissions (AHRQ definitions)	-12%	-15%	-8%
Source: AHIP analysis of FFS 5% sample claims files and data from 7 regional MA plans.			

Issues With the Proposed Health Insurance Exchange

We believe that every state should have a system through which individuals and families can evaluate coverage options offered by all health plans, and receive assistance in understanding their choices. We are concerned, however, that the regulatory structure for the proposed Health Insurance Exchange would replicate functions now being carried out by state insurance commissioners, creating an overly complex regulatory environment without providing an equally meaningful improvement in access. To address this concern, we believe the responsibilities of the Exchange should be redefined to promote a more workable regulatory structure. Moreover, to promote health plan choices that compete based on quality and price and to improve choices for individuals and employers, we encourage you to revise the bill to allow health plan choices to be offered to individuals outside of the Exchange and to ensure that premium assistance is available to all qualifying individuals and families, not just to those who pursue coverage that is offered through the Exchange.

In addition, to maintain employer-provided coverage, we believe the Health Insurance Exchange should focus on serving individuals and micro-groups, and we recognize the committee's caution in this area. Opening the Exchange to larger groups would unravel existing risk pools and undermine the current system of employer-sponsored coverage. Such a proposal would incentivize large employers with younger and healthier workers to self-fund, while those larger

employers with older and less healthy workers would join the insurance pool – significantly driving up premiums for individuals and small employers.

The Bill Imposes a Confusing and Costly New Regulatory Structure

We also are concerned that the bill proposes an overlapping and potentially conflicting regulatory structure for employers and health insurers. In general, the bill would divide responsibility for oversight, rulemaking, and enforcement between six governmental entities: (1) a new independent federal agency, the Health Choices Administration and a Health Choices Commissioner appointed by the President; (2) a newly created Health Insurance Ombudsman; (3) the Department of Health and Human Services; (4) the Department of Labor; (5) the Department of the Treasury; and (6) state insurance regulators.

We believe the federal government should establish consistent rules that are applied across the country and enforced by the states. We encourage the committee to establish consistent rules and clear lines of regulatory responsibility, instead of establishing new structures that create confusion and duplicative state and federal roles.

We also suggest that in establishing new rules for the insurance market, consideration should be given to clarifying what types of coverage will be covered by the new rules. We believe the bill should clarify that the market reforms aimed at major medical coverage do not apply to products that currently are considered to be "excepted benefits" under HIPAA.

Health Choices Commissioner

We have concerns that the proposed legislation delegates too much authority to the new Health Choices Commissioner, and we would recommend that the legislation provide clear and consistent standards that could be implemented inside and outside the Exchange. Under the House bill, the Health Choices Commissioner would be given unprecedented, sweeping authority over employer and union sponsored group health plans, group and individual health insurers, the public health insurance option, Federal Employees Health Benefits plans, and state and local government employee plans, as well as supervision of the Health Insurance Exchange and state-based exchanges.

Age-Based Rating

We are concerned that the House bill fails to sufficiently balance the importance of making premiums affordable for all purchasers with the goal of building a universal system. By strictly

limiting premium variation based on age to a ratio of 2:1, the bill would force young people to heavily subsidize the naturally higher health care costs of older individuals. We believe the balance would be better aligned with subsidies to ensure those with higher costs are not penalized, while allowing premiums to more accurately reflect the natural characteristics of health expenditures that rise with age.

According to the Census Bureau, people in the 18-34 age category currently are twice as likely to be uninsured as those in the 45-64 age category. If Congress establishes a 2:1 ratio for age-based rating, young people will be paying premiums that are significantly higher than their actual health care costs. Moreover, because young people have below-average incomes relative to the broader population, the existing bill language would increase the likelihood that they would qualify for an exemption from the bill's individual coverage requirement – thereby undermining the committee's goal of achieving universal coverage. To avoid this outcome, we urge the committee to consider expanding the ratio for age-based rating.

Synchronization of Market Reforms and Individual Coverage Requirement

It is critical to ensure that the timing of the individual coverage requirement is synchronized with market reforms and the availability of financial assistance to low- and moderate-income families and individuals to bring everyone into the system and ensure that persons who currently have health insurance coverage are not adversely impacted by higher costs. If this objective is not met, individuals and families who are covered in the individual market may experience unintended consequences similar to those experienced in several states where insurance market reforms were enacted in the absence of universal coverage in the 1990s. A 2007 report by Milliman, Inc. found that some people in these states responded to these reforms by deferring coverage until they experienced health problems – resulting in higher premiums for those with insurance, reduced enrollment in the individual health insurance market, and no significant decrease in the number of uninsured.

The Need for Flexibility in Benefit Packages

Our members have been leaders in proposing ideas to not only assure health care coverage to all Americans, but to drive a transformation of our health care system to ensure that our country can support innovation by determining what procedures and technologies are safe and most effective, and to improve clinical quality through better dissemination and transparency of information on safety, effectiveness, and performance. Thus, we are concerned that the bill employs language that would seem to "turn back the clock" and allow the "essential benefits package" to be defined

in terms of "generally accepted standards of medical or other appropriate clinical or professional practice."

Instead of delegating to an advisory committee the task of establishing benefit packages, we believe the House bill should establish categories of coverage and reasonable actuarial value ranges to promote innovation and flexibility, while allowing the availability of an affordable range of benefit offerings. For example, health insurance plans have developed tools to support employer-based prevention initiatives. Recognizing that these tools have had positive results in reducing smoking and improving participation in wellness and chronic care management, we urge the committee to consider making the legislation more flexible to allow employers and their employees to continue to benefit from these tools. By promoting benefit designs that encourage prevention and chronic care management, we can take important steps to improve health outcomes and provide greater value for the dollars we spend on health care.

We recognize and appreciate that the bill takes into account the financial burden of state benefit mandates, which are not always based on clinical evidence or outcomes.

"Medical Loss Ratio" Requirements as Counterproductive

Additional concerns are raised by a provision of the bill that would establish medical loss ratios that fail to measure the value provided by a particular health plan. This requirement has the potential to undermine the bill's objective of advancing administrative simplification and other initiatives to improve quality and contain costs. It also would adversely affect private sector initiatives, as we discussed earlier, to standardize and automate key health plan functions to simplify administrative processes for patients and clinicians.

Because funds spent on administrative simplification are not categorized as patient care expenses for purposes of calculating medical loss ratios, this provision could limit the ability of health insurance plans to devote funds to improving the system for patients and providers and, ultimately, to improving the quality of care that patients receive. Similar challenges would result for initiatives addressing health information technology, disease management, health disparities and culturally and linguistically appropriate services, and other activities that provide value to consumers.

Medicare Advantage Funding

We are deeply concerned that the Medicare Advantage funding cuts proposed by the House bill would have a harmful impact on health care choices and benefits for the 10 million Medicare beneficiaries who rely on Medicare Advantage plans to meet their health care needs. The proposed cuts would cause major disruptions for millions of Medicare beneficiaries, eliminating health plan choices for many and leading to reduced benefits and higher out-of-pocket costs for others. Another serious concern is that if Congress enacts this legislation, many beneficiaries will lose the care coordination and other innovative strategies that Medicare Advantage plans have implemented to help keep beneficiaries healthy, detect diseases at an early stage, and coordinate care across the full range of health care settings and services.

The proposed cuts would have a particularly deleterious effect in rural and other areas with low fee-for-service costs that have benefitted from previous congressional decisions to increase plan participation and beneficiary enrollment in the Medicare Advantage program. To ensure that a minimum level of payment would be maintained in every county, Congress deliberately established payment floors that caused health plan payments to be higher than Medicare FFS spending in certain geographic areas. The impact of these payment floors, first enacted in 1997 and then revised in 2000, continues to be seen today in the benchmarks that form the basis for bidding under the current Medicare Advantage payment system.

Numerous members of Congress – both Democrats and Republicans – sponsored bills proposing higher payment floors as far back as ten years ago. These payment policies were enacted in recognition of market conditions that historically have made it difficult for Medicare health plans to contract with providers who may have local monopolies in certain rural or small urban areas. The establishment of the payment floors has allowed a wide range of Medicare Advantage plans to offer health plan choices to beneficiaries who previously had no options outside of the Medicare FFS program.

The additional value that Medicare Advantage plans provide is especially valuable to low-income beneficiaries. Analyses of CMS data demonstrate that Medicare Advantage plans are the most popular option for beneficiaries with incomes between $10,000 and $20,000. The importance of Medicare Advantage is further demonstrated by the results of an AHIP survey which found that 62 percent of beneficiaries who identified themselves as having annual incomes below $20,000 said they would skip needed health care services their Medicare Advantage plans provide if their plans were to no longer participate in the program.

Previous analysis indicates the impact the House bill would have on Medicare beneficiaries. The Congressional Budget Office's analysis of the 2007 CHAMP Act, which included similar provisions, found that Medicare Advantage enrollment would decline by approximately 3 million beneficiaries within five years – almost one-third of the beneficiaries currently receiving care through Medicare Advantage plans. Recognizing that Medicare Advantage plans offer a coordinated and quality-focused approach to patient care, we urge you to reject funding cuts that would undermine the availability of these important health plan choices.

VI. Improving Public Programs

Separate from the debate on comprehensive health care reform, it is important for policymakers to maintain a strong focus on preserving Medicaid and Medicare as health care safety nets for our nation's elderly, disabled, and low-income citizens.

The Medicaid program has been tremendously successful. Medicaid spares millions of low-income Americans from joining the ranks of the uninsured. A great deal of this success can be explained by the program's focus on the unique needs of the populations it serves. Studies demonstrate that Medicaid beneficiaries are more likely to report they are in fair or poor health and have higher rates of chronic health conditions and a host of co-existing characteristics such as low literacy and inadequate housing. Recognizing these unique needs, we believe it is important that traditional Medicaid beneficiaries continue to be guaranteed coverage outside of the Health Insurance Exchange that the House bill would establish under a reformed health care system.

Medicaid health plans have been key contributors to the success of the Medicaid program. These health plans have developed systems of coordinated care for ensuring that Medicaid beneficiaries are able to access the full range of health care services on a timely basis, while emphasizing prevention and providing access to disease management services for those with chronic conditions. Recognizing that Medicaid health plans are designed to meet the unique needs of low-income individuals, we would like to work with you to ensure that Medicaid beneficiaries continue to have access to the integrated care provided by these plans. This means more vigorous enforcement of federal actuarial soundness requirements for Medicaid health plan rates

and addressing the growing trend of states during the economic downturn to carve out prescription drugs from Medicaid health plan benefits which undermines Medicaid health plan care coordination activities.

We also would like to work with you to promote the increased availability of health plans and the systems of care and services they offer for beneficiaries who have long-term care needs and are dually eligible for Medicare and Medicaid. AHIP's members are working to build upon their experience offering dual eligible special needs plans (SNPs) under the Medicare Advantage program to expand partnerships with state Medicaid programs to serve these beneficiaries. The successful initiatives in several states where health plans and states have worked together to create innovative programs for individuals with disabilities and chronic conditions offer examples of the positive results that can be achieved. These programs typically focus on increasing the opportunities for the elderly and individuals with disabilities to choose home and community settings, decreasing the need for nursing home care, and reducing hospitalizations.. For beneficiaries, this means improved health outcomes and better quality of life. AHIP appreciates the House bill's focus on better coordinating Medicare and Medicaid benefits. We are closely reviewing the provisions for fully integrated dual eligible SNPs and look forward to working with you to promote these common goals.

Our members also believe that Medicare Advantage should be an integral part of any solution for ensuring the long-term stability of the Medicare program. Medicare Advantage plans play an important role in strengthening the Medicare fee-for-service program for beneficiaries by demonstrating the value of coordinated care through integrated delivery systems that are lacking in the traditional program. Medicare Advantage plans focus on prevention and offer disease management programs for beneficiaries with chronic diseases, promote access through comprehensive provider networks, and share performance data with providers to support quality improvement activities.

Medicare Advantage plans also have been an important resource for many low-income Americans who are not eligible for coverage in the Medicaid program. By providing affordable access to coverage of services beyond those covered by the Medicare program and reducing cost-sharing for Medicare-covered services, Medicare Advantage plans have been instrumental in ensuring that many low-income beneficiaries receive the health care services they need.

VII. Conclusion

AHIP appreciates this opportunity to outline our recommendations for comprehensive health care reform and our views on the House's draft legislation. Our complete set of policy proposals are outlined in a series of Board statements we have released since December 2008. We are strongly committed to working with committee members and other stakeholders to develop solutions for ensuring that all Americans have access to high quality, affordable health care coverage.

Mr. PALLONE. Thank you. Ms. Trautwein.

STATEMENT OF JANET TRAUTWEIN

Ms. TRAUTWEIN. Thank you very much. And being the last witness of the day, I will try to not repeat everything that everyone else has said. What I would like to do is I agree with everything Ms. Ignagni has just said except that I do want to say one thing, and that is that the details matter. And one of the things that our members do for a living is we look at a lot of the details, and I feel it incumbent to bring up a couple of those because I think we do need to make sure that we get these things straightened out before we move forward. I do want to stress that we don't want to not move forward. We want health reform and we want it done correctly. I do want to mention a couple of things to illustrate to you that we have got to get some of these things that may appear to be small straight because they could have huge implications.

First of all, I want to mention the rating provisions in the bill, and I want to stress I am not talking about the no pre-existing conditions. I am not talking about the no health status rating. I am not talking about anything like that. I am talking about specifically the modified community rating provisions. Currently the bill uses something called an age band of 2 to 1. I am not going to go into details about that except to tell you that it is too narrow. And, Mr. Chairman, I would like to use your own state for an example of it being too narrow. New Jersey recently went to 3½ to 1 age bands because what they had was too narrow already and it wasn't affordable for people. The gentleman on the last panel that talked about New Jersey rates of $13,000, they are in a situation of 2 to 1 age bands, and that is one of the reasons why it is too expensive. So we want to make sure that we establish bands that allow wide enough adjustments to make it affordable for more people so that we don't end up losing a lot of the young person participation.

In addition, one of our very specific concerns has to do with the fact that this bill tends to lump all groups that are what we call fully insured together, whether they are a group of 10 people, 50 people, or 200 people, and the modified community rating provisions apply to all of them. Today, groups of over 50 on a gradual basis use their own claims experience, and when I talk about claims experience, I don't mean perspective health status ratings where they fill out a health statement in advance. I mean that the group develops community rates based on the experience of their own group of employees. It is very cost effective. It allows them to keep their rates low over time, and I would point out this is not a market that has problems today. These are not the people that are knocking on your doors telling you that they have a problem.

And I would encourage you to not eliminate that ability for them to do that because the rate shock to the employers in that category will be fairly significant. I would also like to point out that the grandfathering provisions really need to be improved, and there are a couple of areas that I am thinking are probably just mistakes, it is a draft, inside the bill that ought to be changed. The provision, first of all, is too strict for individuals. It only allows them to add family members and frequently these policies are reviewed on an annual basis and other minor adjustments need to be made. For

example, a person that has an HAS qualified plan has a legal adjustment to be made relative to the deductible on an annual basis, and the bill doesn't really allow for that. And then groups, of course, are not really grandfathered. They have a phase-in period over 5 years, and we would be hopeful that groups could keep their coverage longer than that period of time.

The one thing I want to talk about that I don't think anyone else has mentioned has to do with risk adjustment. This is something that we look at a lot. We are very involved with risk adjustment and reinsurance plans to make sure that they are stable. I am very concerned that the risk adjustment that is suggested is not adequate for starting up this program.

The risk adjustment suggested is more something you would do once your exchange had been in effect for a period of time and it would adjust risks among the plans inside the exchange. It doesn't account for what is going to happen initially when we have lots of people entering the system, many of whom may have serious health conditions. For example, the way that your bill is written today on day one of guarantee issue every single person in this country that is in a high risk pool will come immediately into that pool, so we got to have something to mitigate the cost of those high risks coming in so that you don't end up with something you don't want which is a pool that results in costs that are higher instead of lower, so again these details are important that we get them straightened out correctly.

I would be remiss if I didn't say something else about the public program. Like many of the people that have talked here today, we are very worried about a government run public program. I want to talk specifically about the cost shifting. There are a lot of things that we have concerns about but we do definitely see the impact of cost shifting. We all have heard the statistic but I think it bears repeating again. Almost $1,800 a year for the average family of 4 is a direct result of today's cost shifting without a new public program. And I want to mention one other thing. I see that I am out of time but I want to mention this very quickly. We have heard state premium taxes mentioned here many times today, but I want to kind of put a face on that because in New Jersey alone state premium taxes are $503 million annually to the state and they are not dedicated to insurance. They have gone to other programs.

We have programs in North Carolina, Connecticut, Kentucky, Pennsylvania, North Dakota that were state premium taxes from firefighter programs. They buy equipment to fight fires and so these funds, I don't think the states can do without this revenue source. It is another example of how we are not going to have a level playing field and we need to think this through a little bit more carefully. And I have additional information but I am out of time so I will go ahead and stop now.

[The prepared statement of Ms. Trautwein follows:]

Statement for the

United States House of Representatives
Committee on Energy and Commerce

June 25, 2009

Hearing on the
Comprehensive Health Reform Discussion Draft

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National Association of Health Underwriters

America's Benefits Specialists

The National Association of Health Underwriters (NAHU) is pleased to be able to play a constructive role in crafting bipartisan, comprehensive health care reform legislation this year. We have an historic opportunity to put in place real solutions to reduce costs, improve quality and ensure choice and access for all Americans in a way that will strengthen our health system and our economy.

As an association representing more than 100,000 health insurance agents, brokers and benefit specialists from every state in the country, the members of NAHU work with both individual and corporate health insurance consumers to help provide them with high-quality affordable health plans specifically suited to their unique needs. NAHU has analyzed the discussion draft and we have a number of questions and concerns about many aspects of the proposed legislation.

Market Reforms

The legislation creates significant market reforms to all health insurance markets. It would require all qualified health benefit plans (QHBPs) to accept enrollees regardless of health status, and would eliminate the use of pre-existing conditions exclusions and limits on benefits (other than cost-sharing) that are unrelated to the clinical appropriateness of the covered treatments. All fully insured plans, regardless of size, would be guaranteed-issue and guaranteed renewable. These plans would also be subject to strict modified community rating standards c· sisting of variances only by family structure, geographic locations and age bands that would limit premium a...erences for the oldest insured individuals to differ from the youngest insureds by a ratio of two to one.

NAHU has very significant concerns about the proposed reforms, particularly that they provide no distinction between small- and large-employer groups, as there is in today's marketplace. Under current law, fully insured employer groups over 50 lives are treated very differently than the small-group market, and these groups are typically rated based on their past claims experience. This market is the health insurance market working best today, and the rating reforms proposed by this measure, which would apply to all fully insured groups regardless of their size, would significantly increase costs in this market. The bill would also create adverse selection to the fully insured market, as the larger groups that chose to fully insure under the proposed rating rules would only do so if they had concerns about their group's claims experience.

NAHU does agree that reforms need to be made to the individual and small-group markets concerning the way that premium rates are determined at the time of application. It is NAHU's view that these markets would benefit from greater premium standardization. But NAHU feels that the rating reforms proposed should only apply to individual health insurance products and fully insured small group plans of two to 50 lives. Furthermore, in order to protect against runaway costs, the federal government should ensure that wide-enough adjustments may be made for several key factors. At a minimum, variations need to be allowed for applicant age at the natural age breakdown rate of at least five to one (meaning that the rate of the oldest applicant may be no more than five times the rate of the youngest applicant). In addition to age, variations in premium rates should also be allowed for participation in wellness programs, smoking status and geography.

We specifically request that groups over 50 be permitted to use claims experience to determine their premium ·es. This is in no way a discriminatory practice and is much different than prospective health status rating. All large groups today develop premiums based on the past claims experience of their entire group. When we hear

that large groups "community rate" their employees, what this really means is that the group develops rates that are the same for all participants in their employer group based on the employer's claims experience. Eliminating the ability to develop premiums in this manner will result in significant rate shock for many employers and their employees. It will also remove employer incentives to reduce costs through implementation of wellness initiatives, since the results of such initiatives will not reduce health plan costs for the employer. It also means that employers and employees will not really be able to "keep the insurance coverage they have" because the structure and pricing of current coverage will be irrevocably changed by these proposed rating reforms.

We also urge caution in the elimination of lifetime limits on benefits. Lifetime caps are rarely met, even by the sickest individuals, but they do help provide a control on pricing for medical costs for all covered individuals. Private reinsurance for an unlimited maximum is expensive for both health plans and self-funded employers, and will impact premium levels. While we do not want any individual to have coverage arbitrarily cut off due to a lifetime limit, we wonder whether a federal financing/reinsurance backstop for those rare individuals whose medical expenses are so great that they would exceed lifetime caps might not better serve the affordability goals we share for all consumers.

Allowing People to Keep Their Current Coverage

While virtually all stakeholders agree that aspects of our health care delivery system are in desperate need of reform, millions of Americans are happy with the private health insurance coverage they already have. In order for comprehensive health reform to be successful, American individuals and employers providing health coverage to their employees must be able to keep their current coverage if they choose to do so. Unfortunately, NAHU feels that many of the requirements in the draft legislation would render this idea impossible.

First of all, the grandfathering provisions proposed for existing plans are insufficient. Existing individual policies could only be retained if the only change to the policy was to add or delete a dependent. Individual policies based on annual contracts with changes of contract terms that benefit the consumer are common at plan renewals, such as a slight change to the deductible or coinsurance, but, under this legislation, individuals would be unable to exercise them. Also, while group plans would be allowed to phase in reform requirements over five years, eventually these plans would have to change to meet the terms of the proposed individual and employer mandates. The required changes to employer plans would change the way policies are rated as well as change their plan designs and included benefits. All of these changes could substantially increase the price of coverage. This all seems highly incongruent with previously stated goals of allowing individuals and businesses to keep their private health insurance coverage if they wished to do so.

Minimum Loss Ratios

The legislation specifies that all qualified health benefits plans will have to operate with a minimum loss ratio of 85%. If non-claims costs exceed 15%, beneficiaries must be rebated on a pro-rata basis for the excess.

NAHU has concerns about a minimum loss ratio requirement, as it does not address the true problem that is driving health insurance premium costs—the skyrocketing cost of medical care. The definition of administrative expenses in the bill is quite broad and may encompass many services that actually benefit consumers. In addition to profits and marketing, non-claims expenses include quality management, disease-management programs, health information technology investment, claims processing, legal compliance, federal and state taxes, employee salaries, consumer education, etc. A 2005 PricewaterhouseCoopers study found that health plan administrative costs were not a factor contributing to health care cost increase; rather, increased utilization of services, an aging population, lifestyle choices and new technologies were the primary cost drivers. In states that have adopted high loss ratio standards, consumers have suffered from less competition, fewer choices and higher premiums.

Essential Benefits Package

NAHU agrees that minimum standards of coverage, both for subsidy-eligible individuals and the general population, are a necessary part of health reform. But we are concerned that the essential benefit requirements proposed in this legislation are overly restrictive and complicated. Instead of the essential benefits package requirements this legislation would impose, we believe that there should be two benefit standards developed: first, a standard for minimum creditable coverage for purposes of an individual mandate and, second, a somewhat higher standard for essential benefits coverage for purposes of subsidized coverage.

We believe the standard for minimum creditable coverage should be one of ensuring that basic appropriate services are available. The quickest implementation standard for this would be to use an existing definition, like the definition for HIPAA creditable coverage. Using this standard would weed out limited-benefit packages and would allow states to be of immediate assistance in helping with enforcement because this is a standard that is already embedded in law for all states.

Working from the standard for minimum creditable coverage, a standard for an essential benefits package can be developed that would apply to subsidy-eligible individuals. This standard would include cost-sharing limits that could be based on a percentage of income. This would still allow for significant choice in product offerings and allow individuals and families to select the coverage most appropriate for their needs. If used in an essential benefits package, account-based plans like HRAs and HSAs could meet the cost-sharing requirements by a combination of the underlying health insurance plan and funds deposited into or available through the account.

Exchanges

The bill would create a national Health Insurance Exchange to purchase coverage. Individuals would be eligible to participate in the first year and employer eligibility would be phased in over five years beginning with the smallest employers. Once someone is deemed eligible to participate in the Exchange, they will remain eligible until they qualify for Medicare, regardless of their other coverage options. States would be allowed to transition their Medicaid populations to the Exchange—with appropriate supplemental wrap-around coverage—after five years. Also, states could establish their own Exchanges, provided that no more than one Exchange operates in any state. However, the new federal commissioner would retain enforcement authority and could terminate the state Exchange at any time.

The bill also requires the commissioner to establish benefit standards for Exchange plans: basic (covering 70% of expenses), enhanced (85% of expenses), premium (95% of expenses) and premium-plus (premium coverage plus additional benefits for an enumerated supplemental premium). Plans would be subject to strict cost-sharing limitations, which could limit plan innovations and designs.

NAHU has many concerns about the structure of the Exchange as proposed in this measure, chief among them that this structure would do little to reduce costs. In this type of arrangement where multiple plans from different insurers compete, there is no common pooling among plans. For example, a pool with 5,000 participants that has 500 enrollees in each of 10 different plans does not get a discount for having 5,000 participants. Even before the Massachusetts model, group purchasing arrangements like this were tried by many states, and few survived due to anti-selection issues among participating carriers and the fact that they were unable to offer a less expensive product through the grouped arrangement. That's why pools have historically not been very successful in lowering cost, although they may provide choices for individual employees in small-group plans. Of course, the cost of this choice has been more limited options than were available outside of the purchasing arrangement, resulting in most of these programs only being able to offer HMO coverage. The most successful state purchasing cooperative was operational in California for 13 years, and the costs for small businesses always exceeded what was available in the traditional private market. This pool, the Health Insurance Plan of California (HIPC), closed its doors on December 31, 2006, because it was not financially viable.

With these facts in mind, we are concerned about any expectations some may have that the Exchange is going to lower costs, and, even more important, to be sure it is not structured in such a way that it might increase costs. For this reason, we urge caution in any attempts to create a single pool of risk within the Exchange for individual and group purchasers. Our experience in states that permit self-employed individuals to be a part of their small-employer market is that small-group rates are higher in those markets. This seems an unfair burden on small employers and we hope that if both individuals and employer groups are permitted to participate in the Exchange, it will continue to be permissible to pool them separately.

We feel strongly that subsidies for lower-income individuals should be available both inside and outside the Exchange. The same holds true with any of the "national" benefit packages. National experience with purchasing pools of all kinds shows that pools that operate at the state level that also fairly compete with plans outside the pool are the least disruptive to the market and are able to provide more long-term value to consumers.

The bill requires the commissioner to establish "a mechanism whereby there is an adjustment made of the premium amounts payable" to plans to reflect differing risk profiles in a manner that minimizes adverse selection—and leaves the commissioner to determine all of the details of this mechanism.

NAHU has concerns that this system of risk adjustment may be insufficient, and feels that there should be a mechanism to cover all aspects of the market, not just the Exchange. Given the new market reforms, there will initially be two types of adverse selection that must be addressed. The first is caused by people who can enter the market with no barriers due to the new guaranteed-issue/no preexisting conditions rules. It will take time to ensure enforcement of an individual mandate, and not all people will initially enter the market before they feel the need to seek medical care. The best way to deal with this type of adverse selection would be through a system of reinsurance at the state level with some federal funding assistance. This would ensure a much more stable transition to the new system. Once all of the reforms are in place, the issue of risk adjustment among participating plans in the exchange can be readdressed to determine the best approach to long-term risk selection issues.

New Health Care Regulatory Entities

The measure provides for the creation of several new government entities to regulate the purchase of health insurance coverage, including a new government agency, the "Health Choices Administration," governed by a commissioner who would be appointed by the president and charged with governing the Exchange, enforcing plan standards and distributing taxpayer-funded subsidies. There would also be a health insurance ombudsman appointed by the new commissioner to: receive and provides assistance with complaints, grievances and requests for information; handle disenrollment problems; provide assistance to individuals selecting plans; and give assistance to individuals with affordability credits. Finally, the bill would establish a new government health board called the "Health Benefits Advisory Committee," chaired by the surgeon general, to make recommendations on minimum federal benefit standards and cost-sharing levels. NAHU has concerns about a creation of a new government-run entity tasked with making coverage determinations for the American people. In addition, we are unsure that this is an appropriate role for the surgeon general, who would generally have no expertise in the area of private insurance.

NAHU has concerns that the creation of these new regulatory bodies will simply waste government resources that would be better directed at subsidies and establish the role of the government as the health care gatekeeper or the controller of prices and the provider of coverage. Health care decisions will be increasingly be made in Washington, DC, and be subject to political pressures that take into account neither patient needs nor economic realities.

Government-Run Public Plan

The measure would create a government-run public plan option that would be made available to consumers purchasing coverage through the Exchange. The bill states the public plan shall comply with requirements related to other Exchange plans, and offer basic, enhanced and premium plan options. Premiums will be established according to Exchange rules. The Exchange will be initially financed by unlimited start-up funding provided by the secretary, but eventually it must be self-sustaining, including establishment of reserves. For the first five years, Medicare participating providers will be compelled to participate, but eventually the plan is to link to a newly created provider network For up to the first three years of Exchange operations, providers will be reimbursed at Medicare levels, but then the intent is to move to a more flexible payment system.

NAHU strongly opposes the creation of government-run plans to compete with the private insurance market. The government-run public plan proposed in this measure could never compete fairly with the private market, nor would it be financially feasible in the long run. The legislation, as proposed, would give the public plan the power to dictate prices and indemnify the government-run plan for unexpected costs. This could guarantee, at least temporarily, that the government-run plan would offer insurance at below-market costs. Based on the provisions described in the discussion draft, the result would likely be over 100 million happily insured Americans displaced from the conventional marketplace.

One of our most serious concerns about the public plan proposed in this measure is its potential to further exacerbate the cost-shift that already drives up average health care spending by $1,788 (or 10.7%) annually per family. Cost-shifting is hidden tax on private payers that occurs when government payment rates are too low and providers shift costs to the privately insured to make up the difference. A government-run plan reimbursing at the rates contemplated by the legislation would actually result in a net **$70 billion decrease** in provider reimbursements, even after accounting for the newly insured. At least some of those costs will be shifted directly onto the backs of those already privately insured, which would be crippling to Americans struggling to obtain affordable coverage in this economy.

We also have concerns about what kind of coverage the public plan would be able to offer to Americans. Existing public plans also provide less coverage and restrict provider access more than the average employer-sponsored plan. The Congressional Budget Office estimated that the benefit package for Medicare is 15% below the average employer-sponsored plan. Under Medicaid, specialists are often inaccessible without long waits. Under a new government-run plan, Americans will find it more and more difficult to make appointments with physicians and other health care providers. This is because lower payments will make it increasingly unaffordable for providers to see patients—particularly the increasing number of patients with public coverage.

Private insurers must combat fraud or go out of business. Indeed, these payers have every incentive to invest in antifraud personnel and strategies down to the point where return and investment are equal. But anyone who thinks that a public plan could serve as a "yardstick" for the private sector needs to consider Medicare's dismal record with regard to fraud, waste and other abuse.

Private administrative costs cover important services like disease-management programs and research to determine which interventions actually work. It is ironic that the same advocates who frequently cite the need for the government to spend billions in taxpayer dollars to improve health outcomes are the same who decry the high administrative costs in health care plans.

NAHU feels that the government-run public plan proposed in this measure would exacerbate the worst elements of the current system: gross inefficiency, high costs and bureaucracy. NAHU believes that a far better use of federal efforts and monies would be helping lower-income Americans afford the cost of private coverage.

Subsidies

The legislation creates a complicated system of sliding scale tax credits for people purchasing coverage through the Exchange with incomes between 100% and 400% of the Federal Poverty Level (FPL).

NAHU has serious concerns about limiting the use of the credit to products purchased through the Exchange. The credits should apply regardless of the place of purchase; otherwise, the result will be an unlevel playing field of some kind. If subsidies are available only inside the Exchange, "crowd out" from existing private plan coverage will be dramatic and could destabilize the market. Subsidies only available in the Exchange can also result in higher-than-expected costs for those in the Exchange and an apparent larger number of uninsured than actually exist.

Past market-reform experience clearly shows that whenever an unlevel playing field is created through a financial incentive or other means, one of the coverage options is always selected against, which ultimately harms the viability of all coverage options in the market. By allowing for an unlevel playing field between the Exchange and the rest of the private market, we are concerned that these options set the stage for long-term market failure.

NAHU also objects to subsidies for families earning up to 400% of the FPL, which, for a family of four, would be $88,200. We believe that this is far too great of an expansion of government assistance, particularly considering the current state of the federal budget deficit.

Similarly, we have concerns about the provisions that would expand Medicaid to 133% of the FPL. The current Medicaid program is financially unsustainable, particularly considering that the cost of this expansion would be borne solely by the federal government and will further contribute to the soaring federal budget deficit. NAHU believes that any expansion of this program should be limited to the truly needy—no more than 100% of the FPL. Furthermore, to reduce the crowd-out of the private market that could occur with a Medicaid expansion, NAHU supports mandatory premium assistance when private coverage is available.

Individual Mandate

The legislation creates an individual mandate to maintain acceptable coverage with a federal income tax penalty equal to two percent of the excess of the taxpayer's adjusted gross income over the threshold amount. The tax shall not exceed the applicable national average premium for individual or family coverage pro-rated for partial year failures. Acceptable coverage includes QHBPs, a grandfathered plan, Medicare, Medicaid, TRICARE and VA coverage. Anyone providing acceptable coverage to individuals must provide them with annual documentation of coverage, and regulations will be promulgated relative to hardship waivers and waivers for people with minimal lapses in coverage.

NAHU supports the concept of individual responsibility in health coverage reform and believes that, in order to achieve universal coverage and ensure that market reforms are successful, an enforceable and effective individual mandate to obtain health insurance coverage is necessary. For individuals with incomes of under $100,000, the cost of complying with the mandate would be under $2,000, which is far less than the cost obtaining health insurance coverage. Clearly, this raises questions as to how effective the mandate, as proposed, will be. To improve this mandate's chance of success, we believe the federal reporting by individuals and insurers should be accompanied by measures at the state level, including enforcement through schools and drivers license bureaus, late enrollment penalties, and auto-enrollment and requirement of proof of coverage through employers.

Employer Mandate

The discussion draft stipulates that all employers must offer coverage through either QHBPs or a grandfathered plan as permitted. Employers would required to pay 72.5% of acceptable coverage for individuals and 65% for family coverage, and part-time employees must be covered on a pro-rata basis based on average hours worked. In lieu of paying for coverage, the measure creates a "pay or play" option allowing the employer to pay instead eight percent of wages to the commissioner. After five years, if an employee declines the traditional employer-sponsored coverage and obtains coverage in the Exchange, the employer will be required make to contribution

on behalf of the employee to the Exchange, even though the employer still has to bear the costs of maintaining its employer-sponsored plan for other employees. Not only will this be a double tax on employers, but it will make traditional employer plans more expensive by undermining employer risk pools. The result will be many employers being left with older and sicker individuals in their traditional plans, while paying taxes on other individuals to finance the Exchange.

Employers that fail to substantially comply with health coverage requirements can face an employment tax or an excise tax and/or civil penalties. The bill notes that small businesses would be exempt from the payroll tax, but provides no details as to the size and scope of this exemption.

Although NAHU is a strong proponent of employer-sponsored coverage, we believe that the employer-based system must continue to be voluntary. A mandate to force employers to provide health insurance to their employees, while well-intentioned, could actually hurt American workers and health insurance coverage. A mandate of this magnitude would substantially decrease jobs and economic growth, and undermine the existing private market. A mandate would have a negative impact on wages and job creation, and discourage production – often in firms with the most vulnerable employees and employers. Recent NFIB research data shows an employer mandate would cause the already shaky economy to lose 1.6 million more jobs.

Employers that can afford to sponsor health insurance typically provide generous benefits – and most large employers do. Employers that cannot currently afford to offer health insurance benefits will not be able to do so simply because they are mandated to do so. Small employers, seasonal employers and businesses that operate on very small profit margins will still be unable to afford to provide benefits. The Massachusetts employer mandate failed to have a meaningful effect on the uninsured, and actually exempted most of the businesses that did not offer insurance – but it was disruptive to existing plans. In fact, reliance on that employer mandate has, in part, contributed to serious funding problems in the Massachusetts plan, because more employers "played" with insurance offerings rather than "paid" the penalty to the state (an occurrence the Massachusetts budgeting experts got wrong).

NAHU believes that the employer-based system must be at the core of any health reform effort. However, we believe that the provision of benefits must be a voluntary action on the part of the employer. We are opposed to the employer mandate provisions in the discussion draft as they would suppress job availability, suppress wages and impose a crippling economic burden on our nation's employers, which is unacceptable, particularly considering the current economic climate.

Medicare Advantage

This legislation would reduce Medicare Advantage payment benchmarks to traditional Medicare fee-for-service levels over a three-year period. NAHU believes the significant funding reductions proposed in this measure would jeopardize the health security of more than 10 million seniors enrolled in Medicare Advantage and would turn back the clock on innovative payment incentives to improve the quality of care that patients receive. Seniors enrolled in Medicare Advantage should not be forced to shoulder the costs to reform the health care system. Also, these funding changes to Medicare Advantage, which could jeopardize the future of the program, fly in the face of the pledge that if Americans like the coverage they have, they will be able to keep it under health reform. The 10 million seniors enrolled in Medicare Advantage plans should be able to keep their current coverage without change if they wish too.

Conclusion

The United States health care system works for the vast majority of its citizens, yet we can do better. Improvement will require strong leadership, a thorough debate of all proposals and, ultimately, difficult compromises and decisions. All stakeholders will feel some pain in order to achieve a universal gain. NAHU

agrees that the status quo is no longer acceptable, and we pledge full participation in meaningful reforms as this legislation moves forward.

Ultimately, we believe the time is right for a solution that controls medical care spending and guarantees access , affordable coverage for all Americans. We believe this can be accomplished in an affordable manner without limiting people's ability to choose the health plan that best fits their needs and without creating expensive and unneeded new government bureaucracies. We look forward to working with the Committee and all interested parties in achieving our common goal: a world-class and affordable health care system for all Americans.

For questions following the hearing, please contact me at either (703) 276-3800 or jtrautwein@nahu.org, or contact Jessica Waltman, senior vice president of government affairs, at jwaltman@nahu.org or (703) 276-3817.

Mr. PALLONE. Thank you. And, as I mentioned earlier, I think I did, that whatever your written testimony is or data that is attached to it, we will put in the record in its entirety. I wanted to—let me start with Ms. Pollitz. The discussion draft takes the step of prohibiting discrimination in insurance based on a person's health status, things such as disability, illness or medication history. However, you know, as we are trying to close the door on that with this bill, some are proposing others, and I am not entirely sure what you said, but I know that you said that, or at least in your written testimony, that insurers should—I am talking about Ms. Trautwein now, that insurers should continue to be able to alter premiums based on a person's past claims experience, and the way I understand it that employers would be permitted to change a person's premium not necessarily on their health status but on certain activities like wellness programs and those kind of things. I don't want to put words in your mouth.

Ms. TRAUTWEIN. What I meant is not what I——

Mr. PALLONE. Sure. Go ahead.

Ms. TRAUTWEIN. We want health status rating to go away for individuals.

Mr. PALLONE. Right, but you said that the employers——

Ms. TRAUTWEIN. But we are talking about employer groups there they look at all of their employees, de-identified information, and they calculate what their anticipated claims are for the next year. This is done all the time. And then they figure out how much they need for reserves and things like that and they develop a rate based on their particular group and it is a very, very cost effective way of doing it. It results in lower rates for the employees, not higher. That is why we were asking for that.

Mr. PALLONE. I just want to make sure, and I am not trying to put words in your mouth, Ms. Trautwein. I am just trying to understand that I want, you know, employers be able to have wellness programs certainly but it just seems to me we have to insure the persons who are, you know, unable to achieve a specific physical or other goal and not penalize and therefore somehow health status comes back again. But I am not just talking about Ms. Trautwein's testimony. I am just talking about in general that we are trying to eliminate a lot of these things. Let me just ask you this, Ms. Pollitz. Can you discuss the role of employer wellness program and what sort of protections we can be sure to include to promote the positives without allowing this discrimination and what it would mean for people if insurers were able to use claims experience and ratings. Again, I am not entirely clear on what Ms. Trautwein was saying so maybe this is not fair, but hopefully between the two of you, you can answer my question.

Ms. POLLITZ. I think those are 2 separate things.

Mr. PALLONE. OK.

Ms. POLLITZ. Just very quickly on the wellness programs. You are right. I think there is a lot of interest. At Georgetown there are a lot of great programs, sponsored walks, time off, free exercise classes in the building, stuff like that, so I think there is a great deal of creativity and good intentions and good results in a lot of employer-sponsored wellness programs. But there are other programs that even take on the name incenta care that all they do is

just apply health screenings, make you take certain health tests, and if you flunk them, that is it. Your benefits get cut, your deductible gets raised, or your premium gets hiked by a lot, and there is nothing else. There is no classes. There is no help. There is no nothing. So I think a return to the original notion under the old Clinton Administration regs for non-discrimination establish some standards for bona fide wellness programs, you know, some indication that there actually is wellness promotion, disease prevention activities going on, opportunities to participate, giving employees opportunities to participate that doesn't kind of come out of their hide.

Privacy considerations, employers are not covered entities under HIPA privacy rules. All that health screen information that goes in, people are very worried about that. And so that is the first thing, and then whatever rewards there are, I think it is important to just keep that separate from the health plan because otherwise it——

Mr. PALLONE. Do you agree with her, Ms. Trautwein, because if you do then I don't need to pursue this any longer.

Ms. TRAUTWEIN. Well, I sort of agree with her. The plan that she talked about that is not a real wellness program, we are not in favor of those. That is not what we are talking about.

Mr. PALLONE. OK.

Ms. TRAUTWEIN. We are talking about very unique programs where each person designs their own goals. Somebody might be in a wheelchair and the other person might be a marathon runner.

Mr. PALLONE. OK.

Ms. TRAUTWEIN. That would be silly.

Mr. PALLONE. I don't want to prolong it. I think we have——

Ms. TRAUTWEIN. I think we agree. I do think you could have some incentives relative to people meeting the goals that they have established for themselves though.

Mr. PALLONE. OK. Now let me ask Karen the second question, and then I will quit. Mr. Shadegg, he is not here, I hate to mention him with his not being here, but I am, Mr. Shadegg and others have suggested that it would make sense to allow insurers to get licensed in one state and sell those license products and others. I have always been worried about that, and I know insurance commissioners don't like it. Can you tell me under this new national market place what would your thoughts be on a proposal like that? Did I say Karen? Either one of you. I meant Ms. Pollitz but you can answer it too, Ms. Ignagni.

Ms. IGNAGNI. Thank you, Mr. Chairman. I didn't mean to step in. I thought you were directing——

Mr. PALLONE. No, go ahead.

Ms. IGNAGNI. Actually just on the last question, I do think there is a combination as you are suggesting. I do think it makes a great deal of sense to have a permissible corridor of activities that could be done in the context of wellness and I think you are right to pursue it. There have been some major advances in the employer context that I think we could take advantage of and if you would like, Ms. Pollitz——

Mr. PALLONE. No, go ahead. Why don't you start with Ms. Pollitz and then we will come back to you.

Ms. POLLITZ. I will be happy to answer.

Mr. PALLONE. All right. This idea that you allow insurers to get licensed in one state and sell the products in another, I have always thought that was a dangerous thing, you know.

Ms. POLLITZ. The experience has been that that is a dangerous thing in association health plans. This is where you see this happening a lot and it is very dangerous and it creates opportunities for fraud.

Mr. PALLONE. But in addition now we have this national proposal in the draft so how does that all fit in with that?

Ms. POLLITZ. Well, now you have got a national proposal, but in your proposal a requirement to sell anywhere outside or inside of the exchange the first requirement that is listed is that you have to be state licensed, so you still need to—you have to have a license. You need to work with licensed agents. You need to meet solvency standards. All of those things are established at the state level. You don't need to replace those at the federal level and you haven't in your bill, but I think you need that close accountability so someone need to be watching the health plans all the time, otherwise, there is great nervousness about selling back and forth. Just the last thing I would mention, and I think it was mentioned in some of the written testimony, I think there may be a little bit of drafting imprecision about sort of what are the federal rules that apply across the board and then what other sort of state rules or rules under the old HIPAA structure that apply and that you probably need to straighten out a little bit in the next draft, but you don't want a situation where a health plan can be licensed in one state and operate under one set of rules but then be able to sell somewhere else under a different set of rules. If your national rules become completely across the board always the same, you still need to be state licensed but then this whole notion of selling across state laws I think won't matter.

Mr. PALLONE. And if you want to comment on——

Ms. IGNAGNI. Thank you, Mr. Chairman. I think this is a tremendous opportunity to look very carefully at the regulatory structure and take a major leap forward. Having everyone in allows the complete overhaul that is baked into the proposal now, guarantee issue, no pre-existing conditions, no health status rating. We ought to specify those guidelines at the federal level, have uniformity and consistency, not re-regulate them at the state level, which is causing a great deal of confusion now in the market with same function regulated at different levels by different entities. We should take this opportunity to make it clear so that consumers can feel protected and know that the health plans will be accountable. We are very comfortable with that. We would have this enforced at the state level. States have done a very good job at maintaining solvency standards, consumer protections, et cetera. We think that is the right balance.

We don't believe that—and we have some advice in our testimony but the drafting of the legislation in terms of these regulatory responsibilities. We think it is absolutely clear and key for consumers to understand how they will be protected, where they will be protected, and what the standards are. And we have such duplication and confusion now in the system it is very, very difficult for con-

sumers to feel protected, so I think this is an opportunity to take a major step forward and really respond to that.

Mr. PALLONE. OK. Thank you. Mr. Burgess is next.

Mr. BURGESS. Let me just be sure I understand something now. The new public government run program is going to have to be licensed in all 50 states? I guess that is a maybe. This new public plan, this new government plan——

Ms. POLLITZ. I would defer to your own staff on that. It is a federal program.

Mr. BURGESS. Right. Medicare is a federal program. It is sold across state lines and it is not licensed individually to every state.

Ms. POLLITZ. I don't see the requirement that it has to be licensed by states. It is a federal program.

Mr. BURGESS. Right. So it seems to me that if Ms. Ignagni's group wants to develop something that meets certain criteria that it ought to be afforded the same courtesy to be sold in every state.

Ms. POLLITZ. Well, I don't know that that is a courtesy. I think it is just an administrative faculty.

Mr. BURGESS. The same administrative faculty then, but we will not call it a courtesy. It just strikes me as we have got 2 sets of rules here, one for the public sector and one for the private. That seems inherently unfair. This is not what I intended to talk about but I am not following. Where is the inherent fairness in the—Ms. Ignagni has already talked about carrying a 50-pound weight on her back because she has got to carry the freight, the cross subsidization from the federal programs, the freight they are not paying in the first place and then on the other hand are we creating a product that is just by definition she can't compete with it because it is something that could be sold without regard to state insurance regulation. Ms. Ignagni, is that your understanding? Is that your understanding of this new public plan?

Ms. IGNAGNI. I know the remedies. I would yield to counsel but I understand that the remedies are federal remedies, and I think the entity is charted at the federal level but I wouldn't want to be presumptuous in that regard.

Mr. BURGESS. Ms. Trautwein, you are the national organization. Do you have an opinion about this?

Ms. TRAUTWEIN. Oh, yes, sir. We have a very—that is what I said in my testimony that we are very concerned about the fact that a playing field would never be level. On one is the payment, which I spoke about in my oral testimony. The other is the rules. Its regulation at the state level is what we have to meet. Having state premium taxes, state regulation, state remedy. That is not the way the bill reads at present.

Mr. BURGESS. Maybe I will figure out a way to say this more clearly and submit it in writing. Ms. Ignagni, I just have to say maybe I am a little bit disappointed after the group of six met down at the White House, and I know my own professional organization was part of that. And we came out of there with, what was it, a trillion dollars, 2 trillion dollars in saving over 10 years, and part of those savings was administrative streamlining, which presumably is one claim form instead of 50 or 60, which we have to deal with now. I did see it reported, but I am also going to assume that perhaps there is one credential form rather than filling out 50

different credentialing forms every January and taking 2 or 3 full-time equivalents to have them do that in a 5-doctor practice. Why the hell didn't we do that a long time ago?

Ms. IGNAGNI. Well, sir, that is a fair point, and we have been working now over a 4-year period. As you probably know, we set up a separate entity to actually take on this issue of simplification in the ways the banks took on the ATM technology. We have worked with physicians. We have worked with all the specialty societies. We have worked with hospitals, the different types of hospitals to make sure that we were going to get the language right. We have taken our time doing it to make sure we had that language right in a way that physicians, physician groups, and hospitals felt satisfied that we are actually solving the problem. So now that we did that, we were able to step forward and say we are not only taking the responsibility of moving forward, we are not going to be doing it voluntarily. We are very committed to legislation. We have said that. We want to make sure it is uniform across our industry. We are comfortable with that, and we will help you draft it.

Mr. BURGESS. Let me ask you because you have been up here a long time and you know the rules we live under with the Congressional Budget Office, and a $2 trillion score, whatever it is, over 10 years, the Congressional Budget Office is going to look at that and say if this is something you were supposed to be doing anyway then we just calculate it into the base line and there in fact is no new money to spend. How are you going to deal with that?

Ms. IGNAGNI. This is a very important question you are asking. First, until we made the announcement no one said from our industry that we were going to be regulated for this, that it would be not only committed to legislation, we would support it and help draft it, so that is a material difference, number 1. Number 2, for the $2 trillion goal to be achieved, as you know well, it is going to take an interdependence among all the stakeholders to achieve that. There are 4 key areas of savings if we are going to bend the curve as a nation, we have to take seriously. One is administrative simplification. We need to make sure that not only everything we have committed to, but where we go in the future is the right direction for hospitals and physicians that they can achieve——

Mr. BURGESS. You have no argument from me about that. I do wonder how we are actually going to get the dollars savings scored by—we all know, we talked about the Medicare prescription drugs. It is much more cost effective to treat something at the front end. Then when the target is destroyed and yet the Congressional Budget Office is never going to score that as an actual savings. It actually scores it as an expense because you are going to be treating more people by virtue of the fact you are treating disease at an earlier point.

Ms. IGNAGNI. Well, we have some ideas on both. Let me just quickly——

Mr. BURGESS. We are about out of time. I am going to submit some other questions in writing. I would just say this. You see what a fluid situation this is, and please forgive me, Mr. Chairman, just close your ears for a minute. Pay no attention to the man behind the curtain. Things are in such flux. Don't be quick to give

things up. By all means, work with us, but don't go to the White House waving the white flag as the first volley. In fact, it can be counterproductive. It is just my opinion. I will return it to the chairman.

Ms. IGNAGNI. Sir, if you will allow me to just—Mr. Chairman, just a quick point.

Mr. PALLONE. Sure.

Ms. IGNAGNI. I will be delighted to—you have some very important technical questions. I will be delighted to submit that for the record, but you ask now, the last point you have made is more in the category of right road, wrong road, so let me give you a very direct answer. If you look at the Council of Economic Advisors report unless we truly bend the cost curve in a sustainable way not only will we not be able to afford the new advances we want to make in getting everybody covered, we won't be able to afford the current system. We participated in an effort with the hospitals, the physicians, as you know, with the SEIU, farm and the device companies to take our seat at the table to say as stakeholders, as private sector entities, we could take part of the responsibility of stepping up and saying we have skills we can bring to the table to get this problem solved.

That is what our plans do. That is the point that we are making here. Mrs. Capps had asked a question earlier to Mr. Castellani about what is the legacy of the private sector. The legacy of the private sector is that we have brought disease management care coordination. We are now recognizing physicians and hospitals, as you know, recognizing high quality performance. We brought the skills to do that. Patient decision support, personal health records, helping physicians not have to sort through loads of paperwork. We are proud of that. We pioneered those tools. We are implementing it. And similarly with administrative simplification, we are the key domino to make that happen. We have taken that very seriously, which is why we participated in this effort to try to contribute to this major goal.

Mr. PALLONE. That sounds like a good——

Mr. BURGESS. Briefly reclaiming my time.

Mr. PALLONE. You don't have any left.

Mr. BURGESS. It is obvious that there have not been people willing to work with you on that for the last 7 years that I have been here. I just cannot tell you how distressed I am that there was never this willingness to work when our side was in power, when a different president was in the White House. I feel personally affronted by this, and it is ironic that you were just at the point now where your industry is going to be delivering on the promise that we all knew it could do, and I don't know what the future holds for you, because there are many people, we have heard it over and over again in this committee this week, that a single payer system is what is down the road for the United States of America.

Mr. PALLONE. All right, let us get moving.

Mr. BURGESS. And all of the things that you have done with care and coordination disease management, that may be something you have developed only to find it is never really fully implemented to use in the private sector.

Mr. PALLONE. All right, Dr. Burgess.

Mr. BURGESS. We could have done a much better job with this. I yield back.

Mr. PALLONE. I don't want to be tough because I kind of like the dialogue, but we need to move on. Mrs. Capps.

Mrs. CAPPS. I find it interesting too, but I really want to commend you all for the last panel of the day and think there ought to be some kind of medal. Do we design medals for the last panel? This is our fourth day of hearings too so if we seem a little kind of flat you will understand, I hope. But this is one I wanted to state in particular because you are so key in what you represent to us getting this right, and that is the goal and that is exactly where we all are. And, Ms. Ignagni, I appreciate you taking us down saying we have got so much we can agree on unless at least agree we don't agree. I don't agree with you on many things, and you know that, but that is OK. We can talk. I want to tell you, Ms. Pollitz, you hold the bar very high, and we are going to try to get as close as we can to the standards you are giving us. And, believe me, I have constituents who are reminding me of that every single day when I go home, which is a good thing. This is all across the map. But everybody's attention is now focused on health care, and I salute that. It is about time.

Mr. Kahn, I have suburban counties north of your region but I am a big fan, as you know, because now I can boast that each of the 3 counties, I represent part of the 3, now has a county operated program, and that yesterday we were able to get Mr. Freeland, who speaks very highly of you, to testify as a provider. It is now called CenCal. And they were one of the first to get a waiver and there are some really exciting options that can be brought to the table now. Call them what you want but they are going to help us deliver care. I have a tough—I want to share what it is like to be a member of Congress and have the phone ring and hear a story, and you know this. But I just want to bring it out and make sure that it is on the record. This panel gives me the chance to relay the story of the constituent whose situation really illustrates why we need to bring honest competition into the insurance market. I represent a little town called Carpinteria, a rural part of Santa Barbara County.

A young woman is a good member of part of a non-profit community organization. She has a 12-year-old daughter who was born with spina bifida and needs surgery to replace a stent in her brain. Her mother's income places her mother just over the threshold to—she is not able to qualify for Medicaid. We call it the Healthy Families, the SCHIP expansion, in California. Though her mother's employer does provide coverage the young girl is covered under the plan but this plan specifically states that it will not cover the surgery she needs for her life because spina bifida is a pre-existing condition. Ms. Ignagni, I am going to start with you. I would like to have comment for as much time as I have, and I don't want to go over time, but this plan that this mother has in rural—parts of my district there is one option in much of it, one private plan, and there are at most in Santa Barbara County, I think 2, maybe 3, at the moment, so she can't shop around very much.

She called my office because she is beside herself. This denial is for a condition that this young woman was born with, and this sur-

gery is needed to relieve the pressure of fluid on her brain. People have been talking about pre-existing conditions in the private sector for a very long time. This is real time. This is happening today in my constituency.

Ms. IGNAGNI. And, Mrs. Capps, I think there is no legitimate answer to your question but to say this is why we have worked so hard to propose change in the comprehensive proposal——

Mrs. CAPPS. It hasn't happened yet.

Ms. IGNAGNI. It has not happened yet because we have a system now where people purchase insurance if they are doing it individually when——

Mrs. CAPPS. No, this is part of her employment, but let me——

Ms. IGNAGNI. If it is part of an employer then guarantee issue——

Mrs. CAPPS. A non-profit organization with very minimal amount that they can spend for employee-covered care but let me see what some other comment is. Maybe, Mr. Kahn, if this young mom was working for this non-profit which abounds in Los Angeles as well, what option might she have?

Mr. KAHN. Well, Congresswoman, and, by the way, you have a beautiful area that you cover. Your district is beautiful and you did have the first of all the country organized health systems there. The problem is a structural one which is the way our regulations and our markets are set up right now that an individual or if they are in a very small group perhaps because usually pre-existing conditions are not excluded from group coverage. It may be such a small group, however, that it is. That could be——

Mrs. CAPPS. Less than 10 employees.

Mr. KAHN. So knowing the situation, that could be the case. And under the current system, to be perfectly honest with you, there is no good answer for that situation for the individual or in a small group like that. That is the problem with the system right now and why I think we all agree we have to change the system. Now depending on our income level, it is——

Mrs. CAPPS. It is not very high.

Mr. KAHN. Not very high. They could actually become eligible for Medicaid if they spend down enough depending on what her income level is.

Mrs. CAPPS. Pretty big price to pay.

Mr. KAHN. And it is a very big price to pay, but that is the problem is that we have a broken system right now that needs to be fixed, and that is why we are all here because of those kinds of situations covered and not covered.

Mrs. CAPPS. Our reform legislation being a remedy?

Mr. KAHN. Absolutely. I think that the solutions that are being addressed——

Mrs. CAPPS. From both the private sector and this public option of course.

Mr. KAHN. Well, I think what we are talking about is reform of the rules around coverage, and indeed you would accomplish that because once everyone is covered then the pre-existing conditions issue should really go away. The problem right now is that—and we don't do individual coverage. We serve only low income people.

Mrs. CAPPS. Right. Right.

Mr. KAHN. But the problem with the system right now is that where people are not covered, they decide once they get sick they need coverage and that is why there is underwriting. I am not defining it. It is just—there are no bad guys in this play. Unfortunately, it is bad structures. It is a bad system.

Mrs. CAPPS. Right, which is why it calls for intervention from us. I am not looking for support for that, and I applaud this is finally the moment that all the stars are aligned. I think we would all agree that we are going to—not everybody is going to be maybe pleased with the outcome, but we are going to make progress. And I am just so hopeful that we can do it in a very bipartisan way.

Ms. IGNAGNI. And, Mrs. Capps, I would be happy if you think it is appropriate to help with your office and see if we can look into the case and see if there is anything that can be done. As a mother, I would be delighted to do that.

Mr. PALLONE. Thank you. Mr. Whitfield.

Mr. WHITFIELD. Thank you, Mr. Chairman, and thank you all for your testimony. One of the common reasons given for having a public option is the fact that there is not competition particularly in rural areas, and there is probably an obvious reason for this that I don't understand but in the prescription drug benefit under Part D of Medicare in my rural district of Kentucky there were like 42 different plans offered to Medicare beneficiaries, so why are there so many plans offered as a prescription drug benefit but not plans competing with each other on the other sector. Would someone answer that for me?

Ms. POLLITZ. Prescriptions are a little different just because you don't need the provider network. I mean if there are pharmacies nearby or even mail order pharmacy it is easier to ensure the costs of prescriptions.

Mr. WHITFIELD. So it is the fact that there is a lack of a provider network and putting that together?

Ms. POLLITZ. I would expect. I am not familiar with your district but prescriptions are a more kind of national market than other health care.

Mr. WHITFIELD. OK.

Ms. IGNAGNI. I think, Mr. Whitfield, one of the things that we have observed is that often there are products available but in particularly rural areas if individuals don't have a broker, for example, they haven't been presented with the information, they don't know where to go, which is why one of the first things that we suggested is this concept of having an organized display on a site, it could be a state site, of the health plans that are available in every part of every state and organized it so people can understand what is available. That would be, I think, a major step forward.

Mr. WHITFIELD. Mr. Kahn, would you want to say something?

Mr. KAHN. Thank you, Congressman. I would just add that the challenge in rural communities beyond the pharmacy situation is that if you are the one hospital in town, you probably don't have to negotiate so it is not very attractive for a health plan. That is why you don't have competition. Now I will say though that in California we have a number of our public plans that compete with private plans, and some of those are in rural areas as well, Kern County, for example, and so there is competition but again by the

nature of that market because all health care is local still and it probably will be for the most part under the reform, so it depends on that market. Ms. Ignagni and Mr. Trautwein, you all are both involved in associations that represent companies that I am sure provide a lot of group insurance plans to rather large employers. Are you at all concerned that employers because of this public option being available might just say, you know, to save money we are just not going to provide health insurance anymore?

Ms. IGNAGNI. We are concerned about that, sir, and we are also concerned about employers seeing the differences in the numbers. As I indicated in my oral testimony there would be very little available or left in the private sector because the incentives are so compelling, and I think there is a strong value in having the best of both, doing a better job in the safety net and then doing a better job as we have talked about in proving the——

Mr. WHITFIELD. Does this draft bill provide the protection that is necessary to protect the private sector?

Ms. IGNAGNI. Well, I think that it is not—we were very concerned, as we indicated, that we would not see a private sector sustained because the playing field isn't level. If you pay at Medicare rates, it is such a major differential that that there is no way to sustain a private sector.

Mr. WHITFIELD. OK.

Ms. POLLITZ. But, Congressman, just to add, under the bill if an employer buys through the exchange they have to agree to let their employees pick the plan and if they elect not to offer coverage and to pay the fee then the employees still get to pick the plan so there is no way that employers can opt to put people in any of the plans available in the exchange. It is always up to the individuals.

Mr. WHITFIELD. Are you saying that employers cannot just decide to refuse to offer a plan?

Ms. POLLITZ. Employers first make an election are they going to play or pay. Are they going to offer a plan or are they going to pay, and if they are outside of the exchange they could offer a plan and they would only have the choice of buying private plans, and then if they come into the exchange it becomes kind of a defined contribution but the employees get to pick the plan that are offered between public and private.

Mr. WHITFIELD. Ms. Trautwein.

Ms. TRAUTWEIN. I just wanted to add to that there is language in the bill that after a period of time even employees that are a part of a program where there is an employer-sponsored plan can elect to spin off of that plan to go into the exchange. This is a direct threat to employer-sponsored coverage. We are very concerned about this because you have to maintain a decent participation level inside an employer group to have that balance of risk that I was talking about earlier. So I think that that is something that we should really look at whether that is a good idea to keep that in the bill language.

Mr. WHITFIELD. I guess my time has expired. Can I just ask one other question? I know you have been here for hours but just one other question. Ms. Trautwein, in your testimony you talked about it is critical that there be a financial backstop to accompany re-

forms of the individual and group insurance markets, and I was curious what do you mean precisely by backstop?

Ms. TRAUTWEIN. Well, it could take many different forms. It is kind of what I talked about earlier, this idea of reinsurance. You know, some states today use a high risk pool to backstop their individual market but it doesn't have to be that. It is just something to make sure that we address the cost of high risk individuals. This is a particular problem during the first 5 years, I am guesstimating that amount, because it is going to take us a while to get the hang of this individual mandate and enforcing it. We won't have everybody in overnight and so there will still be initially adverse selection, the same that we have today in this market, and we have got to do something to make sure that those high cost cases don't make the cost of coverage go up for everybody else so we are not trying to wreck the proposal. We are saying you need to have this thing in here to stabilize your proposal so you will not have these unintended consequences.

Mr. WHITFIELD. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. And I know different members mentioned that they are going to submit written questions and we ask them to get them to you within the next 10 days or so and get back to us as soon as you can.

Mr. BURGESS. Mr. Chairman, I was also supposed to ask unanimous consent that the Blue Cross/Blue Shield data be made part of the record.

Mr. PALLONE. Yes, let me see. I have something too here. I am glad you mentioned it. I almost forgot. So you have, what is this, Blue Cross/Blue Shield, you called it?

Mr. BURGESS. Yes. Ms. Fox testified—as part of her testimony she——

Mr. PALLONE. I am told that it already has been but if it hasn't, then we will do it. And I also have to submit for the record this study by Health Care for America Now showing that 94 percent of the country has a highly concentrated insurance market. This is from the American Medical Association so without objection we will enter both of these in the record.

[The information appears at the conclusion of the hearing.]

Mr. PALLONE. Thank you very much. I thought this was very worthwhile. It is a complex issue but we appreciate your input and your optimism as well. It is very important so thank you very much. And the 3-day marathon of the subcommittee is now adjourned, without objection is adjourned.

[Whereupon, at 6:45 p.m., the Subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Can a Government Plan Operate on a Level Playing Field with Private Health Plans?

Advocates of creating a government health plan to compete with private plans under health reform have argued it is possible to structure a government plan to compete on a level playing field with private health plans. Many are concerned it is not possible to create a level playing field government competitor. Moreover, even if it was possible, the government plan would inevitably use its built-in advantages to eventually take over the market (e.g., by adopting government payment rates for providers). The following provides a listing of major requirements that now apply to private plans and raises questions as to whether the government plan will also meet these requirements.

Private Health Plans	Government Plan
State Licensure Requirements	Would a government plan be required to go through the effort, time, and expense of filing and maintaining an insurance license and certificate of authority in all 50 states, DC, and the territories?
Financial Solvency Requirements • Strong, risk-based capital rules to assure insurers will meet future obligations; • Detailed annual financial reporting; • Quarterly filings of financial statements; • Audits by independent accounting firms; • Independent actuarial certification of reserves and surplus; • On-site regulatory exams; • State oversees corrective action once entity nears minimum standards; • State authority to seize control of a plan that doesn't meet solvency requirements; • Guaranty fund assessments to pay claims in the event an insurer collapses; and • State financial compliance oversight – surveillance regarding solvency, compliance, insurance fraud, etc.	Would the government plan be subject to some kind of "reserve" rules and financial reporting requirements? Would a government plan be required to meet the same stringent Risk-Based Capital (RBC) standards that apply to private plans? These rules require that health plans set aside adequate capital – which can exceed three months of claims – to assure solvency. Compliance with RBC requirements could cost the government tens of billions of dollars. How would the government finance compliance with these capital requirements? Would the government plan instead rely on the backing of the federal government rather than maintaining capital, which would provide a significant cost advantage? Questions also arise about whether the government plan – or a GSE set up to run the government plan – would be subject to state regulatory oversight. There's no precedent for state oversight of a federal program. Specifically: • What would happen if the government plan began to run deficits? Would the government plan be allowed to fail or would it be subsidized by taxpayers? • Would states have the authority to step in and seize control of the plan if it doesn't meet its reserve requirements? • Would the government plan have to pay into state guaranty fund to assure payments to beneficiaries if another plan collapses?

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Private Health Plans	Government Plan
	• Would states have the authority to investigate complaints against the government plan?
Provider Payment, Network and State Requirements Related to Access to Care • Prompt payment requirements, often tighter than Medicare; • Network adequacy rules; • Quality assurance programs; • HMO specific requirements; • Direct access to specialists; • Direct access to OB/GYNs/pediatricians; • Rx access and formulary requirements; • Continuity of care requirements; • Provider complaint and due process requirements; • Mandatory assignment rules; • Mandatory second opinion rules; • Emergency access requirements; • Anti-"gag" rules; and • Provider non-discrimination rules and any willing provider.	Could the government plan actually be network-based? Would it exclude providers from participation? Given the challenges the government would face in picking winners and losers, would the government plan eventually be forced to use Medicare's participation and payment requirements? Would state access requirements apply to the government plan? How would they be enforced? What entity would ensure the government plan is meeting its quality assurance requirements?
Rate and Form Filing and Approval Process • Rate filing; • Policy form/benefit filing; • Actuarial validation of premium sufficiency; • Filing fees; • State approval of rates (prior approval or file and use); • State approval of forms (prior approval or file and use); • Public hearings; and • Public notice of rate changes. **Ongoing State Supervision** • Oversight/investigation of complaints and compliance.	Would the government plan be subject to state rate and form filings requirements or be subject to state rate approval processes? Would the government plan be required to pay filing fees or other assessments that are used to fund oversight and review? Would the government plan simply be deemed to be approved for sale under an exchange or connector while private plans have to meet additional certification requirements for their products? Would states have any ability to supervise/oversee the government plan?
Taxes and Assessments • Federal income taxes; • Premium taxes; • Assessments for High Risk Pools and other access mechanisms; and • Corporate taxes	Would the government plan pay federal income taxes? Would the government plan be subject to state premiums taxes, income taxes, or other state assessments?

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Private Health Plans	Government Plan
• Special state assessments to fund public health priorities, such as uncompensated care, premium subsidy programs, and health information technology improvements.	
Handling of Disputes • Independent external review; • Standards for internal review/appeals; • Standards for utilization review; • Grievance process; • Insurance department handling of complaints; • Consumer Ombudsman Program; • Health plan liability laws (12 states); and • Litigation costs.	Would the government plan be held to the same dispute resolution requirements as private plans? • Medicare has its own dispute resolution process. If the government plan builds on those programs, will it be subject to different requirements than private plans? • Would the government plan be subject to state insurance department oversight of complaints or state ombudsman programs? Would the government plan be subject to state health plan liability laws? Would it be subject to the kinds of lawsuits that consumers can file against private health plans?
State Coverage and Provider Mandates • Potential application of 1800+ specific state benefit and provider mandates, unless preempted for federal benefit packages.	Health reform legislation is likely to identify minimum benefit packages that must be offered by health plans. Would the government plan be exempt from state benefit mandates that may continue to apply to private plans?
State Privacy Protection Rules • State-specific requirements for safeguarding protected health information; • State-specific remedies, penalties; and • State differences among protected populations (e.g., HIV positive, mental health, substance abuse)	Would state privacy requirements be preempted with regard to the government plan?
Marketing / Sales • Filing/approval of advertising materials; • State market conduct examinations; • State unfair trade practices requirements; • Agent training; • Agent licensure, appointment; • Reporting requirements; and • Regulation of commission schedules.	Because the government plan would be competing directly with private entities in the health insurance market, it will need to promote/market itself to consumers. This will likely require employing agents and brokers to sell its coverage. What marketing requirements will the government plan be subject to, and how will they stack up against state marketing requirements? Who will oversee the marketing and sales practices of the government plan? Once again, it is unlikely the plan will be subject to state oversight.

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Private Health Plans	Government Plan
State Oversight of Plans • Handles complaints from consumers and providers; • Oversees and enforces all rules; • Investigates complaints, etc.; • Resolves issues; and • Takes appropriate action, including penalties, cease and desist orders, and license revocation.	States have well-developed programs to oversee and enforce all rules applying to private health plans. There's no parallel system that can be tapped to oversee a new government plan at the local level, and no precedent for state oversight of a federal program. Would states have the authority to investigate consumer complaints against a government plan?

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June 15, 2009

The Honorable Jane Harman
U.S. House of Representatives
2400 Rayburn House Office Building
Washington, D.C. 20515

Dear Representative Harman:

On behalf of the County of Los Angeles, I am writing to urge your support for preserving Medicaid Disproportionate Share Hospital (DSH) funding, which is a critically important funding source for public hospitals. We are concerned that the Obama Administration has proposed deep reductions in Medicaid DSH payments as part of its proposed financing of health care reform.

As longtime advocates for increased and affordable health care access for all Americans, the County Board of Supervisors strongly supports health care reform legislation that would advance those objectives while maintaining the safety net provided by public hospitals, such as those operated by the Los Angeles County Department of Health Services. The Department provides a wide range of services, including trauma and emergency care for all residents, while also serving as the safety net for an estimated 2.1 million uninsured residents. Annually, the County serves nearly 700,000 patients totaling 1.9 million outpatient contacts and more than 300,000 visits to our emergency rooms.

Deep reductions in Medicaid DSH funding should not be enacted without knowing with certainty that health care reform will significantly reduce public hospitals' uncompensated costs. A large segment of the County's population is likely to remain uninsured, in part, because health care reform proposals currently under consideration would not extend coverage to undocumented immigrants. Therefore, the County still could have hundreds of thousands of uninsured residents -- more than enough to keep our public hospitals operating at their current capacity. Moreover, Medicaid DSH funds

will continue to be needed to fully reimburse public hospitals for the cost of care provided to Medicaid recipients not covered by low Medicaid payment rates and to help finance surge capacity, trauma care, and burn care needed by the entire County population while ensuring access to care for our most vulnerable populations.

Therefore, we urge you to oppose reductions in Medicaid DSH funding. Thank you for your assistance on this important matter.

Sincerely,

DON KNABE
Chairman of the Board
Supervisor, Fourth District
County of Los Angeles

DK:lm

Premiums Soaring in Consolidated Health Insurance Market

Lack of Competition Hurts Rural States, Small Businesses

MAY 2009

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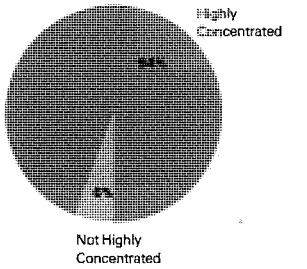
Families, Businesses Suffer as Insurers Pursue Local Monopolies Across U.S.

HEALTH CARE COSTS have surged in recent years, outpacing the growth in Americans' income. Commercial health insurance premiums have risen four times faster than wages and have more than doubled in the last nine years.[1] Shrinking competition among health insurance companies is a major cause of these spiraling costs. In the past 13 years more than 400 corporate mergers have involved health insurers, and a small number of companies now dominate local markets. The American Medical Association reports that 94 percent of insurance markets in the United States are now highly concentrated. Contrary to industry assertions, these mergers have undermined market efficiency; premiums have skyrocketed, increasing more than 87 percent, on average, over the past six years.[2,3] Families and employers—and the U.S. economy as a whole—cannot sustain that kind of cost growth. "The consequences of lax [antitrust] enforcement for consumers are clear," then-Senator Barack Obama said in a September 2007 address to the American Antitrust Institute. "The number of insurers has fallen by just under 20 percent since 2000. These changes were supposed to make the industry more efficient, but instead premiums have skyrocketed."[4]

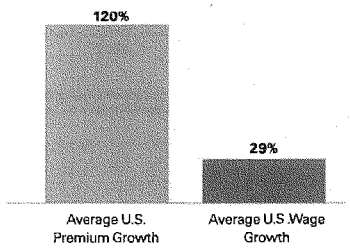
Insurer consolidation of market share disproportionately disadvantages rural and lower-population states. In Hawaii, Rhode Island, Alaska, Vermont, Alabama, Maine, Montana, Wyoming, Arkansas and Iowa, the two largest health insurers control at least 80 percent of the statewide market.[5] In Alabama,

Percentage of Statewide Health Insurance Markets Deemed "Highly Concentrated" Under U.S. Department of Justice Guidelines



Source: American Medical Association, "Competition in Health Insurance: A Comprehensive Study of U.S. Markets: 2008 Update."

Percent Increase in Premiums vs Income Nationwide, 1999–2007



Sources: The Henry J. Kaiser Family Foundation. Employee Health Benefits: 2008 Annual Survey.

Insurance Market Concentration: Ranked List (2007)

Rank	State	Health Insurer with Largest Market Share	Market Share %	Health Insurer with No. 2 Market Share	Market Share %	Combined Market Share % of Top Two Insurers
1	Hawaii	Blue Cross Blue Shield HI	78	Kaiser Permanente	20	98
2	Rhode Island	Blue Cross Blue Shield RI	79	UnitedHealth Group Inc.	16	95
3	Alaska	Premera Blue Cross	60	Aetna Inc.	35	95
4	Vermont	Blue Cross Blue Shield VT	77	CIGNA Corp.	13	90
5	Alabama	Blue Cross Blue Shield AL	83	Health Choice	5	88
6	Maine	WellPoint Inc. (BCBS)	78	Aetna Inc.	10	88
7	Montana	Blue Cross Blue Shield MT	75	New West Health Services	10	85
8	Wyoming	Blue Cross Blue Shield WY	70	UnitedHealth Group Inc.	15	85
9	Arkansas	Blue Cross Blue Shield AR	75	UnitedHealth Group Inc.	6	81
10	Iowa	Wellmark BC and BS	71	UnitedHealth Group Inc.	9	80
11	Missouri	WellPoint Inc. (BCBS)	68	UnitedHealth Group Inc.	11	79
12	Minnesota	Blue Cross Blue Shield MN	50	Medica	26	76
13	South Carolina	Blue Cross Blue Shield SC	66	CIGNA Corp.	9	75
14	Indiana	WellPoint Inc. (BCBS)	60	M*Plan (HealthCare Group)	15	75
15	New Hampshire	WellPoint Inc. (BCBS)	51	CIGNA Corp.	24	75
16	Idaho	Blue Cross of ID	46	Regence BS of Idaho	29	75
17	Louisiana	Blue Cross Blue Shield LA	61	UnitedHealth Group Inc.	13	74
18	Michigan	Blue Cross Blue Shield MI	65	Henry Ford Health System	8	73
19	North Carolina	Blue Cross Blue Shield NC	53	UnitedHealth Group Inc.	20	73
20	Maryland	CareFirst Blue Cross Blue Shield	52	UnitedHealth Group Inc.	19	71
21	Oklahoma	BCBS OK	45	CommunityCare	26	71
22	Georgia	WellPoint Inc. (BCBS)	61	UnitedHealth Group Inc.	8	69
23	Kentucky	WellPoint Inc. (BCBS)	59	Health Partners	10	69
24	Illinois	HCSC (Blue Cross Blue Shield)	47	WellPoint Inc. (BCBS)	22	69
25	Nebraska	Blue Cross Blue Shield NE	44	UnitedHealth Group Inc.	25	69
26	Utah	Regence Blue Cross Blue Shield	47	Intermountain Healthcare	21	68
27	Massachusetts	Blue Cross Blue Shield MA	50	Tufts Health Plan	17	67
28	Connecticut	WellPoint Inc. (BCBS)	55	Health Net Inc.	11	66
29	Arizona	Blue Cross Blue Shield AZ	43	UnitedHealth Group Inc.	22	65
30	Delaware	CareFirst Blue Cross Blue Shield	42	Coventry Health Care Inc.	23	65
31	New Mexico	HCSC (Blue Cross Blue Shield)	35	Presbyterian Hlth	30	65
32	Tennessee	Blue Cross Blue Shield TN	50	Total Choice	12	62
33	Virginia	WellPoint Inc. (BCBS)	50	Aetna Inc.	11	61
34	Washington	Premera Blue Cross	38	Regence Blue Shield	23	61
35	Texas	HCSC (Blue Cross Blue Shield)	39	Aetna Inc.	20	59
36	New Jersey	Horizon Blue Cross Blue Shield	34	Aetna Inc.	25	59
37	Ohio	WellPoint Inc. (BCBS)	41	Medical Mutual of Ohio	17	58
38	Nevada	Sierra Health	29	WellPoint Inc. (BCBS)	28	57
39	Colorado	WellPoint Inc. (BCBS)	29	UnitedHealth Group Inc.	24	53
40	Oregon	Providence Health & Services	25	Regence Blue Cross Blue Shield	23	48
41	New York	GHI	26	WellPoint Inc. (Empire BCBS)	21	47
42	Florida	Blue Cross Blue Shield FL	30	Aetna Inc.	15	45
43	California	Kaiser Permanente	24	WellPoint Inc. (Blue Cross)	20	44

Source: American Medical Association, "Competition in health insurance: A comprehensive study of U.S. Markets: 2007 Update."
Some states are not presented because available data does not reliably capture a sufficient portion of the insured population.

agreement that accelerated [the] health cost crisis."[24] The chiefs of the largest provider group in Massachusetts and the state's largest health insurer made a handshake deal to avoid creating written evidence of the arrangement. In that agreement, Blue Cross Blue Shield of Massachusetts pledged to increase payments if the provider group, Partners HealthCare, ensured that no other health plan would be charged less.[25]

When small, independent providers want to negotiate with multiple health plans, large insurers exert enormous pressure to stop them. The statewide trade group for doctors in New York sued UnitedHealth Group Inc., the nation's second-largest health insurer by enrollment, for allegedly using illegal coercion in just such a scheme to limit competition.[26]

In a separate matter UnitedHealth agreed to pay $400 million to settle multiple suits alleging price fixing and other anti-competitive behavior.[27,28] The attorney general of New York, Andrew Cuomo, stated that this was, "a huge scam that affected hundreds of millions of Americans [who were] ripped off by their health insurance companies."[29] Numerous other insurers were implicated in the same scheme, including Aetna Inc., Cigna Corp. and WellPoint Inc.[30]

If they chose to, private insurers could use their market power to drive hard bargains and lower costs, but instead they have passed along these costs through higher premiums to enrollees and employers. John Holahan and Linda Blumberg of the Urban Institute note that "[d]ominant insurers do not seem to use their market power to drive hard bargains with providers."[31] Large insurers do not face pressure from smaller insurers, which use premiums that "shadow" those of dominant insurers. Consequently, insurers are able to pass costs on to individuals.[32]

The Medicare Payment Advisory Commission, a respected expert panel appointed by Congress, reported that while, "insurers appear to be unable or unwilling to 'push back' and restrain payments to providers, they have been able to pass costs on to the purchasers of insurance and maintain their profit margins."[33] In a recent paper Jacob Hacker of the University of California, Berkeley, showed that Medicare demonstrates it is possible for savings to be shared with individuals instead of being taken as profit. Between 1997 and 2006, private health insurance spending per enrollee grew at an annual rate of 7.3 percent, compared with an annual growth rate of 4.6 percent in Medicare-a 37 percent difference.[34]

Oversized Profits, Executive Pay

Profits at 10 of the country's largest publicly-traded health insurance companies in 2007 rose 428 percent from 2000 to 2007, from $2.4 billion to $12.9 billion, according to U.S. Securities and Exchange Commission filings. In 2007 alone the chief executive officers at these companies collected combined total compensation of $118.6 million—an average of $11.9 million each. That is 468 times more than the $25,434 an average American worker made that year.[35]

The rising premiums paid by employers and families not only generate oversized net earnings, they also fuel controversial financial maneuvers designed to pump up insurers' stock prices, which in turn help executives reach their personal bonus targets. From 2003 through 2008 the seven largest publicly traded health insurers, which cover 116 million Americans, spent $52.4 billion buying back their own shares. Buybacks reduce the number of shares that are publicly traded, raising the value of existing shareholders' stakes. Companies make share repurchases with excess cash on hand or with borrowed funds. Buybacks are a way of removing money from a company's balance sheet for the benefit of investors, reflecting management's decision not to invest in improving a company's operations, making the health system run more efficiently or reducing customers' premiums. The companies prefer to hand over the money

Premiums Rising Out of Reach

Rising health premiums are exacerbating income inequality and making coverage too costly for many Americans. The Kaiser Family Foundation found that employer-sponsored health insurance premiums have more than doubled in the last nine years, a rate four times faster than wage increases.[38] A study by McKinsey Global Institute of widening income gaps among U.S. households found that rising employer-health insurance premiums constitute a much larger share of the income of lower-paid employees than higher-paid ones, and consume a bigger share of the household budget for lower income individuals who are lucky enough to have access to a workplace health plan. McKinsey found that in the bottom income group only one in five workers is covered. Moreover, families in the lowest income category spend 20 percent of household income on contributions to employer-sponsored health plan premiums, compared with only 3.3 percent for families in the top income group. The report concludes that rising health costs, reflected by spiraling insurance premiums, are widening income-group discrepancies as measured by participation rates in employer-paid health plans and insured workers' ability to afford premiums and out-of-pocket health care costs.[39]

As premiums have skyrocketed, many businesses have found themselves unable to offer their workers health benefits. One result is that more than 47 million people, or one out of seven Americans under age 65, are uninsured.[40] Low-wage workers are especially hard hit. The McKinsey survey found that 78 percent of low-wage workers don't receive health benefits from their employers.[41] Those not offered employer-sponsored health coverage must find insurance in the individual market.

The individual market generally provides more expensive plans with less comprehensive benefits. Insurers base individual coverage premiums on sex, age and health status, and they deny applications at a higher rate because risk usually isn't pooled effectively.[42]

For a typical family that moves from group to individual coverage with identical benefits, annual premiums will rise by more than $2,000.[43] The biggest losers in the individual market are those who are less healthy or coping with a chronic illness. Two-thirds of respondents in a recent survey said they found it difficult or impossible to find affordable coverage in the individual market.[44] The chronically ill aren't the only ones whose applications for coverage are rejected or whose rates are aggressively raised by insurers; people who don't consider themselves to be sick, such as women with a history of cesarean section, are treated in the same way.[45]

With premiums rising faster than peoples' ability to pay them, many Americans are being forced to choose between no coverage and inadequate coverage. Through a wave of consolidation, private health insurers have rigged the system to manufacture oversized profits while the country pays the price in the form of high premiums and poorer health.

Creating Healthy Competition

A public health insurance plan option would introduce a healthy dose of competition in the arenas of cost and quality. In a recent proposal the Commonwealth Fund recommended the creation of a public health insurance plan, saying it "plays a central role in harnessing markets for positive change."[46] Establishing a public health insurance plan, according to Commonwealth, would introduce "a new competitive dynamic in insurance markets and provide a strong foundation for payment and system reforms."[47]

In a March 2009 report, the Center for American Progress said, "Fortunately, our nation's health insurance market can be fixed with a big dose of what fixes most sectors of our economy—healthy, well-supervised competition. One of the best ways to introduce this much-needed competition is for the federal government to offer a public health insurance plan that can compete with private insurers within an insurance 'exchange' that ensures public and

ENDNOTES

[1] Kaiser Family Foundation & Health Research And Education Trust, "Employer Health Benefits: 2008 Annual Survey." Accessed at http://ehbs.kff.org/pdf/7790.pdf.

[2] David Balto, "The Right Prescription? Consolidation in The Pennsylvania Health Insurance Industry," Senate Judiciary Subcommittee on Antitrust, Competition Policy, and Consumer Rights, July 31, 2008. Accessed at http://www.americanprogressaction.org/issues/2008/balto_testimony.html.

[3] Karen Davis, "Slowing the Growth of US Health Care Expenditures: What Are the Options?," The Commonwealth Fund, 2007. Accessed at http://www.commonwealthfund.org/usr_doc/Davis_slowinggrowthUShltcareexpenditureswhatareoptions_989.pdf.

[4] Barack Obama, "Statement of Senator Barack Obama for the American Antitrust Institute," September 2007. Accessed at http://www.antitrustinstitute.org/archives/files/aai-%20Presidential%20campaign%20-%20Obama%209-07_092720071759.pdf.

[5] AMA data in this report is based on combined enrollment in preferred provider organizations (PPOs) and health maintenance organizations (HMOs) in metropolitan statistical areas (MSAs) as defined by the U.S. Census Bureau. The AMA calculates market share by dividing an insurer's enrollment in a given product by the total enrollment across all insurers in a market multiplied by 100. Total enrollment is for commercial products only, including self-insured employer-sponsored plans and individual coverage, and does not include Medicare, Medicaid, or Children's Health Insurance Program enrollments.

[6] American Medical Association, "Competition in health insurance: A comprehensive study of U.S. Markets: 2008 update."

[7] Government Accountability Office, "Private Health Insurance: 2008 Survey Results on Number and Market Share of Carriers in the Small Group Health Insurance Market, "February, 2009. Accessed at http://www.gao.gov/new.items/d09363r.pdf.

[8] Local markets are defined using the U.S. Census Bureau standard for metropolitan statistical areas. Each of the 363 metropolitan areas in the U.S. has a core urbanized area of 50,000 or more inhabitants forming a population nucleus, together with adjacent communities having a high degree of social and economic integration with that core. Census reports that 83.6 percent of the U.S. population lives in metropolitan areas. See http://www.census.gov/Press-Release/www/releases/archives/population/013426.html.

[9] US Department of Justice, "The Herfindahl-Hirschman Index." Accessed at http://www.usdoj.gov/atr/public/guidelines/horiz_book/15.html.

[10] American Medical Association, "Competition in health insurance: A comprehensive study of U.S. Markets: 2008 update."

[11] American Medical Association, "Competition in health insurance: A comprehensive study of U.S. Markets: 2008 update."

[12] Ibid.

[13] Jacob Hacker, "The Case for Public Plan Choice In National Health Reform," 2008. Accessed at http://institute.ourfuture.org/files/Jacob_Hacker_Public_Plan_Choice.pdf.

[14] John Holahan & Linda Blumberg, "Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform?," Urban Institute Health Policy Center, 2008.

[15] Commission on a High Performance Health System "The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way," The Commonwealth Fund, Feburary, 2009. Accessed at http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/Feb/The-Path-to-a-High-Performance-US-Health-System.aspx.

[16] Peter Harbage and Karen Davenport, "A Public Health Insurance Plan that Delivers Market Discipline," Center for American Progress, March 2009. Accessed at http://www.americanprogressaction.org/issues/2009/03/public_plan.html.

[17] David Balto, "The Right Prescription? Consolidation in The Pennsylvania Health Insurance Industry," Senate Judiciary Subcommittee on Antitrust, Competition Policy, and Consumer Rights, July 31, 2008. Accessed at http://www.americanprogressaction.org/issues/2008/balto_testimony.html.

[18] Lawton Burns, "Testimony at Hearings on IBC - Highmark Merger," Senate Judiciary Committee, Subcommittee on Antitrust April 9, 2007. Accessed at http://judiciary.senate.gov/hearings/testimony.cfm?id=2677&wit_id=6272.

[19] Government Accountability Office, "Private Health Insurance: 2008 Survey Results on Number and Market Share of Carriers in the Small Group Health Insurance Market, "February, 2009. Accessed at http://www.gao.gov/new.items/d09363r.pdf.

[20] Ibid.

[21] Ibid.

[22] Stephen Foreman, "Written Comments of the Pennsylvania Medical Society: Federal Trade Commission Workshop on Health Care Competition Law and Policy," September, 2002. Accessed at http://www.ftc.gov/ogc/healthcare/pms.pdf.

[23] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2009. Accessed at http://www.medpac.gov/documents/Mar09_EntireReport.pdf.

[24] Globe Spotlight Team, "A handshake that made healthcare history," The Boston Globe, December, 2008. Accessed at http://www.boston.com/news/health/articles/2008/12/28/a_handshake_that_made_healthcare_history/.

[25] Ibid.

[26] Richard Perez-Pena, "Doctors' Group Sues Two Insurers, Charging Unfair Coercion,"The New York Times, September, 2006. Accessed at http://www.nytimes.com/2006/09/21/nyregion/21oxford.html.

HEALTH CARE FOR AMERICA NOW!

July 2, 2009

The Honorable George Miller
Chairman, Committee on Education and Labor

The Honorable Robert Andrews
Chairman, Subcommittee on Health, Employment, Labor and Pensions
Committee on Education and Labor

The Honorable Charles Rangel
Chairman, Committee on Ways and Means

The Honorable Pete Stark
Chairman, Subcommittee on Health

The Honorable Henry Waxman
Chairman, Committee on Energy and Commerce

The Honorable Frank Pallone, Jr
Chairman, Subcommittee on Health

United States House of Representatives
Washington, DC 20515

Re: Comments on House Tri-Committee Draft Health Care Reform Legislation

Dear Chairman Waxman and Chairman Pallone:

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

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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 two 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 non-covering 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 twelve 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 five 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 U.S. 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 US, 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 policy-making 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 under. 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 must 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 participating 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 work force 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 pre-existing 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 decision-making 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. HC AN, 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 indentifying and endorsing patient-centered measure.** 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 re-hospitalized 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 source 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 payment 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 stake-holder 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 non-discrimination 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 US, 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 U.S., 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 non-physician 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 non-traditional Medicaid-eligible populations. In addition, we urge the Committees to repeal the five-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 that 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 sub-population, socioeconomic position, sexual orientation, gender identity, gender, and age. Additionally, health plans should report data on key health plan performance indicators (e.g., non-patient 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 evidence. 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 decision-making to prevent non-clinical or non-biological 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

Sec. 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 nonimmigrant 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 U.S., 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 U.S. 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," HR. 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 (page 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 "non-resident aliens" (p. 138). However, there is no parallel between "non-resident 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 non-citizen who is neither a lawful permanent resident nor a person who has had a "substantial presence" in the U.S. 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 one

million tax returns are filed with Individual Taxpayer Identification Numbers, most of which are assumed to belong to undocumented 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 five-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 USC 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 USC 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 USC 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 USCS § 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 USC 1395i-2(a)(3) is amended by striking subparagraph (B) and inserting:

"(B) an individual who is lawfully present in the United States."

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REPRESENTATIVE EDWARD J. MARKEY (D-MA)
HOUSE ENERGY AND COMMERCE COMMITTEE HEARING
DRAFT HEALTH CARE REFORM LEGISLATION
QUESTIONS FOR THE RECORD
JUNE 26, 2009

Kathleen M. White, Ph.D.
Chair, Congress on Nursing Practice and Economics
American Nurses Association
Panel on Doctor, Nurse, Hospital, and Other Provider Views

Dr. White, first of all, thank you and the American Nurses Association for endorsing the Independence at Home Act (H.R. 2560), which I recently re-introduced. As you know, my bill creates a Medicare pilot program to bring primary care services and care coordination to high-cost beneficiaries with multiple chronic conditions. A key part of the proposal is the use of a multidisciplinary team of health care professionals, such as nurse practitioners and physicians, to deliver care to patients in their own homes.

QUESTIONS

1. How will including nurse practitioners in this proposal to direct interdisciplinary teams of health professionals help address the primary care shortage our country is facing? How will it affect costs? Is there a sufficient supply of nurse practitioners who have the necessary training and the professional interest to serve the patient pool who would qualify to participate in the Independence at Home program?

ANA believes strongly in the value of Advanced Practice Registered Nurses. We presented APRNs as one of the keys to solving America's health care crisis when we outlined the need for APRN autonomous care delivery in *Nursing's Agenda for Health Care Reform*. APRN's skill and education, which emphasizes patient and family-centered, whole-person care, makes them particularly well suited providers to participate in the Independence at Home program. They 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. According to the American Academy of Nurse Practitioners, there are over 125,000 Nurse Practitioners (NPs) practicing in the United States today. Of those NPs, 66% serve in at least one primary care setting. Therefore, approximately 82,500 NPs are practicing in primary care. Nurse Practitioners widely practice, as primary care providers, particularly in underserved and rural areas, with outcomes equivalent to their physician and physician assistant colleagues.

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. Several comprehensive reviews of the research literature, medical malpractice claims data,[1] governmental evaluations,[2, 3] systematic reviews,[4, 5, 6, 7, 8, 9] and meta-analyses[10, 11] have

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1 Jordan, L. M., Kremer, M., Crawforth, K., Shott, S. (2001). Data-driven practice improvement: the AANA Foundation closed malpractice claims study. *AANA J*; 69(4): 301-11.

been conducted to evaluate APRN practice. All have found that the quality of care provided by APRNs is high and comparable to that provided by MDs. In fact, the editor of the Annals of Internal Medicine determined that the "quality of primary ambulatory care given by NPs was indistinguishable from that given by physicians."12 Similarly, data from the National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB) reveal overwhelming evidence of the safe care provided by APRNs.

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.13 Nurse practitioners and certified nurse-midwives play an essential role in federally-funded community health centers. Between 2000 and 2006, the number of primary care physicians at these centers grew by 57%, while the combined number of nurse practitioners, physician assistants, and certified nurse-midwives grew by 64%.14 The American College of Physicians has noted that more nurse practitioners are needed to fill the gaps in primary care.15

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. Twenty percent of NPs

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2 United States Congress. Office of Technology Assessment (1981). *The costs and effectiveness of nurse practitioners.* Washington, DC: US Government Printing Office.
3 United States Congress, Office of Technology Assessment (1986). *Nurse practitioners, physician assistants, and certified nurse-midwives: A policy analysis.* Washington, DC: US Government Printing Office.
4 Sox, H. (1979). Quality of patient care by nurse practitioners and physician's assistants: A ten-year perspective. *Annals of Internal Medicine*, 91, 459 – 468.
5 Ventura, M., Feldman, M. & Crosby, F. (1991). An information synthesis to evaluate nurse practitioner effectiveness. *Military Medicine*, 156, 286–291.
6 Horrocks, S., Anderson, E., & Salisbury, C. (2002). Systematic review of whether nurse practitioner working in primary care can provide equivalent care to doctors. *British Medical Journal*, 324, 819-823.
7 Laurant, M., Reeves, D., Hermens, R., Braspenning, J., Grol, R., Sibbald, B. (2005). Substitution of doctors by nurses in primary care. *The Cochrane Library*, Issue 4.
8 Hatem, M., Sandall, J., Devance, D., Soltani, H., Gates, S. (2008). Midwife-led versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews*, Issue 4. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub2.
9 O'grady, E. Advanced practice registered nurses: The impact on patient safety and quality. Vol 2, Chapter 43 (pg 601 – 620). In Hughes, R. (Ed). (2008). *Patient Safety and Quality: An Evidence-Based Handbook for Nurses* (AHRQ Publication No. 08-0043). Agency for Healthcare Research and Quality. Rockville, MD. http://www.ahrq.gov/qual/nurseshdbk/.
10 Brown, S. & Grimes, D. (1995). A meta-analysis of nurse practitioners and nurse-midwives in primary care. *Nursing Research*, 44(8),332-339.
11 Horrocks, S., Anderson, E., & Salisbury, C. (2002). Systematic review of whether nurse practitioner working in primary care can provide equivalent care to doctors. *British Medicel Journal*, 324, 819-823.
12 Sox, H. (1979). Quality of patient care by nurse practitioners and physician's assistants: A ten-year perspective. *Annals of Internal Medicine*, 91, 465.
13 American Academy of Nurse Practitioners, *Nurse Practitioner Facts.* AANP Web site: www.aanp.org/NR/rdonlyres/51C6BCOF-F1CO-4718-B42F-3DEDC6F5F635/O/AANPNPFacts.pdf.
14 National Association of Community Health Centers (NACHC), the Robert Graham Center and the George Washington University School of Public Health and Health Services published "Access Transformed: Building a Primary Care Workforce for the 21st Century," http://www.nachc.com/client/documents/ACCESS%20Transformed%20full%20report.PDF.
15 American College of Physicians (2009), *Nurse Practitioners in Primary Care*: 12.

practice in remote rural or frontier settings.16 Unfortunately, the significant contributions of APRNs are not accurately reflected in many key surveys and data systems, because these fail to separately identify or collect data specific to APRNs. As autonomous health care providers, APRNs may bill Medicare and many other payers for their services. However, certain billing practices also render "invisible" much of the care provided by APRNs.

2. What are the benefits of utilizing nurse practitioners to serve in the primary care role when treating patients with multiple chronic conditions and difficulty with two or more ADLs in their homes?

ANA is especially pleased that under the Independence at Home Act, Nurse Practitioners have been recognized as primary care providers. APRN's skill and education, which emphasizes patient and family-centered, whole-person care, makes them particularly well-suited providers to serve in the primary care role in the Independence at Home program.

According to an article by Tom Brodenheimer, Ellen Chen and Heather D. Bennett "*Confronting The Growing Burden of Chronic Disease: Can The U.S. Health Care Workforce Do The Job?"(* Health Affairs, Vol. 28, No. 1 Jan/February 2009), most chronic illness care is handled in primary care offices and primary care providers provide equal quality of care at lower cost for patients with chronic conditions such as diabetes and hypertension. This article further states, that generalists are better able to handle multiple health care issues than specialists. "In several health care systems, nurse-led planned visits achieve better disease control than patients receiving physician-only care." Pg. 69.

According to a document written by Karen Robinson an AARP/AAN Fellow (Care Coordination: What Every Nurse Should Know), "Nurse practitioners are uniquely qualified to coordinate increasingly complex patient care and improve communication between multiple health care providers to prevent the fragmentation of care that results in a corresponding rise in cost and medical errors. (U.S. Government Accountability Office, 2008).p.11." This article further states that ". . . NPs were more likely to meet standard set by national guidelines that physician-only practicies." A transitions model of care-coordination which involved nurse practitioners for the coordination of care for older adults who had been hospitalized for heart failure complicated by other chronic conditions noted that rehospitalizations, deaths, and total costs were significantly lower and the intervention involved using advanced practice nurses to make in-hospital visits, postdischarge home visits and phone consultations.

These examples further emphasize why ANA deeply appreciates Rep. Markey'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 Independence at Home Act of 2009.

Given the importance of APRN's to primary care, we encourage Rep. Markey and others on the Committee to consider an initiative that would cover the cost of Graduate Nursing Education

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16 American Academy of Nurse Practitioners, *Nurse Practitioner Facts.* AANP Web site: www.aanp.org/NR/rdonlyres/51C6BCOF-F1CO-4718-B42F-3DEDC6F5F635/O/AANPNPFacts.pdf.

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.

3. As you know, the beneficiaries addressed by this bill are especially frail and often have difficulty leaving their homes for visits. Please comment on the advantages of bringing primary care services and care coordination to these patients in their homes.

A reformed health care system must value primary care and prevention to achieve improved health status of individuals, families and the community. As Rep. Markey and 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.

The Mary Naylor transitions model of care coordination demonstrate the effectiveness of utilizing nurse practitioners for care coordination of older adults. This intervention of NP in hospital visits, postdischarge home visits and phone consultations has shown that this care can reduce rehospitalizations, deaths and total costs. By managing patients in less costly environments, one manages chronic illness and conditions more effectively which reduces costly emergency room admissions and hospitalizations.

Nursing through these care coordination models can demonstrate why it is important for care to be more holistic and more patient and family focused. These are the goals and values of the nursing profession which can be successfully implemented to achieve quality, patient centered, effective care. Reimbursement models must be reformed in order to incentivize care coordination and quality of care.