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HEALTH REFORM IN THE 21ST CENTURY: EXPANDING COVERAGE, IMPROVING QUALITY AND CONTROLLING COSTS

HEARING

BEFORE THE

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

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CONTENTS

Page

WITNESSES

John Z. Ayanian, M.D., MPP, on behalf of the Institute of Medicine Committee on Health Insurance Status and Its Consequences 10
Karen Davis, Ph.D., President, The Commonwealth Fund, New York, New York 23
John M. Pickering, FSA, MAAA, Principal, Consulting Actuary, Milliman, Inc, Seattle, Washington 70

SUBMISSIONS FOR THE RECORD

America Health Care Association and National Center for Assisted Living, Statement 131
American Academy of Physician Assistants, Statement 134
American College of Obstetricians and Gynecologists, Statement 138
American Federation of State, County and Municipal Employees, Statement 143
American Health Quality Association, Statement 144
American Society of Association Executives, Statement 149
Argus Health Systems, Inc., Letter 151
Families, USA, Statement 153
J. Kirk Peffers, Statement 154
National Association of Professional Employer Organizations, Statement 154
National Association of Realtors, Statement 156
Newbery, Ungerer & Hickert LLP, Statement 157

HEALTH REFORM IN THE 21ST CENTURY: EXPANDING COVERAGE, IMPROVING QUALITY AND CONTROLLING COSTS

WEDNESDAY, MARCH 11, 2009

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

The Committee met, pursuant to notice, at 10:18 a.m. in 1100 Longworth House Office Building, Honorable Charles B. Rangel, (Chairman of the Committee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
March 04, 2009
FC–4

CONTACT: (202) 225–3625

Health Reform in the 21st Century: Expanding Coverage, Improving Quality and Controlling Costs

House Ways and Means Chairman Charles B. Rangel (D–NY) announced today that the Committee will hold its first health reform hearing in the 111th Congress. **The hearing will take place at 10:30 a.m. on Wednesday, March 11, 2009, in the main committee hearing room, 1100 Longworth House Office Building.**

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

BACKGROUND:

Healthcare spending is expected to consume 17.6 percent of Gross Domestic Product (GDP) in 2009, and it is projected to rise to 20.3 percent by 2018 if current trends continue.[1] Since 2000, healthcare premiums have grown four times faster than wages.[2] The U.S. spends twice as much per person for healthcare as any other country in the world, and yet continues to lag behind other countries in terms of coverage and quality. There are nearly 46 million uninsured people in America, and millions more have inadequate coverage. The U.S. has lower life expectancy rates than all other high-income countries, including Japan, Germany, Australia and Switzerland. These premature deaths might be prevented through timely, effective healthcare or early efforts to screen and prevent diseases from progressing.[3]

Lack of health insurance coverage, rising costs and lower quality are intimately intertwined. The uninsured crisis is not just affecting those families without coverage; it affects costs and quality for everyone. A recent report from the Institute of Medicine found negative "spillover" effects that occur for people with health insurance who are in communities with a large uninsured population. These effects for the insured include decreased access to both primary care physicians and specialists, strained emergency services, and less access to state-of-the-art treatments.[4] Widespread lack of coverage also increases healthcare costs for providers, plans, and those with health insurance through cost-shifting.

The flaws in the U.S. health system have contributed to the economic downtown by putting enormous pressures on the Federal budget and making it harder for businesses to provide coverage for their employees. In addition, medical debt threatens the health and economic security of millions of Americans families. As the President said on Monday, March 2, "If we're going to help families, save businesses, and im-

[1] Sisko, Andrea, et al, "Health Spending Projections Through 2018: Recession Effects Add Uncertainty to the Outlook." *Health Affairs*. February 24, 2009 Web Exclusive: w346–357

[2] 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).

[3] C. Schoen, R. Osborn, S.K.H. How, M.M. Doty, and J. Peugh, In Chronic Condition: Experiences of Patients with Complex Health Care Needs, in Eight Countries, 2008, *Health Affairs* Web Exclusive, Nov. 13, 2008, w1–w16.

[4] Institute of Medicine, "America's Uninsured Crisis: Consequences for Health and Health Care", February 24th, 2009.

prove the long-term economic health of our nation, we must realize that fixing what's wrong with our healthcare system is no longer just a moral imperative but a fiscal imperative."

Reform will require a comprehensive approach that addresses coverage, cost and quality. *The Commonwealth Fund's Commission on a High Performance Health System* recently released a report that details key elements of a reform plan that could guarantee coverage for all, reduce health spending and improve quality.[5] The Commonwealth Commission proposes a series of insurance, payment and delivery system reforms designed to change the way the nation pays for care, invest in information systems to improve quality and safety, and promote better health. These changes could yield higher value and substantial savings for families, businesses, and the Federal and state Governments.

In announcing this hearing, Chairman Rangel said,**"Health reform cannot wait any longer. President Obama made a significant investment in health reform in his budget and this Committee is eager to continue working with the Administration to ensure success in our shared goal of improving the health system."**

FOCUS OF THE HEARING:

The hearing will focus on the need for comprehensive health reform and key features of a reformed health system.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, http://waysandmeans.house.gov, select "*Committee Hearings*". Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record.*" Once you have followed the online instructions, complete all informational forms and click "submit" on the final page. ***ATTACH*** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **Wednesday, March 25, 2009**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

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

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

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

[5] The Commonwealth Fund Commission on a High Performing Health System, "The Path to a High Performance U.S. Health System: A 2020 Vision and The Policies to Pave the Way", February 2009.

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

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

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

Chairman RANGEL. The Committee will come to order, and I cannot tell you how proud I and Mr. Camp are in terms of being one of the lead Committees in tackling a very serious and national problem.

It is the hope of our new President that all of the people, not just the patients and potential people in need of healthcare, could come together, insurance companies, Government, local and state, unions, and management. He brought us together at the White House to see how at the end of the day we can make this country more healthy.

It involves our workforce, international trade, competition, cost, prevention, reimbursement, universality, and I really believe on the House side that we can do it, notwithstanding the fact that more than one Committee has jurisdiction.

We will be working with the Committee on Energy and Commerce and Education and Labor, not only in informal hearings, but informal Republicans and Democrats to see if at the end of the day we can get a bipartisan piece of legislation.

This gives us an opportunity to reform the system, to deal with reimbursements, to deal with a variety of things, because there is no question that the healthcare system in our country has broken down.

It is not just the question of the 46 billion people that are not covered, it is also the cost to other people who have coverage, because these people are getting healthcare, and the Government and private companies are paying for it.

Most all of the work on this has been done by Mr. Stark, Chairman Stark and his Subcommittee. I would like to now yield to him to get his views for the direction which the Full Committee will be taking.

Chairman Stark.

Mr. STARK. Thank you, Mr. Chairman, and thank all of you, our witnesses.

We made some moves toward what President Obama has talked about as a moral and economic imperative for our economy. As we will hear today, the quality of our healthcare is based on geography, health insurance status, the number of uninsured in our community, a whole lot of things that are not really relevant.

We did deal with health IT and made a step toward comparative effectiveness research, but with those advancements, our healthcare system will still be inefficient and unfair unless we do

what virtually every other nation in the world has done, and that is extend coverage to everyone.

You have got cost shifting, a fractured system, and unless we have a system where everybody is a part of the program, we will not have achieved our goals. We can improve a lot of things in Medicare and Medicaid and SCHIP, but when we talk about reform, I guess I think of coverage for everyone.

It is interesting that more than two-thirds of the public, in the polls at least that we have seen, believe that they want an option to choose between a public plan or a private plan. That seems to be at least the direction in which the Committees are going in and following the President's request.

We are going to hear from three witnesses this morning. We are going to hear from the Institute of Medicine, who is going to tell us about the cost of being uninsured, and it has a lot of ramifications other than bankruptcy.

We will hear from The Commonwealth Fund, and they have spent a lot of time designing an outline—I guess they call it a framework. They have reviewed—my only disappointment was once they reviewed all the health plans that were available, mine came in first, so, I think they did not like that, so they wrote their own. That is okay with me.

Then we will hear from an actuary with Milliman Incorporated, and I do want to note that their analysis was conducted on behalf of the health insurance plans and the hospital association, and MedPAC takes exception to the analysis, and I would ask that MedPAC's statement prepared for the record for today be made part of the record.

[The information referred to follows:]

MEDPAC Medicare Payment Advisory Commission

STATEMENT

Statement for the Record
March 10, 2009
Committee on Ways and Means

In December 2008, Milliman, Inc conducted an analysis on behalf of the American Health Insurance Plans, American Hospital Association, Blue Cross and Blue Shield, and Premera Blue Cross, which argues that Medicare pays too little and that as a result, private payers have to pay well above costs to keep hospitals solvent. In other words there is a cost-shift from Medicare to the private sector. MedPAC analysis published in the March 2009 *Medicare Payment Policy* Report to Congress calls this argument into question.[1]

The traditional "cost-shift" argument starts with the assumption that costs are largely outside hospitals' control, or immutable. When external forces cause costs to be higher than Medicare prices, hospitals ask private insurers to increase their payment rates to cover the losses on Medicare patients. Hospitals argue that cost shifting is needed to maintain financial viability. Recently, Milliman implied that if Medicare paid hospitals more, hospitals would obtain less from private insurers and insurers would lower premiums for employers and consumers. If this Milliman hypothesis is valid, it would predict that if Medicare were to increase its payment rates, hospitals would accept lower payment rates from private insurers. While hospitals plead to insurers that they are under financial stress due to "cost shifting" and need payment increases from private insurers, the degree to which private insurer rates are driven by this plea from hospitals is an empirical question.

In contrast, the MedPAC has argued that high profits from non-Medicare sources permit

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hospitals to spend more. The causal chain is as follows: A hospital's market power relative to insurers, payer mix, and donations determines its level of financial resources. When financial resources are abundant, hospitals spend more and increase their costs per unit of service. High costs by definition lead to lower Medicare margins because costs do not affect Medicare revenues (which are based on predetermined payment rates). Therefore, when costs increase, Medicare margins decrease. In other words, income affects spending and in turn costs per unit of service. Hence, if Medicare were to increase its payment rates, it is not reasonable to think that hospitals with market power will voluntarily lower the prices charged to insurers and reduce their revenue. Instead, hospitals might spend some or all of that revenue, resulting in higher costs.

In MedPAC's March 2009 report, we explore an empirical analysis of this hypothesis. First, if the MedPAC argument is correct we would expect hospitals under high fiscal pressure (i.e., low private margins; low endowments) to have lower costs than low fiscal pressure hospitals (with high private margins and high endowments). The data supports this expectation. Using 2007 data (Table 1), we find that hospitals under pressure have lower costs per discharge ($5,800) than hospitals under little fiscal pressure ($6,400). In fact, this should not be a surprise for those who recall the managed care experience in the 1990s – managed care plans exerted pressure on hospital costs, and costs grew much more slowly.

Table 1. High financial pressure leads hospitals to constrain costs

	Level of financial pressure 2002 to 2006	
2007 Financial characteristics (medians)	High pressure	Low pressure
Standardized cost per discharge		
All hospitals	$5,800	$6,400
Non-profit hospitals	5,700	6,500
For-profit hospitals	5,900	6,000
Annual growth in cost per discharge 2004 to 2007	4.8%	5.0%
Non-Medicare margin (private, Medicaid, uninsured)	–2.4%	13.5%
Overall Medicare margin	4.2	–11.7

Note: High pressure hospitals had median non-Medicare profit margins of 1 percent or less from 2002 to 2006 and net worth would have grown by less than 1 percent per year from 2002 to 2006 if the hospital's Medicare profits had been zero. Low pressure hospitals had median non-Medicare margins were greater than 5 percent from 2002 to 2006 and a net worth that would have grown by more than 1 percent per year if its Medicare profits were zero. Standardized costs are adjusted for case mix, wage index, outliers, transfer cases, interest expense, and the effect of teaching and low-income Medicare patients on costs per discharge.

Source: MedPAC analysis of Medicare Cost Report and claims files from CMS available as of August, 2008.

The second empirical question is whether the hospitals with high Medicare losses tend to have financial resources that allow high costs or if they tend to be financially troubled facilities that require higher private rates to keep them afloat. The data indicate that the hospitals with the largest Medicare losses tend to be in better financial shape than other hospitals. From 2002 to 2006, hospitals with low Medicare margins had median total (all payer) margins of 4.6 percent compared with 3.4 percent for hospitals with high Medicare margins (Table 2). In addition, net worth for the high-cost hospitals rose by 17 percent from 2004 to 2006 compared with a 14 percent rise for low-cost hospitals.

Table 2. Revenue drives costs

	Overall Medicare profit margin in 2007		
	<-10%	-10% to 0%	>0%
Financial characteristics (medians)			
Standardized costs (2007)	6,900	6,100	5,500
Number of hospitals	1,138	789	964
Medicare margin (2007)	-20.0%	-5.1%	7.6%
Median total margin in 2004-2006*	4.6%	3.8%	3.4%
Percent change in net worth 2004-2006	17%	15%	14%

Total margin refers to total revenue from all sources (including Medicare) less total expenses, divided by total revenue.
*When comparing the highest cost to the lowest cost groups, the difference in median total margins from 2004 to 2006 is statistically significant (p=.0003) using a Wilcoxon rank test. The difference in equity growth rates is not statistically significant (p=.088).

It may appear odd that hospitals with high costs have high total profit margins. In a typical industry, high profits are not associated with high unit costs. The hospital industry is different, however, because of the dominance of nonprofit providers, the influence of payer mix, hospital and insurer market power, and the effect of investments and donations on hospital finances.

One final point, people might reasonably be concerned that fiscal pressure results in lower costs and possibly lower quality. To look at this - we asked if there were hospitals that consistently control their costs and have at least average quality. We identified over 300 Medicare hospitals that have performed well on a mix of quality measures and costs over a three year period (2004-2006). Using 2007 data we compared them to all other hospitals in Medicare. The group had lower costs and consistently out performed the other hospitals on a range of mortality measures.

To be clear – not all low cost hospitals have high quality, but there are hospitals that consistently control their costs yet perform outperform other hospitals on quality measures.

[1] For a longer discussion of this MedPAC analysis, please refer to pages 57 to 67 in *Medicare Payment Policy*, MedPAC's March 2009 Report to Congress, available at www.medpac.gov.

Chairman RANGEL. I wanted to say to Mr. Camp that it appears as though the other body is attempting to proceed in a bipartisan way. I do not know whether we will have that flexibility, but I hope after we listen to the witnesses, we can determine whether there are serious differences in the approaches that we are going to take. But if indeed they are not serious, then whatever can be worked out, I would hope we would at least try to work it out.

I yield to you whatever time that you would like.

Mr. CAMP. Well, thank you, Mr. Chairman.

As you have said, this is an important hearing following a historic meeting at the White House last week. I first want to thank the Chairman for so readily turning over the microphone this time.

[Laughter.]

Mr. CAMP. I know if we cooperate with this, I think there is really no limit on what we can accomplish together, but too many families are struggling to pay for their healthcare. Too many employers are being forced to reduce or eliminate coverage, and, yes, too many Americans are uninsured.

These are facts that we all agree on. As I told the President last week, I think there is broad agreement on the principles of any successful healthcare reform: lowering costs, increasing access, ensuring portability, having a strong prevention and wellness component among others.

The difficulty is how do we get there, and that is why I want to begin my remarks by highlighting one fact, that 61 percent of Americans have their health insurance through their employer for those 65 years and under. Let me also say that 65 percent of Americans less than 65 are covered with some form of private insurance.

The reason I wanted to highlight those numbers is just for one specific reason. It is clear a majority of Americans receive their healthcare through their employer or other private means. I think the first principle we must follow in healthcare reform is protecting the coverage Americans already have, and that is the coverage they receive through their workplace.

Increasing the Government's role in healthcare has a cost for taxpayers, and as Mr. Pickering will testify, for employers providing coverage and the workers they cover.

This Government to employer and employee cost shift will eliminate the manner in which about 120 million Americans receive their healthcare, and that runs the risk of violating the Hippocratic Oath, which is first, do no harm.

Sometimes on television you see an ad for new medicine and the latest cure-all, and as usual, at the very end of the commercial, you hear what the side effects are. You might hear "mild nausea," and

you think, well, okay. An occasional headache, that might be worth it, but a fatal stroke, that is obviously not a chance.

That, I fear, is exactly what some witnesses today are asking us to risk, a fatal stroke that will eliminate the ability of employers to offer affordable healthcare to their workers and their families.

Mr. Chairman, you well know that employers are already having enough difficulty maintaining coverage for their employees, and I think you would agree with me that they deserve to be commended for giving millions of Americans access to critical care.

Let us make sure that we continue to support them and their employees.

I look forward to working together to make sure healthcare remains a benefit provided by employers while driving down the high cost of care that every single American faces, and I look forward to working with you on trying to see if there is a path forward to ensure that more Americans have access to healthcare, more Americans have insurance, and the reforms of wellness and prevention are incorporated into any plan that might move forward.

With that, I yield back the balance of my time. Thank you.

Chairman RANGEL. Thank you. We have three witnesses today, John Ayanian, Karen Davis, and John Pickering.

John Ayanian is a doctor from the Institute of Medicine, the Committee on Health Insurance Status and its Consequences, and a Professor of Medicine and Healthcare Policy at Harvard Medical School.

He will be testifying on behalf of the Institute of Medicine Committee about the recently commissioned report summarizing the research on effects of un-insurance We look forward to your testimony.

The procedure is that you would have 5 minutes, but you will be allowed to finish your thought on that. So, welcome, and we welcome your testimony this morning.

STATEMENT OF JOHN Z. AYANIAN, M.D. ON BEHALF OF THE INSTITUTE OF MEDICINE, COMMITTEE ON HEALTH INSURANCE STATUS AND ITS CONSEQUENCES

Dr. AYANIAN. Thank you, Chairman Rangel, Representative Camp, and Members of the Committee on Ways and Means.

My name is Dr. John Ayanian. I am a Professor of Medicine and Healthcare Policy at Harvard, a practicing physician at Brigham and Women's Hospital in Boston, and member of the Institute of Medicine Committee on Health Insurance Status and Its Consequences.

I am honored to present to you today the Institute of Medicine's most recent report, "America's Uninsured Crisis: Consequences For Health Health Care."

Our report addressed three key questions. First, what are the dynamics driving downward trends in health insurance coverage? Second, is being uninsured harmful to the health of children and adults? Third, are insured people affected by high rates of un-insurance in their community?

The first topic of our report assessed the continuing decline in health insurance coverage. With eroding private coverage and expanded public programs from 2000 to 2007, the proportion of unin-

sured children remained steady at about 11 percent, while the proportion of uninsured adults increased from 17 to 20 percent.

The principal cause of declining private insurance coverage has been the rising cost of healthcare. Between 1999 and 2008, family health insurance premiums rose nearly 120 percent, more than triple the increase in workers' earnings.

Employers are less able to sponsor coverage, and employees are less able to afford the premiums if coverage is offered. Our Committee concluded that these trends will not reverse without concerted action.

Current economic conditions and rising unemployment will only exacerbate the problem as more individuals and families lose employment based coverage.

The second major topic of our report focused on the health consequences of being uninsured for children and adults.

Based on nearly 100 new and generally stronger studies that we reviewed, we found that uninsured Americans frequently delay or forego doctors' visits, medications, and other effective treatments, even when they have serious or life threatening conditions.

Uninsured children receive fewer immunizations and basic dental services. When they have serious conditions such as asthma or diabetes, they have more unmet healthcare needs. Uninsured children are also more likely than insured children to miss school due to health problems.

Among uninsured adults, 40 percent have one or more chronic condition, such as high blood pressure, diabetes or depression. Many of them receive little or no medical care, and their health declines more rapidly than for insured adults with these conditions.

Uninsured adults are also more often diagnosed with later stage cancers. As a result, they are more likely to die more prematurely than insured adults, and with serious conditions such as heart disease, cancer or trauma, the risk of death can be 40 to 50 percent higher.

Fortunately, our Committee also found good news to report about the benefits of gaining coverage. When uninsured children gain coverage, they have serious health problems identified sooner, better preventive services, fewer hospital stays, improved asthma outcomes, and fewer missed days of school.

When uninsured adults enroll in Medicare, they receive more appropriate tests and treatments that improve their health and prevent costly complications. The risk of death is also reduced when they are hospitalized for heart disease and other serious conditions, such as strokes or hip fractures.

Therefore, our Committee concluded that lacking health insurance is hazardous to the health of children and adults. More importantly, gaining health insurance provides substantial health benefits to uninsured Americans.

The third and final topic of our report focused on the affects of high rates of un-insurance for Americans who have health insurance.

When rates of un-insurance in communities are relatively high, insured adults report more difficulty obtaining needed healthcare and less satisfaction with the care they receive.

Furthermore, weaknesses in local healthcare systems are intensified by high rates of un-insurance, and these problems have potentially grave consequences for the quality and timeliness of emergency services and trauma care for everyone in the community, both insured and uninsured.

In conclusion, we determined that the evidence on the adverse health consequences of being uninsured is stronger than ever before.

This evidence makes a compelling case for urgent action, because insurance coverage matters for the health of children, adults and communities.

Given the harms of lacking health insurance and the benefits of gaining coverage, the Institute of Medicine recommends that the Congress and President work with other public and private sector leaders on an urgent basis to achieve health insurance coverage for everyone and to reduce the escalating costs of healthcare to make coverage for all sustainable for the nation.

Thank you.

[The prepared statement of Dr. Ayanian follows:]

AMERICA'S UNINSURED CRISIS:
CONSEQUENCES FOR HEALTH AND HEALTH CARE

Statement of
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Boston, Massachusetts
&
Member, Committee on Health Insurance Status and Its Consequences
Board on Health Care Services
Institute of Medicine
The National Academies

Presented to
Committee on Ways and Means
United States House of Representatives
Public Hearing on "Health Reform in the 21st Century:
Expanding Coverage, Improving Quality and Controlling Costs"

March 11, 2009

THE NATIONAL ACADEMIES
Advisers to the Nation on Science, Engineering, and Medicine

Chairman Rangel, Representative Camp, and members of the Committee on Ways and Means, my name is Dr. John Ayanian. I am honored to present to you today the findings and recommendations of the Institute of Medicine (IOM) Committee on Health Insurance Status and Its Consequences, as detailed last month in our report, *America's Uninsured Crisis: Consequences for Health and Health Care* (http://www.iom.edu/CMS/3809/54070/63118.aspx).

Our Committee was convened in 2008 with funding from the Robert Wood Johnson Foundation to update the six prior IOM reports on the consequences of uninsurance that were issued from 2001 through 2004. Our 14-member Committee included health economists, physicians, a nurse, and experts in health policy and public health with substantial leadership experience in state and federal government, private-sector corporations, health-care delivery, and medical research.

I will review the findings of our most recent report concerning three key questions: First, what are the dynamics driving downward trends in health insurance coverage? Second, is being uninsured harmful to the health of children and adults? Third, are insured people affected by high rates of uninsurance in their community?

Caught in a Downward Spiral: Health Insurance Coverage is Declining

A number of signs point to a continuing decline in health insurance coverage. Health care costs and insurance premiums have been growing substantially faster than the economy and family incomes. Rising health care costs and a severely weakened economy threaten not only employer-sponsored insurance, the cornerstone of private health coverage in the United States, but also threaten recent expansions in public health insurance through Medicaid and the Children's Health Insurance Program.

Employment-based health benefits have served as the primary source of health coverage for several generations of workers and their families. However, in the years 2000 through 2007 that our Committee examined, rates of employer-sponsored coverage declined by 9 percentage points for children (from 66 percent to 57 percent) and by 5 percentage points for non-elderly adults (from 69 percent to 64 percent).

The principal cause of declining rates of private health insurance coverage is the ever-rising cost of health care. Between 1999 and 2008, family health insurance premiums rose 119 percent, more than triple the 34 percent increase in workers' earnings in the same time period. Employers are finding it more difficult to sponsor coverage and their employees are increasingly unable to afford the premiums if offered coverage, particularly those workers with lower wages.

Fundamental changes in the workplace are also contributing to the decline in coverage. Jobs in the U.S. have shifted away from industries with traditionally high rates of health coverage, such as manufacturing, to service jobs, such as wholesale and retail trade, with historically lower rates of coverage. In some industries, employers are relying more heavily on jobs without health benefits, including part-time and short-term employment, as well as contract and temporary jobs. Early retirees are also less likely to be offered retiree health insurance benefits than in the past.

Many more low-income Americans would be uninsured today were it not for state and federal efforts to expand coverage in the past decade. By expanding eligibility, conducting outreach to people already eligible, and expediting enrollment in Medicaid and SCHIP (now CHIP), which has been reauthorized and expanded, states and the federal government have substantially increased health coverage among low-income children and to a lesser degree among adults. The net result of eroding employment-based coverage and improved public programs is that the portion of children

who are uninsured has remained at about 11 percent from 2000-2007, while the portion of adults under age 65 who are uninsured has increased from 17 percent to 20 percent.

For those Americans without access to employer-sponsored or public insurance, acquiring health insurance in the non-group health insurance market can be very difficult if not impossible. In most states, insurers may deny applicants for nongroup coverage completely; impose either a permanent or temporary preexisting condition limitation on coverage; or charge a higher premium based on health status, occupation, and other personal characteristics. As a result, nongroup insurance policies are often unaffordable, particularly for those with preexisting conditions. Individual medical insurability also depends on how recently one has been covered by a group health plan. Applicants with recent group coverage have some protections under the federal Health Insurance Portability and Accountability Act (HIPAA). However, HIPAA coverage can also be expensive, include high cost-sharing requirements, and offer only limited benefits. Moreover, HIPAA's rules do not protect individuals from future increases in premiums. As a consequence, someone who suffers a serious medical condition or trauma may be charged extremely high premiums.

The Committee concluded that there is no evidence that the trends will reverse without concerted action by policymakers. Current economic conditions and rising unemployment will only exacerbate the problem as more individuals and families lose employment-based benefits and many of them turn to public insurance programs in an exceptionally challenging fiscal time for state and local governments. The Administration and Congress have already taken recent steps beyond the reauthorization of the CHIP program to deal with the impact of the recession. To mitigate the effects of expected private-sector coverage losses and increased costs to state programs, short-term financing for some of the cost of COBRA benefits has been provided for workers who have lost

their jobs, and supplemental federal matching has been extended to hard-pressed state Medicaid programs. However, net losses in overall coverage rates are still expected in the near term.

Coverage Matters: Health Insurance is Integral to Personal Well-Being and Health

Important new research has emerged since 2002 when the IOM last studied the health consequences of being uninsured for children and adults, including nearly 100 new studies that our Committee reviewed. These new studies have confirmed and extended the evidence regarding the harms of being uninsured that were featured in earlier IOM reports. Furthermore, rigorous new research in the past six years has demonstrated the benefits of gaining health insurance for both children and adults.

Uninsured Americans frequently delay or forgo doctors' visits, prescription medications, and other effective treatments, even when they have serious disease or life-threatening conditions. Uninsured children are 20 to 30 percent more likely to lack immunizations, prescription medications, asthma care, and basic dental care. Uninsured children with conditions requiring ongoing medical attention, such as asthma or diabetes, are 6 to 8 times more likely to have unmet health care needs. Uninsured children are also more likely than insured children to miss school due to health problems and to experience preventable hospitalizations.

Among working-age uninsured adults, 40 percent have one or more chronic health conditions such as asthma, hypertension, depression, diabetes, chronic lung disease, cancer, or heart disease. Uninsured adults with such chronic conditions are two to four times more likely than their insured counterparts to have received no medical attention in the prior year. Because uninsured adults seek health care less often than insured adults, they are often unaware of health problems such as high blood pressure, high cholesterol, or early-stage cancer. Uninsured adults are also much less likely to

receive vaccinations, cancer screening services such as mammography and colonoscopy, and other effective preventive services.

These deficits in care have important consequences for uninsured adults. Middle-aged adults with chronic conditions such as diabetes or hypertension experience more rapid declines in health than insured adults with these conditions. Uninsured adults are also more likely to be diagnosed with later-stage cancers compared to their insured peers. If hospitalized for a serious acute condition, such as a heart attack, stroke, or major trauma, uninsured adults are more likely to die after admission to a hospital. Uninsured adults are 25 percent more likely to die prematurely than insured adults overall, and with serious conditions such as heart disease, diabetes or cancer, their risk of premature death can be 40 to 50 percent higher.

Fortunately, our Committee also found *good* news to report: when uninsured people acquire health insurance they can experience both immediate and long-term improvements in their health. Since 2002, numerous well designed studies have focused on what happens to uninsured people after they gain health insurance. For children, this research shows substantial benefits for previously uninsured children after enrolling in SCHIP or Medicaid, particularly if they have special health needs. Once enrolled in a public insurance program, children experience numerous health benefits. They are more likely to have serious health problems identified early, have fewer avoidable hospital stays, enjoy better asthma outcomes, have fewer missed days of school, and receive more appropriate preventive services such as immunizations and basic dental care.

For previously uninsured adults, the health benefits of becoming eligible for Medicare at age 65 are substantial. Once enrolled in Medicare, these adults are much more likely to receive appropriate cholesterol testing, cancer screening tests such as mammograms, physician services, and hospital care. Recent evidence shows that acquiring Medicare coverage improves the health of

uninsured adults and prevents costly complications such as hospitalizations for heart failure, particularly for adults with cardiovascular disease or diabetes. The risk of death when hospitalized for serious conditions, such as stroke, respiratory failure, or hip fractures, is also reduced after uninsured adults become eligible for Medicare.

Despite the availability of some safety net services for uninsured Americans, these new research findings demonstrate that lacking health insurance reduces access to effective health care services and is thus hazardous to the health of children and adults. Most importantly, based on numerous new published studies, our Committee determined that gaining health insurance provides substantial health benefits to uninsured Americans

High Levels of Uninsurance May Undermine Health Care for the Insured Population

National trends in uninsurance rates mask the tremendous variation in uninsurance across the country among states, counties, and even areas within counties. For example, across zip codes in Los Angeles County, uninsurance rates for the nonelderly population ranged from 6 percent to 45 percent in 2005.

As the size of the local uninsured population grows, even those who have health insurance become vulnerable. While more research is needed on this topic, a growing body of evidence since the last IOM report suggests that when community-level rates of uninsurance are relatively high, worrisome "spillover" effects are experienced by the *insured* population. Rigorous surveys of 60 communities across the United States over the last decade suggest real risks to living in communities with high rates of uninsurance. The Institute of Medicine commissioned a special study by economists Mark Pauly and Jose Pagan to explore this issue further.

When rates of uninsurance in communities are relatively high *insured* adults in those communities are more likely to report difficulty obtaining needed health care and to be less

satisfied with the care they receive. Privately insured, working-age adults in higher uninsurance areas, for example, are significantly less likely to report having a place to go when sick, having a doctor's visit or routine preventive care (including mammography), and seeing a specialist when needed. They are also less likely to be satisfied with their choice of primary care and specialty physicians or to trust their doctor's decisions.

Our Committee also examined widespread vulnerabilities in local health care delivery. These vulnerabilities are not necessarily attributable to uninsurance but they are sensitive to financial pressures and may be exacerbated by higher rates of uninsurance in local communities:

- Health care providers and capital investment tend to locate in well-insured areas (and away from communities of high rates of uninsurance). It is common for hospitals to focus major investments in more affluent locations with well-insured populations.
- Physicians and other health care providers are drawn to newer facilities with the most up-to-date technologies. This phenomenon makes it challenging for financially stressed hospitals in communities with high uninsurance rates to recruit on-call specialists for emergencies.
- A range of problems with hospital-based emergency services — including limits on inpatient bed capacity, outpatient emergency services, and the availability and timeliness of trauma care — have serious implications for the quality of care for insured as well as uninsured patients in need of these services.

These community effects of uninsurance are complex and not fully defined, in part because empirical data to inform the issue are limited. Nonetheless, weaknesses in local health care delivery are intensified by high rates of uninsurance, and these problems have potentially grave consequences for the quality and timeliness of care for everyone in the community, both insured and uninsured.

Conclusions and Recommendation of the Institute of Medicine

Our Committee determined the evidence on the adverse health consequences of being uninsured is stronger than ever before. This evidence makes a compelling case for urgent action, because health insurance coverage matters for the health of children, adults, and communities. Expanding health coverage to all Americans is essential and should be done as swiftly as possible. Without such action, preventable suffering due to the lack of health insurance will persist. Our Committee also concluded that steps to reduce the costs of health care and the rate of increase in health care spending are of paramount importance if coverage for all is to be achieved and sustained. In the Committee's consensus view, however, action to expand coverage should not be delayed pending the development of a long-term solution to curbing underlying health care costs. Given the demonstrated harms of lacking health insurance for children and adults, the Committee determined that action to achieve coverage for all should proceed immediately, coupled with concerted attention to addressing the long-term underlying trends in health care costs to assure sustainability of the system for all.

Therefore, the Institute of Medicine recommends that the President work with Congress and other public and private sector leaders on an urgent basis to achieve health insurance coverage for everyone and, in order to make that coverage sustainable, to reduce the costs of health care and the rate of increase in per capita health care spending.

COMMITTEE ON HEALTH INSURANCE STATUS AND ITS CONSEQUENCES

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ROGER HERDMAN, Director, IOM Board on Health Care Services

Chairman RANGEL. I would like to have Mr. Stark introduce our next witness who is a friend of the Congress and has been so helpful to us even when she thought we were wrong.

Mr. Stark.

Mr. STARK. Well, I am pleased to introduce a person for this Committee who needs no introduction, Karen Davis, who is Presi-

dent of The Commonwealth Fund in New York, and has spent much of her career and directed untold resources from The Commonwealth Fund toward studying the ways we can improve the delivery of healthcare in this country.

They have come up with this as suggested in the eleventh hour, and I think we all have a copy of it with us, a plan, a scheme.

She, too, has hired an actuary, but I think it is important to note that whatever the exact numbers in your report are, they are less important than the direction that the curve moves. I do not think at this point it is worth arguing about the exact hours.

It is the fact that we have trends which will get us over a period of years to savings, and those savings will allow us to provide quality care to more people.

Karen, I look forward to you enlightening us this morning. Thank you.

STATEMENT OF KAREN DAVIS, PRESIDENT, THE COMMONWEALTH FUND

Ms. DAVIS. Thank you, Representative Stark, for that gracious introduction.

Mr. Chairman, Mr. Camp, Members of the Committee, really it is a great opportunity to be here on this very important hearing on health reform in the 21st Century.

With the economy in crisis, healthcare costs rising as Representative Camp said, too many families are struggling with the cost of healthcare and the cost of health insurance premiums, and too many employers are cutting back on coverage.

We can certainly do much better than we are currently doing, and we cannot afford to continue on our current course. It is urgent to start now.

In fact, the longer we wait, the worse these problems will get, and the more difficult they are to confront. As Representative Stark said, The Commonwealth Fund Board of Directors established a commission on a high performance health system in 2005.

They have recently released the report they were pleased to share with you on "The Path to a High Performance U.S. Health System, a 20–20 Vision and the Policies to Pave the Way."

There are five key strategies in the commission's report: affordable coverage for all including an insurance exchange that gives employers and individuals choices of private plans and a new public health insurance plan that would change the way the insurance markets work, fostering competition, enhanced choice, while preserving, as Representative Camp stressed, employment-sponsored insurance.

The second strategy is aligning incentives to reward physicians, hospitals, and other providers for the results we would like to achieve and enhance value moving away from fee-for-service payment.

The third strategy is changing the healthcare delivery system to reward accountable, patient-centered, coordinated care. The four step strategy, which the Congress has already moved forward on with the American Recovery and Reinvestment Act, is to provide the support to hospitals and physicians that they need to provide

benchmark levels of high quality care by investing in infrastructure and information, promoting health and disease prevention.

The fifth strategy is leadership and collaboration among private and public stakeholders to achieve these goals.

As Representative Stark stressed, the exact numbers can differ depending upon whose models are being used, but The Lewin Group estimated for the commission the following effects of this set of strategies.

It would lower the annual rate of increase from 6.7 percent a year to 5.5 percent a year.

The effect of slowing the growth and health spending would be a cumulative $3 trillion in savings to the health system from 2010 to 2020. Employers would share in this savings. Employees would share in this savings. Employers would save $321 billion over that period, which would provide needed relief to struggling businesses.

State and local governments that are hard hit by the economic crisis would save $1 trillion over that period of time, and families would save $2.3 trillion or $2300 per family in 2020 alone.

As the central source of financing for coverage, the Federal Government's cost would increase during early years—the net cumulative cost to the Federal Government of the PATH framework over the 2010 to 2020 period would be $593 billion.

Most of the Federal expenses would occur in the early years as a result of initial investments. These up front investments yield a substantial return for the nation, resulting in nearly offsetting all of the increased annual Federal spending, compared to baseline projections by 2020.

Most importantly, the PATH framework would benefit patients achieving near universal coverage, improving choices. It would increase those covered by employer coverage from 164 million to 196 million. It would improve coverage or make more affordable coverage for over 130 million individuals.

The U.S. needs to find its own unique path forward building on the strengths of our public and private health insurance system, fostering competitive market forces in the public interest, aligning incentives to reward value.

The result of this would be bold change on behalf of the entire population. The President has called for such bold change, has advocated the creation of a health reform reserve fund, which if included in budget resolution, would provide the essential start for reform.

Medicare can innovate, but it cannot go it alone. Reforms to bend the cost curve and improve coverage for those under 65 must be a part of an overall system approach to change. The cost of inaction is high. We really have a historic opportunity and a clear path forward to a high performance health system.

Thank you very much.

[The prepared statement of Ms. Davis follows:]

PUTTING THE U.S. HEALTH SYSTEM ON THE PATH TO HIGH PERFORMANCE

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Invited Testimony

HEARING ON "HEALTH REFORM IN THE 21ST CENTURY: EXPANDING COVERAGE, IMPROVING QUALITY AND CONTROLLING COSTS

House of Representatives Committee on Ways and Means

March 11, 2009

The co-authorship of Cathy Schoen, Senior Vice President, comments by Stuart Guterman, Assistant Vice President and Rachel Nuzum, Senior Policy Director, research assistance of Kristof Stremikis, Research Associate, and editorial assistance of Chris Hollander of The Commonwealth Fund are gratefully acknowledged. Background information adapted from The Commonwealth Fund Commission on a High Performance Health System, *Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund, February 2009).

The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

PUTTING THE U.S. HEALTH SYSTEM ON THE PATH TO HIGH PERFORMANCE

Karen Davis and Cathy Schoen

Executive Summary

Thank you, Mr. Chairman, for this invitation to testify on Health Reform in the 21st Century: Expanding Coverage, Improving Quality and Controlling Costs. With the economy in crisis and health costs increasing faster than incomes, families, employers, and federal, state, and local government budgets are feeling the pressure. Yet, despite the high level of spending, the U.S. health system falls short of producing the quality and outcomes that should be possible. We can do much better. But to do so will require extending insurance coverage to everyone; changing the way insurance markets work; moving away from fee-for-service payment to encourage value rather than volume; rewarding more patient-centered, effective, and efficient care; and the leadership and commitment required. It is urgent to start now – the longer we wait, the worse these problems get and the more difficult they are to confront.

A recent report of the Commonwealth Fund 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,* offers an integrated system framework that moves the U.S. health system on a path to a high performance health system – slowing the growth in health care costs, ensuring access to quality care, and protecting families. The Path framework encompasses five key strategies:

- **Affordable coverage for all: access and foundation for payment and system reforms**
  - Insurance exchange: choice of private plans and new public health insurance plan
  - Market reforms, affordability, and shared responsibility
- **Align incentives: payment reform to enhance value**
  - Accessible patient-centered primary care
  - Move from fee-for-service to more "bundled" payment, with accountability
  - Align price signals with efficient care and value
- **Accountable, patient-centered, coordinated care**
- **Aim high to improve quality and health outcomes**
  - Invest in infrastructure and information
  - Promote health and disease prevention
- **Leadership and collaboration among private and public stakeholders**

Analysis of specific policies consistent with this approach indicates that an integrated set of policies could slow the growth in national health spending from a 6.7 percent annual rate of growth over the 2010-2020 period to 5.5 percent. Doing so would yield total system savings of a cumulative $3 trillion through 2020, compared with current projections. Employers would save $231 billion over this period – providing much needed relief to struggling businesses. State and local governments, hard hit by the economic crisis would save $1 trillion. Households would save $2.3 trillion over the

period, averaging $2,300 per family per year in 2020 alone. As the central source of financing for coverage expansions, the federal government's costs would increase during early years. The federal government's cumulative net costs—with all of the components of the Path framework in place—would be $593 billion over 2010-2020. Most of the federal expenses would occur in early years as a result of initial investments. These upfront investments would yield a substantial return for the nation and the federal government: by 2020, payment and system reform savings would offset nearly all the increase in annual federal spending compared with baseline projections.

The Path framework would achieve near-universal coverage, ensure access, enable continuity of care and coverage, and lower premiums. The numbers of uninsured would drop quickly, falling to less than one percent of the population without health insurance coverage by 2012. In addition, coverage would be improved for millions of the under-insured, those with inadequate coverage that put them at high financial risk if sick or injured.

The central feature of the Path framework is an insurance foundation that would enable rapid progress toward slowing the growth in national health spending – with gains in efficiency and value nationwide. Based on the belief that the U.S. needs to find its own unique path forward, the insurance framework builds on the strengths of private and public insurance while offering new choices for families and businesses. The creation of a national health insurance exchange with a choice of private plans and a new public health insurance plan would provide a mechanism for employers and individuals to obtain coverage with multiple advantages. The approach would:

- Build on and harness the strengths of both private insurance and publicly-sponsored insurance;
- Improve choice and continuity, and provide a secure option nationwide that will always be there;
- Broaden the foundation for rapid implementation of payment and system reforms that align incentives to enhance value and bend the cost curve;
- Ensure that markets work in the public interest and serve as a counterbalance to undue market power by insurers or providers;
- Reduce administrative cost and complexity – making it easy to enroll, select a plan, and change or keep coverage; and
- Provide a less expensive foundation for expanding health insurance coverage to everyone and thus lower the federal cost of covering the uninsured and improving coverage for the underinsured.

By focusing competitive market forces in the public interest, this framework offers a path to rapid gains in slowing the growth in national health spending, and it does so in a way that also improves access and financial protection for families.

One major advantage of the public health insurance plan is that it broadens the foundation for rapid implementation of payment and system reforms that align incentives to enhance value and bend the cost curve. The Commission recommended payment policies that would reward value – better outcomes and more efficient care. The payment reforms

would apply to Medicare, Medicaid, and the public health insurance plan and could be adopted and adapted by private insurance. The reforms would:

- Enhance payment for primary care by revising the Medicare fee schedule and updates;
- Encourage adoption of the medical home model to promote coordinated care with new payment methods for primary care;
- Implement bundled payment for acute care episodes to encourage integrated care; and
- Correct price signals in health care markets to align payments with value.

These policies replace the adverse incentives posed by the current fee-for-service system that pay for volume with reforms to spur the reorganization and reorientation of the health care delivery system to improve quality and promote more prudent use of resources.

The President has called for bold change to address the crushing financing burdens of rising health care costs for both businesses and families. His proposed health reform reserve fund, included in budget reconciliation, would provide the essential start for reform. The American Recovery and Reinvestment Act of 2009 made key investments in health information technology and generation of evidence-based information about medical care to support patients and clinicians.

Building on this start and moving forward will require deciding how to secure insurance coverage and change payment incentives to emphasize value not volume. Medicare can innovate but it can not go alone. Reforms that seek to bend the cost curve and improve coverage for those under 65 will need to incorporate these payment and system reforms to have coherent policies and a significant impact. In short, we need a "system" approach to take a new Path for the nation's health system.

Although politically difficult, there is an urgent need to move in a new direction. The comprehensive reforms proposed here will help spark economic recovery, put the nation back on a path to fiscal responsibility, and ensure all families are able to get the care they need with financial security. The cost of inaction is high. With both an historic political opportunity and a clear path toward a high performance health system, the time has come to take bold steps to ensure the health and economic security of this and future generations.

PUTTING THE U.S. HEALTH SYSTEM ON THE PATH TO HIGH PERFORMANCE

Karen Davis and Cathy Schoen
The Commonwealth Fund

Thank you, Mr. Chairman, for this invitation to testify on Health Reform in the 21st Century: Expanding Coverage, Improving Quality and Controlling Costs. Even before our severe economic crisis, it was clear that we can not afford to continue on our current course – with ever-rising numbers of uninsured and the health sector consuming an ever-greater share of our national economy. With the economy in crisis and health costs increasing faster than incomes, a growing number of adults and children are losing access to care and coverage, placing them at health and financial risk if they become sick. Even millions of insured families today are confronting access barriers and facing financial hardship as a result of inadequate coverage and uncovered medical bills. Employers, also, are feeling the pressure as health care becomes a larger and larger part of their operating costs, making it more difficult for them to compete in an increasingly difficult market. Moreover, the federal and state and local budgets are being increasingly consumed by health care spending. Yet, despite the high level of spending, the U.S. health system falls short of producing the quality and outcomes that should be possible, considering the available resources, medical science, and centers of excellence.

We can do much better. But to do so will require extending insurance coverage to everyone; changing the way insurance markets work; moving away from fee-for-service payment to encourage value rather than volume: rewarding more patient-centered, effective, and efficient care; providing information to support better health care decision-making; and setting ambitious goals for improvement in population health with the leadership and commitment required to meet those goals. All of these changes are necessary to alter the unsustainable path we are now on. It is urgent to start now – the longer we wait, the worse these problems get and the more difficult they are to confront It will take leadership and bold steps to move over the next decade toward a health system that achieves better access, quality, and value in return for our investment. It

requires health reform that focuses on access, quality, and cost – not just one component of the problem, but rather an integrated, systems approach.

An integrated set of policies building on our current mixed private and public insurance system would establish a new insurance foundation that could harness market forces to work in the public interest. This framework, coverage for all, combined with payment and system reforms, has the potential to slow the growth of health costs that confront families and businesses across the U.S. substantially *and* improve access, quality, and health outcomes. These comprehensive reforms emphasize choice, build on the best in our current system and help it work better, and enhance the value the nation receives in return for our substantial investment in health care.

Path to a High Performance Health System

The Commonwealth Fund Board of Directors established a Commission on a High Performance Health System in 2005 with the charge to develop such a framework for policy action. Its recent report, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way,* is an integrated system approach that moves the U.S. health system on a path to a high performance health system – slowing the growth in health care costs, ensuring access to quality care, and protecting families.[1] In offering this framework (referred to as the Path framework), the Commission recognizes that while the path ahead is clearly visible, it is daunting. However, the human and economic costs if we fail to act are worse. Thus, the Commission urges that leadership, political will, and resolve be summoned now to overcome resistance to change and proceed to put the U.S. health system on the path to high performance.

The Path framework encompasses five key strategies:

- **Affordable coverage for all: access and foundation for payment and system reforms**

[1] The Commonwealth Fund 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, February 2009.

  - Insurance exchange: choice of private plans and new public health insurance plan
  - Market reforms, affordability, and shared responsibility
- **Align incentives: payment reform to enhance value**
  - Accessible patient-centered primary care
  - Move from fee-for-service to more "bundled" payment, with accountability
  - Align price signals with efficient care and value
- **Accountable, patient-centered, coordinated care**
- **Aim high to improve quality and health outcomes**
  - Invest in infrastructure and information (information technology; research on evidence-based care; transparency and public reporting; training, technical assistance, and support to improve care)
  - Promote health and disease prevention
- **Leadership and collaboration among private and public stakeholders**

The Commission recommends an integrated set of policies to extend coverage to all by: establishing a national insurance exchange that offers a choice of private plans and a new public health insurance plan; requiring everyone to have coverage, with income-related premiums to make coverage affordable; and instituting insurance market reforms that focus competition on outcomes and value. On this foundation, payment policies would change the way we pay for care to enhance the value of primary care and move from fee-for-service to more "bundled" methods of paying that encourage coordinated care and hold providers accountable (and provide rewards as well) for improving health outcomes and prudent use of resources. Investment policies would accelerate the spread and use of health information technology and establish a center for comparative effectiveness to enhance knowledge and appropriate use of evidence-based care. Population health policies would promote health and disease prevention, with benchmarks and goals to spur a culture of innovation and continuous improvement.

A central feature of the design is an insurance exchange, offering expanded choices of private plans and a new public health insurance plan. Offered through the exchange, the

new public health insurance plan would use Medicare's provider networks and claims administration while modernizing payments and benefits. To avoid the need for supplemental coverage, benefits would include a comprehensive package similar to the standard option offered to federal employees and members of Congress with value-based benefits that encourage prevention and essential care (Exhibit 1). Cost-sharing and deductibles would be lowered to provide positive incentives to designate a primary care practice as a medical home or to encourage care essential to managing chronic conditions.

To allow time for implementation and for insurance markets to adjust, the exchange would be initially open to individuals and small employers (i.e., those with fewer than 100 employees). In three years (2012), it would open to employers with fewer than 500 employees. In five years (2014), it would open to all employer groups. To avoid fragmentation of employer groups, in firms that offer group coverage, employees would only be eligible to buy through the exchange if the employer elected this arrangement for all employees.

This framework provides a foundation for more affordable and continuous insurance coverage, offers more choice, and lays the groundwork for payment and system reforms. All payment reforms recommended for Medicare would also apply to the new public health insurance plan, considerably increasing leverage to achieve transformation of the delivery system. To streamline public purchasing and improve access for Medicaid beneficiaries, the reforms peg Medicaid payment to Medicare levels and methods, with an increase in federal matching rates to offset costs to states.

A summary of policy modeling specifications prepared by Commission staff used in generating coverage and cost estimates is contained in the Appendix. Estimates were prepared by the Lewin Group. The Lewin Group is a wholly owned subsidiary of Ingenix, which in turn is owned by UnitedHealth Group. The Lewin Group maintains editorial independence from its owners and is responsible for the integrity of any data that it produces for the Commonwealth Fund.

Estimated Impacts and Outcomes

The Path framework could achieve access for all while providing more affordable choices for those who currently are insured, substantially slow the growth in health costs, and improve population health, with more positive patient experiences. Analysis of specific policies consistent with this approach indicates that an integrated set of policies could slow the growth in national health spending from a 6.7 percent annual rate of growth over the 2010-2020 period to 5.5 percent. Doing so would yield total system savings of a cumulative $3 trillion through 2020, compared with current projections (Exhibits 2, 3, and 4).

Designed to extend affordable insurance to everyone and create a foundation for essential payment and system reforms, the insurance framework would achieve near-universal coverage, ensure access and continuity, and lower premiums. If we continue on our current path, the numbers of uninsured will increase from 48 million to 61 million in 2020 – even assuming our economy quickly recovers. Under the Path framework, the numbers of uninsured would drop quickly to about four million people or one percent of the population without health insurance coverage (Exhibit 5).

The most important aspiration we all share for the health system is that it will ensure that our families and we are able to attain and maintain the best possible health. Studies by the Institute of Medicine as well as The Commonwealth Fund Commission's national and state scorecards have documented that we currently fall far short of attainable benchmarks for quality, safety, and health outcomes.[2] If we were to embrace the policies set forth in the Path report, we should be able to achieve benchmarks of high performance. By 2020 there could be 100,000 fewer deaths a year, 80 percent of adults receiving all recommended preventive care (instead of 50 percent currently), better control of chronic conditions, and major reductions in hospitalizations for preventable conditions (Exhibit 6). The value we obtain for our investment in the health care sector

[2] The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008*, The Commonwealth Fund, July 2008; J. C. Cantor, C. Schoen, D. Belloff, S. K. H. How, and D. McCarthy, *Aiming Higher: Results from a State Scorecard on Health System Performance*, The Commonwealth Fund Commission on a High Performance Health System, June 2007.

would be improved markedly, and put the U.S. in its rightful place as a leader in the health and health care it provides to its people.

The savings from this transformation of the health system would be shared by businesses, households, and state and local governments. Employers that currently provide insurance would realize savings as a result of lower premiums and sharing the costs of coverage more equitably across all employers. Initially, employers that do not currently contribute to employee coverage would pay more, but these costs would be built into the wage structure of the nation, creating an equal playing field in the labor markets. This shared responsibility approach involves all businesses contributing to support the nation's health insurance system. Over time, as premium growth slows, new system savings would offset costs for employers, with net cumulative savings of $231 billion by 2020 (Exhibit 7).

The combination of slower cost growth and policies specified in the analysis result in an estimated $1 trillion in state and local government cumulative savings by 2020, compared with projected levels. Savings would come from four sources: 1) federal support for dually eligible Medicaid and Medicare beneficiaries with a new Medicare Extra supplemental option; 2) eliminating the two-year waiting period for the disabled, many of whom are on Medicaid; 3) reduced state and local support for the uninsured in public clinics and hospitals; and 4) state and local government savings due to lower and slower-growing public employee health benefit costs.

Most of the savings, however, would accrue to individuals and families as a result of federal support of premium assistance, expansion of public programs to make insurance affordable, and the reduction in the growth in premium and health care costs over time. Household cumulative savings would exceed $2 trillion by 2020, not including potential increases in wages if employers convert premium savings to higher pay or other employee compensation.

Savings would extend across the income spectrum. Income-related premiums and low-income program expansion would be of particular benefit to modest- and lower-income families. But with lower premiums available through the exchange, high-income families,

as well as middle- and low-income families, would save. By 2020, savings per family would result from less rapid cost growth in premiums due to delivery system changes in response to reforms. Estimated savings would be an average $2,300 per family per year in 2020 (Exhibit 8).

As the central source of financing for coverage expansions, the federal government's costs would increase during early years. The Path framework provides federal funding to offset the state and local costs of expanding Medicaid and raising Medicaid payment rates to Medicare levels; the estimates of its impact did not involve reallocating state/local government savings from other reforms. Similarly, no new sources of federal revenue were specified to offset the cost of providing income-related premium protection for the entire population, including current Medicare beneficiaries. As a result, the federal government's cumulative net costs—with all of the components of the Path framework in place—would increase by $593 billion through 2020. Federal savings from the payment and system reforms provide increasing offsets to the additional federal costs of insurance expansion and system investments, so that the estimated additional cost to the federal government falls sharply from 2015 to 2020. By 2020, payment and system reform savings would offset nearly all the increase in annual federal spending compared with baseline projections (Exhibit 9).

Transforming the Market for Insurance

Employment-sponsored health insurance would continue to be the mainstay of health insurance coverage for those under age 65. However, the Path framework addresses many of the flaws in the current system. It gives employers the option of either purchasing coverage directly from private insurers or bringing their employees as a group into the national health insurance exchange. Creating a national health insurance exchange with choice of private plans and a public health insurance plan as a mechanism for employers to obtain coverage for their employees as well as for individuals outside the employment-based system has many advantages. The approach would:

- Build on and harness strengths of both private insurance and publicly-sponsored insurance;
- Improve choice and continuity, and provide a secure option nationwide that will always be there;
- Broaden the foundation for rapid implementation of payment and system reforms that align incentives to enhance value and bend the cost curve;
- Ensure that markets work in the public interest and serve as a counterbalance to undue market power by insurers or providers;
- Reduce administrative cost and complexity – making it easy to enroll, select a plan, and change or keep coverage; and
- Provide a less expensive foundation for expanding health insurance coverage to everyone and thus lower the federal cost of covering the uninsured and improving coverage for the underinsured.

By focusing competitive market forces in the public interest, this framework offers a path to rapid gains in slowing the growth in national health spending, and it does so in a way that also improves access and financial protection for families. To focus insurance competition on improving outcomes, market reforms would require that all insurers offer coverage to everyone wishing to enroll and charge the same premium for the same benefits, irrespective of health status.

Private insurers would be able to add value and compete with a focus on improving health outcomes and prudent use of resources. Private insurers would have the flexibility to select provider networks of high performing physicians and hospitals, to innovate with new payment incentives, to improve care management tools, and value-benefit designs. Such flexibility would help foster partnerships with health care systems to improve value.

The exchange would open up markets to regional health plans. Currently, employers often restrict choices to a few plans and most small firms are unable to offer choices. It is thus difficult for regional health plans and care systems to market to these employers. The insurance exchange, operating at state as well as national level, would open up

markets and enable such local and regional private health systems to offer coverage to residents in their geographic area participating in the exchange.

A public health insurance plan has the advantages of simplicity with one fixed benefit design, nationwide availability, broad provider networks with nearly all hospitals and physicians participating as they do in Medicare, and leverage to align provider incentives to foster transformation of health care delivery to achieve better quality and greater efficiency. Private insurers would be free to adopt innovations in payment reform in the public health insurance plan, as they have in the past in the case of Medicare's physician resource-based fee schedule. The public health insurance plan might also over time adopt private sector innovations, as they are moving to do with "pay for results" bonuses for higher quality. The competition of private and public insurers would spur each to improve and also offer opportunities to learn and collaborate.

Notably, the public insurance plan would pay claims using contracts with private insurers, as Medicare does today. This would assure economies of scale. For the first time, there would also be the opportunity for pooled all-payer data systems for the under-65 population.

By 2014 when all employers are eligible to purchase coverage through the national health insurance exchange, an estimated 64 percent of the U.S. population (196 million people) would have coverage under employer-sponsored insurance, rather than 53 percent currently. This would include those employer groups who opt to join the insurance exchange. When coverage is obtained through the exchange – and it is estimated that by 2014 over 70 percent of the workforce would do so, attracted by lower premiums, better benefits, and greater choice – employees could select from among a number of private health plans as well as the new public health insurance plan. An estimated 26 million uninsured would be covered through the exchange, and over 130 million of the currently insured would also participate to obtain improved or more affordable coverage (Exhibits 10 and 11).

For most employees, this would provide considerably greater choice of plans than is now offered by their employers. It would reduce turnover in coverage. As more employers join the exchange, people could keep coverage as they change jobs or lose jobs during a period of unemployment. And, unlike the experience in the late 1990s and early 2000s in the Medicare managed care market, enrollees in the nation-wide public health insurance plan could be assured that their plan would not be dropped from their geographic area. Notably, the decision to join the exchange or select private or public health insurance plans would be voluntary – decisions to switch would indicate a move to more affordable or higher quality options.

Initially, premiums available under the public health insurance plan would be an estimated 20 percent or more lower than private insurance now available to small firms. (Exhibit 12) The reduced cost stems from lower administrative costs as well as payment rates. Within the exchange and the public health insurance plan, small firms would for the first time have the economies of large group coverage. This would be a major source of relief to businesses that provide health insurance to their employees in these tough economic times. Small businesses face higher premiums for the same benefits than large businesses – or the same premium buys far less. As a result, employees working for small businesses that sponsor coverage typically face much higher deductibles, limits or caps on benefits and gaps in benefits – putting them at high risk when sick or injured. The exchange would provide small firms with many of the advantages of scale and broad risk pools.

Phasing of enrollment in the exchange would first open coverage to employees of firms with fewer than 100 employees and individuals under age 65 not covered under employer plans, followed by employees of firms with fewer than 500 employees in 2012, and by 2014 firms of all sizes. This gradual opening of exchange enrollment gives private insurers who cover larger firms time to adjust their business plans to take advantage of their inherent strengths and develop strategies for meeting the premium competition posed by a public health insurance plan. The staged expansion also provides time for private insurance payment rates to realign to markets where there are no longer large numbers uninsured and Medicaid pays at Medicare levels.

To compete, private insurers will need to add value and lower overhead. If private insurers continue on their current premium trend course, the market would shift markedly toward enrollment in the public health insurance plan. If they fail to respond, they would lose market share. In 2010 when only small firms are in the exchange, an estimated 14 percent would be enrolled in the public health insurance plan and 55 percent would be in private insurance plans – either through the exchange or purchased directly by employers. (Exhibit 13) By 2014, if private insurance premium trends continue – and private insurers fail to respond to new opportunities, the market would be split evenly between private plans and the public health insurance plan, with 35 percent in private plans and 34 percent in the public health insurance plan. Many, if not most, of private insurance enrollees, would be enrolled through community health plans associated with integrated delivery systems that can achieve economies by redesigning the delivery of services. Private plans could use their greater flexibility – as well as the fact that, with everyone covered and Medicaid rates improved, they would no longer need to pay higher rates to subsidize care for the uninsured or make up Medicaid shortfalls – to compete for enrollees in the new market mechanism.

Key Role of an Insurance Exchange and Public Health Insurance Plan

One major advantage of the public health insurance plan is that it broadens the foundation for rapid implementation of payment and system reforms that align incentives to enhance value and bend the cost curve. The Commission recommended that payment policy provisions in Medicare, Medicaid, and the public health insurance plan would:

- Enhance payment for primary care by revising the Medicare fee schedule and updates;
- Encourage adoption of the medical home model to promote coordinated care with new payment methods for primary care;
- Implement bundled payment for acute care episodes to encourage integrated care; and
- Correct price signals in health care markets to align payments with value.

These policies replace the adverse incentives posed by the current fee-for-service system that emphasize volume with reforms to spur the reorganization and reorientation of the health care delivery system to improve quality and make more prudent use of resources. Medicare is the single most important source of payment for providers, representing 28 percent of hospital revenues and 20 percent of physician revenues. But this is still a minority of revenues. Extending provider payment reform to Medicaid and the public health insurance plan would apply this leverage to well over half of provider revenues. The primary care payment reforms would thus give primary care physicians and nurse practitioners the wherewithal to transform their practices into medical homes. Similarly, changed incentives for hospital and care systems would provide significant rewards to hospitals accountable for care not just during an initial hospitalization but over the course of patient recovery. Hospitals could gain rather than lose money by preventing complications that put patients at risk and lead to re-admissions or churning in and out of post-acute care facilities. Shared savings from these changes in practice would ensure that efficient accountable providers thrive, while substantially easing the financial burdens on businesses and families. Without a public health insurance plan, the rewards may not be sufficiently strong to effect major changes in provider behavior, and in any event any savings would only accrue to Medicare, not to employers and other payers of health care.

In recent years, the market for health insurance has become increasingly concentrated.[3] In most states, three or fewer insurers account for over half of all enrollment. Indeed, in many states one carrier dominates, accounting for half or more of enrollment in the under-65 market. Insurance company margins increased rapidly in the early 2000s as market consolidation occurred and premiums outstripped increases in medical care outlays. Health care providers have also consolidated into larger systems of care, or into larger units bargaining with large insurers. One advantage of a public health insurance plan is that it ensures markets work in the public interest and serves as a counterbalance to undue market power by insurers or providers. By offering a public health insurance

[3] J. C. Robinson, "Consolidation and the Transformation of Competition in Health Insurance," *Health Affairs*, November/December 2004 23(5):11–24.

plan that does not aim to make a profit and employing provider payment methods and rates that reward efficient providers, it protects the public interest against concentrated market power.

The exchange reduces administrative cost and complexity, making it easy for individuals to compare plans and premiums, select and enroll in a plan, and change or keep coverage. An estimated $337 billion in administrative costs would be saved over the period 2010-2020. Small businesses and individuals gain the most – as administrative costs now represent on average 40 percent of premiums in the individual market and 15-35 percent of premiums in small businesses with fewer than 100 employees. (Exhibit 14) Private plans offered through the exchange would have much lower administrative costs than currently as a result of reducing churning, lower marketing costs, and eliminating costs for underwriting for health risks. (Exhibit 14 and 15) Overall, the exchange is expected to have administrative expenses of 4.5 percent of average premiums – in addition to administrative costs within health plans. The public health insurance plan is estimated to have administrative expenses of 3.5 percent, similar to large group risk pools. Including the costs of operating the exchange, the premium for the public health insurance plan would include administrative costs of 8 percent. These costs would likely be lower than the average for private plans. Some of the advantages of the public health insurance plan include the absence of expenses for commissions, advertising, lower administrative salaries, and no markups for returns to investors. With a large risk pool, the public health insurance plan would hold its own reserves and earn the return on reserves similar to arrangements for federal employees and large firms. The public health insurance plan would contract with private companies to administer claims.

Most importantly from a federal budget perspective, the public health insurance plan provides a less expensive foundation for expanding health insurance coverage to everyone and thus lowers the federal cost of covering the uninsured and improving coverage for the underinsured. Twenty-six million of the uninsured obtain coverage through the national health insurance exchange, while 13 million are added to Medicaid or the Children's Health Insurance Program (CHIP) (Exhibit 10). Many – an estimated 9 million - would buy directly through the exchange as individuals. Most of the remainder

would be insured through their employers, including those participating in the exchange and thus offering the new public insurance option. To share responsibility for financing, the reforms include a requirement that employers cover their employees or contribute to a national coverage trust fund.

Without a public health insurance plan, the uninsured covered through the exchange would be covered at commercial insurer premiums with providers paid at commercial insurer rates. This would substantially increase the costs of covering the uninsured. It would increase federal budget outlays by an additional $500 billion over the 2010-2020 period relative to what it would cost under an exchange with a public health insurance plan – even assuming that all of the Path recommended payment, system, and public health reforms are adopted (Exhibit 16).

Accelerating Gains in Efficiency and Value: Bending the Cost Curve

The Commonwealth Fund Commission came to the inescapable conclusion that bending the curve of health spending requires a marked departure from the current health care financing and delivery system. By creating a uniquely American system in building on the best that both the private sector has to offer as well as tapping the leverage that a public health insurance plan can provide, significant health system savings can be realized.

The insurance exchange and opportunity to enroll in a public health insurance plan play a central role in stimulating the competitive markets and gaining leverage. In coming to this conclusion, the Commission examined two other insurance scenarios. One would limit enrollment through the insurance exchange and access to the public plan to individuals and small employers. The other would limit choices in the insurance exchange to private plans, with no public health insurance plan. In all three scenarios, the payment reforms would continue to apply to Medicare and Medicaid, as would all other system reforms, including investment in information systems. Private plans could follow Medicare's lead, but in one scenario there would be no public health insurance plan competitor to set a price mark.

The modeling indicates that all three scenarios have the potential for significant savings by 2020. But the original scenario—an exchange that sponsors a public health insurance plan, in addition to private plans, and is open to all employers—would achieve the greatest reduction in spending growth. This scenario could save nearly $3 trillion by 2020 if opened to all employers in 2014, compared with $1.5 trillion if the exchange and public plan were only open to individuals and small employers with fewer than 100 employees. An exchange offering only private plans would save about $800 billion by 2020. This scenario assumes that private insurers continue to pay well above Medicare rates, without downward adjustment in private payments once higher payments are no longer necessary to cover costs of uncompensated care or Medicaid shortfalls, because no mechanism exists to realign private insurance payment levels with resource costs. (Exhibit 17)

Without a public health insurance plan alternative, spending on health care still slows from 6.7 percent annual increases to 6.1 percent. However, employers would see their costs increase by $905 billion over 2010-2020, rather than the net savings of $231 billion with a public health insurance plan available in the exchange. Administrative savings would be $70 billion over the 2010-2020 period rather than $337 billion, and savings from various payment reforms would be similarly reduced. (Exhibit 18, 19, and 20)

The insurance framework and new public health insurance plan seek a dynamic, competitive solution that retains a mixed private and public insurance system with the best of what each sector has to offer. The challenge will be achieving a balance where the public health insurance plan and private plans compete with each other with market rules that stimulate innovation and outcomes in the public interest. Developing a mechanism to set the price point and payment policies in a non-arbitrary fashion will be important to value-added constructive competition. The goal should be to provide incentives and support for high-quality and efficient care systems, with rational public and private insurance payment policies.

Slowing Cost Growth with Payment Reform that Emphasizes Value

With increased emphasis on primary care, improved coordination, and the elimination of unnecessary and duplicative services, spending growth would slow relative to current projections. The payment reforms each yield substantial savings compared to projected trends. (Exhibit 21) As a set, the reforms would realign incentives with a focus on better health outcomes and more efficient use of resources, including duplication of tests and preventing complications that lead to admission to the hospital or use of emergency rooms for chronic disease or complications that result in re-admission to the hospital after discharge.

Yet, national health expenditures would continue to grow over the decade, albeit at a slower pace. With payment and system reforms, and the leverage afforded by the public health insurance plan available to all employers, health spending by 2020 would still be 73 percent higher than current spending.

While slowing annual expenditure growth from 6.7 percent to 5.5 percent amounts to a significant change, hospital, physician, and other provider revenues would continue to experience growth each year. Growth would only be marginally slower than current projections, as demand for care continues to increase due to medical advances and an aging population. (Exhibit 22 and 23) Medicaid would help offset the effect of the public health insurance plan paying at Medicare rates. These provisions will be particularly beneficial to safety net providers that now carry a disproportionate share of care to the uninsured and Medicaid beneficiaries.

In the initial years (2010-2013), these increased revenues offset any shift from small business and individual coverage into the public health insurance plan. By 2014, as large businesses have access to the exchange, if insurers do not adopt the public health insurance payment rates or use other private insurer strategies to compete effectively and slow the growth of premiums, more workers would enroll in the public health insurance plan.

Nonetheless, it should be stressed that providers as a whole will continue to experience revenue gains steadily throughout the period. The phasing also gives them an opportunity

to redesign care in a way that lowers avoidable hospital readmissions and hospitalizations for chronic conditions that are not adequately controlled – thus becoming eligible for shared savings. Payment incentives that emphasize value would support practice innovations. Efficient practices and care systems could gain from bundled payment methods and more productive resource use. Hospitals, physicians, and other health care practitioners—especially those who redesign their systems to deliver care more efficiently—should see increases in net revenue.

Benefits for Patients

The Commission's report makes a compelling case for systemic change in our health system. (Exhibit 24) Most importantly, these reforms would make the health care system work better for patients and families.

Affordable Premiums

The Path proposal's approach to coverage builds on what works best in our private-public insurance system. A national health insurance exchange offering a public health insurance plan and a variety of private plans would ensure that everyone has access to affordable coverage. Income-related premium help would be available to make sure that individuals and families in the lowest tax brackets spend no more than 5 percent of income on premiums, and that people in middle-income tax brackets pay no more than 10 percent of income on premiums. For the many working families facing a steep decline in job security, the insurance exchange would provide a stable and portable source of affordable coverage. The plan also calls for opening up Medicaid and CHIP to people with incomes below 150 percent of the federal poverty level (under $33,000 for a family of four).

No Discrimination Against the Sick

Under the Path proposal, insurance plans could no longer turn people away because they have an existing medical condition or are considered to be at high risk for one. Nor would individuals with health conditions be charged higher premiums than healthy people because of their health status. As a result, people in poor health who lose their jobs and insurance coverage—who today have few prospects of retaining or affording coverage—

would be much less likely to suffer from a lack of care, delayed care, or low-quality care.

Protection from Ruinous Medical Expenses

The public plan offered through the national health insurance exchange would establish a minimum standard benefit package based on the standard option available to members of Congress and federal employees. Employer plans and plans offered through the exchange would be required to meet this standard of coverage – they could also offer more. Deductibles would be $250 per person or $500 per family rather than the $2,000 to $10,000 deductibles found in some health insurance policies today. Preventive services and services required for treatment of chronic conditions would be covered in full.

Family Savings

The average family would save $1,140 in 2010 under the plan, thanks to reforms that reduce administrative costs and promote efficiency in the health care system, as well as those that guarantee financial protection from health care bills. By 2020, the average family would save $2,314 annually, with families of all income levels spending less due to slower cost growth. These dollars would provide substantial relief to families that are now financially strapped because of medical bills and often have to choose between medical care and other basic necessities.

Coverage and Care and Security for All

The Path proposal would extend affordable health insurance to everyone. The number of uninsured—now at 46 million and projected to rise to 61 million in 2020—would instead fall to an estimated 4 million, or about 1 percent of the U.S. population. Even hard-to-reach individuals would likely qualify for free or low-cost coverage if they became ill and sought health care. The proposal would improve coverage or affordability for over 130 million more – with enhanced choice and continuity. Through the exchange families could stay with their physicians and health plans where arrangements are working well – a change of job or circumstances would no longer trigger involuntary disruptions or churning. An estimated 100,000 lives could be saved through the coverage and system reforms included in the Path framework.

Challenging Change

While health care providers, employers, insurers, the health industry, and taxpayers would benefit in significant ways, the Path framework includes several significant challenges and important decisions for the country to make as it moves down the path to high performance.

Health Care Providers

The most important benefit for physicians is that health insurance for all, with a minimum standard to ensure access and financial protection, would help them deliver the care their patients need. No longer would nearly 40 percent of adults under age 65 say they do not obtain needed care because of cost.[4] No longer would patients fail to fill a prescription or take it as indicated, fail to receive a mammogram or colonoscopy or see a specialist, or fail to come back for follow-up care because of trouble paying medical bills.

To help physicians deliver care in a way that works for patients, the Path framework makes changes that would change the way hospitals and doctors are paid to provide incentives and support for changing the way health care is organized. The reforms would also provide incentives for patients. All patients would be encouraged to enroll with a physician or nurse practitioner practice that meets the standards of a "patient-centered medical home" that makes care available 24/7 – with lower-cost sharing to provide incentives to designate a primary care "home." Such practices would be paid to provide enhanced access and coordination and held accountable for ensuring that their patients get all recommended care by using information technology and office systems to remind patients about preventive care and assisting them with obtaining needed specialty care.

These practices would be supported and rewarded with an extra "medical home" fee per enrolled patient paid by insurers and public programs, as well as extra bonuses for high performance in preventive care and chronic care management. Physicians would be encouraged to practice in more integrated delivery systems or virtual networks, working with other physicians, nurses, pharmacists, and other health professionals in a team

[4] The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008.* The Commonwealth Fund. July 2008.

approach to ensure coordination of care and shared accountability for health outcomes. This is a major change from our current isolated solo or small physician practice style of care, and will require not just funding but technical assistance and infrastructure support. To support provider groups as they reorganize—a challenging task even for large providers—the government could fund regional or state health information exchange networks, facilities that offer after-hours care to patients from different practices, case management help, and more.

Likewise, hospitals would be accountable not only for care during the hospital stay but follow-up care for 30-days following discharge, with incentives to improve transitions in care, reduce complications that result in re-admissions, and coordinate care as patients go back home or to rehabilitation facilities or other post-acute care. Hospitals would be rewarded and share savings for reducing complications and assisting patients with recovery, as well as ensuring that post-acute services are tailored to patients' needs. To carry out this role, hospitals would need to modernize their information systems and participate in health information exchange networks that ensure prompt information about hospital and emergency room care gets back to patients' primary care physicians.

Providers who accept accountability for patient health outcomes and prudent use of resources would be rewarded. Those who provide unnecessary, duplicative, or avoidable services would face revenue losses and would need to improve their processes of care and reposition their business operations. Moreover, a phased approach to payment reform will give providers time to prepare for the new payment methods and allow Medicare to develop appropriate rates, methods, and administrative structures that will support greater care coordination.

Employers

Along with households and governments, employers are expected to be part of the solution to gaps in coverage, variable quality, and high costs. In the estimates, all employers would be required to either provide health insurance that meets minimum standards to their employees or contribute 7 percent of worker earnings, up to $1.25 an hour, toward an insurance trust fund to help finance affordable premiums.

While costs will initially increase for employers who do not currently shoulder some of the responsibility for providing coverage, businesses of all sizes stand to gain under the Path framework. Reforms will slow the rise in premiums with net cumulative employer savings of $231 billion over the period from 2010 to 2020 – and both employers and their employees would no longer have to deal with a health insurance system that frequently fails to provide reliable coverage, adequate protection against the financial burden of illness, and reasonable control over cost growth.

Insurers

Perhaps the most challenging change is the proposed shift in the role of private insurers. Insurers would be required to provide coverage to all—healthy and sick alike—on the same terms. In addition, they would need to compete with a public health insurance plan that would be offered to all individuals and employers at a starting premium at least 20 percent lower than current premiums in the individual and small-business market.

To compete against a public health insurance plan with lower administrative costs and greater leverage over provider prices, private plans would need to bring added value, improved quality, and greater efficiency through tools available to them, such as selection of provider networks, utilization management, and benefit design. Competition from a public health insurance plan has the potential to transform—rather than undermine—the private health insurance market. This transformation will require insurers to focus on adding value and lower the current projected trend in premiums.

Offering a public health insurance plan as a choice is key to system savings. The Path report shows that $0.8 trillion would be saved by the coverage, payment, and system reforms without a public plan option, while $3 trillion would be saved with a public plan. The public health insurance plan is critical to lower administrative costs and to ensure that savings from payment reform are passed on to employers and workers.

Under the Path framework, if private insurers fail to respond appropriately, an estimated 109 million Americans would retain private coverage, compared with the 178 million

they now cover. But it is entirely likely that private insurers will, in fact, alter their business operations to compete effectively with the public health insurance plan. Moreover, like Medicare, the public health insurance plan would contract with private insurers to administer claims for those enrolled through the public plan, which would expand their administered services business. Private insurers would play an important role, but they would have to adjust to new market circumstances and focus on providing more effective and efficient coverage.

An example of a model that would thrive under the new system is integrated delivery systems that are able to provide higher quality care more efficiently—through their own hospitals and physician group practices. They would experience a major expansion of enrollment, with an estimated 50 million enrolled in such systems of care. Private insurers that are not linked to integrated delivery system may try to emulate some of the practices that lead organized care systems to achieve substantial savings, such as funding nurses in physician practices to help patients with chronic conditions.

Health Industry

Any reform that estimates $3 trillion in savings compared to current trends in a sector of the economy that is otherwise expected to spend $42 trillion represents a major shift to stakeholders. Pharmaceutical companies, for example, could expect to be paid lower prices for some high-priced medications as the government becomes a more active purchaser of prescription drugs. In addition, research on comparative effectiveness and information to enable more evidence-based medicine may find that certain new drugs do not offer added benefits compared to those currently available. Although such medications might be included in formularies, this information would make it unlikely that private or public insurers would pay more for the new drugs. Making information available to physicians would be critical – too often they now rely on manufacturers rather than independent sources of information regarding what works well for which patients nor comparative prices for similarly effective treatment options..

There are also business opportunities for the health industry. The uninsured will be able to afford needed medications. Currently only 40 percent of adults with hypertension, for

example, have that condition controlled.[5] New information systems and incentives for chronic care management could lead to a major increase in use of effective medications.

The almost universal adoption of information technology and health information exchange networks envisioned by the Path report—and given an important jumpstart by the American Recovery and Reinvestment Act of 2009—will also provide business opportunities for the health industry. Accelerating the adoption and use of effective health information technology—with the capacity for decision support and information exchange across care sites—is required to bring about needed change in our care delivery system.

These investments will yield significant returns. Rather than denying patients effective care, utilizing value-based benefit design based on comparative effectiveness research will facilitate the use of safe, clinically proven care within the system and provide the information needed to improve value.

Taxpayers

The President's budget establishes a health reform reserve fund of $634 billion to help finance improved coverage. This includes $318 billion over 10 years (2010-2019) in new tax revenues, and $316 billion in savings, largely from Medicare and Medicaid. Including these funds in budget reconciliation will be key to fashioning a health reform proposal. The President has indicated that this is a down-payment on coverage for all.

The Path framework envisions affordable health insurance for all, and pays for those reforms with significantly more extensive reforms than yet set forth by the President. As currently configured, the Path set of policies would also result in net federal budget outlays of $593 billion over the 2010–2020 period. By contrast state and local government net outlays would decline by $1.034 trillion. Other design choices—such as increasing premiums paid by states to buy public coverage for the low-income elderly and disabled—could re-allocate more of the savings to the federal government.

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[5] The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008,* The Commonwealth Fund, July 2008.

Deficit financing in the early years can be justified as part of an economic recovery program because expanded health insurance coverage will help stimulate the economy and create jobs, as well as contribute to better health and productivity. Making important investments in coverage, payment, and delivery reform now will reap savings in the long term. These actions, taken together, have the potential to bend the curve of our unsustainable spending on health and generate system-wide savings of $3 trillion by the end of the next decade, reaping the return in future years for investments made now.

Health Security and Long-term Fiscal Responsibility: A 2020 Vision

The President has called for bold change to address the crushing financing burdens of rising health care costs for both businesses and families. As he signaled at the Health Summit, the "perfect" should not be the enemy of the "essential." His budget calls for bending the health care cost curve for the nation, while achieving better outcomes and quality, and more secure insurance for all, including those who now have insurance. His proposed health reform reserve fund is an essential down payment to be included in budget reconciliation. The American Recovery and Reinvestment Act of 2009 made key investments in health information technology and generation of evidence-based information about medical care to support patients and clinicians. Building on this start and moving forward will require deciding how to secure insurance coverage and change payment incentives to emphasize value not volume. Medicare can innovate but it can not go alone. It accounts for 20 percent of all health expenditures – the single largest payer but still only a minority of revenues for most providers. In most markets, private insurers have even less leverage and tend to follow Medicare payment methods, paying more rather than innovating. The currently fractured insurance system has layers of complexity, multiple prices for the same care, and few incentives focused on value. Reforms that seek to bend the cost curve and improve coverage for those under 65 will need to incorporate these payment and system reforms to have coherent policies and a significant impact. In short, we need a "system" approach to take a new Path for the nation's health system.

Although politically difficult, there is an urgent need to move in a new direction. (Exhibit 25) The comprehensive reforms proposed by the Commission will help spark economic recovery, put the nation back on a path to fiscal responsibility, and ensure that all families and individuals are able to get the care they need with financial security. The cost of inaction is high. The nation needs national leadership and public–private sector collaboration to forge consensus to move in a positive direction. With both an historic political opportunity and a clear path toward a high performance health system, the time has come to take bold steps to ensure the health and economic security of this and future generations.

1

Benefit Design for Public Health Insurance Plan Offered in Insurance Exchange

	Current Medicare benefits*	New Public Health Insurance Plan in Exchange
Deductible	Hospital: $1,024/benefit period Physician: $135/year Rx: $275/year**	Hospital/Physician: $250/year for individuals; $500 for families Rx: $0
Coinsurance	Physician: 20% Rx: Depends on Part D plan	Physician: 10% Rx: 25% Reduce for high-value & chronic disease care/medical home Preventive services: 0%
Ceiling on out-of-pocket	No ceiling	$5,000 for individuals $7,000 for families
Insurance-related premium subsidies	Medicare Savings Programs Low-Income Subsidy	Premium cap ceiling of 5% of income for low-income beneficiary premiums or 10% if higher income

* Basic benefits before Medigap.
** Part D coverage varies, often deductible. Most have "doughnut" hole and use tiered, flat-dollar copayments.
Note: Benefit design also would apply to Medicare Extra supplement option available to Medicare beneficiaries.
Source: The Commonwealth Fund 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*, (New York: The Commonwealth Fund, February 2009).

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2

Overall Findings

- **Possible to extend affordable insurance to all and improve health outcomes and cost performance**
  - Nearly all, 99 percent, insured within 2 years
  - Insurance reforms would enhance access, choice, continuity and lower premiums
- **Insurance, payment, and system reforms could slow spending growth by cumulative $3 trillion through 2020**
  - Decreases annual growth from 6.7 to 5.5 percent
- **Families, businesses, and the public sector all would spend less compared to current projections**
  - Savings accrue across all income groups
  - Savings could partially offset federal costs of investing in insurance and system reforms
- **Critical to start now: policies interact over time**
- **A comprehensive approach is essential**

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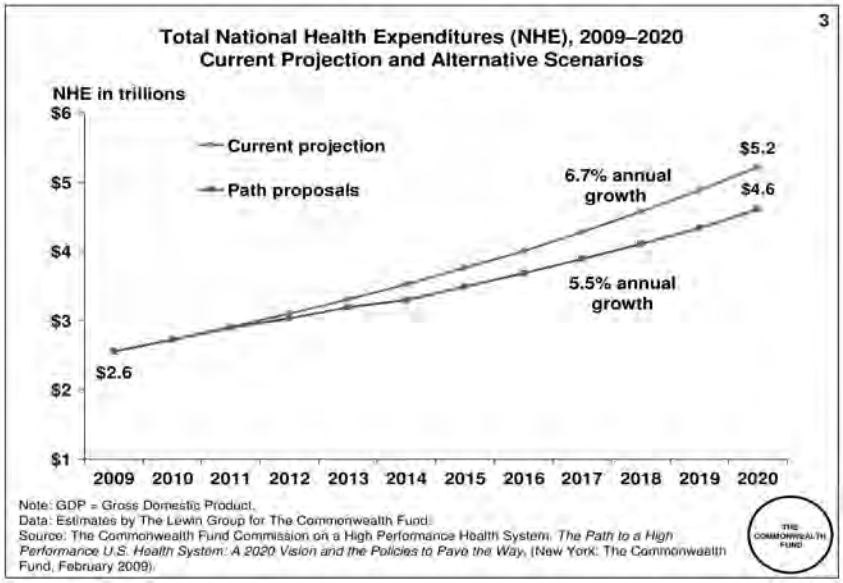
3
Total National Health Expenditures (NHE), 2009–2020
Current Projection and Alternative Scenarios
NHE in trillions
$6
$5
$4
$3
$2
$1
Current projection
Path proposals
6.7% annual growth
5.5% annual growth
$5.2
$4.6
$2.6
2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020
Note: GDP = Gross Domestic Product.
Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: The Commonwealth Fund 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, (New York: The Commonwealth Fund, February 2009).
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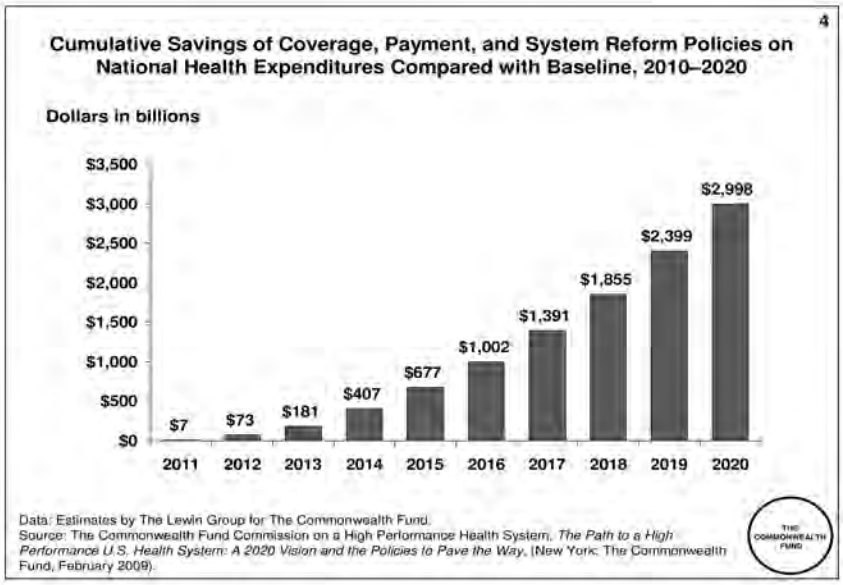
4
Cumulative Savings of Coverage, Payment, and System Reform Policies on National Health Expenditures Compared with Baseline, 2010–2020
Dollars in billions
$3,500
$3,000
$2,500
$2,000
$1,500
$1,000
$500
$0
$7
$73
$181
$407
$677
$1,002
$1,391
$1,855
$2,399
$2,998
2011 2012 2013 2014 2015 2016 2017 2018 2019 2020
Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: The Commonwealth Fund 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, (New York: The Commonwealth Fund, February 2009).
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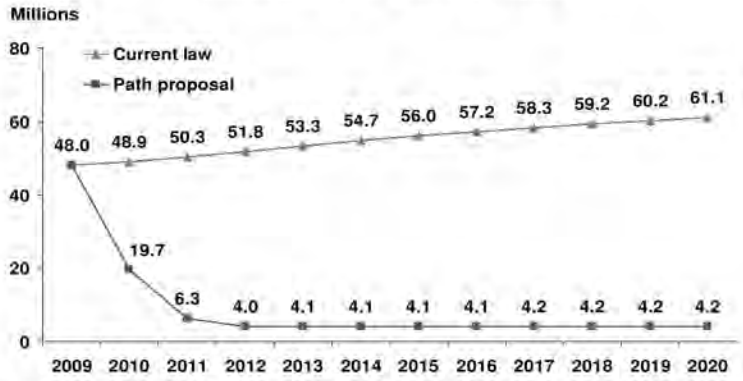
5

Trend in the Number of Uninsured, 2009–2020 Under Current Law and Path Proposal



Note: Assumes insurance exchange opens in 2010 and take-up by uninsured occurs over two years.
Remaining uninsured are mainly non-tax-filers.
Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: The Commonwealth Fund 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*, (New York: The Commonwealth Fund, February 2009).

6

Achieving Benchmarks: Potential People Impact if the United States Improved National Performance to the Level of the Benchmark

	Current national average	2020 target*	Impact on number of people
Percent of adults (ages 19–64) insured, not underinsured	58%	99%	73 million increase
Percent of adults (age 18 and older) receiving all recommended preventive care	50%	80%	68 million increase
Percent of adults (ages 19–64) with an accessible primary care provider	65%	85%	37 million increase
Percent of children (ages 0–17) with a medical home	46%	60%	10 million increase
Percent of adult hospital stays (age 18 and older) in which hospital staff always explained medicines and side effects	58%	70%	5 million increase
Percent of Medicare beneficiaries (age 65 and older) readmitted to hospital within 30 days	16%	14%	180,000 decrease
Admissions to hospital for diabetes complications, per 100,000 adults (age 18 and older)	240	126	250,000 decrease
Pediatric admissions to hospital for asthma, per 100,000 children (ages 2–17)	156	49	70,000 decrease
Medicare admissions to hospital for ambulatory care-sensitive conditions, per 100,000 beneficiaries (age 65 and older)	700	465	640,000 decrease
Deaths before age 75 from conditions amenable to health care, per 100,000 population	110	69	100,000 decrease
Percent of primary care doctors with electronic medical records	28%	98%	180,000 increase

* Targets are benchmarks of top 10% performance within the U.S. or top countries (mortality amenable and electronic medical records). All preventive care is a target.
Source: Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008* (New York: The Commonwealth Fund, July 2008), with benchmarks from top performance.

7

Path Net Cumulative Impact on National Health Expenditures (NHE) 2010–2020 Compared with Baseline, by Major Payer Groups

Dollars in billions

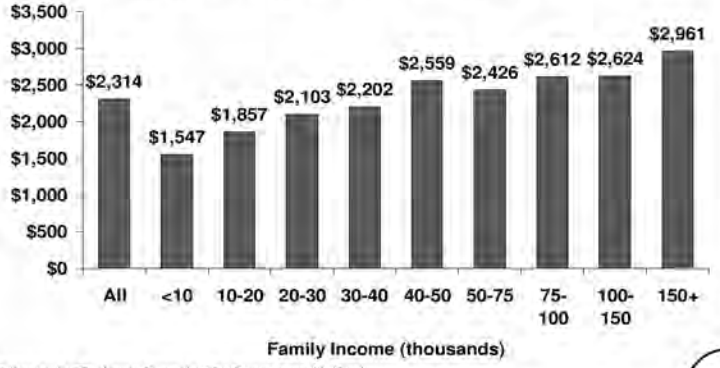
	Total NHE	Net federal government	Net state/local government	Private employers	Households
2010–2015	–$677	$448	–$344	$111	–$891
2010–2020	–$2,998	$593	–$1,034	–$231	–$2,325

Note: A negative number indicates spending decreases compared with projected expenditures (i.e., savings); a positive indicates spending increases.
Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: The Commonwealth Fund 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*, (New York: The Commonwealth Fund, February 2009).

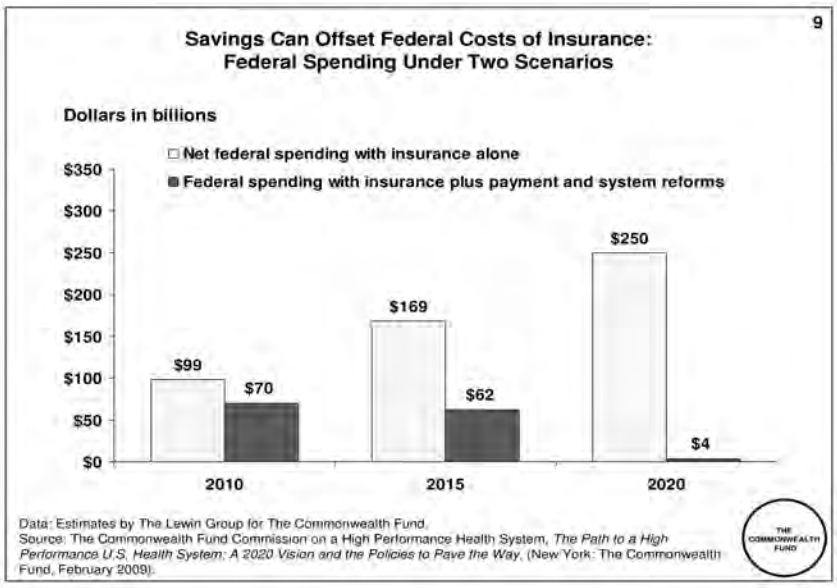
8

Average Annual Savings per Family Under Path Proposal, 2020

Savings in healthcare spending compared to projected trends



Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: The Commonwealth Fund 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*, (New York: The Commonwealth Fund, February 2009).


9
Savings Can Offset Federal Costs of Insurance:
Federal Spending Under Two Scenarios
Dollars in billions
Net federal spending with insurance alone
Federal spending with insurance plus payment and system reforms
$350
$300
$250
$200
$150
$100
$50
$0
$99
$70
$169
$62
$250
$4
2010
2015
2020
Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: The Commonwealth Fund 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, (New York: The Commonwealth Fund, February 2009).
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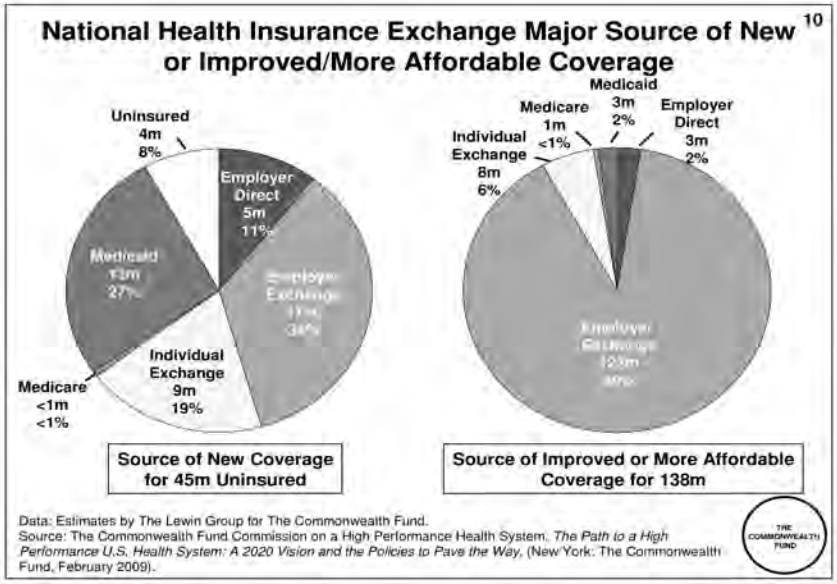
National Health Insurance Exchange Major Source of New or Improved/More Affordable Coverage
10
Uninsured
4m
8%
Employer
Direct
5m
11%
Medicaid
13m
27%
Individual
Exchange
9m
19%
Medicare
<1m
<1%
Source of New Coverage for 45m Uninsured
Medicaid
3m
2%
Medicare
1m
<1%
Employer
Direct
3m
2%
Individual
Exchange
8m
6%
Source of Improved or More Affordable Coverage for 138m
Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: The Commonwealth Fund 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, (New York: The Commonwealth Fund, February 2009).
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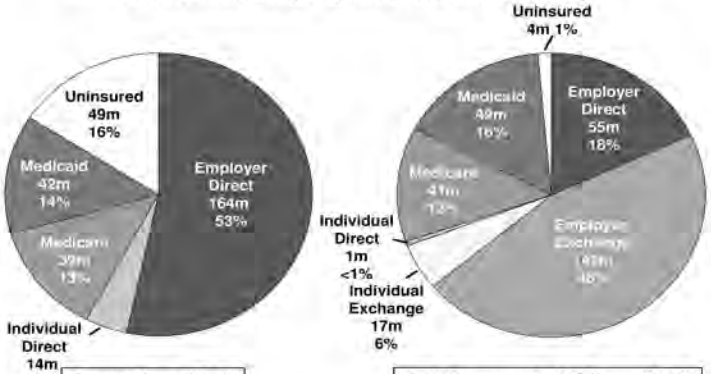
11

Employers Remain Primary Sponsor of Coverage under Path Framework

Distribution of 307 Million People by Primary Source of Coverage Under Current Law (2010) and Path Framework (2014)



Current Law (2010)

Total Employer 164m (53%)
Total Individual 14m (5%)

Path Framework, All Firms (2014)

Total Employer 196m (64%)
Total Individual 18m (6%)

Source: The Lewin Group, "Path to a High Performance Health System: Technical Documentation," Washington, DC. The Lewin Group, 2009.

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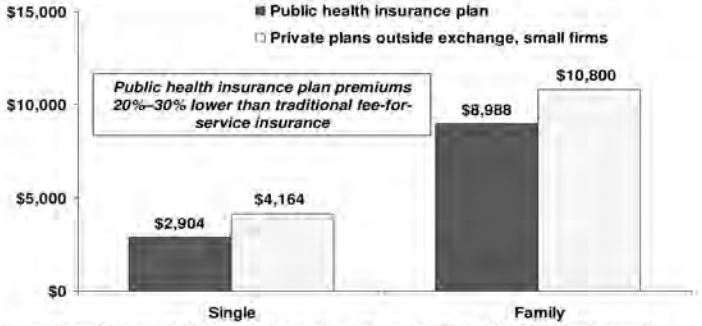
12

Estimated Premiums for New Public Health Insurance Plan Compared with Average Individual/Small Employer Private Market, 2010

Average annual premium for equivalent benefits at community rate*



* Benefits used for modeling include full scope of acute care medical benefits; $250 individual/$500 family deductible; 10% coinsurance for physician service; 25% coinsurance and no deductible for prescription drugs; reduced for high-value medications; full coverage checkups/preventive care. $5,000 individual/$7,000 family out-of-pocket limit.
Note: Premiums include administrative load.
Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: The Commonwealth Fund 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*, (New York: The Commonwealth Fund, February 2009).

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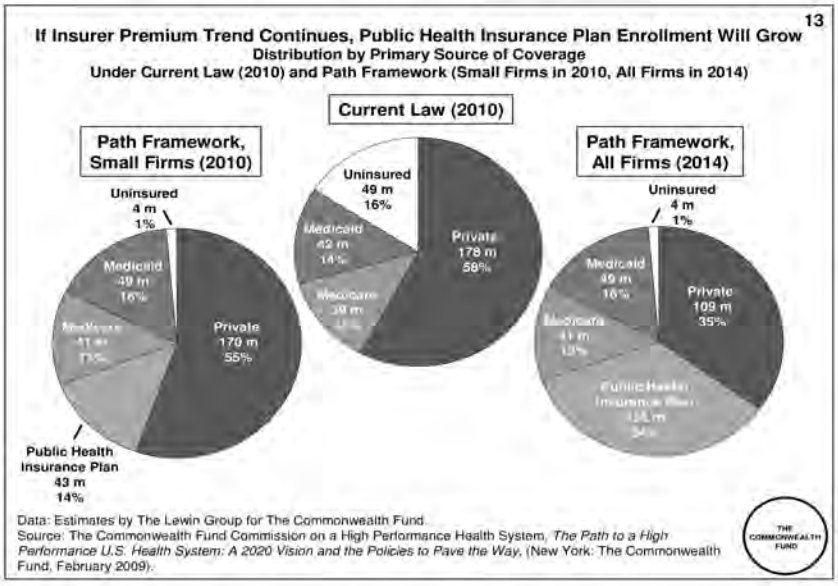
13
If Insurer Premium Trend Continues, Public Health Insurance Plan Enrollment Will Grow
Distribution by Primary Source of Coverage
Under Current Law (2010) and Path Framework (Small Firms in 2010, All Firms in 2014)
Path Framework, Small Firms (2010)
Current Law (2010)
Path Framework, All Firms (2014)
Uninsured 4 m 1%
Medicaid 49 m 16%
Private 170 m 55%
Public Health Insurance Plan 43 m 14%
Uninsured 49 m 16%
Medicaid 42 m 14%
Private 178 m 58%
Uninsured 4 m 1%
Medicaid 49 m 16%
Private 109 m 35%
Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: The Commonwealth Fund 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, (New York: The Commonwealth Fund, February 2009).
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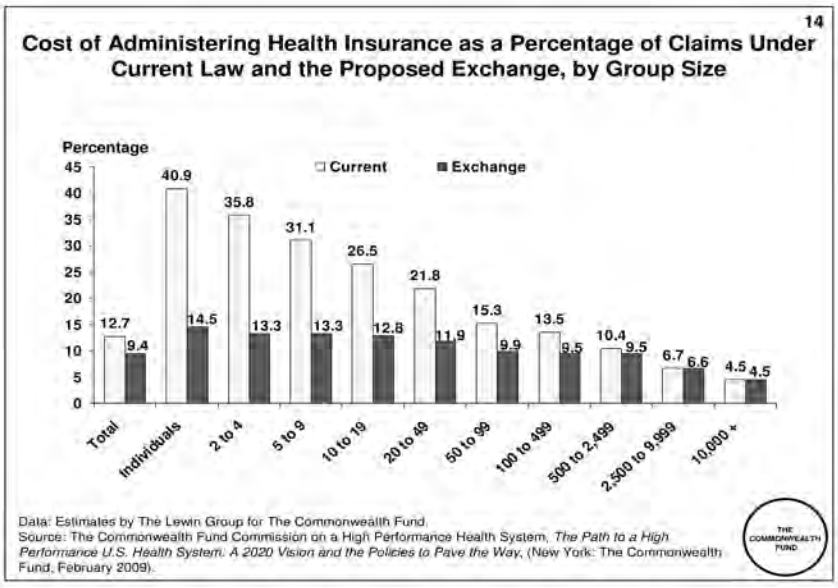
14
Cost of Administering Health Insurance as a Percentage of Claims Under Current Law and the Proposed Exchange, by Group Size
Percentage
Current
Exchange
45
40
35
30
25
20
15
10
5
0
12.7
9.4
40.9
14.5
35.8
13.3
31.1
13.3
26.5
12.8
21.8
11.9
15.3
9.9
13.5
9.5
10.4
9.5
6.7
6.6
4.5
4.5
Total
Individuals
2 to 4
5 to 9
10 to 19
20 to 49
50 to 99
100 to 499
500 to 2,499
2,500 to 9,999
10,000 +
Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: The Commonwealth Fund 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, (New York: The Commonwealth Fund, February 2009).
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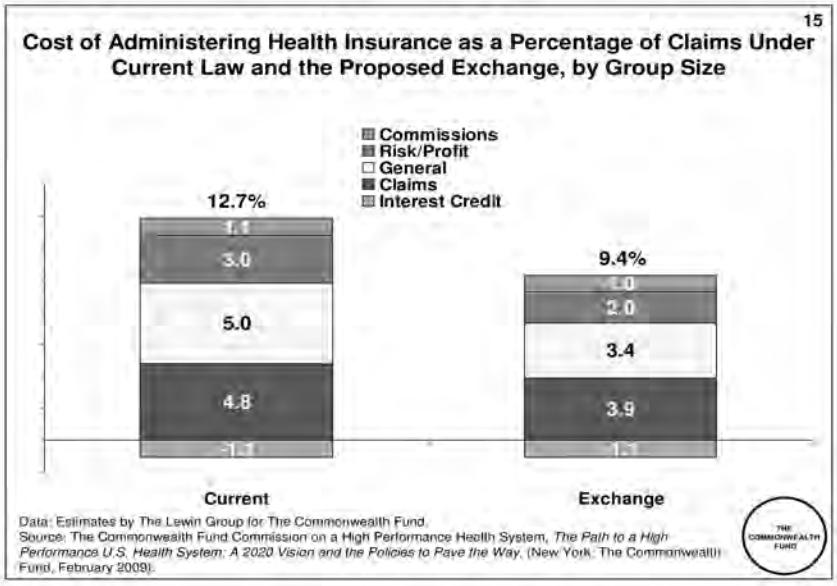
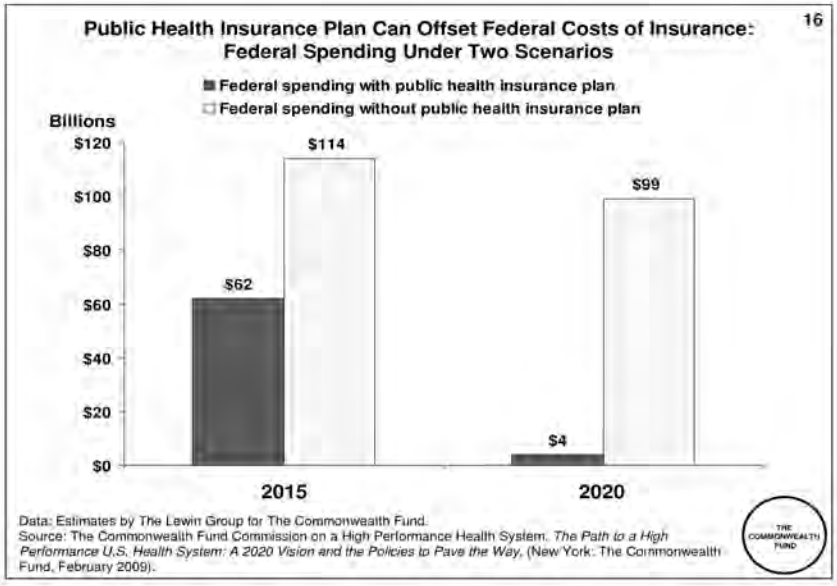
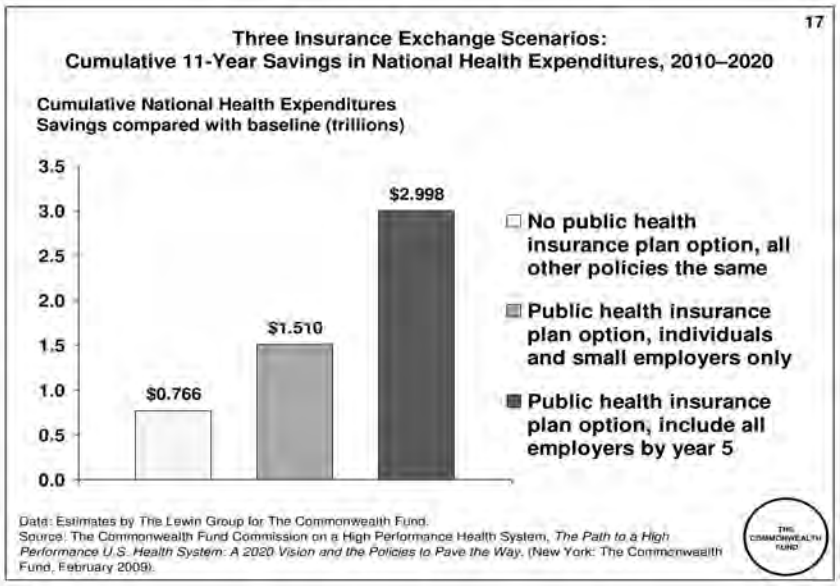
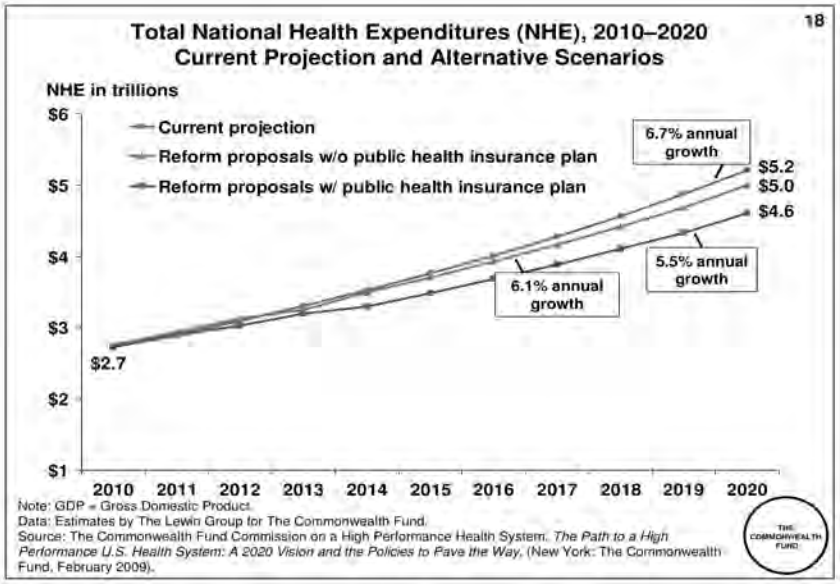

15
Cost of Administering Health Insurance as a Percentage of Claims Under Current Law and the Proposed Exchange, by Group Size
Commissions
Risk/Profit
General
Claims
Interest Credit
12.7%
1.1
3.0
5.0
4.8
-1.1
9.4%
2.0
3.4
3.9
Current
Exchange
Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: The Commonwealth Fund 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, (New York: The Commonwealth Fund, February 2009).


16
Public Health Insurance Plan Can Offset Federal Costs of Insurance: Federal Spending Under Two Scenarios
Federal spending with public health insurance plan
Federal spending without public health insurance plan
Billions
$120
$100
$80
$60
$40
$20
$0
$62
$114
$4
$99
2015
2020
Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: The Commonwealth Fund 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, (New York: The Commonwealth Fund, February 2009).


17
Three Insurance Exchange Scenarios:
Cumulative 11-Year Savings in National Health Expenditures, 2010–2020
Cumulative National Health Expenditures
Savings compared with baseline (trillions)
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0
$0.766
$1.510
$2.998
No public health insurance plan option, all other policies the same
Public health insurance plan option, individuals and small employers only
Public health insurance plan option, include all employers by year 5
Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: The Commonwealth Fund 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, (New York: The Commonwealth Fund, February 2009).


18
Total National Health Expenditures (NHE), 2010–2020
Current Projection and Alternative Scenarios
NHE in trillions
$6
$5
$4
$3
$2
$1
Current projection
Reform proposals w/o public health insurance plan
Reform proposals w/ public health insurance plan
6.7% annual growth
$5.2
$5.0
$4.6
5.5% annual growth
6.1% annual growth
$2.7
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
Note: GDP = Gross Domestic Product.
Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: The Commonwealth Fund 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, (New York: The Commonwealth Fund, February 2009).

19

Path Net Cumulative Impact on National Health Expenditures (NHE) 2010–2020 Compared with Baseline, With and Without Public Health Insurance Plan, by Major Payer Groups

Dollars in billions

	Total NHE	Net federal government	Net state/local government	Private employers	Households
With Public Health Insurance Plan	–$2,998	$593	–$1,034	–$231	–$2,325
Without Public Health Insurance Plan	-$766	$1,112	-$655	$905	-$2,128

Note: A negative number indicates spending decreases compared with projected expenditures (i.e., savings); a positive indicates spending increases.
Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: The Commonwealth Fund 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*, (New York: The Commonwealth Fund, February 2009).

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20

Major Sources of Savings Compared with Projected Spending, Net Cumulative Reduction of National Health Expenditures, 2010–2020 Exchange With and Without Public Health Insurance Plan as in Path Report

	With Public Health Insurance Plan	Without Public Health Insurance Plan
Affordable Coverage for All: Ensuring Access and Providing a Foundation for System Reform		
•Net costs of insurance expansion	–$94 billion	$1,385 billion
•Reduced administrative costs	–$337 billion	–$70 billion
Payment Reform: Aligning Incentives to Enhance Value		
•Enhancing payment for primary care	–$71 billion	–$63 billion
•Encouraging adoption of the medical home model	–$175 billion	–$155 billion
•Bundled payment for acute care episodes	–$301 billion	–$266 billion
•Correcting price signals	–$464 billion	–$407 billion

Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: The Commonwealth Fund 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*, (New York: The Commonwealth Fund, February 2009).

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21

Net Impact of Path Payment Reform Recommendations on National Health Expenditures Compared to Current Projection, 2010–2020 (in billions)

	Total NHE	Private Employers	State & Local Governments	Households	Federal Budget
Total Payment Reforms	-$1,010	-$170	-$10	-$82	-$749
Enhanced payment for primary care	-$71	-$28	-$2	-$11	-$30
Encouraged adoption of Medical Home model	-$175	-$25	-$13	-$36	-$101
Bundled payment for acute care episodes	-$301	-$75	-$4	-$11	-$211
Correcting price signals					
- High cost area updates	-$223	-$64	-$3	-$29	-$127
- Prescription drugs	-$76	+$22	+$12	+$5	-$115
- Medicare Advantage	-$165	$0	$0	$0	-$165

Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: S. Guterman et al., *Reforming Provider Payment: Essential Building Block for Health Reform.* (New York: The Commonwealth Fund, March 2009).

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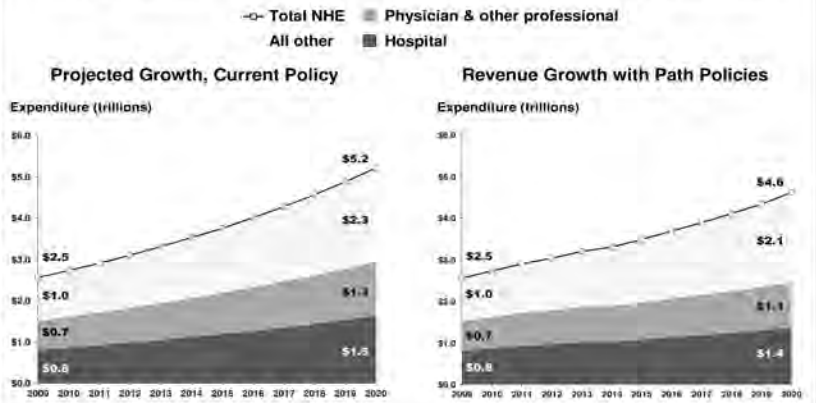
22

Total National Health Expenditure (NHE) Growth by Provider Sector, Current Projections and with Policy Changes, 2009–2020



Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: The Commonwealth Fund 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*, (New York: The Commonwealth Fund, February 2009).

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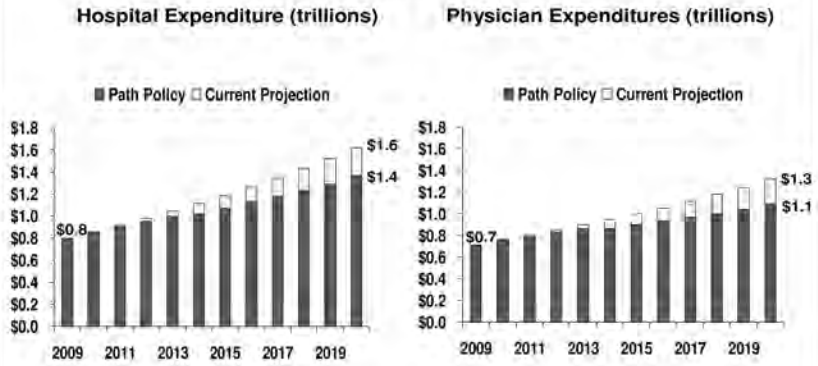
23

Total National Health Expenditure Growth for Hospitals and Physicians, Current Projections and With Policy Changes 2009–2020



Data: Estimates by the Lewin Group for The Commonwealth Fund.
Source: S. Guterman et al., *Reforming Provider Payment: Essential Building Block for Health Reform*. (New York: The Commonwealth Fund, March 2009).

24

Implications for Stakeholders of Path

- System Savings
  - $3.0 trillion system savings 2010-2020 with a public health insurance plan option; $0.8 trillion system savings 2010-2020 without public health insurance plan option
- Employers
  - Public health insurance plan option more affordable than premiums in small business market: 20-30% lower premiums
  - Savings to employers including payment and system reforms of $231 billion over 2010-2020
- Families
  - Secure and affordable coverage for all
  - Households save $2.3 trillion over 2010-2020, average savings of $2314 per family in 2020
- Providers
  - Provider revenues enhanced by increasing Medicaid payment to Medicare levels and buying in uninsured at Medicare rates
  - Payment reforms reward primary care and high performers
    - But slower revenue growth over time than current law
- Insurers
  - Rewards integrated delivery system and private insurers that enhance value
  - Administrative savings of $337 billion over 2010-2020

25

Agenda for Change

- **The U.S. has an historic opportunity to adopt reforms that will achieve a high performance health system**
- **The key ingredient is instituting a reform proposal that will ensure quality, affordable health insurance for all**
  - The U.S. has a path towards expansion of health insurance to all
- **Coverage for all must be pursued *simultaneously* with comprehensive reforms in cost, quality and access**
  - Payment reform to encourage integrated health care organizations and other providers to be accountable for results and resources
  - Rewarding primary care and patient-centered medical homes
  - Instituting a global fee covering hospital, physician, and other services including 30-day follow-up for acute episodes of care
  - Incentives for adoption of information technology
  - Information on comparative effectiveness and evidence-based medicine

Appendix: Summary of Policy Modeling Specifications for Coverage and Cost Estimates

Coverage

- **National Health Insurance Exchange.** Offers businesses and individuals a choice of private plans and a new public plan, phased in by size of firm with all eligible by 2014. Premium of the public plan would be community rated within broad age bands. Benefits are similar to the standard option in the Federal Employees Health Benefits Program. The plan would use Medicare's claims administrative structure and reformed payment methods and rates.

- **Individual Mandate.** All individuals are required to obtain coverage.

- **Affordability.** Premiums are capped at 5 percent of income for low-income individuals and 10 percent of income for those in higher-income tax brackets.

- **Shared Financial Responsibility.** Employers are required to provide coverage or contribute to a trust fund. The example used in the model included 7 percent of payroll, up to $1.25 an hour.

- **Medicaid/SCHIP Expansion.** All individuals with incomes up to 150 percent of the federal poverty income level are eligible for Medicaid acute care benefits. Medicaid provider payment rates are raised to Medicare levels. The federal matching rate is increased to offset state costs.

- **Medicare.** The two-year waiting period for coverage of the disabled is eliminated. Medicare beneficiaries are offered a supplement with the same acute care benefits as in new public plan and premium affordability provisions.

- **Insurance Market Reforms.** Require community-rate premiums (age bands permitted) and guaranteed issue and renewal of policies. Premium and insurance information would be publicly available on the Web.

Payment Reform: Aligning Incentives to Enhance Value

- **Enhance Payment for Primary Care.** Increase Medicare payments for primary care by 5 percent and apply differential updates for primary care and other care.

- **Encourage Development and Spread of Patient-Centered Medical Homes.** Provide payment per patient in addition to fee-for-service to practices qualified to provide patient-centered care. Reduced premiums and cost-sharing available to patients who designate a primary care practice as their medical home. Shared savings would be distributed on the basis of performance.

- **Bundled Payments for Acute Care Episodes.** Expand acute care payment to include services during the hospital stay and 30 days post-discharge in a global fee. The policy would be phased in, starting with inpatient services in 2010, then post-acute care in 2013, and hospital inpatient and outpatient physician care in 2016.

- **Correcting Price Signals.** Modify payments by: 1) slowing the rate of Medicare payment updates in geographic areas with high costs; 2) reducing prescription drug costs by having Medicare pay Medicaid prices for drugs used by dually eligible beneficiaries and determining Medicare payments for unique drugs with effective monopolies based on prices paid in other countries; and 3) resetting benchmarks for Medicare Advantage plans in each county to projected per-capita spending under traditional Medicare.

Investing in Information Infrastructure

- **Accelerate the Adoption and Use of Health Information Technology.** Require all providers to report key health outcomes electronically by 2015 to qualify for payment updates. Provide funding to support health information networks and assistance for safety-net providers and small practices through a 1 percent assessment on insurance premiums and Medicare outlays.

- **Center for Medical Effectiveness and Health Care Decision-Making.** Create a mechanism to develop information on the clinical and cost-effectiveness of alternative treatment options. Fund the Center with a .05 percent assessment on insurance premiums and Medicare and Medicaid spending. Use the information in benefit designs with higher out-of-pocket costs or differential pricing depending on comparative effectiveness and include physician–patient shared decision-making.

Promoting Health and Disease Prevention

- **Reduce Tobacco Use.** Increase federal taxes on tobacco products by $2 per pack of cigarettes. Use revenues to fund public health programs and insurance expansion.

- **Reduce Obesity and Alcohol Use.** Establish a new tax on sugar-sweetened soft drinks of 1 cent per 12-ounces to finance state obesity prevention programs, and increase the federal excise tax on alcohol by 5 cents per 12-ounce can of beer, with proportionate increases on other alcohol products. Use funds for prevention and insurance expansion.

Methodology Note: Modeling the Commission recommendations required detailed specifications for each of the policy approaches. The following specifications were used for illustrative purposes. Recognizing that multiple policy variations are feasible for key policy reforms, the Commission endorses the strategic approaches rather than the specific policy parameters used to model potential effects. The main report provides further detail. The Lewin Group technical report, *The Path to a High Performance U.S. Health System: Technical Documentation,* is available online at www.Lewin.com for data and parameters used to estimate 2010–2020 impacts.

Major Sources of Savings Compared with Projected Spending, Net Cumulative Reduction of National Health Expenditures, 2010–2020

Affordable Coverage for All: Ensuring Access and Providing a Foundation for System Reform	
• Net costs of insurance expansion	–$94 billion
• Reduced administrative costs	–$337 billion
Payment Reform: Aligning Incentives to Enhance Value	
• Enhancing payment for primary care	–$71 billion
• Encouraging adoption of the medical home model	–$175 billion
• Bundled payment for acute care episodes	–$301 billion
• Correcting price signals	–$464 billion
Improving Quality and Health Outcomes: Investing in Infrastructure and Public Health Policies to Aim Higher	
• Accelerating the spread and use of HIT	–$261 billion
• Center for Comparative Effectiveness	–$634 billion
• Reducing tobacco use	–$255 billion
• Reducing obesity	–$406 billion
Total Net Impact on National Health Expenditures, 2010–2020	–$2,998 billion

Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

Chairman RANGEL. We have with us an expert in healthcare. I will ask Congressman Reichert to tell us more about him.

Mr. REICHERT. Thank you, Mr. Chairman.

I am very pleased to be able to introduce a constituent of mine today, John Pickering. Mr. Pickering is a principal and consulting actuary with the Seattle Office of Milliman.

He has a Bachelor of Science Degree in Mathematics from Central Washington University, and just to take a moment to boast a little bit, the same university my son received his mathematics degree from.

He also has a BA in Communications from the University of Washington, more than 10 years of health actuarial experience, and he currently resides in Sammamish, Washington, grew up in North Bend, Washington, all within the Eighth District of Washington State.

I am very much looking forward to hearing his ideas on how we can improve and reform our current healthcare system.

Welcome, Mr. Pickering.

STATEMENT OF JOHN M. PICKERING, FSA, MAAA, PRINCIPAL AND CONSULTING ACTUARY, MILLIMAN, INC.

Mr. PICKERING. Thank you, Representative Reichert, for the introduction, and thank you, Chairman Rangel, Ranking Member Camp, for the invitation to testify this morning.

I am John Pickering, a principal and consulting actuary with Milliman in Seattle, and I appreciate the opportunity to contribute to the healthcare reform dialog.

Milliman is the largest actuarial employer in the country, with offices in approximately 30 U.S. cities. In healthcare, we work with health plans, providers, employer groups, and Government entities nationwide.

We recently conducted a study of hospital and physician payment rates among Medicare, Medicaid, and commercial payers at the request of AHIP, the American Hospital Association, the Blue Cross Blue Shield Association, and primarily Blue Cross.

I will summarize the findings of our study in my testimony today. My goal is not to advocate for or against any specific reform proposal, but rather to help inform the debate.

We measure the cost shift as the change in provider payment that would be required by Medicare, Medicaid, and commercial payers, such that all three would pay equivalent rates. Together, these three main payer types must also cover the unpaid costs for services for the uninsured.

Chart 1 presents our findings for hospitals. This is based on 2006 data.

We estimate that on average, hospitals had a negative 9.4 percent margin on Medicare patients, a negative 14.7 percent margin on Medicaid patients, a 23.1 percent margin on commercial patients, and a negative 25.1 percent margin on uninsured and other Government patients.

These combine for an overall operating margin of 3.8, with the Medicare, Medicaid, commercial subtotal operating margin of 6.4.

In order for each hospital to achieve consistent margins on Medicare, Medicaid and commercial business, we estimate Medicare and

Medicaid combined would have needed to pay an additional $51 billion, and commercial payers would have paid $51 billion less.

This would amount to an 18-percent reduction in commercial payment rates.

Table 2 presents our findings for physicians. This is based on 2007 data.

The values in Chart 2 represent relative payment levels. 1.0 represents the weighted average of all three payers. We estimate that Medicare paid 11 percent less than the average, Medicaid paid 40 percent less than the average, and commercial payers paid 14 percent more than the average.

In order for each to pay the average rate, Medicare and Medicaid would have needed to pay an additional $38 billion and commercial payers would have paid $38 billion less. This would represent a 12-percent reduction in commercial payment rates.

Chart 3 summarizes our cost shift estimates. In total, we estimate the cost shift burden on commercial payers is approximately $89 billion. This calculation of the cost shift is revenue neutral to hospitals and physicians.

We have held the total payment to providers constant, but reallocated the source.

These cost shift estimates are not based on our opinions of an appropriate payment level, but rather our measurement of the magnitude of the current differences in rates.

The impact of the cost shift varies geographically and by provider. Hospitals vary in their patient mix. Those with higher percentages of Medicare, Medicaid and uninsured patients face a bigger burden.

Hospitals also vary in their cost efficiency. Some hospitals are able to make a positive margin on Medicare.

The payment rate differential puts pressure on commercial premiums. Chart 4 presents our estimates of the cost shift impact on a typical family of four in an employer sponsored PPO plan.

The left side of the chart presents the total annual healthcare cost for this family, including premium and cost sharing, such as deductibles, co-pays and co-insurance, and split between amounts paid by the employer and the family.

The right side of the chart represents the amount that is due to the cost shift. In total, we estimate that if the cost shift were eliminated, healthcare spending for this family of four would be reduced by almost $1,800 per year or 10.7 percent.

We were able to evaluate hospitals' margins going back to 1995. Chart 5 presents the results.

Commercial margins bottomed in 1999 and have increased since. Medicare margins peaked in 1997 and have since declined. Medicaid margins began declining in 2003.

The rising commercial margin indicates that the trends in payment from commercial payers have exceeded the trends in hospital operating costs. This excess trend has been one component in commercial premium trends in recent years.

While my comments today are focused on the financing of healthcare, I also want to acknowledge the importance of improving the efficiency in the delivery system.

To be successful in the long term, reform must address both the financing of care and the cost efficiency in quality of care delivery.

Thank you.

[The prepared statement of John M. Pickering follows:]

Milliman

Milliman

Testimony before the Committee on Ways and Means
Hearing on Health Reform in the 21st Century

Prepared for:
The Committee on Ways and Means

Prepared by:
John M. Pickering, FSA, MAA
Principal & Consulting Actuary
Milliman, Inc.

Thank you Chairman Rangel and Ranking Member Camp for the invitation to testify this morning. I am John Pickering, a Principal and Consulting Actuary with Milliman in Seattle, and I appreciate the opportunity to contribute to this healthcare reform dialogue. Milliman is the largest actuarial employer in the country, with offices in approximately 30 US cities. In healthcare, we work with health plans, providers, employer groups, and government entities nationwide.

We recently conducted a study of hospital and physician payment rates among Medicare, Medicaid, and commercial payers at the request of AHIP, the American Hospital Association, the Blue Cross Blue Shield Association, and Premera Blue Cross. I will summarize the findings of our study in my testimony today.

My goal is not to advocate for or against any specific reform proposal, but rather to help inform the debate.

We measure the cost shift as the change in provider payment that would be required by Medicare, Medicaid, and commercial payers such that all three would pay equivalent rates. Together, these three main payer types must also cover the unpaid costs of services for the uninsured.

Chart 1 presents our findings for hospitals, based on 2006 data. We estimate that on average, hospitals had a -9.4% margin on Medicare patients, a -14.7% margin on Medicaid patients, a 23.1% margin on commercial patients, and a -25.1% margin on uninsured and other government patients. These combined for an overall operating margin of 3.8%. The Medicare/Medicaid/commercial subtotal operating margin was 6.4%.

Chart 1
2006 Hospital Operating Margins
in billions

	(A)	(B)	(C)=A+B	(D)	(E)=C+D	(F)=E/C	
	Patient Revenue	*Other Operating Revenue*	*Total Revenue*	*Operating Expense*	*Gain/ (Loss)*	*Operating Margin*	*Cost Shift*
Medicare	$195.7	$10.0	$205.7	($225.1)	($19.4)	-9.4%	
Medicaid	$67.8	$4.8	$72.6	($83.3)	($10.7)	-14.7%	$51.0
Commercial	$276.4	$10.7	$287.1	($220.6)	$66.5	23.1%	
Subtotal	$539.9	$25.6	$565.5	($529.1)	$36.4	6.4%	
Uninsured & Other Gov't	$43.7	$6.7	$50.5	($63.2)	($12.7)	-25.1%	
Operating Total	$583.6	$32.3	$616.0	($592.3)	$23.7	3.8%	

In order for each hospital to achieve consistent margins on Medicare, Medicaid, and commercial business, we estimate Medicare and Medicaid combined would have needed to pay an additional $51 billion, and commercial payers would have paid $51 billion less. This would amount to an 18% reduction in commercial payment rates.

Chart 2 presents our findings for physicians, based on 2007 data. The values in Chart 2 represent relative payment levels. 1.0 represents the weighted average of all three payers. We estimate that Medicare paid 11% less than the average, Medicaid paid 40% less than the average, and commercial payers paid 14% more than the average.

Chart 2
2007 Physician Relative Payment Levels

Medicare	0.89
Medicaid	0.60
Commercial	1.14
Average	1.00

In order for each to pay the average rate, Medicare and Medicaid would have needed to pay an additional $38 billion, and commercial payers would have paid $38 billion less. This would represent a 12% reduction in commercial payment rates.

Chart 3 summarizes our cost shift estimates. In total, we estimate the cost shift burden on commercial payers is approximately $89 billion. This calculation of the cost shift is revenue neutral to hospitals and physicians. We have held total payment to providers constant, but reallocated the source.

Chart 3
Medicare & Medicaid Cost Shift
in billions

	Medicare	*Medicaid*	*Commercial*	*Total*
Hospital	($34.8)	($16.2)	$51.0	$0.0
Physician	($14.1)	($23.7)	$37.8	$0.0
Total	($48.9)	($39.9)	$88.8	$0.0

These cost shift estimates are not based on our opinion of an appropriate payment level, but rather are a measurement of the magnitude of current differences in rates.

The impact of the cost shift varies geographically and by provider. Hospitals vary in their patient mix; those with higher percentages of Medicare, Medicaid, and uninsured patients face a bigger burden. Hospitals also vary in their cost efficiency. Some hospitals are able to make a positive margin on Medicare.

The payment rate differential puts pressure on commercial premiums. Chart 4 presents our estimates of the cost shift impact on a typical family of four in an employer sponsored PPO plan. The left side of the chart presents the total annual healthcare cost for this family, including premium and cost sharing, such as deductibles, copays, and coinsurance, and split between amounts paid by the employer and the family.

Chart 4
Annual Medicare & Medicaid Cost Shift Burden for Typical Family of Four in a Commercial PPO Plan

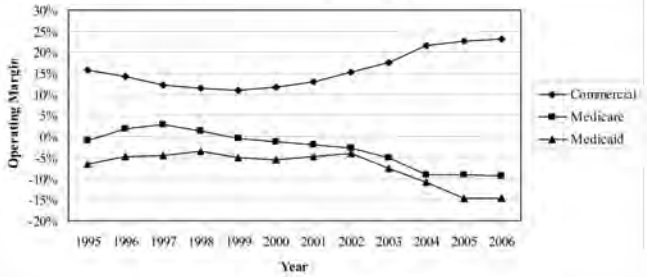
	Total Annual Cost[1]			Portion Due to Cost Shift		
	Premium	*Cost Sharing*	*Total*	*Premium*	*Cost Sharing*	*Total*
Employer	$10,481		$10,481	$1,115		$1,115
Subscriber	$3,731	$2,420	$6,151	$397	$276	$673
Total	$14,212	$2,420	$16,632	$1,512	$276	$1,788
% of Total				10.6%	11.4%	10.7%

1) Based on the 2007 Milliman Medical Index, with an 85% loss ratio assumed.

The right side of the chart represents the amount that is due to the cost shift. In total, we estimate that if the cost shift were eliminated, healthcare spending for this family of four would be reduced by almost $1,800 per year, or 10.7%.

We were able to evaluate hospital operating margins going back to 1995. Chart 5 presents the results. Commercial margins bottomed in 1999, and have increased since. Medicare margins peaked in 1997, and have since declined. Medicaid margins began declining in 2003.

Chart 5
Hospital Operating Margins by Year



The rising commercial margin indicates that the trend in payment from commercial payers has exceeded the trend in hospital operating cost. This excess trend has been one component in commercial premium trend in recent years.

While my comments today are focused on the financing of healthcare, I also want to acknowledge the importance of improving efficiency in the delivery system. To be successful in the long term, reform must address both the financing of care and the cost efficiency and quality of care delivered.

Thank you.

Chairman RANGEL. Mr. Pickering, you have heard the testimony of Karen Davis, and most everybody that I have talked with believes there should be an option for the potential patient for a public plan.

I think your position is that a public plan would increase the premiums and the cost of the private plans. Is that your position?

Mr. PICKERING. It could. I believe it could.

Chairman RANGEL. You do not believe there is any room for compatibility and competition and wider choice for the potential enrollee in healthcare?

Shelley Berkley said at a meeting we had today, our people out there, they do not care whether it is Medicare, Medicaid, private, public. All they want is the assurances that if something happens to them or their loved ones, that they can get affordable healthcare, quality healthcare.

That is what most, not Republicans, not Democrats, not people from rural areas, that is what the average human being want.

Do you believe that you could draft if commissioned a plan that would include the public option?

Mr. PICKERING. That would be a challenge.

Chairman RANGEL. Well, you are a professional. If you knew that it was going to happen, and you can say I do not think it is a good idea, and we say that is nice, but it is going to happen, do you believe you could have one that would be fair and equitable to the private providers?

Mr. PICKERING. Let me outline what I think one main concern would be. If the public plan paid at Medicare payment rates, which are significantly below, in most geographic areas, what commercial payers pay, and it varies geographically across the country, but in areas where commercial payers currently pay much higher rates, and if a public plan came in at Medicare rates, I think it would be very difficult for the commercial plans to compete.

Could we devise a way around that?

Chairman RANGEL. Yes—no. That is the question; yes.

Mr. PICKERING. I hope so. I do not know the answer to that, but I hope so.

Chairman RANGEL. I do not understand why you would assume that the private companies would be asking for more, or that a public company would be asking for less.

One, the public plan would be under serving the Government taxpayer if they were asking for less than what they should. Two, it is possible that the private plan would be overcharging.

If we had this type of thing, you and I would want the providers to know that they are getting an equitable reimbursement where they monitor each other, public and private.

Mr. PICKERING. I think one issue is we do not have price competition at the provider level. We only have price competition at the plan level.

For example, consumers are shielded from making choices of providers on price, such that if the public plan paid a lower rate to providers than the commercial plans could, it would be very difficult for the commercial plans to compete on premium with the public plan.

Chairman RANGEL. If the insurance markets were reformed such that plans could no longer underwrite, would that help plans lower their administrative costs?

Mr. PICKERING. It potentially could. Any insurance reform we would hope would be based on sound insurance and actuarial principles. Right now in the market, if we look at the individual market, plans need to medically underwrite so they do not get selected against.

If a plan gets too much adverse selection, its claims costs will grow and it could face what we call a death spiral, where they retain only their sickest members and their premium becomes unaffordable.

It is a challenge to payer availability with affordability.

Chairman RANGEL. It seems that with your reputation and that of your firm as you were introduced, that you welcome challenges.

Mr. PICKERING. Certainly.

Chairman RANGEL. You believe it could be handled if it had to be?

Mr. PICKERING. Yes.

Chairman RANGEL. I yield to Mr. Camp.

Mr. CAMP. Well, thank you, Mr. Chairman.

Your report really talks about the fact or explains that every American with private insurance is really paying a hidden cost or hidden tax on their health insurance because healthcare providers shift some of their financial losses onto them.

The Lewin Group did a study and said that as a percentage of private payments for services, Medicare, Medicaid under paid hospitals 71 to 67 percent, and under paid physicians 81 to 56 percent.

Can you explain why this cost shift occurs?

Mr. PICKERING. Yes, and let me very briefly outline by "cost shift" what I am talking about. It is not just losses on the public programs.

In our program, when we are talking about cost shift, we are looking at the difference in payment rates from the overall combined average of commercial, Medicare, and Medicaid.

In those terms, when you think of why the cost shift exists, you need to think of why are payment rates different for Medicaid, Medicare and commercial plans.

There are several reasons. First off, commercial plans are the only entities that need to negotiate rates with providers. The Medicaid fee schedule is administratively set as is the Medicare fee schedule, for the most part. The managed Medicaid and Medicare will negotiate.

Medicare and Medicaid are obviously very large programs. Negotiating power between hospitals and physicians and health plans will come into play in terms of raising commercial payment rates.

Also, providers' attitudes toward participating in Medicare and Medicaid. Many providers have as part of their mission to serve the whole community, so regardless of low payments, they do want to serve these individuals.

For Medicaid and SCHIP, many providers consider that as a replacement for uninsured, such that they will accept low rates on Medicaid because if Medicaid were not there, there would be the uninsured.

There are legitimate reasons for price differences between Medicare, Medicaid and commercial plans. What employer groups have been concerned about in recent years is those rates have been widening, putting more pressure on employer premiums.

Mr. CAMP. Assuming we all want to have people keep their coverage if they like it, I do not see how the introduction of a Government run health plan actually lends itself to that assumption.

You point out that Government run health programs, like Medicare and Medicaid, under pay providers, and then providers charge more for their services to those with private insurance to make up for the lost revenue.

Will not the introduction of a Government run plan using similar payment policies make it more difficult for employers to continue to offer health insurance and will not employees find it more difficult to pay for or afford their current coverage if we expand Government run care?

Mr. PICKERING. I believe that could be the case. I think there are a few dynamics that could happen. If we consider a public plan in direct competition with the commercial plan, again, in an area where right now commercial payers pay higher rates to providers then the public plan would, when the public plan comes in, it will have a large advantage because its premiums would be lower.

People shift from the commercial plan to the public plan. The providers are now paid the lower public plan rates. There are a few options that could happen.

One is those providers could then shift the costs to the remaining commercial population. They could try to. Those providers could become more cost efficient to make a margin under the lower rate, or those providers could simply make less money than they had been making, potentially a loss.

In the market today, we do believe that many providers and many health plans do shift those costs onto the commercial market.

The dynamic may be different if the commercial market were competing directly with the public plan. The commercial payers then may be less willing to pick up that excess cost, because the dynamic then would be they would be raising their premiums or their costs and therefore their premiums even higher above the public plan, making them even less competitive.

It may raise premiums. It may squeeze providers.

Mr. CAMP. Thank you. Thank you, Mr. Chairman.

Chairman RANGEL. The Chair would like to recognize the Chairman of the Subcommittee on Health for the remainder of the hearing. Chairman Stark?

Mr. STARK [presiding]. Thank you, Mr. Chairman.

Two things. First, I wanted to go back to Mr. Camp's concern earlier on in his opening remarks about the 160 million or however many people get their insurance currently through their place of employment.

You have an illustrative list of financing mechanisms, and one of them is capping the employer tax exclusion. I caution and I think join with Mr. Camp, about doing anything that undermines the existing coverage for the individuals who receive their health coverage through their employer, and I would hope as we work to work on reform and finance it, we could build on what works.

Should we be concerned about the effects of capping the employer exclusion on existing coverage and then what happens to employer sponsored insurance under the plan you have suggested?

Ms. DAVIS. The commission did not endorse specific revenue measures, so it provided for the Congress' and the public's information estimates of what revenues would be generated.

I think your concern that any cap on employer benefits might well lead employers to drop coverage and to erode, in fact, the employment based coverage that we would like to preserve as one of the essential strengths in our system.

By offering competition and choices, by letting employers either directly purchase coverage or bring their employees into a national health insurance exchange with many more private plans, and a public health insurance alternative, employers could in fact find more affordable choices. Employees could find more affordable choices.

Our estimates are that the number with employer sponsored coverage would increase from 164 million to 196 million.

On the other hand, private plans could compete with that and hold onto much of that business.

The first point I think it is really important that the Committee understand is this is in the context of health insurance for everyone.

The Urban Institute estimates there is $122 billion more revenue that would flow to providers as a result of covering the uninsured.

In addition, the commission's PATH framework recommends bringing Medicaid rates up to Medicare levels. That is another 20 to $30 billion.

If one really believes in the cost shift argument that we have heard from Mr. Pickering, then providers should be reducing their prices to commercial insurers, and that will bring commercial insurers down because they do not have to cross subsidize the care of the uninsured. They do not have to cross subsidize lower payment rates from Medicaid.

The second point, private insurance administrative costs go down when they offer plans through the national health insurance exchange. They do not have the high administrative costs that they have when they have to market individually to small businesses and individuals.

Private insurers can compete more effectively by eliminating the cost shift of the uninsured, if it exists, the cost shift from lower Medicaid payments, and the lower administrative costs.

Private insurers bring to the table many inherent strengths. We need to tap into those. Yes, a public health insurance plan has the advantages of being a single set of benefits available nationwide, will never go away, and having leverage over provider payments, but private insurers can innovate. They can use utilization management. They can have variable benefit designs. They can select certain groups of hospitals or doctors that have higher quality or are more efficient.

Mr. STARK. Thank you. I appreciate that [continuing]. I recognize Mr. McDermott to inquire.

Dr. MCDERMOTT. Thank you, Mr. Chairman.

Dr. Shaw from Harvard described a single payer plan as a single set of benefits with a single source of funding. I understand that has been sort of discarded in many minds in this Congress.

What is hard to understand is the French for 8 percent of GDP provide the best healthcare in the world, but we spend 16 percent of GDP and have worse results than they have in France. That is according to the World Health Organization.

It is hard to see why we step away from that. Let us talk about the plan that The Commonwealth Fund has put on the table.

Is it possible to control costs without a robust public program, to compete with the private sector that has been unable to control costs over the last 50 years?

Ms. DAVIS. Mr. McDermott, that is a very important point. We are at 16 percent of GDP. Actually, almost 17 percent now and headed to 21 percent. Other countries cover everyone at about half the per capita cost of the U.S.

We need an uniquely American solution, and this building on the best of public health insurance and private insurance, giving employers and individuals that choice to tap into it.

What our estimates show is if you do not have a public health insurance plan offered to really create this competitive dynamic, instead of saving $3 trillion over this period, one would save three-quarters of a trillion. That is real money. It is markedly less.

Employers would pay much more without the option of this dynamic change in the insurance market, so instead of saving $231 billion, they would spend $900 billion. It is in an employer's advantage to have access to premiums that take advantage of innovative payment methods, that take advantage of lower administrative costs.

Dr. MCDERMOTT. Can I then explore the public option? My biggest fear is that the public option will become the dumping ground for the expensive patients while the insurance industry continues to siphon off those who are not sick or ill or in certain categories, that will make it possible for them to be profitable, leaving the Government with all the sick patients, the chronic patients with diabetes, the chronic patients with asthma, all those cases, all the deliveries. Let us get those out so we do no have to worry about any high cost deliveries.

How do we prevent that from happening in the exchange that you are creating here? I think that is the real crux of what is going to happen.

Industry wants to off load their costs. They do not care where they off load it. If they can off load it to a private company, that is fine, or if they off load to the public, that is fine.

We are going to get stuck, I think, with the high cost patients. It is part of the reason why we have the cost shift in Medicare. The private sector did not want old people, so the Government took them. The private sector did not want poor people, so the Government took them.

We have had all the high cost patients and we are heading for another trench of them, it seems to me, unless we design this very carefully.

Ms. DAVIS. That is a very important point. There are two things that are essential to do. The first is to set rules on the sale of private insurance inside the exchange and outside the exchange.

Dr. MCDERMOTT. Nationwide insurance rules?

Ms. DAVIS. Nationwide. They must take everyone and they must charge the same premium regardless of the health status, so not charge the sick more. It is called a community rating, guaranteed issue in the insurance industry.

Those rules are absolutely important to prevent the kind of risk selection dumping that you are talking about.

The second thing that is important to do is what is called risk adjustment. If chronically ill people prefer a public health insurance plan because it is more innovative about rewarding medical homes, rewarding hospitals for controlling chronic conditions, then we want to make sure premiums are not higher as a result and they are risk adjusted.

Those two protections are very important.

Dr. MCDERMOTT. Does this imply that we are going to take health insurance regulation away from the states and we will do it at the Federal level?

Ms. DAVIS. In this framework, there needs to be national rules that set a minimum standard on the conduct and sale of insurance, and particularly, the key ones are exactly what you have pointed to.

Same premium for everyone regardless of health status. It can vary by age, if you want to have age bands. That you have to take all comers. It has to be open enrollment, guaranteed renewal. You cannot get rid of people because they got cancer.

Those protections are very important.

Dr. MCDERMOTT. The patient bill of rights is basically what you are saying has to be built into this?

Ms. DAVIS. We will never have security and affordability for American families if we let discrimination against the sick continue in insurance markets.

Dr. MCDERMOTT. Thank you.

Mr. STARK. Mr. Herger?

Mr. HERGER. Thank you, Mr. Chairman.

One principle the President has repeatedly stated and that I fully agree with is that people who like the coverage they have should be able to keep it.

Mr. Pickering, I think it is very important that we are hearing your testimony on the cost shifting that occurs as a result of inaccurate payments by Government run plans.

The 22.7 million Californians who have employment based or individual coverage are paying a hidden tax, probably even higher than the 1,788 average you cited, since California has the lowest Medicaid payment rates in the country.

I am afraid there is a real danger of making this hidden tax higher when we talk about placing more people in Government run programs.

Mr. Pickering, The Lewin Group has estimated that if a Government run health plan which reimbursed providers at Medicare rates were created, nearly 120 million individuals would be forced out of their current health insurance and into the Government plan.

If this new Government run health plan was created, would not the current cost shift be made worse, leading to even higher costs for those who wanted to remain in their current private health plan, and what effect would this have on employers who want to continue offering health insurance?

Mr. PICKERING. The one thing we know for sure from our study is that right now, the commercial plans are paying higher provider payment rates.

If we assume 120 million people shift from those higher commercial rates to lower Medicare rates, we are putting tremendous pressure on the providers who accept those new patients at Medicare rates. Obviously, their revenue is way down.

What options do they have? Try to raise more revenue from the one source where they can negotiate more revenue, which is the remaining commercial population.

Become more efficient, if they can, or lose money.

A change of this magnitude, 120 million people, I would worry that shifting the cost onto the remaining commercial population may not be tenable, just because it would be too large of an amount.

I think in this scenario, it is difficult to know what the outcome would be, but I think there would be tremendous pressure on these providers.

Mr. HERGER. Your last two options, that they are going to lose money or skimp, is that not really unrealistic that they would do this? You cannot lose money. The Government, we know, can continue losing money. That is why we deficit spend. A private company cannot continue doing that very long, or if you skimp, people are going to move away from your plan.

Is that not in reality correct?

Mr. PICKERING. Yes, I agree. The hope is that they could improve their efficiency of delivery of care. Is that feasible? Maybe, maybe not. Right now, a lot of physicians balance their caseloads with Medicare, Medicaid and commercial with the commercial to offset the low payments.

Hospitals will try to attract higher paying commercial patients for the same reason. If that higher paying segment goes away, those providers need a new strategy or they need to readjust to lower revenue expectations, which may mean losses.

I agree you cannot have losses forever.

Mr. HERGER. With that in mind, does it not seem totally unrealistic that somehow these independent companies and health plans, private, can compete with the Government who can go indefinitely losing money, as we have been doing in the past?

Just on the surface, is this not just completely out of the realm of reality?

Mr. PICKERING. In this case, I do not think it would be the Government that would be losing money. It would be the providers who are accepting that Government payment rate.

Mr. HERGER. I guess I am switching the question a little bit here. The whole idea is that we are going to have competition from the Government. In reality, it is impossible for the private sector to ever compete with the Government because the Government does not have to show a profit. They can indefinitely, as we have shown we are doing, run a deficit, where a company cannot.

Mr. PICKERING. I agree. Even if the Government does run a break-even on the plan, I think it would be very difficult in many geographic areas for commercial plans to compete, just because in many geographic areas, it is not feasible for a commercial plan to

try to negotiate rates at 100 percent of Medicare. They just cannot do it.

Mr. HERGER. Difficult, but I would even say impossible. Thank you very much.Thank you, Mr. Chairman.

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

Mr. LEWIS. Thank you very much, Mr. Chairman. Let me thank each of you for being here this morning.

It is no secret and I have said it last week and I will say it again today, I believe healthcare is a right and it is not a privilege. As a nation, we have a moral obligation to provide healthcare for all of our citizens.

Today, many of our citizens are one illness away from losing everything. Every day people put off going to a doctor. Even when they know they are in pain, they know they cannot afford to see the doctor. They cannot afford the treatment for whatever is wrong.

This should never happen in our country; never.

This hearing is an important first step as we start the process of making healthcare available to all Americans.

I want to thank you for your studies, your reports. I think when historians pick up their pens and write about this period, they would have to say that the studies and the reports made a lasting contribution to moving us down the road toward comprehensive healthcare for all of our citizens.

Dr. Davis, why is having a public plan so important? Can we actually change the way healthcare is delivered and save money, save dollars without a public plan?

Ms. DAVIS. It absolutely is essential to getting the kind of performance we want. If we do not, we are going to continue the way we are. I think what we have heard from Mr. Pickering is the insurance companies do not think they can change the way they pay providers, do not think they can achieve efficiencies.

We have to have a different kind of system. We are talking about slowing the increase from 6.7 percent to 5.5 percent. Providers have more revenue. Every year, they have more revenue. They get paid for the uninsured. They do not get paid now. They get paid decent rates for Medicaid.

Most importantly, they get rewarded for providing better care. They get medical home fees under Medicare, Medicaid, the public health insurance plan, for all the patients that sign up with their practice. They get rewarded. They get additional payments if those patients are up to date with preventive care, if they have their chronic conditions controlled.

Hospitals get rewarded if they have fewer re-admissions, fewer complications, patients going back into the emergency room or back into the hospital after they have been discharged because they did not know what to expect and how to take care of them.

Unless we change fundamentally the way we pay providers, as would happen under Medicare, Medicaid, the public health insurance plan, private insurers are going to continue the way they are now.

If they see the light as they did sometimes with Medicare's physician payment methods in the past, and adopt those methods, then we can have even bigger change. Otherwise, we are just going to continue.

Who is going to pay? Families are going to continue to pay. Businesses are going to continue to pay. We are going to have higher Federal budget cuts.

The Federal budget cost of covering the uninsured would double without a public insurance plan. You do not want to bring the uninsured in at high commercial premiums and at high provider payment rates.

It is a very important option, a plan, a choice, to have available in the insurance exchange to make sure that their scheduled dollars are used efficiently to cover the uninsured and improve coverage for the under insured.

Mr. LEWIS. Dr. Davis, in Mr. Pickering's testimony, he talked about a cost shift from public payers to a private plan. Maybe, Mr. Pickering, you can correct me. I believe your report was financed and commissioned by the insurance companies.

Do you have any reaction to that? It seems like that may be a little vested interest there.

Ms. DAVIS. I think there are three concerns I have about Mr. Pickering's report. The first is it does not assume we cover the uninsured or improve Medicaid rates. If we did that, most of this cost shift goes away.

If providers get $122 billion for the uninsured, if they get 30 or $40 billion more from Medicaid, the $80 billion they have in their study is wrong.

The second problem is they assume the current levels of payment of providers are right. In fact, if you look over a longer historical period, from 1980 through the current period, hospital margins are higher than they have been historically.

What the MedPAC study shows, that the Chairman referred to, is that hospitals that are under some economic pressure find ways of being more efficient. When money is rolling in where commercial payers are paying at high rates, then they can find ways for using that revenue. You need some economic pressure to promote efficiency.

The third point that I would say is that this is an arithmetic study. It is not a behavioral study. It does not look at what would commercial insurers do. Would they cut premiums if Medicare were to pay more. Would they cut premiums if Medicaid were to pay more, or would they pocket the difference.

The truth of the matter is the insurance industry is very concentrated in many geographic areas. Sometimes you have one company selling most of the business, over half of the business in a state.

In fact, in nearly every state in the U.S., three companies or fewer control over half of the enrollment.

One important reason to have a public health insurance plan available in the exchange to employers is that it is a counterbalance to undue market power by insurance companies or by providers that may be the only system that is available in a geographic area.

By setting a price mark with this public health insurance plan, we can foster competition and real choice.

Mr. LEWIS. Dr. Davis, my time has expired. The Chairman has been quite liberal for me. I do not know if Mr. Pickering wants to respond.

Mr. STARK. We will have lots of time. I recognize Mr. Neal. I am going to ask some of my colleagues on the other side, Dr. Ayanian has raised this issue also in his testimony about how the under insured exacerbate the cost for the insured in many communities. I hope we will not overlook that.

Mr. Neal, would you like to inquire?

Mr. NEAL. Thank you, Mr. Chairman.

Dr. Ayanian, the Massachusetts' model has drawn a considerable amount of attention everywhere. The end result is 97 percent, I think, of the citizens of Massachusetts are now covered under the Pioneering plan.

What are the lessons learned, what are the legitimate criticisms of the initiative?

Dr. AYANIAN. You raised an important point about the Massachusetts' health reform being a potential model for the nation.

Our Committee was commissioned to look at the consequences of un-insurance. We were not asked to look at specific approaches.

I think the conclusions we drew by consensus from the evidence that we have in front of us is that regardless of the way we choose to extend coverage and finance coverage for all members of the population, what is critically important is that we make that coverage available to everyone.

Our Committee followed an important landmark report that was issued by the Institute of Medicine in 2004 titled "Insuring America's Health, Principles and Recommendations."

Our work endorsed the findings of that previous Institute of Medicine Committee, which asserted and endorsed that coverage should be universal, it should be continuous, it needs to be affordable to individuals and families, affordable and sustainable to society, and promote health and well-being through access to high quality care.

To the extent that any solution or approach is developed to this problem of large numbers of uninsured we have in our country and the severe health consequences that we find when we have looked at the medical evidence and the scientific evidence, it really needs to address these principles.

The Massachusetts' model is one important example where we are moving very close to universal coverage, and we hope to learn much more from that experience going forward.

Mr. NEAL. Thank you. Dr. Davis, would you like to comment?

Ms. DAVIS. I agree completely.

Mr. NEAL. Mr. Pickering, would you like to comment on the Massachusetts' model?

Mr. PICKERING. I agree. It seems like a great success in reducing un-insurance.

Mr. NEAL. Just a thought. The success at least initially of the plan, it largely is a reflection of the fact that the business community and the labor community as well as the consumer, they all came together to find some common ground on the way forward.

In the end, everybody accepted something they did not like.

Mr. STARK. A mandate?

Mr. NEAL. A mandate. In that instance, I think you could make the argument that after a lot of careful negotiations, a lot of pretty hot rhetoric, there still was an opportunity to go forward.

Mr. STARK. How did the costs come out in the Massachusetts' plan?

Mr. NEAL. Maybe Dr. Ayanian would give a better response to that.

Mr. STARK. If the gentleman would yield. I am sorry.

Ms. DAVIS. Mr. Kingsdale, the head of the Commonwealth Connector, made a presentation to our commission, and in fact, premiums went down for many of the people who had this greater variety of plans available through their connector.

Obviously, the total costs went up because far more people got covered than they ever thought they would reach, but if you look at the premiums, if you look at the cost per person, that was in fact in many cases lower.

Mr. NEAL. Mr. Chairman, during the year, you receive a statement and a reminder from the Department of Revenue. All you have to do is indicate if you have private insurance, where you have it.

Ms. DAVIS. That is a very important way in which a national plan could be administered, something like a 1099–G form, like they use in Massachusetts, to document they have coverage, and if you do not have coverage, get enrolled in automatically using the tax system to help facilitate that, and facilitate income related premium assistance to make premiums affordable for lower income taxpayers.

Mr. NEAL. Thank you, Mr. Chairman.

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

Mr. JOHNSON. Thank you, Mr. Chairman. I appreciate that.

My understanding was that the premiums in Massachusetts went way up and then they dropped, but not below what they were before. I question that statement.

I think all my colleagues on this side of the aisle want to have every American in the country have access, get them access to healthcare, health insurance.

However, I would also think that everyone would agree that not all health insurance is created equal.

How many people in this room would trade their current health insurance policy to enroll in a Government run program like Medicaid?

While I am at it, I might add that you have not talked about CMS at all. They have not done their job very well. They are always two or three years behind on their statistics. Probably under your Government insurance idea, they are going to have to increase their oversight.

While we can listen and talk about studies that show health insurance helps people be healthier, I think we need to talk about what kind of coverage is Congress going to decide is the type of coverage that is good enough for all Americans.

Dr. Ayanian, when the Institute of Medicine did their review of the literature, did they distinguish whether an insured person had private insurance, Medicare or Medicaid when you looked at the health outcomes?

Dr. AYANIAN. We reviewed nearly 100 studies on this topic that have been published in the last 5 to 7 years. Many of those studies included both public and privately insured people, comparing them to the uninsured.

Some studies focused particularly on the privately insured population relative to the uninsured.

What we found, and I think you raise an important point, it is not just having an insurance card but it is what that insurance card covers, what it gives you access to.

It is very important, for example, for the people with chronic conditions, what we might think of as the silent killers in the American population, high blood pressure, diabetes, or unrecognized heart disease, there are many things that medical care can do very effectively to identify health risks early on, to treat those risks and reduce the chance of costly complications like heart attacks, strokes, kidney failure.

For the most part, the research literature that we identified was comparing people who had any insurance to no insurance. There was a clear message there, that no insurance is the wrong level of coverage, and there is no doubt about that from a health perspective.

We also learned from the studies that as medical care has made more progress, in fact, we run the risk of the gap between the uninsured getting larger in terms of the health consequences. As we get better at treating depression, diabetes, and heart disease, or detecting cancer at an early stage when we can cure it, that is the kind of coverage that we need to give people access to.

In the existing studies, sometimes that coverage is available through public programs, sometimes through private programs. In either case, it is better than being without insurance at all.

Mr. JOHNSON. Thank you. I do not think we have to look very far to see there is a difference in health outcomes as you indicate based on what kind of insurance you have.

In this area alone, there have been children who have literally died from a toothache because even though they had health insurance, Medicaid, in these examples, they did not have access to a doctor.

The Medicare Program is showing similar signs. I have heard of seniors who have become eligible for the Medicare Program and cannot find a doctor who will take new Medicare patients. That is a problem across the country, I think.

I think this Committee will be doing a disservice to our constituents if we did not just talk about getting people insurance without discussing what type of insurance we are going to be offering.

Ms. Davis, The Commonwealth Fund included a Government run plan in their reform proposal; is that right?

Ms. DAVIS. The framework, it creates a national health insurance exchange. It does offer private plans and a public health insurance plan. People can keep what they have if they want to keep what they have.

Mr. JOHNSON. After your proposal is fully implemented, how many Americans would be enrolled in some sort of Government run healthcare program?

Ms. DAVIS. It depends on whether the private insurance industry continues premiums going up the way they are, but if they respond to the competition, they could hold onto market share.

In the worse case, 105 million would still have private coverage, largely sponsored by employers, either purchased directly by employers or choices that they pick once they are involved through the national health insurance plan.

Mr. JOHNSON. That is private plans. How many in Government plans?

Ms. DAVIS. The balance of the working age population, setting Medicare and Medicaid aside, about 35 percent of the population would be in a private plan, 34 percent in the public health insurance plan. That is the worse case scenario.

That assumes insurance companies do not respond to the competition, do not take advantage of some of their inherent strengths. So, roughly equal.

Mr. JOHNSON. Thank you. I do not know. I think 188 million is what you said earlier, which includes Medicare, Medicaid and SCHIP that would be insured under a Government plan.

Ms. DAVIS. About a fourth of the population are covered by Medicare and Medicaid. Some of those now covered by Medicaid actually go into the employer plans because they have premium assistance to help afford their share of the coverage. Others, of the uninsured, about 26 million would get coverage through the national health insurance exchange, have these various plans available to them, about 13 million would go into Medicaid.

Medicaid stays at about the same, going from 42 million to 49 million on balance. Medicare stays at about the same, going from about 39 million to 42 million.

The public programs, the current programs, stay about the same. Private insurance, again, this is assuming they do not respond to competition, continue business as usual, premiums continue to go up the way they have been going up, then private insurance would have about 105 million of the working population market, public plans would have just a little bit less. Private would have 109 million and the public health insurance plan would have 105 million.

Mr. JOHNSON. Okay. My time has expired. Thank you, Mr. Chairman.

Mr. STARK. Thank you, Mr. Johnson. Mr. Becerra, would you like to inquire?

Mr. BECERRA. Thank you, Mr. Chairman. Thank you for your testimony. We appreciate you helping us kick off what we hope will be a series of great hearings to try to take us to a place where we really do reform this healthcare system and make it far better.

It sounds to me like from what I am hearing more and more, that we should rest reform of our system, not someone else's system, not some other country's system, but our American healthcare system.

We should rest it on a few fundamental pillars. One is consumer choice. All of us as Americans who seek out healthcare should have a choice. If you like who you have, you like your health insurance, you should get to keep it. Maybe we will even make it cheaper for you because we will make it more efficient.

No free riders. We should all share in this responsibility, and everyone should participate. You have some that say I do not need to, I am still young and healthy. You may get hit all of a sudden by a car and all of a sudden, you are our responsibility.

Everyone should participate, no free riders. Of course, no lemons. None of us wants to find out that we are paying $5.00 for an aspirin tablet when we go to the hospital. No one should be asked to pay for anything less than quality healthcare.

Those seem to be three very fundamental pillars that we should all really seek to achieve when we talk about healthcare reform.

On the issue of choice, which also includes the issue of competition, we want to make it robust. Consumers should be the ones that choose who their doctor or provider is. It should not be the other way around.

In that regard, I would like to ask Mr. Pickering a question. You talk about this cost shifting and why we should not have a public health insurance option. Most Americans would say I want to have as many options as I can, I will select. Do not tell me I cannot have this option. Let me decide if I want that option or not.

It sounds like you are saying, no, let us not give folks that particular option. Do you believe that today we should eliminate Medicare?

Mr. PICKERING. No.

Mr. BECERRA. No. That is a public health insurance plan that seniors get today. Some 48 million seniors rely on Medicare. That is a public health insurance plan.

Do you think the Veterans' healthcare services through the Veterans' Administration that our men and women of uniform who are now veterans receive should be eliminated?

Mr. PICKERING. No.

Mr. BECERRA. That is also a public health insurance plan, is it not?

Mr. PICKERING. Yes.

Mr. BECERRA. You would want to tell veterans, you can choose, there is a private health insurance plan out here, you can choose that, or if you happen to have access to the Veterans' Administration's hospitals and doctors, you can choose that. We leave it to the veterans to decide where they go; right?

Mr. PICKERING. Yes.

Mr. BECERRA. To seniors, a senior can collect—use their money to buy a private health insurance policy today or can choose to use the Medicare Program that is available to a senior today, some 48 million seniors.

That is a choice they should get to make versus any of us; right?

Mr. PICKERING. Agreed.

Mr. BECERRA. My question is why is it okay for seniors to have all that choice, why is it okay for veterans to have that choice, but not to decide to allow all those Americans who we are trying to bring into the system so we can make it far more efficient and cost less, that they get to have that choice of deciding whether it is a private health insurance plan or some public health insurance plan that might be an option to them as well, something similar to Medicare, and Medicare for middle aged Americans.

Why would you want to limit an American's choice to a Medicare type health insurance plan?

Mr. PICKERING. It is not that I would want to limit the choice, but I fear that with the current payment structures of private plans versus a public plan, that the private plans could not compete against those rates.

Mr. BECERRA. Because of what you call the "cost shift?"

Mr. PICKERING. Could I draw one distinction? It is interesting, in the Medicare Advantage program, you have the Government plan, traditional Medicare, competing against the managed care plans. Most of those managed care plans are able to contract at approximately 100 percent of Medicare with providers because providers will accept that from Medicare patients.

It is not the same situation on the commercial side right now in the country.

Mr. BECERRA. Actually, it is interesting you would bring up the private for profit health insurance plans that participate through the Medicare Advantage program within Medicare because in a way, you have a private plan within a public health insurance program, Medicare.

Everything I have seen shows that those private for profit health insurance plans within the Medicare system actually get reimbursed at higher rates than those doctors and hospitals that are going through traditional public health insurance plan options within Medicare.

That would seem to me to actually show the cost shift going in the opposite direction of where you are saying that right now, we are shifting cost from the public sector, the public health insurance plans, to the private plans, when in fact you have the Medicare Advantage program, which actually shifts the costs from taxpayers—from the Medicare private for profit plans to the taxpayers.

I know, Mr. Chairman, my time has expired, if I could make this last point.

I should take you down to Los Angeles where I live. In my County of Los Angeles, the County hospitals take care of any number of people. Only 8 percent of the people that come in through the doors of the County hospitals in Los Angeles are covered by private for profit health insurance plans in combination with Medicare.

What I see, at least in Los Angeles, is that public health insurance plans and options are subsidizing private for profit health insurance plans that are unwilling to offer plans to the poor or the sicker Americans, and as a result, the public hospitals and these public health insurance plans are having to take the burden of the fact that the private for profit health insurance plans are not yet willing to take all these millions of Americans.

I would actually say you should take a closer look at your study. It looks to me like the cost shift is occurring in the private for profit health insurance plans, shifting costs onto the taxpayers who end up paying through these public hospitals or through programs, public health insurance programs like Medicare and Medicaid.

Thank you. I thank the Chairman for the time.

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

Mr. DOGGETT. Thank you very much, Mr. Chairman, and thanks to all our witnesses for your testimony this morning, although I believe my questions will be directed just to Dr. Davis.

We have focused this morning on the millions, but I think it is important to keep remembering the way this crisis is affecting the lives of people across the country. I was reminded about that again last week when I had communications that I received from neighbors in Austin, Texas, and the stories of two women.

One, a younger woman, Lisa Elmore, wrote me about her experiences as an employee at a small business in Austin that had several employees that were of child bearing age. Because of the high cost of premiums, the small business could not afford insurance.

The first time that she got ill on that job, she said she just toughed it out, missed some days of work, but could not afford to see a doctor. The second time, she went to several clinics because her problems were so severe, and finally was able to go to a local clinic, a wonderful facility called People's Clinic in Austin, that tries to serve the uninsured, and does a really good job at it.

She said but then the prescriptions that she had to buy, since she was uninsured, she had to pay the highest price for prescriptions. It took most of her income.

It really set her back significantly to have to delay care and then to have so much of her income taken by healthcare.

The other woman is an older woman, and her son, John Mason from Austin, wrote me about his 62 year old mother who like so many others in this terrible economy we inherited from the last Administration, lost her job after 29 years.

She had a heart attack and subsequent bypass surgery, and she has never smoked. She followed her doctor's dietary suggestions. She is without insurance to cover the problems that she has, and now if she is able this late in life to get another job, her preexisting heart condition will weigh against her.

He says it is truly sad that after three decades of service to one company, my mother is now frightened that she will no longer be insurable since she had this heart attack and a stroke, these kind of problems.

I think, Dr. Davis, that your study confirms, does it not, the urgency of addressing this issue not next year but this year as President Obama has fortunately indicated he wants to do?

Ms. DAVIS. Absolutely. President Obama said it was these kinds of stories that he heard on the campaign trail that broke his heart. I think they illustrate much of what is wrong with the current system.

When people work for a small business and that small business cannot afford to provide insurance or has to drop the coverage or has very limited coverage, the uninsured pay a higher price than anybody else for prescription drugs, for physician visits, for hospital care, because they do not get the discounts that people who are covered by either a public health insurance plan or by Medicare.

Older adults, a woman 62 years old with a heart condition, has very few affordable options available to her. She is not going to qualify for insurance on the individual market, and Mr. Becerra is

absolutely right, that is a cost shift from the private sector to the public sector.

They are the only ones that will take the disabled. They are the only ones who will take children who have developmental disabilities. The sickest tend to eventually find themselves onto Medicare or Medicaid, but for the disabled, this woman would have to wait 2 years, really two and a half years to qualify for Medicare as a disabled person.

She cannot find a plan that will take her at all, she certainly cannot find a plan at an affordable premium.

We must act and must act now.

Mr. DOGGETT. Mr. Becerra just pointed out when John Mason's mother is three years older, she will be eligible for a public option. If she were a veteran, she would be eligible for a public option.

It is difficult to understand the resistance of some people. I think it is based more on ideology than reality to providing a public alternative.

You responded to Dr. McDermott and his questions earlier, but if the goal is to contain costs and assure coverage options for everybody in America, is not having a public option, a public plan, essential for reform of our healthcare system?

Ms. DAVIS. Absolutely. It really goes right to the heart of it when you consider disabled and older adults. Let them buy into Medicare early. Eliminate the 2 year waiting period for the coverage of the disabled when they need coverage the most to treat their cancer, to recover from a heart attack.

Mr. DOGGETT. Mr. Chairman, you have had an excellent bill to do just that. Let me just say in conclusion that I think adding to what Mr. Becerra said, we have already excellent evidence on the importance of the public health option under Medicare, under Medicare Part C, we have the public option.

Under Medicare Part D, we have not had it. Medicare Part D began with many plans. It is now consolidating, the rates are going up. The Subcommittee on Health that you chair has studied the many problems with Medicare Part D.

I think it is amazing that anyone would look at the Part C experience versus the Part D experience on prescription drugs and not feel that any plan that omits the public option is just not much of a plan.

I yield back. Thank you.

Mr. STARK. Thank you. If you want to talk more about my great bills, I will yield to you for some more time.

[Laughter.]

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

Mr. LINDER. Thank you, Mr. Chairman.

Mr. Pickering, we have heard a lot about options today. Consumer choice, let the individuals make their choice, give them options and let them make their choice.

For the last 40 or 50 years in the private healthcare market, who made the choice? The consumer or their employer?

Mr. PICKERING. The employer.

Mr. LINDER. With all the choices in the world, that consumer is still going to go with what their employer decides to pay for?

Mr. PICKERING. Yes.

Mr. LINDER. Kaufman Rand has done a study on how much it cost businesses to provide healthcare for their employees. Among all firms, it is 7 to 10 percent of the payroll costs. Among smaller firms, it is 11 percent of payroll costs. Among half of all small businesses, they pay 10 percent plus of their payroll costs to provide health insurance for their employees.

This proposal suggests, that Dr. Davis has put forth, that the penalty for those companies not providing health insurance will be 7 percent of their payroll costs.

If you were the owner of that business and you are paying 10 percent now and you could get out of it for 7 percent and let the taxpayers pick it up with a Government run program, what would you do?

Mr. PICKERING. You will tend to find employers dumping their plans.

Mr. LINDER. In large numbers, right now, about 120 million people say they are satisfied, but of those 120 million people, a very small percent are going to get any choices at all; is that not correct?

Mr. PICKERING. I believe so.

Mr. LINDER. The employers are going to make that choice for them.

Mr. PICKERING. Yes.

Mr. LINDER. Dr. Davis, you said under the worse case scenario, one-third of Americans would be in private plans and two-thirds would be in Government plans. You said that is only if the private plans do not respond to competition.

They do respond to competition in the private sector today, but if you are suggesting they have to respond to competition in a Government program that is subsidized by taxpayers and mandates, how can they compete?

Ms. DAVIS. First of all, the private plan administrative costs go down through the exchange. For this small business you are talking about, now they are paying for firms under 50 employees, 22 percent in administrative overhead. For those under ten employees, 31 to 36 percent of the premium goes for administrative overhead.

If they buy even a private plan through the exchange, that will drop to 12 or 13 percent.

Mr. LINDER. Or they can go to 7 percent and dump it on the taxpayers.

Ms. DAVIS. They are required to either provide coverage——

Mr. LINDER. Let me talk about another worse case scenario.

Ms. DAVIS. Or contribute to a fund.

Mr. LINDER. Another worse case scenario was in 1965. President Johnson was proposing both Medicare and Medicaid. There were questions as to the cost of those programs down the road. He said using easily quantifiable user statistics, I can tell you that by 1990, Medicare will cost $9 billion and Medicaid will cost $1 billion, and we are a wealthy nation and we can afford that.

Those easily quantifiable user statistics disappeared when other people were paying the bills. Medicare cost about $100 billion plus and Medicaid costs about $76 billion.

How comfortable are you with these worse case scenario's and your user statistics?

Ms. DAVIS. I think one lesson from Medicare and Medicaid is that we cannot accept the delivery system the way it is now. We need to change away from fee-for-service payments that was the basis of Medicare, which was built on the private insurance methods when Medicare came in, to new methods that really reward physicians for controlling chronic conditions, new methods that reward hospitals for keeping people well after they leave the hospital.

We know what trend we are on now. That is why we cannot afford to continue. There are potential savings from these new models of payments. There are potential savings from new methods of care where people enroll with a physician practice, and really hold providers accountable for both giving good care, great outcomes, but prudent use of resources.

Mr. LINDER. What you are talking about is potential savings in a variety of areas as long as the Government has enough people to oversee the doctors and tell them how to do it, but none of that adds to the options or choices of consumers.

This program is going to drive people out of the private markets and into Government run healthcare, and you and I both know it.

I yield back, Mr. Chairman.

Mr. STARK. Thank you, Mr. Linder. Mr. Pomeroy, would you like to inquire?

Mr. POMEROY. Mr. Chairman, I would, and I thank you for the opportunity.

I used to be a state insurance commissioner. I have spent a lot of time thinking about these options. I believe that a public plan option within the exchange is a very important part of the program.

As outlined by The Commonwealth report, there is a very important relationship to whether a public plan is available within the exchange and our ability to get coverage to those who do not have it, so we can get coverage to those who do not have it, allow people to keep what they have if they want, give them another option if they want, and that is how it all hangs together.

I really do believe that failure to have the public plan is going to raise real questions about whether we can do the job we want to do in getting coverage to those who need it and do not have it.

There are some other things where I believe we could all agree, and I would hope my friends on the other side as well, and that is incentive reform within medical care delivery to improve outcomes and achieve some cost efficiencies.

Mr. Pickering, I noticed in your last line of testimony, you seem to allude to this possibly being an area of common ground. "To be successful in the long term, reform must address both the financing of care and the cost efficiency and quality of care delivered."

What do you mean by that?

Mr. PICKERING. I believe in the country today, our healthcare system is very fragmented, when you look at some of the best practice private plans out there, there are integrated delivery systems that deliver the best care for the lowest cost.

I think we need to try to model reforms to integrate the rest of our delivery system.

Mr. POMEROY. I am very proud to represent an area that has largely integrated systems, five of the six large medical centers in

the state I represent are integrated, the primary care focus. You are absolutely right.

The Medicare data is showing we are achieving high outcomes from the lowest costs in the country.

Dr. Davis, what can we do to evolve our care delivery systems along this way?

Ms. DAVIS. Absolutely. One of the main thrusts would be to encourage the growth of private integrated delivery systems. We took our commission, as you know, to North Dakota, looked at the very fine results that you are getting with many of the integrated delivery systems in North Dakota.

In fact, our estimates are that if 50 million people would enroll in these private integrated delivery systems, and they have the ability to both improve care by the way they control chronic conditions in your state and have lower costs—right now, a small business often does not offer these community health plans that are aligned with integrated delivery systems.

They can only offer one choice. Once the employer decides to take their employees into the exchange, they have access to all of these community integrated delivery systems.

Those systems do not have to invest in marketing, sales people to go out and visit all these small businesses. All of a sudden, they have access to a much broader enrollment market and they are the ones that are going to thrive in this kind of competition.

Mr. POMEROY. One question I have involves the evolution of our reimbursement system. It literally is a stunning disparity in reimbursements. I am not just talking about under payment in certain parts of the country, but just the cost for which Medicare pays for care on a per capita basis.

2005 data shows that a Medicare enrollee in Miami, Florida involved $14,000 in healthcare costs. In Rapid City, South Dakota, it was $5,000.

This is a program for the country, but basically we feel like we are surely not reaping the kind of support that goes to other parts of the country. There must be something going on that is driving this differential in cost that is not related to quality of care delivered.

In fact, from an outcome analysis, if I can make any sense of it at all, it is the more it cost, the worse it gets. The lower it cost, the better it gets.

Dr. Davis, how does Commonwealth try to address this over payment? How do we ever get this straightened out?

Ms. DAVIS. Absolutely. We have a map of the United States that shows those areas, that over 125 percent of the median in Miami shows up in red. For North Dakota, you will be pleased, all of North Dakota is white and under 105 percent of the median.

I think we have to look at things like our update policy in Medicare and look at how we reward areas that have done a good job of integrating care, controlling chronic conditions, and apply some economic pressure in these areas that as you say are two, almost three times as high in terms of Medicare spending.

Mr. POMEROY. Thank you, Mr. Chairman.

Mr. STARK. Thank you, Mr. Pomeroy. Mr. Thompson, would you like to inquire?

Mr. THOMPSON. Yes, thank you, Mr. Chairman. Thank you for holding the hearing.

I would like to thank Mr. Pickering for his comments about the VA medical system and the importance of keeping that. As a disabled war veteran, I have used their services in the past, and sometimes use them currently. It is an outstanding public system. I think everybody recognizes the importance of maintaining a public component to our delivery of healthcare.

I also recognize that we need to change the way that medical care is delivered in this country if we are ever going to get our arms around this enormous problem.

I appreciate the commitment that this Administration has made to doing just that.

Dr. Davis, your study also speaks to this. I would like to just focus on one aspect of that needed change, and that is the expansion of preventive healthcare in healthcare today.

I think it is extremely important to do a lot more to provide preventive healthcare for children, to make sure we can detect problems before they become acute and more harmful and more expensive, but also an expansion of preventive healthcare for adults.

The good example is "The Welcome to Medicare" program and how we really need to grow that and make sure folks get the screening necessary that go into that.

The IOM report talks about the access to preventive healthcare without healthcare insurance and how that is impacted.

Dr. Davis, I would like to hear what your recommendations are to ensure that we can implement a much more comprehensive preventive healthcare system here in this country.

Ms. DAVIS. Absolutely. That has to be a very key part, as Dr. Ayanian said, and research has shown investing in preventive care can have payoff's in terms of better health. It can also improve the health of older adults as they go onto Medicare.

In terms of the framework that is set forth here, there are a couple of things that try to focus on prevention. First, the public health insurance plan would lower any cost sharing for preventive services. Just as you have done with Medicare, to make sure people are getting colon cancer screening, getting breast cancer screening, the cost sharing for that would be eliminated.

The second thing it does is this emphasis on a medical home. North Carolina has shown that if you pay physician practices the medical home fee and you provide support from nurses to work with families, that you can reduce pediatric asthma hospitalization rates.

That type of intervention, the medical home investment, nurses to work with families, can work.

In addition, we include in our plan moneys that would go to state and local government to work with schools on childhood obesity, to work on smoking cessation programs, make it easier for employees to participate in those kinds of programs.

Mr. THOMPSON. Thank you. Dr. Ayanian, the IOM study talks about the effects of the un-insurance and communities that are impacted differently in regard to—I think you say small communities.

I represent a rural district. We have, I think, the same barriers to access to expensive and specialty type care.

How do we address that issue in rural and small communities, I guess?

Dr. AYANIAN. What we find based on the available research is that communities, large or small, rural or urban with high rates——

Mr. THOMPSON. Under served.

Dr. AYANIAN. Under served, basically, with high rates of un-insurance, the insured population in those communities can be adversely affected.

There are strains on the healthcare system, particularly for services that require a high initial investment, such as trauma care, cancer care, and advanced cardiac services for people with heart disease.

When those fixed costs are high and there is a lower rate of insurance in the community, the hospitals in those communities are less able to invest in the services for the whole community, both uninsured and insured. Doctors are less willing to locate to those communities.

That can play out in trauma care, for example, if a hospital is the trauma center for a region, and there is a large proportion of uninsured individuals in that area, it is harder to obtain the types of specialists, such as neurosurgeons or orthopedic surgeons that we all need when someone is in a severe motor vehicle accident, for example.

In short, people can be affected in those communities with high rates of un-insurance. We also find that insured people in survey data are less satisfied with the care they are getting.

We commissioned some research by Mark Pauly, a health economist at the University of Pennsylvania, and José Pagan at the University of Texas. Their work shows that insured people in those communities are less satisfied with their access to care and their quality of care because of these financial strains in the system.

Mr. THOMPSON. The greater the expansion of the risk pool, the better the services and the lower the costs?

Dr. AYANIAN. That is right.

Mr. THOMPSON. Thank you very much. I yield back.

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

Mr. TIBERI. Yes, Mr. Chairman.

Dr. Davis, I represent a district in central Ohio. For years, I have had hospital officials and docs complain to me about Medicare reimbursement rates, Medicaid reimbursement rates. Your plan appears to acknowledge a portion of this by increasing Medicaid reimbursement rates to the Medicare rates. Why did you do that in your plan?

Ms. DAVIS. Thank you. Obviously, Medicaid has been a problem, as we have seen from the study that Mr. Pickering has talked about. It has underpaid to the point that doctors don't participate. We think it's very important to bring Medicaid payment rates up to the Medicare level.

It is also important to address the imbalance in the Medicare Program. I think it's clear we underpay for primary care.

So, what this proposal would do would be to have a 5 percent increase in primary care, office visits, called evaluation and manage-

ment services. It would also provide a medical home fee to primary care physicians.

Nonetheless, having said that, the MedPAC study shows that nearly all doctors now participate in Medicare, and it's easier for a Medicare beneficiary to get a specialist appointment, and even——

Mr. TIBERI. Did you just acknowledge, though, that you—did you say that primary care docs are under-reimbursed for——

Ms. DAVIS. Primary care physicians are underpaid, in my view, by Medicare, as well as by commercial insurers that follow Medicare payments. But they pay a bit more than Medicare. They pay a lot more than Medicare for specialists. So, they kind of perpetuate that imbalance between primary care compensation.

Mr. TIBERI. Dr. Pickering, isn't that essentially what you have testified to, that—the fact that Medicare and Medicaid reimburse less, and therefore there is a cost shifting to help the hospitals and providers recoup some of that loss?

Mr. PICKERING. Yes, that's exactly the cost shift.

Mr. TIBERI. Can you expand on it, what's happening out there?

Mr. PICKERING. Yes. In many communities—take my hometown of Seattle—public—or, excuse me, commercial plans would pay a doctor around a, I don't know, $52, $53 conversion factor. What that means is that, for an office visit, maybe they pay $70, whereas Medicare might pay $50.

Now, different health plans will pay primary care and specialist care potentially different rates. But, across the board, commercial plans will pay both primary care and specialty care at—significantly higher than Medicare.

Now, I do want to stress it will vary, geographically. There are some areas in the country where commercial plans pay on par with——

Mr. TIBERI. So, if I run a hospital, a non-profit hospital in Columbus, Ohio, today, and essentially I am losing money on Medicaid and Medicare reimbursements—which I have been told happens—and I am making up for that with private insurance reimbursement, under—and I don't want to put words in your mouth—but under your thought or study, you're saying that if we expand public options, Government options, the more Government options crowd out the private options, the more difficulty it is going to be for the private options to continue, and the more difficulty it's going to be for hospitals and certain providers to survive.

Mr. PICKERING. That's right, that's right. As they have less people enrolled in the commercial plans that are effectively subsidizing the public plans, you have less money going to the providers. As providers face more financial pressure, they need to either become more efficient, or put an even higher burden on their remaining commercial membership.

Mr. TIBERI. Or, we could substantially increase reimbursement rates for Medicaid and Medicare to providers, hospitals, docs.

Mr. PICKERING. Yes. For example, like an FEP plan pays much higher rates than Medicare.

Mr. TIBERI. How much higher?

Mr. PICKERING. FEP pays commercial rates. It's administered by Booz and other plans around the country.

Mr. TIBERI. That would go to both hospitals and primary care and specialty docs?

Mr. PICKERING. That's correct.

Mr. TIBERI. Across the board?

Mr. PICKERING. Mm-hmm.

Mr. TIBERI. One final question across the board. I just want to see if you guys acknowledge this number. I got a U.S. Census stat that says in 2006 20 percent—nearly 20 percent—of the uninsured in America—this is a U.S. Census Bureau stat—lived in-households that had an income, IRS income limit, of $75,000 or above.

So, nearly 20 percent of the uninsured Americans lived in a household where the income was $75,000 or above. Can you comment?

Ms. DAVIS. That's roughly right. About a third have incomes below the poverty level, about another third below twice the poverty level, which, for a family, would be about $45,000. So, yes, there are about 10, or maybe it's as high as 20, who have incomes above $75,000.

But with premiums now being $15,000 a year, or $13,000, for a family, even a family with $75,000 income, they would have to pay——

Mr. TIBERI. I don't want to have a debate with you about it, I just wanted to know if you thought that number was right.

I have run out of time. Mr. Chairman, thank you.

Mr. STARK. Thank you. The Committee will recess for 45 minutes. My understanding, there are three votes. Give the witnesses a chance to stretch. We could have some more, but we will come back at 12:45.

In the meantime, if Mr. Larson would like to inquire, he can proceed.

Mr. LARSON. Thank you, Mr. Chairman. Let me thank you and the panelists for their very thoughtful presentation, and their responses to Members' questions.

My question, sir, for Dr. Karen Davis, Dr. Davis, in my state of Connecticut, we have lost more than 40,000 jobs this last year, and have already lost over 3,500 this January. When we talk about portability in healthcare——

Mr. STARK. If our guests could—if they are rushing for lunch, if they could do so quietly, so that our witnesses and the Members could hear, we would appreciate it. Thank you very much.

Mr. LARSON. Usually, when we're talking about portability, we are talking about people moving from one job to another. What are some of the ways that you would propose to make sure that someone who has lost their job, especially in this kind of economy, can maintain their insurance coverage at a rate that they can afford? The stories about COBRA coverage being just out of reach for so many begs this question.

Secondly, one of the biggest causes of bankruptcy in this country is medical debt. For many of my constituents, having a serious health condition that has led to financial ruin, even if they had health insurance, how would this new system be designed to deal with catastrophic health events, and how much of the burden of paying for catastrophic healthcare costs would fall to the Government or the private sector?

Ms. DAVIS. Well, I think your district is feeling the pain that a lot of American communities are feeling with the severe economic crisis, unemployment over 8 percent, and we don't know where it's going.

So, portability of coverage is very important. Under the PATH framework that we put forward today, eventually about 70 percent of the workforce, the employers would buy the coverage through the exchange, and so people in those kinds of employment situations could hold on to their coverage, and wouldn't have to change because they've lost their job.

But you are pointing to the affordability of the premium, and that——

Mr. LARSON. Also to the fact that if you don't—if you are unfortunate enough not to have another job, but you still have a family, and you're existing under COBRA payments, how do you envision those payments being affordable payments, as we go forward?

Ms. DAVIS. So, what this does is set a ceiling on the premium as a percent of income. So, in the lowest two tax brackets, you would never pay more than 5 percent of your income toward the premium. The rest would be provided through general tax revenues.

For the other tax brackets, it would be—10 percent of income would be the maximum you would have to pay for premiums. The benefits would be based on what Members of Congress have, the standard option Blue Cross Blue Shield, Federal employees benefit. So, it's comprehensive, doesn't make you bankrupt when you have a serious illness. So, it's both comprehensive benefits, and premium assistance that guarantees that you're not paying more than a reasonable share of your income.

Mr. LARSON. Now, for those, how does this plan envision dealing with catastrophic health occurrences, and catastrophic——

Ms. DAVIS. There is a ceiling on out-of-pocket expenses, again, modeled on the standard option Blue Cross Blue Shield. So, it's roughly $5,000 for an individual, $7,000 for a family. The deductible is $250 a person, $500 for a family, basically about 25 percent coinsurance for drugs, 10 percent for physician services, but a ceiling on out-of-pocket costs on something like $7,000 per family, and a ceiling on your premium obligation as a share of your income.

Mr. LARSON. Dr. Ayanian, I—what are some of the proposals—of your proposals—to create incentives, in terms of prevention and wellness?

Dr. AYANIAN. Our Committee reviewed the evidence on the types of preventive services that make a difference for children and adults. So, for children, for example, immunizations, basic dental care, well child screenings, preventive asthma care to keep kids healthy at home, as opposed to getting sick and ending up in emergency rooms and hospitals.

We know that those problems are much more common for children when they're uninsured. When coverage is expanded to uninsured children, their risk of those problems goes down.

Similarly, for adults, we know that there are a number of very important medical services: cancer screenings, screening for cardiovascular risk factors, and diabetes——

Mr. LARSON. Is there a cost benefit analysis to that, in terms of the direct correlation between prevention, wellness, and preventative care, and what the cost savings is, or——

Dr. AYANIAN. I can't put an exact number on it for you, but we know, from a number of studies, that when children or adults get effective preventive services, particularly those with chronic conditions, we're preventing more immediate complications. There is primary prevention for the long term, and there is secondary prevention for people who already have an established condition, such as diabetes or heart disease.

We know that when we provide them with the right preventive services, their risk of complications goes down, and their risk of the costs associated with those complications also goes down.

Mr. LARSON. Thank you, Doctor.

Mr. STARK. Mr. Blumenauer, would you like to wind up this part——

Mr. BLUMENAUER. Thank you. Thank you very much, Mr. Chairman, and I do appreciate that—the testimony that has been advanced. I think we are getting the context here that is going to be extraordinarily useful.

I have two questions that I would put. There may not be time for you to elaborate, but there seems to be a straw person reflexive challenge that is being posed to this, in terms of the threat to the private insurance system that we have now through employers.

Dr. Davis, can you just summarize the downward trajectory that this current system faces for the threats to private employer-provided insurance if we don't have a comprehensive approach like you're describing?

Ms. DAVIS. Absolutely. If we stay on our current course, we are going to go from 46 million uninsured to 61 million uninsured. Nearly all of that is the erosion of employer coverage.

So, businesses need effective competition that will slow the growth of private insurance. It's not an option, to continue on our current path.

Mr. BLUMENAUER. Okay. I appreciate your saying it again, but that is something that seems to—needs to be like a beacon. We are in a downward spiral now. The status quo is no longer the status quo. It's higher copayments, it's worse service, and it's less coverage.

Ms. DAVIS. Absolutely.

Mr. BLUMENAUER. The other straw man that seems to be established is this fear that—the comparative effectiveness research. Somehow, if we find out and document what works, that that's going to lead to unacceptable intrusion into the practice of medicine.

I am reintroducing legislation on end-of-life treatment, where right now Medicare doesn't even pay a doctor to talk to families about the choices they face. Too often, people are steered to intensive, invasive, disruptive, expensive treatment that doesn't add to the quality of life, doesn't even extend life, at great expense.

Can you speak for a moment to the benefits of our actually doing this comparative research, so that we know what we're getting into?

Dr. AYANIAN. Certainly I can address your question, as a practicing physician, myself. My colleagues and I—I practice in the Boston area, and have colleagues around the country—we want the best possible evidence to serve our patients. It's difficult for any individual physician to know what the best way is. We learn from studies of many patients, and comparing different treatments.

Personal experience of a talented physician is obviously important, but the best medical care comes from blending that clinical experience with effective evidence, scientific evidence, about what works, and the relative pros and cons of different treatment options.

So, I think, in terms of developing a more efficient and equitable healthcare system, anything we can do to improve the quality of the evidence for making medical decisions will benefit our patients.

Mr. BLUMENAUER. Mr. Chairman, I appreciate the hard work that you have been doing. I am hopeful that we are going to be able to actually do a little evidence-based research ourselves, look at what is happening to the system, look at realistic options, give people more choices, more ammunition.

I am convinced that we can meet our goals, save money, improve the quality of healthcare in this country, in a way that's entirely consistent with what the stated goals are. But somehow people talk past each other. I appreciate your courtesy.

Mr. STARK. Well, thank you. I look forward to your assistance. We will now recess. It will probably be closer to 1:00 before we get back. I will see if the staff can find the witnesses some refreshments, and we will see you in about 45 minutes.

[Recess.]

Mr. STARK. We will resume. I guess I—it would be Mr. Pascrell's turn to inquire on our list, here. If you would like, Bill? Would you like to?

Mr. PASCRELL. Thank you, Mr. Chairman. Thank you to the panel. You did an exquisite job this morning. I have some questions.

Just very briefly, Dr. Davis, where does chronic illness—you know, asthma, be it diabetes—there is 133 million Americans have at least 1 chronic disease. Where does it fit into your plan of trying to find meaningful health reform? Very briefly do this, because there is only a certain amount of time that we have.

Ms. DAVIS. I think chronic care, and improving chronic care, is really at the heart of health reform. I think it's the real potential for savings, and the real potential for better care.

Only 40 percent of people with hypertension have their hypertension detected and controlled. What we would build into the payment reform is accountability for working with patients on those conditions. They would get a medical home fee, they would get bonuses if they have a high proportion of their patients with those chronic conditions controlled. So, a——

Mr. PASCRELL. So, chronic disease is at the very heart? If we don't address that, we're not really going to get to meaningful health reform.

Ms. DAVIS. Absolutely.

Mr. PASCRELL. I'd like to—you know, we could spend a whole many hours on that subject, alone. Let me move on to my second subject, here.

The—I want to ask this question of Mr. Pickering. Some of the Members have referred to the area, already. I want to bring the example of Medicare part D into this. I find it a fascinating subject. It's providing a vital benefit to our Nation's seniors, but I still believe it has some serious flaws.

So, choice is a good thing, but we may have too much of it in part D. Each region has at least 45 plans to choose from, and as many—there is a couple of regions—one of the regions goes up to 57 plans. So, an issue brief created by the Commonwealth Fund last year found that the complexity and variation in Medicare part D may prevent people from finding the plan that best fits their needs. Please follow me.

I firmly believe that we must have a minimum set of benefits to make our promise to cover even the sickest individuals. But the term "actual equivalence" leaves a bad taste in my mouth. I can only speak for myself. So, it leaves the door open for insurance plans to tweak their benefit structures to attract a healthier mix of people, and leave behind the sick ones.

So, here is my question. In providing individuals with a choice of private insurance plans, we want to avoid some of the design flaws of Medicare part D, the prescription drug plan. How can we make a large number of plan choices transparent and easy to understand? Are there any mechanisms we can use to remove the incentives for insurance companies to cherry-pick the system? I want to ask you that question.

Mr. PICKERING. Okay. Yes, let me first address part D. It's—I do want to work on Medicare Advantage bids. The actuarial equivalent is a very real standard. It's very confusing, but it's real. Let me go to the meat of your question.

When—how do we have a large range of plans, and avoid cherry-picking? I think we need sound insurance principles. We need to avoid adverse selection.

Mr. PASCRELL. We need to avoid what?

Mr. PICKERING. Adverse selection. So, for example, now, in the individual market, if we don't have an individual mandate, and sick people can sign up for coverage, they will tend to sign up, healthy people will tend to not sign up, and then you spiral the premium. So, you know, we just need to make sure that we get our insurance principles accurate.

In terms of interpreting the benefit, you know, I think that's something that plans should always strive to offer. The Medicare part D certainly can be difficult. I know I've helped my parents get through it, and it hasn't been the easiest thing in the world, but——

Mr. PASCRELL. It hasn't been the easiest thing in the world, but I want to avoid those flaws.

How would you answer that question, Dr. Davis?

Ms. DAVIS. First of all, I think a public health insurance plan should have a defined benefit, as I suggested, modeled out. It doesn't—well, it's clear, so every—in every place people know what

it is, and know what it covers. So, having a comprehensive benefit package that's guaranteed.

The second would be information that lets people compare plans. We found, in the Medicare part C, that some of the plans were charging $40 a day for radiation treatment. Well, you didn't know you were going to—you didn't know that provision was in there, and that you could pay more in a Medicare Advantage plan, than you were paying in Medicare, itself.

So, I think some standardization is going to be required on the benefits, and clear information, so that people can compare——

Mr. PASCRELL. Finally, do you agree that the major core of debate around reform of the health system will—is going to center around the question of defined benefit?

Ms. DAVIS. I think there are many issues, but I do think having a standard benefit that applies everywhere as a minimum is important. We have suggested the standard option Blue Cross Blue Shield package and the Federal employees plan.

Mr. PASCRELL. Thank you, Mr. Chairman.

Mr. STARK. Thank you. Ms. Brown-Waite, would you like to inquire?

Ms. BROWN-WAITE. Thank you very much, Mr. Chairman. I would like to hear from all three of you on this issue. I have the highest number of people on Medicare, not just in Florida, but of any Member of Congress.

So, many of my constituents are very happy with Medicare Advantage, and they tend to, very often, be the poor seniors, the disabled. The reason why they are happy is either it pays part B for them, which is over $80 a month savings, and/or offer gym plans, silver sneakers, you name it. They have all sorts of benefits for the seniors, certainly part of any well care plan of preventative illness that we would want to have.

What do you say to the—those currently on Medicare Advantage, and well over—approaching 30 percent of my seniors are on Medicare Advantage. What do you say to them when those benefits of being on Medicare Advantage may not be there through a Government plan? Because they are saving upward—almost $90 a month, right now. So, how do you break the news to people who—my, how times have changed, people are really happy in the Medicare Advantage plans.

So, if we can start, anybody want to jump in here?

Ms. DAVIS. Well, certainly, I think we need to address the fact that Medicare benefits really aren't adequate for all Medicare beneficiaries. So, what the PATH framework does is improve Medicare benefits for all Medicare beneficiaries, again, up to this standard Blue Cross Blue Shield option, and the Federal employees plan.

So, the fact that now we have a very high deductible in Medicare for hospital services, that would be eliminated. You would get a single, consolidated deductible that was more affordable. So, improving benefits for all Medicare beneficiaries is the first step.

The second is to——

Ms. BROWN-WAITE. But, ma'am, first of all, I don't have the Federal plan. Second of all, it doesn't offer to have any kind of reimbursement for part B. In addition, you know, the wellness plan of, for example, being able to go to the Y for a senior, YMCA, use

their pool, all their exercise equipment, et cetera, and/or saving $80 a month on part B, that means a lot.

So, those benefits aren't available in the traditional Blue Cross Blue Shield plan.

Ms. DAVIS. Right. Now, we need better premium protection. So, that part B would be $100 a month, in addition. For those who buy Medigap, they might be paying over $2,000 a year for that supplemental coverage.

What this does is to say for any low-income senior, they wouldn't pay more than 5 percent of their income for their premium, for a middle-income senior, no more than 10 percent of their income for the premium.

Certainly if a plan wants to go beyond the standard benefits to include fitness incentives, and they do that on a level playingfield because they're more efficient, or they've got a more innovative way of controlling a chronic condition, then they could use those efficiencies to improve benefits.

Ms. BROWN-WAITE. Could I hear from the other members?

Mr. PICKERING. Yes. I think you have seen seniors vote with their feet. Medicare Advantage plan has had tremendous membership growth. I think plans have done a nice job of recognizing benefits that seniors want, and delivering them in an efficient manner.

One element of the program that enables them to do so are the risk-adjusted payments, such that the sicker people have a risk score, and the plan is paid based on the risk score. So, it's paid on a true expected value of that person's cost. That's—also affects a lot of dual-eligible beneficiaries, people who are eligible for both Medicaid and Medicare.

Now you ask, you know, what happens if we take those benefits away? You know, one way that plans have been delivering those additional benefits, which are great for the seniors, is that the payment rates to the plans have been higher than fee-for-service payment rates, based on MedPAC. So, it's—you know, I think it's a fair policy question. Do we want to pay that extra amount over the fee-for-service benchmarks, or do we not?

Ms. BROWN-WAITE. Well, would the question also be fair to ask, do we want to have healthy seniors, and seniors who are able to—and people on Medicare, not just seniors, but everyone on Medicare—able to save the part B premium cost? You know, that's an offset that I think that we need to address.

I can just tell you that the—and there are about—there are a lot of Members of Congress who have a high number of people on Medicare Advantage. You know, it's going to be a very, very difficult sell to say, "Oh, by the way, we're no longer going to be having the plans be able to pay part B for you and/or an exercise plan, which is going to keep you healthy and perhaps out of the hospital, and your diabetes under control, and your weight, et cetera." So, that's not going to be a real easy sell.

Mr. STARK. Thank you. Mr. Kind?

Mr. KIND. Thank you, sir [continuing]. It's good to have you back in the seat again. I want to thank the witnesses for your testimony today.

Dr. Davis, let me start with you. First of all, I want to thank you for the work that the Commonwealth Fund—to lay out a kind of

a road map on what healthcare reform should look like. I enjoyed the conversation that we shared at the White House during the fiscal responsibility summit that we both went to just a couple of weeks ago.

But let me just get back to an issue that Mr. Pomeroy raised a little bit earlier with you all. Here is my concern. You know, when we discuss healthcare reform, different people, different groups, hear different things. For some, it means getting universal coverage. For others, it means cost containment.

Here is my concern. I don't think we can do coverage without also doing cost at the same time, or it will become unaffordable very, very quickly. I think for too long—Mr. Pickering, I want you to address this issue, as well—but for too long, we have had a healthcare incentive-based system, a reimbursement system, that's been focused on quantity, instead of quality. I think that's the real dynamic that we have to change.

The golden grail of any healthcare reform is, yes, coverage, making sure everyone has access to affordable plans. But it's also improving quality and saving costs at the same time. If we can't do that working together and moving forward, it's going to be very tough to pull this off at the end of the day.

That gets me back to the geographic variation issue, where I come, too, from an area where we have had high quality of care, based on any standard of measure throughout the country, yet it's one of the most lowest reimbursed areas in the entire nation, too. I hear some of the same concerns with private payers and private plans, about the cost shifting that's going on.

But, Mr. Pickering, isn't it—your theory is that, because Medicare under-reimburses, that cost gets shifted onto the private plans, and that's why having some type of public health plan option out there is very dangerous, because, with the current payment rates, that cost is just going to continue to be shifted to private plans.

But the very premise of that is assuming that, at the end of the day, we're going to have the same payment rates, we're going to have the same type of reimburse incentives that exist today. I refuse to accept that premise, as we move forward with healthcare reform.

So, would you then agree that, if we can change the incentive, move to an outcome or performance-based, quality-based system, as opposed to the one that's based on utilization and consumption, as it is today, that that would change the dynamic, then, when it comes to private health plans, as well?

Mr. PICKERING. I think we definitely need to change the payment methodology. I think you would still have a problem of—let's say we move away from fee-for-service, and move to bundled payments.

Well, when we do that, quite often when we make a transition like that, we will do revenue neutral, right? So, in the first year——

Mr. KIND. Right.

Mr. PICKERING [continuing]. It's an amount of money to the providers.

In that scenario, then, if we had a commercial plan that was paying the provider 150 percent of Medicare to start with, they're still going to be paying Medicare, you know, 150 percent of Medicare, in the new system. So, somehow we need to figure out, if we put a public plan up against a private plan, how to level that playingfield.

Mr. KIND. Right, and I would agree with that. When I'm talking about the reimbursement, I'm not just talking about Medicare and Medicaid reimbursement, but private reimbursement, as well. Because if we're going to do this, we're all going to have to do this together. You can't have one system of reimbursement in the public sphere, and then an entirely separate one in the private sphere.

Dr. Davis, you are shaking your head.

Ms. DAVIS. Absolutely. I think it's imperative that we address coverage, quality, and cost simultaneously, and not just do one.

We need to get—move away from fee-for-service volume payment to value for what we're paying. There is nothing to trigger that in the private insurance market, unless there is this alternative of the public health insurance plan. I mean, private insurers have had the option all along to move to these methods. So, I think Medicare needs to lead.

But the main point that I want to just stress is that provider payment goes up. It goes up 73 percent over this period from 2010 to 2020. It goes up 5½ percent every year. Granted, that's lower than the 6——

Mr. KIND. But the rate of growth would be different.

Ms. DAVIS. But we eliminate uncompensated care. We eliminate underpayment by Medicaid. That's a tremendous boost——

Mr. KIND. Right.

Ms. DAVIS [continuing]. To providers. It gives them time to——

Mr. KIND. Here is the rub, and here is my additional concern. You know, in order to get to a quality-based incentive system, as opposed to quantity right now, you've got to get the HIT built out, it's got to be interoperable, you've got to do the comparative effectiveness studies. That's going to take time.

So, are we going to be getting too far out ahead with reform, dealing with coverage before the rest has a chance to catch up?

Ms. DAVIS. Well, we do have a gradual phased-in schedule for the Congress to consider.

First of all, this opened up initially the exchange and a public health insurance plan to just small firms with 100 or fewer employees, in the third year 500 employees. That really gives providers a time when they're getting extra revenue from coverage of the uninsured, Medicaid reforms, to really position themselves.

On the payment reforms, the bundled payment for hospital is also phased in gradually. It starts with just the hospital piece, then adds post-acute care, and then, eventually, in 2016, adds the physicians' inpatient services.

So, yes, we need time. But we need to get started, and we need to start now.

Mr. KIND. Great. Thank you all. Thank you, Mr. Chairman.

Mr. STARK. Ms. Berkley, would you like to inquire?

Ms. BERKLEY. Yes, I would, Mr. Chairman.

Mr. STARK. Okay.

Ms. BERKLEY. Thank you very much for staying. I am not addressing—I have some random musings, and then I have a couple of questions. Whoever would like to answer them is very welcome.

I think we have a wonderful opportunity to expand coverage, slow the growth of health expenditures, and improve quality. We have a system now that the hospitals hate, the doctors hate, and the patients hate. In addition to all of that hate, it's unsustainable. We spend a fortune in healthcare, and we don't get the best bang for the buck, certainly, in the industrialized world.

In the State of Nevada, I represent Las Vegas, where 70 percent of the state population is—we have one of the highest uninsured rates in the country. I think we're ninth highest. That doesn't give me a great feeling, to be in that position.

The state budget is in a mess, so Medicaid is kaput. The reimbursement is so low, you know, you can't make it up—you can't see a lot of patients and lose money on each patient and make it up in volume. It just doesn't work that way. So, many of my doctors just are no longer accepting Medicaid patients.

Before the cut, the physician reimbursement cut that we reversed several months ago, I had people in the medical community calling me and saying, "Look, I—if you cut this by 10 percent, I can't take any more Medicare patients. I'm not going to cut the ones I have, or stop seeing them, I just can't take any more." If I've got the highest senior—growing senior population in the United States, short of going to medical school myself so when I go home on weekends I could care for my constituents, there is no one that is going to be able to take care of them.

Now, in the interest of full disclosure, my husband is a nephrologist, my daughter is a family practitioner. She does not make enough money, and he is not real anxious to give up some of his to supplement hers. I think that's a problem, when you're coming up with how you're going to take care of the family physicians. You can't keep robbing Peter to pay Paul. It doesn't work that way.

Having said all that, we need to do something about the SGR. If we don't fix this, we have a 20 percent cut coming up, and that is impossible to lay on the doctors. We are going to need to do something about that.

The other thing is—and I said this in the library before we got started—the way we do healthcare in this country, in my opinion, is "bass ackward". We put a fortune into end-of-life care, keeping people alive with extraordinary means. We should be changing the paradigm, and putting our healthcare resources into early detection and prevention of diseases. We will keep people healthier, they will live longer, and we will save billions of dollars of taxpayers' money if we can change the paradigm.

Having said that, it makes no sense to me—and I'm just about to reintroduce legislation—let me give you an example. I have osteoporosis. My husband had a machine, a bone density machine, a DEXA machine, that I tried. That's how I discovered that I had the osteoporosis. Now I'm taking Fosamax, I'm taking hormones. I'm never going to have a straight back, but I'm not going to have the broken bones that both my grandmothers suffered, because they didn't even know they had osteoporosis.

However, the cuts—reimbursement cuts to doctors for their bone density test was cut in half. The result of that is many doctors have taken out their machine. Now, the cost of treating osteoporosis patients that break bones and have other side issues is astronomical, and this is something that we can stop with the proper early detection of the disease.

Do you think, one, what are we going to—the two questions: what are we going to do at the SGR, and what are we going to do to ensure that doctors get ample reimbursement so they can continue doing tests like the DEXA test to identify problems before they get out of hand?

Ms. DAVIS. Well, that's a great question. Certainly, as I understand it, the President is trying to address the SGR in his budget, realizing that it's really accounting gimmicks, and that we might as well be honest, that we weren't really going to be able to enforce that provision.

I think your point about osteoporosis prevention is very well taken. I just heard yesterday about Kaiser Permanente in southern California having had an aggressive osteoporosis identification and management program, having resulted in reduced broken bones. So, they've got studies that now document that effect.

So, one can do that either by rewarding integrated delivery systems that participate in a national health insurance exchange. One can do it by rewarding patients—for what proportion of their patients do they really screen for, get extra money if they do that.

I do think we are probably going to have to pit your daughter against your husband, and improve primary care compensation. On average, primary care physicians in this country make about $180,000 a year. Most of the specialists, you know, are averaging around $300,000 to $400,000 a year. That's the differential that exists.

Mr. PICKERING. May I add one thing on there? The other thing we can do on the machine, if we put the choice back in the patient's hands, as opposed to the plan level, if we let the patient choose what was valuable to them, you want to pay, you know, $20 for a copay to use the osteoporosis machine, it should be available to you. You should be able to vote with your feet, that you want that.

I think if we put pricing in plans where members are—have cost sharing that reflects price differences that providers can set, you know, a doctor can choose to be paid more with the member bearing that extra cost. So, if you want to go see that doctor, that's available to you.

Right now, the plan pays—Medicare will pay all the doctors the one set fee schedule, and then there is no consumer choice.

Mr. STARK. Thank you all. Mr. Davis, Kentucky, would you like to inquire?

Mr. DAVIS of Kentucky. Thank you, Mr. Chairman. Two things I might highlight that have not been mentioned in this dialog at all that kind of underpin where I'm going to go with my question is when we talk about qualities, or quality outcomes, I have a lot of professional experience in that arena—not in medicine, certainly, but out in industry.

But the—we have—get into this idea that somehow compensation is unjust if it is dealing with high-risk specialties.

The other area related to this is we haven't addressed liability reform, which is at the core of many of the reactive procedures that are driven by Medicare. I have lived this with my mother for a year-and-a-half of her life at the end, and saw the incredible procedures that were unnecessary that were done to her, so doctors could get paid, and also avoid liability.

But here is the problem you run into. If you go into a quality situation—and what we haven't talked about is, unlike—or not unlike what happened in New York in the 1990s, where cardiac surgeons, to be top-rated, had to turn away high-risk patients. So what you saw were—the people being downrated were those who were actually practicing their Hippocratic oath, and trying to treat people.

There are—I think some premises I want to get a little explanation on from you all, and I would appreciate that, just being a simple manufacturing guy here—but nobody remotely has mentioned the gross inefficiencies of the CMS, which runs on a 1960 system architecture. There is no way that they can implement a system for which they are not now equipped. The regional RIOs can do it at a local level, but the state can't. You know, we're dealing with high fixed costs and overhead that are imposed on the delivery system, no matter what.

Secondly, Mr. McDermott made a statement that I have to disagree with, saying that France has the highest healthcare quality in the world at less than half of the GDP contribution, or impact, than the United States does. But what France doesn't have is the R&B and exportable job creation capability and technology that we have had, nor the speed of delivery, and they have a rationed care system. I think their cancer patients would probably rather be treated in the United States, with the unlimited potential.

The concern—I think a lot of our Members here are disdaining actuarial rules. It's kind of like a pilot who decides not to trust the instruments in a storm. Eventually there is going to be a sensory illusion about the system that you're part of, and you're going to crash, which leads me to one real question here.

For the commercial sector to work, they've got to be able to market. To not market is not—it guarantees that eventually they're going to be consumed by the state which holds this, because those 61 percent of people who have private pay insurance also happen to make up more than the number of people who actually pay taxes in this country, the overwhelming majority of whom pay for their coverage.

They also underpin and subsidize the public sector healthcare delivery. That can't be denied. To say it's the inverse, as one of my colleagues suggested, doesn't fly with just simple math.

I guess this is the question that I come down to. If any of the premises that I have shared are correct in this—and virtually everything is coming just from historical fact here—how do you justify these conclusions, that going to this public system will, in fact, reduce cost?

I don't see that, because what we're actually doing is heaping a burden on—at the same time, saying we're going to compensate the providers for a quality outcome that, in many treatment modalities, is guaranteed not to happen by dealing with this high-risk aspect. I want to see how the Government can do a more efficient job at

the provision of healthcare than the private sector can, once you remove the economic incentives for individuals.

Ms. DAVIS. You know, the two strong advantages of the public health insurance plan are lower administrative costs, so——

Mr. DAVIS of Kentucky. Reclaiming my time, as somebody who has dealt with the computer systems on healthcare in the large corporate world, how do you reduce that cost without changing the CMS system itself, which is flawed?

Ms. DAVIS. Medicare doesn't advertise, it doesn't pay commissions. It doesn't pay, I grant, a profit to——

Mr. DAVIS of Kentucky. Okay. Reclaiming my time, again, you're right. They don't pay commissions, they don't pay—they don't advertise. But the one thing they do do is impose a percentage cost on the cost of operations of a medical office.

Each medical practitioner that I know of that ran an independent practice had to hire one more staff member to do HIPAA compliance when that was put into force by the CMS in April of 2003. So, no, they don't advertise, but they have imposed increased costs on the medical practices and on an exponential order of magnitude on the hospitals. Now, tell me how that reduces costs for compliance.

Ms. DAVIS. I think we do have to worry about administrative costs on physicians. We funded a study, and the biggest single cost on physicians are all the different formularies they have to deal with in private plans. They have pharmacists calling them up, saying, "Your patient is not covered for this drug, can you prescribe a different drug?"

So, there are high administrative costs. But a lot of that comes because we're not willing to standardize. If we can standardize, we can strip out a lot of that administrative cost.

Mr. DAVIS of Kentucky. Based on that, would you say that two things have to happen? Would you agree that the CMS needs to be dramatically reformed in its process, and we need to impose realistic liability protections for our providers?

Ms. DAVIS. I am very supportive of both. I think we need liability for providers. That's recommended in our plan. I think we need to give CMS the resources it needs to do the job.

Mr. DAVIS of Kentucky. Would you agree CMS could be better performed if it were downsized?

Ms. DAVIS. I think, in fact, they are understaffed. To take on the responsibilities that we need them to take on, they need to be modernized with their information systems. They need to recruit top talent. But I wouldn't do that by downsizing them.

Mr. DAVIS of Kentucky. Just as a closing statement—you don't need to reply to this—but while I would suggest that the use of modern technologies would, in fact, not require a lot of the redundant non-value-adding procedures that our providers are forced to go through, to comply with, that are generated from this end.

I think every sector of private industry has demonstrated that you can actually redirect those personnel to actual value-adding services, instead of non-value-adding compliance.

Thank you. I yield back.

Mr. STARK. Thank the gentleman. Ms. Schwartz, would you like to inquire?

Ms. SCHWARTZ. Thank you, Mr. Chairman. I appreciate this first hearing. We're going to hopefully be engaged in serious dialog about how we're going to accomplish about our—what we talked about, our dual goals here, which is to contain costs for everyone.

We have heard the President say, and we have said, that cost to the Federal Government, to families, and to businesses, both financial and personal ones, are serious and they're unsustainable. We could do better. We know we can.

I would say that we have actually made some really good progress in just the last few weeks. In the last 6 weeks, we have done more on healthcare than the last 8 years, and we should be extremely proud of that.

But what we do know is that we—and I will mention an expansion of CHIP to four million more children in this country, so what you talked about, getting children health coverage, is extremely important. Health IT, enormously important to getting the efficiencies and duplications out of the system, and being able to make sure we're more efficient. Better quality care is extremely important, and what I think you mentioned, Dr. Davis, certainly the very fragmented health system that many of us live with.

I represent a part of Philadelphia and a part of the suburbs of Philadelphia. We are extremely proud of our hospitals and our physicians. Yet, I know there are strong—well, in too many sectors of the city that lack primary care providers, lack OB/GYNs, that people are not getting the primary care they need. It's pretty inefficient. We're all paying for that.

So, the first step that—I wanted to ask you about just two things. If we were going to expand coverage, we have to contain cost, and we have to really change the incentives in our delivery system. That's the first thing.

We had already talked a bit about health IT, talked about some of the other—folks had mentioned about primary care physicians. I would like you to just elaborate a little bit on other efficiencies. How do we get more primary care physicians? It's—payment is part of it, but incentivizing them, making sure we incentivize, medical homes are more integrated, systems of care, interoperability of information is extremely important. But so is the way we manage chronic diseases, and how physicians relate to patients. You might want to mention patient responsibility in all of this, too, and the ability to do that.

If we have time—and I'm just going to just put this out there, it's a second question—is to—the fact that our insurance system now has been really quite—well, I hope that Mr. Pickering is wrong, and that our commercial insurance providers, in fact, can step up to the plate and make real changes.

I think if I was an insurance company—and I am not—I would be extremely upset and disappointed about your testimony that they are unable to respond to changes in the medical system, the efficiencies, reformulating how they reimburse, really dealing with changes that we would hope they can.

I hope you're wrong. I think that we can see a competitive private-public partnership, and I hope that we will.

But there are clear problems with coverage, and I don't think this has come up at all in this hearing yet. Waiting periods, pre-

existing condition exclusions, lack of portability of coverage I think was mentioned, just about the 2-year wait to get on a public plan for disability. This really—the increasing number of patients who have to pay out of pocket for preventative services, so they delay it, particularly in a downturned economy. They don't have the money to do that, and they wait to be able to provide—to get the kind of care they need.

So, with that, if you could just specifically—and I guess I will just start with Dr. Davis, and then I would ask you, Doctor, to talk as well about the need for delivery system reform, about the need for insurance reform, so that: we can get the coverage we need; when we get insurance it means something to people, it's useful; and that, when we have insurance coverage, there are actually providers there that can help us be able to stay healthy, stay well, and reduce the duplications and expenses that we know exist in the system.

Ms. DAVIS. Absolutely. I think we need both insurance reform and delivery system reform, and you have ticked them off.

I think the design of insurance, so that there are such high deductibles people can't afford preventative care, we've been going in the wrong direction. As you said, lack of portability. HIPAA provides some protection, but that's certain-sized firms.

We need to make sure that people can keep their coverage when they change jobs——

Ms. SCHWARTZ. So, is that Federal conditions?

Ms. DAVIS. Yes.

Ms. SCHWARTZ. We have to make some Federal rules about this, so that everyone is—actually knows—they can expect certain protections?

Ms. DAVIS. Absolutely.

Ms. SCHWARTZ. Okay.

Ms. DAVIS. That they will not be discriminated against because of their health problems.

On the delivery system reform, I think everything you've said about—primary care physicians need time to do care management, care coordination, work with patients with chronic conditions. We need to reform the payment to reward that.

Ms. SCHWARTZ. So, in other words, we should actually pay them for that?

Ms. DAVIS. Pay them for that. As well as a team approach to care—and I think doctors can't do it alone, they need to be able to hire nurses, pharmacists can play a role.

Basically, primary care works best if it's part of a larger system. Some people call it a medical neighborhood, but certainly an integrated delivery system that can provide support to those practices, provide them with IT, provide them with care redesign, make sure that those specialty referrals happen easily and smoothly. That's all part of the broader system reform.

Mr. STARK. Thank you.

Ms. SCHWARTZ. Thank you.

Mr. STARK. Mr. Davis of Illinois may inquire.

Mr. DAVIS of Illinois. Thank you very much, Mr. Chairman. Let me just say that I think, first of all, that the best and most effective way to deal with the issues we've been discussing is to have

a national health plan, one that everybody is in, and nobody is out. I think, once we do that, and make it seamless, we will find that many of the problems we're discussing will actually go away.

Let me also say it's my belief that the most effective things that we have seen that have helped provide healthcare to low-income people in this country has been Medicare and Medicaid.

It is also my belief that community health centers are the most effective instruments that we currently have to provide cost-effective quality healthcare to large numbers of low-income and poor people.

My question, actually, is to you, Dr. Davis. Would you see the expansion of this network of clinics throughout the country fitting into a plan that would increase access seriously, and thereby reduce the numbers of people who are uninsured in this country?

Ms. DAVIS. Absolutely. I think our network of community health centers is a vital care delivery system in many low-income neighborhoods. I think they need the support to upgrade their services to this level that we call a patient-centered medical home. We are funding community health centers to do exactly that, enabling them to take a team approach to care, to have services available. But it's a very important part of this, and we would certainly see in a plan, designing payment systems that reward community health centers for taking on that responsibility.

You also stressed the importance of Medicaid. We have talked a little bit about Medicaid—maybe doesn't pay as well as Medicare. But it is the safety net for our Nation's most vulnerable, sickest, poorest people, and it's vital that that program be maintained for those who are the poorest of the poor.

Mr. DAVIS of Illinois. Thank you very much. Let me ask you, Mr. Pickering, many people feel that there is a great deal of waste and inefficiency in our current healthcare delivery system.

If you had to pinpoint some of the places where some of that waste might be, where would you look?

Mr. PICKERING. I think the biggest amount of waste is in overutilization. As actuaries, we create what we call cost models, where we have a very detailed snapshot of delivery of care, breaking out inpatient hospital, outpatient hospital, various physician services. We look at utilization per thousand, average cost per service. It gives us the total cost.

What we see when we look at the best managed health plans out there, comparing them to loosely managed health plans, is a dramatic difference in utilization. That's directly a cost savings, if you can achieve that lower utilization. Usually you see quality scores correlated with the lower utilization from those organizations that are able to deliver it.

So, I think that's the biggest opportunity, is to optimize utilization.

Mr. DAVIS of Illinois. I hope I get a chance to get back to that in a second.

But let me ask you, Dr. Ayanian, obviously Massachusetts has the highest number or percentage of its population that has health insurance. Are you aware of any studies that have compared the health status of the population there, or the cost with what's being paid overall for healthcare in other places?

Dr. AYANIAN. In our Committee's work, we completed our review before some of the newer evidence was available from Massachusetts.

What we did find, though, was from a whole series of studies, and much stronger studies of what happens, for instance, when Medicaid and CHIP coverage has been expanded for children, that access to care improves, as well as some important health outcomes, like avoiding hospitalizations for asthma. Those hospitalizations are reduced among kids with asthma who were previously uninsured.

So, I think there are clear indications that bringing everybody into the insurance system and providing good preventive and primary care can avoid some of these costly complications that are not good for patients and their families, and they're not good for us as a society, and as a nation, especially when they're avoidable.

Mr. DAVIS of Illinois. Do you think that might reduce cost? I mean, we talk a great deal about cost, and we talk about cost containment. Do you think that might, in a real sense, when we get to the real bottom line, reduce costs?

Dr. AYANIAN. It's a very important question. What we strive for in healthcare is cost-effective care. Are we getting good value for the money we're spending?

There are occasions where we can prevent complications, and it may actually be cost saving. Most of the time, what we're striving for, though, is to achieve cost-effective care, meaning that, for the dollars that we're spending, we're getting good value, in terms of the health outcomes.

We know, from a series of studies, that extending insurance coverage, and covering effective primary and preventive services gets us that good value. We may have to pay a little bit more, but we get much more, in terms of a return in improved health outcomes for children that can be lifelong, and then improved health outcomes for the working-age population that can help them to be more productive and have a higher quality of life.

Mr. DAVIS of Illinois. Longer life. Thank you so much. I appreciate your answers, all of you.

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

Mr. REICHERT. Yes, sir, Mr. Chairman. Thank you. First of all, all of here on this Committee come from all different walks of life, so we come at the questions in a little bit different way. My background was in law enforcement for 33 years, and I saw a lot of things. I certainly agree with the statement that, Doctor, you made in your study, "Lacking in healthcare is hazardous to your health." I have seen it over and over and over again in my past profession.

So, I have some questions that center around the—your IOM report. It doesn't make any specific recommendations about the shape healthcare reform should have. But you recommend to the President and Congress that we need to do something now. It's urgent that we do something now.

I really have a concern—and I'm going back to someone's earlier question about waste, fraud, and abuse—and overutilization is one of the things mentioned already. How do you propose—and maybe all three of you could respond to this—to address the issue of overutilization, or waste, fraud, and abuse?

In my opinion, if we get the Government more involved, we have more waste, fraud, and abuse.

Dr. AYANIAN. From the standpoint of an effective healthcare system, the theme has already been emphasized. But I would just echo it, that coordination of care is where we can achieve greater efficiency.

So, when we have a fragmented healthcare system, when people are moving in and out of insurance, or unsure what's covered, or needing to stop in the middle of a treatment process when they reach financial barriers, that's when we have an inefficient and fragmented system.

So, in order to achieve the health benefits that our report outlines that can come with expanded coverage, that coverage has to emphasize doing what's effective and doing it in an efficient manner. We do that by having primary care and specialty care working together, by having team-based care, using nurse practitioners, nurses, nutritionists, pharmacists. We have a great deal of expertise in our healthcare system; we don't always piece it together well——

Mr. REICHERT. Just to interrupt, so coordinated care, I get that, and all three—I think all of us would agree with that.

Health IT plays into that, right? So, we've got $20 billion we want to spend in the stimulus package on health IT, but we're going to do that by September and October, and we don't have a plan. We don't even know if it's going to be interoperable, but we're going to spend $20 billion. Can anyone address that issue?

Ms. DAVIS. Well, I think it's very important that Congress has designated those funds in the American Recovery and Reinvestment Act. I think——

Mr. REICHERT. Do you think October is too early, though, to allocate those funds, those $20 billion?

Ms. DAVIS. I think it's——

Mr. REICHERT. Are we ready for that much money out there?

Ms. DAVIS. I think it is going to take that kind of investment to——

Mr. REICHERT. I do, too. But the timing——

Ms. DAVIS. But you're right, you're right about the strings——

Mr. REICHERT. Yes, ma'am. Thank you.

Ms. DAVIS. It's got to have decision support, so that physicians know what the latest evidence is, as they are prescribing a treatment, and it has to have a health information exchange network that pulls data from all the different——

Mr. REICHERT. How long do you think that might take? Could we do that in the next 10 months, 8 months?

Ms. DAVIS. I think we can set out the standards for what we want in——

Mr. REICHERT. Should we have a national standard?

Ms. DAVIS. In terms of the characteristics of the systems, I think what you've charged the office of the national coordinator for information technology, to have those standards by 2010, is a realistic goal.

I have certainly seen these systems in countries as small as Denmark, where they have 98 percent of their physicians on these systems. All of a patient's tests, hospital records, specialist consults

are all right there. They are able to do disease registries, they know their diabetic patients who are out of control, and can bring them in.

So, there are models out there that we can learn from. So, I think it's very definitely a step in the right direction.

Mr. REICHERT. I know a lot about interoperability, coming from the law enforcement world, and I know we weren't ready for some of the money that came out. I saw cities, police departments purchase systems for a million dollars, and a year later not work, and that's what I am concerned about.

I agree with you, that we need health IT, and it needs to be interoperable, and we need to be talking with each other. I also agree that it would help coordinate care, it would help eliminate some of the waste, fraud, and abuse. But I just—I feel very strongly that we don't have a system in place yet to spend that $20 billion. I am very concerned about that.

I also want to touch on, Dr. Davis, your proposal would require every American to purchase a health insurance plan. There is, for all intents and purposes, a mandate to carry car insurance in this country, but yet 16 percent of Americans don't carry car insurance.

How, when I was a cop, you know what I would do, is when a person got into an accident, I would write them a ticket for not having car insurance, or you know, in the event of another stop, I might be able to get that information and write a citation. How do you enforce that, that mandate, that every person have health insurance?

Ms. DAVIS. Some countries, again, we can learn from. Netherlands and Switzerland have a mandate. They get all but 1 percent enrolled, so they do have problems with not everyone. We can use the tax system, so people verify their insurance coverage every year, when they file their personal income taxes. It may still not catch some non-tax filers.

Certainly in Massachusetts, where they have had the individual responsibility, they have gotten the rates up to 97, 98 percent insured. So, I don't think we're actually going to get to 100, but I think we can get to 99 percent, by building on some administrative——

Mr. REICHERT. Thank you for your answer. Thank you, Mr. Chairman.

Mr. STARK. Thank you, Mr. Reichert. Mr. Davis of Alabama, would you like to inquire?

Mr. DAVIS of Alabama. Thank you. Thank you, Mr. Chairman. Let me, if I can, Dr. Davis, start with you, and ask you to react to a couple of points.

I don't, by any means, want to adopt the ideology or the theology of my friends on the other side of the aisle, who I think are skeptical at the notion of a public plan for ideological reasons. But I do want to pick up on some practical concerns they have raised that I think are actually worthy of some examination.

Let me lay out one real-world political scenario that I think is likely to happen here. Let's assume that your plan, or something like it, were to pass the Congress. There would be intense political debate around it. As a practical matter, the opposition would beat up this public plan. They would talk about it as something that

wasn't providing the highest kind of quality, something that wasn't providing the highest levels of efficiency. That would be the lines of political debate that would go in this city, and, I suspect, around the country.

So, as you lay out, and as we think about the incentive structure for someone to opt into the public plan, as opposed to opting into a private plan, I almost think that we have to factor how people are going to think about the public plan after the political debate, and after there has been a systematic effort to discredit it. That strikes me as problematic.

Would either you or Mr. Pickering like to comment on that very practical political aspect of this?

Ms. DAVIS. Well, I think we heard at this hearing that Americans want choices. They would appreciate having the choice of a public health insurance plan. Medicare is very highly rated by its beneficiaries. We have done surveys of older adults. They would like to be given the choice of buying into Medicare early.

I think our whole experience with Medicare, that, yes, physicians expressed some concern about were they going to be paid enough, and it turned out they did very well under these plans.

So, I think that people are satisfied with the quality of coverage, with their access to services through public health insurance. We have got a lot to build on. But I think what we want is the best of both, we want——

Mr. DAVIS of Alabama. Let me interrupt you for 1 second, and make sure I'm driving this point home. There has not been a public attack on Medicare for 43 years in this country. So, that's why Medicare enjoys a certain political sustainability and durability; it's not under public attack.

As a practical matter, even if this plan or something like it were to pass, it would be, I suspect, with an enormous amount of political baggage around it that doesn't exist. It's not tied around the ankles of Medicare right now. I do think we have to think about that, because I think everyone on the panel agrees that we have to have an incentive structure for a diverse group of people, in terms of their healthcare going into a public plan, so it doesn't simply become a receptacle for people who have chronic diseases, or are low-income.

I would submit that, if we do anything like this, we have to wrestle with what the public plan will look like after it's been represented, or misrepresented, in the public debate. Will it be less attractive? Will certain kinds of people be less drawn to it? Will the public debate and the advertising around it create perverse incentives for certain healthy, wealthy, affluent people to opt into a private plan? All of those are factors that I think may alter the incentive structure in ways beyond cost.

Now, there is one other factor that we would focus on. It's not just critical and important to have a level playingfield, in terms of regulations, and in terms of cost structure. I think we're also going to have to grapple with the preemption issues.

Hypothetically, if there was a Federal standard that obviously covered the public plan, and if some of these private plans were more governed by state standards, that seems to be another thing that we would have to grapple with, to make sure that you didn't

have an incentive structure for certain kinds of plans, to not participate in this consortium or network you described.

Do any of you want to speak to that issue, how we level out the preemption issues, and the whole question of Federal versus state law?

Ms. DAVIS. Well, you raise good points. But what we know isn't working, and that's the system now. So, universally, the polls show that people want change.

In Massachusetts, which moved to their system in 2006, polls are very high. People are very satisfied with what they've done there. I think it does require an ongoing education campaign, so people know what the truth is about the program. But those who now see that they have economic security, they have choices, they have good benefits, you're going to see much higher levels of satisfaction than we find today.

Mr. DAVIS of Alabama. Well, my time is up, Dr. Davis, but I would just summarize with this observation. I am not quite as sanguine as you are about comparing this to Medicare, because Medicare is an accepted, established, entrenched plan that has not come under attack in the public debate since 1965.

As a practical matter, there would be an enormously contentious political debate around this plan. Whatever we passed would already be discredited in the eyes of significant numbers of people in the country. I think, as we think through the whole incentive structure, that's a really, really big problem, how we deal with the potential baggage that would have attached to a public plan. But my time is up.

Mr. PICKERING. May I just—just one thing? You mentioned we don't want the public plan to become a dumping ground for the sick, and the private plans to become a place where the healthy go.

I definitely agree with that. I don't know if, in the plan, we have risk-based funding, like we have in Medicare Advantage where, you know, a chronically ill person who is going to use a lot of healthcare resources, their health plan gets more money for them. They don't pay more premium, but their health plan gets more money. I think you would definitely want to consider something like that, so that plans could focus on carrying for the sickest without being penalized.

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

Mr. ETHERIDGE. Thank you, Mr. Chairman. Let me thank each of you for being here. You know, we come to this place after the issue has been raised during a Presidential campaign to a high level at a time when the economy was in a different place than it is today.

I say that because, even then, the public was engaged in either one of two things. They neither had healthcare and wanted it, or what they had was so expensive, and the copays and deductibles are so high, they felt they still weren't getting the benefit of any insurance.

Well, today we find ourselves in a little different place. The economy is in a different situation. For instance, in my home state of North Carolina, they have just released the new unemployment rates today in North Carolina. Our jobless rate has now jumped to

a 26-year high of 9.7 percent. In the last month, it was—it became one of the highest top six in the country, in terms of unemployment. In the last 12 months, it is number 1 in the nation, in terms of the amount of job loss from January of 2008 to January of 2009.

I say that in context, because I think this is sort of where we are in a lot of other places. As Mr. Reichert said, from having been in education and state superintendent, and so many times we talk about children having healthcare and the need for it, and that is absolutely true, but the last time I checked, most children come from homes somewhere. If the families don't have the health insurance, it's awful hard, even when it's made available through state, local, Federal, wherever, for children to be able to engage in it, because if parents don't have it, they may not get the attention they need.

So, my question is they get hit twice. They've lost their job, and in a lot of cases now, they've lost their healthcare. We are helping in the recovery package with COBRA, but for some of these families COBRA is very difficult because they've lost their job and, in some cases, they may not have unemployment insurance.

So, Doctor, let me ask a question to you this way, because I think the issue currently—and I think we have to deal with where we are, so we can get to where we want to get to, wherever that place may be.

Can you describe to us some of the issues that individuals face when they're trying to buy a policy today in the marketplace? I think it's helpful for us to sort of be reminded of that one more time.

Dr. AYANIAN. Our report addressed a number of those issues. For example, we heard the story earlier about a 62-year-old constituent who had had a heart attack and had lost her insurance, and she was essentially counting the days until she could qualify for Medicare at age 65.

So, people with any sort of acute or chronic condition, if they aren't eligible for employer-sponsored coverage, and don't have a low-enough income to qualify for a current public program, they are really very much on their own and adrift. And if they try to buy insurance on their own in the non-group market, it may not be available to them, or may not cover the pre-existing conditions for which they most need the insurance. Or, if it is available, the premium may be so expensive that they can't afford it, that it just crowds out the rest of their income.

There are clear examples where people are losing coverage when they lose jobs, unless, for example, low-income children can qualify for the children's health insurance program. We know from previous Institute of Medicine work, that when parents and children are covered together—I think that you were referencing this—that parents use the system more effectively, both for themselves and for their children. So, there is a positive spillover effect there across the family, when the whole family is covered.

So, these are just some of the ways in which a weakening economy is going to make the health insurance crisis worse for families and people losing their jobs.

Mr. ETHERIDGE. Dr. Davis, I represent an area that is probably representative of America. We have urban and rural.

One of the real problems we face is that, as we try to address—we have in the past, I think, with Medicare Plus Choice, it became Medicare Advantage, et cetera. Insurers sort of rushed in to sign up beneficiaries, and then sort of backed out of that market when the margins really didn't—were high enough to be where they wanted to be.

In some regions of the country they have only one option in a plan, which creates some problems.

My question to you is how would the Commonwealth Plan serve rural communities, and ensure access? Because access is critical, as well as containing that cost. If you don't have access, you don't have to worry about the cost.

Ms. DAVIS. Absolutely. You couldn't be more right. One of the advantages of having the public health insurance plan is that you've got a guaranteed, secure, stable option that is available everywhere.

As you say, private insurers will move in and out of markets, depending upon whether they calculate they can make the kind of return for their shareholders they want to make. So, it's very important to have a public health insurance choice that's available, particularly in the kind of rural area that you've mentioned.

Mr. ETHERIDGE. Thank you, Mr. Chairman. I yield back.

Mr. STARK. Mr. Boustany, would you like to inquire, sir?

Dr. BOUSTANY. Thank you, Mr. Chairman. You know, as a cardiac surgeon with over 20 years experience in an academic center, public hospitals, and a very successful private practice, I would talk at length about the problems with the healthcare system, both in the private and the public sector.

My friend earlier—from Alabama—mentioned that he thought that those of us on our side have an ideological skepticism. I would submit that I have a very deep skepticism of having a Government plan competing with private plans, for a simple reason, and that is, what's in the interest of the patient, in terms of high-quality medicine?

Now, a couple of things I want to point out. One, we have a significant longstanding and extensive liability with Medicare and Medicaid, and that has to be addressed. There are no plans to do that.

So, as we look at a plan that will potentially push more people from the private sector into the public sector—and, Dr. Davis, the Lewin Group that contributed to your research has concerns that 120 million Americans would lose their current private coverage under your plan—there is a real problem here. We need to be careful with this, in the interest of real quality patient care.

Secondly, access to a doctor-patient relationship is very different than coverage. I know Dr. Ayanian knows that, as a practitioner. There is a profound difference. One of the things that is missing in all of our Government plans to a large degree right now—in Medicare, Medicaid, and SCHIP—is a difficulty in developing the doctor/patient relationship. There are access problems to the doctor, and the development of that kind of relationship, in all three of those programs. It's worse in some than others, but it's there in all of them.

One of the things that we know, in addition to this, is we've got a significant shortage of healthcare providers looming, and getting worse. Dr. Ayanian, if you would speak to Dr. John Mayer at the Brigham Hospital, a cardiac surgeon, he would be the first to tell you that half of the cardiothoracic surgery spots in the country did not fill last year. That's half of 139 training spots. If we don't have cardiac surgeons, cardiology programs go away, pulmonology programs go away, intensive care units tend to disappear.

We also, at the base, are losing our primary care and our general surgeons. Rural care is going to suffer. If we don't have the providers, we've got a problem. That's another major issue that relates to reimbursement.

Currently, the healthcare system is basically a price-controlled system across the board. Medicare rates are determined very arbitrarily. In the private sector, they are pegged at some multiple of Medicare. This is creating a severe distortion throughout the healthcare system that is hurting access to developing a doctor/patient relationship.

So, I guess my question would be that if we shift patients from the private sector into Government-run healthcare, which is going to happen, what are we going to do about the longer waiting lines, and the difficulty in gaining access to developing a doctor-patient relationship, which is the essence of quality, where prevention and screening and early detection really take place?

Dr. AYANIAN. I will speak to the importance of the healthcare provider community: the physicians, the nurses, the people on the front lines. You and I have experience in practicing ourselves, and collaborating with our colleagues. While this debate, for most of today, has been about insurance——

Mr. BOUSTANY. Coverage.

Dr. AYANIAN [continuing]. And coverage, and that's critically important, I think it's clear that the provider community—the doctors, the hospital leaders, the nursing leaders—need to be brought into this, and we need—and we have had some discussion today about not just reforming the insurance system, but reforming the delivery system. Ideally, our healthcare system works best when those two systems work together, as opposed to in opposition to each other.

So, it's clear from the work that we've done at the Institute of Medicine, that we need both pieces. We need the coverage, because without coverage it's very, very difficult to even have a chance at getting that effective doctor-patient relationship that you're highlighting——

Mr. BOUSTANY. But what I'm pointing out is that, as we work on coverage, we have to keep our eye on the ball, and make sure that the access to doctor-patient relationship is also given at least equal treatment, if not more, because some of these coverage decisions, I am fearful, are going to lead to severe access problems, which we are already seeing today in the current healthcare system.

Dr. AYANIAN. So, I think that just underscores that we need a very thoughtful approach. It can't just be expanding coverage, and then sort of into——

Mr. BOUSTANY. That is what——

Dr. AYANIAN. A system that is malfunctioning.

Mr. BOUSTANY. That's what I find missing in much of the debate we have had, and in the proposal put forth by the Commonwealth Fund. It's a very deep concern to somebody who has had extensive experience with this at the ground level.

The other thing is there was some mention of alignment of incentives, which is critically important. There are so many legal impediments to doing this in healthcare today, that this is another issue that I think needs to be addressed if we're going to actually get to that point of quality. I see that my time has expired, and I——

Mr. STARK. I thank the gentleman, and I would ask if Mr. Levin wants to inquire.

Mr. LEVIN. Thank you very much. Welcome. A long day for you.

By the way, I haven't been able to be here the entire hearing, but I did hear some discussion about IT, and I just wanted to indicate, based on what I've heard from across the board in the health field, as well as my own family's experience, I think there is a thirst for information technology. I do believe that the money that was appropriated is an absolutely essential break-through. I have confidence it will be administered effectively.

So, let me just ask, and Dr. Davis, I will start with you, and others may want to comment. There has been some—a lot of discussion about a public plan. I heard it suggested that maybe its nose may be bloodied so much that people won't be attracted to it.

I don't think that's true. I remember when I was first here, or a few years after that, there was some discussion about Medicare, and some complaint about the new system. Some seniors were not entirely happy with it. But those problems were straightened out, and the DRG turned out to be workable.

So, I really think one of the basic issues is not whether there will be public support for a public ingredient, but whether the support might sooner or later be so strong that there wouldn't be private competition, that it would become essentially the only option, or the main option that was exercised. I think we need to get right at that, because I think, underlying the arguments against this plan, in part, is the belief that what we're starting with here is what we would necessarily end up with, alone.

So, Dr. Davis, do you want to start talking about the whole relationship between the public and private sector under this plan?

Ms. DAVIS. Well, I think the most important point to stress is that nobody loses coverage. People have choices, and they only change coverage if they feel that what they're changing to is better or more affordable.

I think that having a public health insurance plan provides a challenge to change business as usual in the private insurance industry. I met last week with the executives of the Wellmark Blue Cross Blue Shield plan of Iowa and South Dakota. Their board has given them a charge to have their premium trend be equal to the consumer price index. So, they are on a journey to get premium increases down to the same as general inflation.

I think we're not suggesting something as tight as that, or as ambitious as that, but certainly a plan like that would fare very well in a national health insurance exchange, where the goal is to

slow spending to five-and-a-half percent a year, substantially above the consumer price index.

Private insurers have strengths. There are ways that they can adapt to this. First of all, they can pay according to these innovative methods, so it can't just be Medicare, Medicaid, and a public health insurance plan.

In addition, if something better comes along, they can be very quick to innovate and test that. They can modify benefit designs if there is a change that attracts individuals to their plans. They can have effective utilization management.

So, some think it means the demise of private coverage, and we will just march toward public coverage. I think we will have a healthy balance between the two, and they will both find the kinds of patients, the kinds of enrollees, that are attracted to the strengths that they bring to the table.

The main thing is to change competition in the insurance market, so that everybody is bringing value-added, they're bringing what they do best that winds up getting us better value for the dollars we're spending.

Mr. LEVIN. Well, put. I have less than a minute, too. Mr. Pickering or Dr. Ayanian, either of you want to quickly comment?

Mr. PICKERING. I will quickly comment. If it happens that the public plan is so good that everyone wants in, well, that's a good problem to have. I guess you lose the value of competition to drive future efficiency, but you have succeeded in creating a good public health plan.

Mr. LEVIN. Gee, I hope your message is heard. I think Dr. Davis indicates that the competition is likely to continue, and would be healthy for health.

Dr. Ayanian, do you want to—I have 15 seconds, less than that.

Dr. AYANIAN. Just to echo that the important issue here is to get people covered, from the Institute of Medicine's perspective, that the longer we wait to achieve that goal, the more negative health consequences that we're going to experience among Americans. And for the country as a whole, and that has a real human cost that we need to keep our eyes on, and keep as a motivation, going forward.

Mr. LEVIN. Thank you for this excellent hearing.

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

Mr. MEEK. Thank you so very much, Mr. Chairman. I thank our witnesses for being here, and monitoring the hearing. I must say, from Florida, as you know, we are almost ground zero, as it relates to healthcare. I think it will be a big part of healthcare reform.

I wanted to ask a question about doctors, and how you think we will be able to meet the demanding needs of doctors right now.

In Florida, the average age of the doctors that are there that are what you may call general docs that deal with issues, primary doctors that are dealing with a number of individuals in Florida that are getting older and older—we had physicians in teaching hospitals, to allow more of those physicians to be authorized in the future to be able to meet the growing needs of Florida.

I will tell you, in 15 years, many of our docs would have aged out. A number of them, as it relates to this healthcare reform, as we look at cost, will they be properly incentivized to be a part of

any reform that we want to—we are trying to carry out right now, and also be willing to go into the medical profession in Florida or in other parts of the country?

So, my question is mainly going down the line of how do we address the issue of the failing recruitment, I think, in getting more young doctors involved in the healthcare arena? Maybe you can answer that question.

Dr. AYANIAN. Speaking from my perspective as a physician working in a teaching hospital—and, this is not directly addressed by the Institute of Medicine report—but I think we need to recognize that physicians are attracted to the field for the opportunity to be healers. Most physicians want to focus their energy and attention on taking care of patients.

So, to the extent that health reform can reduce the administrative burdens on physicians, and free them up to focus more on what the calling of medicine is, there is, I think, an opportunity to make medicine and other health professions even more attractive to young people considering different career options.

So, that is, a perspective that I have, that if we can reduce some of the administrative hassles, and the fragmentation in the healthcare system, and develop a sense that everyone is a part of this, that all Americans are part of the system and can gain coverage, that makes the calling of medicine much more attractive.

Mr. MEEK. When we talk about docs in Florida, we talk about—of course, in your report, you talk about the quality of—improving the quality of care. Many of the docs who I've spoken to are saying, "Kendrick, I don't know who is going to come behind me to do this job under this environment."

As we look at opening this book of healthcare reform throughout the country, especially as it relates to coverage, as it relates to docs that are practicing outside of—you know, by themselves, will they be able to still be in the profession of providing medical care?

Many rural areas, not only in Florida, but throughout the country, are finding themselves in a situation where they're traveling for miles and miles and miles, because no one wants to come to their community.

So, I am—that's where I am trying to go. It's a broad question, but I'm just trying to go there, and how we can deal with it as a Committee, because sometimes we may lift the hood of a car, and may not necessarily twist a sparkplug the way it's supposed to be twisted to get, you know, the kind of fire you need to start the engine.

So, that's a concern, and probably will be a—some dialog, because when you start talking about first controlling costs, and then trying to improve healthcare, you have to think about those that are in the healthcare profession, if they are going to be able to meet the requirements, or the threshold that we call ourselves, you know, reforming on behalf of the many.

Insurance is another issue for many doctors, and something that we have been trying to address.

So, I'm just trying to figure that out, because I feel that we have a lot of folks that are finding areas, and in this report, how we can do it. But those professionals that are there, especially the docs, it's

important. We know nurses, shortages and all of that, but how do we incentivize them?

Dr. AYANIAN. Well, and our report speaks directly to this, in terms of spillover effects.

Mr. MEEK. Yes.

Dr. AYANIAN. So, communities that have high rates of uninsurance are less able to attract physicians, and less able to attract high-quality providers to their communities, or to retain the ones that they already have. When healthcare systems or hospitals look to make investments, it's less attractive to them to make those investments in communities where there are high rates of charity care, and uninsured patients who may just not be able to seek care when they need it, and use those services to their benefit.

So, clearly, there are these spillover effects that we could use in a positive direction, if we raised rates of insurance. Communities that currently have high rates of uninsurance would be better positioned to attract and retain the healthcare professionals and the medical services that they need.

Mr. MEEK. Thank you so very much. Looking forward to working with you. Thank you, Mr. Chairman.

Mr. STARK. Mr. Roskam. Finally, sir, your patience and—thank you for—would you like to inquire?

Mr. ROSKAM. Yes, sir.

Mr. STARK. Be our wrap-up?

Mr. ROSKAM. Thank you, Mr. Chairman.

Mr. STARK. Thank you.

Mr. ROSKAM. To all the witnesses, thank you very much. It's clear to me that you are thoughtful people that are taking on a very serious, complicated issue. I, for one—and I know I speak, I think, for everyone—really appreciate the depth of thought that you have given to this.

You know, I was reflecting, Dr. Davis, in your conversation with the gentleman from Kentucky a couple of minutes ago. You talked about the liability reform side of things.

We had OMB director Peter Orszag here last week, who shared with us a story of his own personal experience. It was kind of interesting. It's not often that people come before a House Committee and disclose medical information, but he said that he was a runner, and had recently had some sort of an episode with his leg or his knee, went to the physician, and the physician said, "Yes, there is something going on, and let's do an x-ray." The x-ray came back positive.

My memory is that Director Orszag sort of resisted the physician's next line of diagnosis, which was an MRI. The director said, "Well, what is that going to show me?" According to him, the physician said, "Nothing, really, but it's kind of what we do." The director was a little bit proud of himself, I must say, and he said, "Well, I don't want that test. I will be okay," and off he goes.

I thought about that a little bit, and I thought, you know, that's great. But what if it hadn't worked out well, right? What if the director had actually had some subsequent injury that got worse and worse and worse? You know, memory may fade about what that visit was actually like.

So, I got to thinking, what would it be like if Marcus Welby, MD, was Dr. Orszag's physician, and it didn't work out well, and Dr. Orszag filed a malpractice case against Dr. Welby? I think this is a couple of lines in a cross examination that I would do, if I was the plaintiff's lawyer against Dr. Welby.

You can just imagine Marcus Welby on the stand, and you would say, "Dr. Welby, Peter Orszag was your patient. Isn't that right?" "Yes." "He came in, complaining of problems with his knee, isn't that right?" "Yes." "They were enough complaints, Dr. Welby, that you thought it was wise to get an x-ray, correct?" "Yes." "There were positive indications of trauma, isn't that right, Dr. Welby?" "Yes, there were."

"Your first instinct was to order him an MRI, isn't that right, Doctor?" "Yes." "The reason it was your first instinct, Doctor, is because you have had the training, and it's the standard of care for reasonable and prudent physicians who are in your ordinary area of practice, isn't that right?" "Yes. But he talked me out of it."

"Well, Dr. Welby, Peter Orszag never went to medical school, right?" "Right." "He never had any residency training, correct? He has never seen a patient. He has never read the medical literature. So, you let yourself be talked out of a reasonable and prudent"—you see where I'm going with this? Okay.

So, Dr. Davis, when you said that you were in favor of liability reform, I heartened a little, and I thought, oh great, you know, that's sort of an unconventional thing, coming from a Majority witness. I read the liability that you're proposing, and it's really not what the normal conversation about medical liability is.

In other words, what you are doing is recrafting, in your words, "enterprise liability to create an interlocking liability relationship between physicians and other entities," presumably hospitals and so forth. But you're not really—I mean, this plan is silent as to the duplication of testing, the defense of medicine that is sort of inherent in things. I just think it's important.

Would you acknowledge that defensive medicine is driving costs up, and that that is something that has to be dealt with? Or—and just tell me if it's true—is the orthodoxy, from your philosophical point of view, is it impossible to contemplate that caps on non-economic damages makes sense in a system, when we're trying to control costs?

Ms. DAVIS. Yes. Truthfully, I have never seen a good study on defensive medicine. People toss out numbers—a billion dollars—but when you look into them, the good data aren't there.

What I would recommend, and what we're funding to evaluate in the State of Washington, was legislation that gave protection to physicians in liability cases if they had systematically given their patients what is called shared decisionmaking, which is not just some advice that Dr. Orszag got, but, say, a video that explains very carefully the risk and benefits of getting surgery, not getting surgery, getting an MRI, not getting an MRI.

If the physician has the patient be educated about their treatment options, the risks and benefits, then they are protected in liability situations, because they have at least informed the patient, the patient decided they didn't want the surgery, they didn't want that test.

So, we are funding an evaluation of the effect of that on quality, on outcomes, on cost. But I think that is a very intriguing way—I certainly would favor that over something very crude, like caps on damages for pain and suffering.

Mr. ROSKAM. My time is expired, but I am interested in following up with you, particularly about the definition of—well, the nature of that protection, from a liability point of view, because, as you know, the devil is in the details on that. But thank you for your testimony today. Thank you, Mr. Chairman.

Mr. STARK. I thank the gentleman. I would just point out that, in California, when we did cap it, they didn't lower the premiums to the doctors. The insurance companies charged more, but there was no real savings to the docs. So, a lot of that is how these caps are carried out.

Mr. Camp.

Mr. CAMP. I would just say, first of all, thank you all for being here. I think one of the concerns that many of us have with a Government option competing against private plans is that the private plans would all be required to meet the criteria set forth in the Government option, but wouldn't have the subsidy of the Government option. Therefore, over time, there wouldn't be any competition.

I mean, there are no private plans for people over 65 for a reason. They can't do it. Yet, we know Medicare isn't always adequate, because 42 percent of seniors have Medigap insurance.

The other concern is, I think, one that—the Government plan causes private plans to charge more. As more people would be eroding off private insurance and into the Government program, because there is cost shifting—and we have all agreed, at least certainly in Medicaid we can agree there is cost shifting, and there are seniors on Medicaid, and physicians certainly have that issue as well—then that further erodes, again, private insurance.

For this—for us to really continue to have people have the insurance, that they not lose what they have, we cannot see the erosion of the private side.

Now, I don't really see a way around that, frankly. Maybe it is that—and I guess I would like to hear you comment on that particular part—and maybe it is that the Government sets some basic criteria for plans, as opposed to being in the insurance business themselves, for those that are not on Medicare or Medicaid.

I guess I would like to hear any comments that you might have on that. Anybody?

Ms. DAVIS. It's late——

Mr. CAMP. Yes, and thank you for all of the time you have spent this afternoon.

Ms. DAVIS. It is late in the afternoon for an economic theory on cost shifting. What I use as a test is what does a payer pay enough to get the providers to participate? What Medicare pays is enough to get hospitals to participate. It's enough to get nearly all doctors to participate. It's not enough to get them to participate in Medicaid. So, that, to me, is a problem. I am comfortable with that kind of evidence.

I personally don't think there is a strong empirical database that says if Medicare pays a lot more, if we pay for the uninsured, if

we raise rates for Medicaid, that commercial insurers will cut rates, or that providers will be happy taking less money, because now they're getting a lot more money from Medicaid patients and from uninsured patients.

But if you believe it, then private premiums should come down, not go up, because there is a huge infusion of funds for covering the uninsured, you know, $100 billion, and a huge infusion of funds for bringing Medicaid up to at least Medicare level.

Mr. CAMP. We have seen premiums go down in part D from where they were projected to be.

Ms. DAVIS. Yes. So, unfortunately, in economics we never know what would have been the case if we hadn't done it, but you're right——

Mr. CAMP. We had a potential amendment that the premium should be $35. Clearly, you can get a Medicare part D plan for much less than a $35 premium. So, that would have been the wrong approach.

Ms. DAVIS. Right. My friends who are actuaries are very good at extrapolating trends. They sometimes miss turning points. Prescription drugs peaked at about the time the Medicare prescription drug law came in. So, they were projecting part D plans on the basis of that upward trend.

So, whether they overestimated what the premium would be, and it came in lower, or whether it was the market working, I think they will never be able to——

Mr. CAMP. Well, and some of that is the, you know, more extensive use of generics. I understand that. It's not all competition. In a sense it is, but there are other alternatives that have helped contribute to that. I will freely admit that.

Ms. DAVIS. But I think the basic argument is that private plans should be able to participate with a public health insurance plan that pays fair rates, that they can adopt those rates if they want to in private plans, they can do something better than that if they want to, they can use all the other tools that are available to them that are unlikely to be adopted by a public health insurance plan, like selective networks, like utilization reviews, like benefit designs.

So, certainly I think the worst case scenario is what you see in this report, that they just keep on charging what they're charging. But, even with that, they would still have over 100 million who are privately insured. Plus, they would have the business of paying the claims on all of those people covered through the public health insurance plan, just as they pay the claims under the Medicare Program.

Mr. STARK. If everybody has inquired, I want to, first of all, ask the witnesses to raise their right hand and take a pledge that they won't tell any future witnesses how long you have to sit there on those hard chairs when you're a witness, but to thank all three of you for participating with us today.

I think it has been a useful hearing, and I really thank you for your patience, your indulgence. I have enjoyed working with all of you. I hope we can have you back. Thank you very much, and——

Chairman RANGEL. Hold it.

Mr. STARK. Mr. Chairman?

Chairman RANGEL. Pete had an idea that I hope might be receptive to you, and that is that if we get close to resolving this issue, whether we could have an informal roundtable without the mics and the testimony, including Republicans, to be able to, not in 5 minutes, but to get normal conversations about problems that all of you know that we're going to have.

You, Karen, you have dedicated your life to this, and so we're going to staple you to the bill, and just send it to the floor. But we really want to thank you for sticking with us today. This is the first, I am convinced that we are going to work this out. Thank you so much.

[Whereupon, at 2:41 p.m., the hearing was adjourned.]

[Submissions for the Record follow:]

Statement of America Health Care Association and National Center for Assisted Living

On behalf of the millions of caring employees within the long term care sector, and the millions of Americans who rely on these compassionate caregivers for essential care and services, the American Health Care Association and National Center for Assisted Living (AHCA/NCAL), commend Chairman Charles Rangel (D–NY) and Ranking Member Dave Camp (R–MI) and the members of this committee for today's hearing on health reform in the 21st Century. As you consider expert testimony and review options regarding the reforms our nation must implement in order to expand coverage, improve quality and control cots, we ask that you keep one fact in mind—the majority of Americans will require long term care services at some point in their lives, which is why any national health reform plan must address long term care.

The long term care sector is a significant contributor to the economic health of communities nationwide, and its stability is vital to stimulate economic growth, especially as the demand for long term care services continues to grow.

Presently, long term care accounts for 1.1 percent of the nation's Gross Domestic Product (GDP)—$153.8 billion annually—with substantial economic impact in nearly every community across the country. With long term care facilities contributing to the employment of more than 4.4 million individuals, the long term care sector represents one of the few growth areas in the U.S. economy. As a major driver of economic activity, the sector further supports more than $160 billion annually in labor income, and generated $56 billion in tax revenue in 2007 alone.

Long Term Care—A Crucial Component of Healthcare Reform

Americans are living longer and our nation's aging population is growing. Each year, more than 3 million Americans are cared for one of the nearly 16,000 nursing facilities in the United States with nearly 80 percent relying on Medicare or Medicaid to pay for the care they need. Millions more of America's seniors depend upon care and services offered by assisted living communities or in their own homes. The demand for this kind of care is projected to more than double with as many as 9.3 million older Americans expected to rely on paid long term care services every year—either in a nursing facility or with paid home care—by 2040.

Given this growing demand, it is imperative that all of us—Government, providers, and consumers—work together to ensure that America's healthcare system can both meet the care needs of our frail and elderly while preserving individual choice, and be cost-effective and sustainable when demand for long term care and services will dramatically increase in the coming years. Nearly two-thirds of frail, elderly, and disabled residents who require nursing facility care—about a million individuals on any given day—rely on Medicaid to pay for the care they need. Another 115,000 assisted living residents have their care services paid through Medicaid waivers. Yet, many states are finding it difficult to keep pace with those needs as Medicaid spending often consumes the largest share of a state's budget.

Medicaid is the single largest purchaser of nursing home and other long term care services, a fact of great concern as future growth could mean state Medicaid programs may not be able to meet the care needs of patients in the years ahead. In 2004, nearly 1.7 million individuals relied on Medicaid to cover their nursing facility care. That year, Medicaid payments for nursing facility services exceeded $47 billion, which falls an estimated $4.6 billion shy of the actual cost of providing that care. Such disparity highlights the ongoing struggle that exists for Federal and state

Governments to commit adequate resources to meet today's needs and tomorrow's expectations.

Home and community-based services (HCBS) address the long term care needs of millions of Americans annually. Certainly, we believe that individual choice in the type and setting of long term care and services must be preserved, to include the availability of HCBS for all consumers. In fact, HCBS and facility-based long term care should be complementary to one another, as both fulfill unique needs for the consumer. Our concern is not about expanding the HCBS option to all Medicaid beneficiaries who meet the requirements for receiving facility-based care, but rather that such an expansion would come at a significant cost for state and Federal Governments that can ill-afford it. The Congressional Budget Office's *Budget Options* that was released in December 2008 analyzed this very proposal stating that, "this option would increase Medicaid spending by approximately $20 billion over the 2010–2014 periods and by about $90 billion over the 2010–2019 periods. That estimate incorporates a reduction in nursing home spending as a result of a modest decline—compared with current law—in the number of Medicaid beneficiaries who receive care in nursing homes and a subsequent increase in the number of individuals receiving HCBS." In short, according to CBO, expansion of HCBS would further contribute to the financial crisis facing the entire long term care sector and our nation at this time.

Person-Focused, Cost-Effective Reform Proposal

In an effort to bring thoughtful ideas and potential solutions to the table, AHCA/NCAL and the Alliance for Quality Nursing Care have engaged Avalere Health to develop a comprehensive healthcare reform plan. Our proposal addresses the need for change—both in the financing and delivery of long term and post-acute care. Highlights of our proposal include replacing the current patchwork of financing with a voluntary Federal system; developing a new, Federal, catastrophic long term care benefit; enhancing private long term care financing; and streamlining our post-acute care delivery system. We believe that our plan would provide a single, unified method for maximizing individual preferences and program value, which ensures people are cared for in the most clinically appropriate, high-quality setting.

In the coming weeks, Avalere Health will release an updated long term and post-acute care financing and coverage reform model that expands upon our existing proposal and includes conservative cost-estimates that illustrate how this comprehensive reform plan would provide budgetary savings over time. We look forward to sharing that update with Chairman Rangel, Ranking Member Camp, and the members of this committee.

Quality—AHCA/NCAL's First Priority

Long before the words quality and transparency were the catch words of the Federal Government and their oversight of healthcare, they were truly the compass for AHCA/NCAL and our member facilities.

We have been working diligently to change the debate regarding long term 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 which seek to enhance the overall performance and excellence of the entire long term care sector. While keeping patients and their care needs at the center of our collective efforts, we keep challenging ourselves to do better, and enhance quality.

Quality & Outcomes Are Improving

The Online Survey, Certification and Reporting (OSCAR) data tracked by the Centers for Medicare and Medicaid Services (CMS) clearly points to improvements in patient outcomes, increases in overall direct care staffing levels, and significant decreases in quality of care survey deficiencies in our nation's skilled nursing facilities.

A few examples which highlight some of the positive trends in nursing facility care according to data tracked by CMS:

- Nationally, direct care staffing levels (which include all levels of nursing care: Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Certified Nursing Assistants (CNAs)) have increased 8.7 percent between 2000 and 2007—from 3.12 hours per patient day in 2000 to 3.39 hours in 2007;

- The Quality Measure[1] tracking pain for long term stay residents vastly improved from a rate of 10.7 percent in 2002 to 4.6 percent in 2007—more than a 50 percent decrease;
- The Quality Measure tracking the use of physical restraints for long stay residents dropped from 9.7 percent in 2002 to 5.6 percent in 2007;
- The Quality Measure tracking pressure ulcers for post-acute skilled nursing facility patients (many of whom are admitted to the nursing facility with a pre-existing pressure ulcer) improved by 23 percent over the course of four years, from 20.4 percent in 2003 to 15.8 percent in 2007; and
- Substandard Quality of Care Citations as tracked by CMS surveys were reduced by 30 percent in five years—from 4.4 percent in 2001 to 3.1 percent in 2006.
- In January 2006, the Government Accountability Office stated that from 1999–2005 there was a nearly 50 percent decrease in the "proportion of nursing homes with serious quality problems."

Satisfaction of patients and family members is a critical measure of quality. AHCA has recognized this vital link between satisfaction and performance, and has urged facilities to conduct such assessments for more than a decade. In recent years, we have encouraged facilities to use a nationally-recognized company, *My InnerView*, to conduct consumer and staff satisfaction surveys to establish a national database for benchmarking and trend analysis. Last year's independent survey of nursing home patients and their families indicates that a vast majority (82%) of consumers nationwide are very satisfied with the care provided at our nation's nursing homes and would rate the care as either good or excellent.

The long term care sector remain committed to sustaining—and building upon—these quality improvements for the future.

Culture of Cooperation—Leading to Continued Improvement

Positive trends related to quality are also evidenced by profession-based initiatives including Quality First and the Advancing Excellence in America's Nursing Homes campaign—both of which are having a significant impact on the quality of care and quality of life for the frail, elderly and disabled citizens who require nursing facility 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. In December 2007, the Commission released its final report which addressed four critical components of long term care—quality, workforce, information technology & financing. We encourage Congress to take the recommendations of this commission under consideration—and further investigate their feasibility.

Quality First and other initiatives have been recognized by former Secretary of Health & Human Services Tommy Thompson, by former Administrator of CMS Dr. Mark McClellan, and by former CMS Acting Administrator Leslie Norwalk when she stated in a 2007 column she wrote for Provider magazine: "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 the Advancing Excellence in America's Nursing Homes campaign—a coordinated initiative among providers, caregivers, consumers, Government and others that promote quality around eight measurable goals. This campaign takes a step further than previous initiatives. It not only measures outcomes, but it establishes numerical targets and benchmarks. It 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 are improving in the more than 7,000 participating facilities. Since the onset of the campaign, there has been progress among participants in reducing the incidence of pressure

[1] **Quality Measures** track nursing facility residents who have and are at risk for specific functional problems needing further evaluation. Improvements in these measures indicate positive trends in patient outcomes, but it is important to clarify that the quality measures do not reflect a percentage of the entire population, rather the percentage of those who are at risk and have the condition.

ulcers in nursing homes, reducing use of physical restraints, managing pain for long term nursing home residents, and managing pain for short stay, post-acute nursing home residents. Our association is diligently working to increase the number of facilities that actively participate in this program and embrace the concepts embodied in the *Advancing Excellence in America's Nursing Homes* campaign.

Reforming an Oversight System to Reward and Encourage Quality

As well as including long term care in any dialogue addressing national healthcare reform, if we are truly going to be able to create a high performing long term care system, Congress must address regulatory reform. Today's regulatory and oversight system does little to recognize or reward quality outcomes. In fact, it defines "success" and quality in a context that is often measured by the level of fines levied and the violations tallied—not by the quality of care, or quality of life, as was Congress' original intent in implementing the Nursing Home Reform Act.

In fact, a January 2006 GAO report on nursing home oversight indicates that the nation's Survey and Enforcement System for nursing homes is consistently inconsistent, with significant variations from state to state. AHCA and our members have long maintained that a one-dimensional, punitive approach does not get to the overall goal of achieving quality care.

We believe that achieving a sustained level of quality care will only be fully realized when there is a collaborative effort to recognize and implement improved healthcare technologies and best clinical practices that are designed to improve and enhance patient outcomes. This type of culture change is essential to appropriately address the needs of a growing and changing patient population and a shrinking pool of caregivers.

We believe that such a reformed, fair, and effective survey process should embody three guiding principles:

- Surveys should be fair, accurate, and consistent;
- Surveys should protect the health and safety of residents; and
- Surveys should focus on areas requiring improvement.

Today, we know far more about promoting quality, and we have better tools with which to measure it than we did twenty years ago when the *Nursing Home Reform Act* was enacted. 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.

The fact is healthcare reform has been delayed—and long term care has been left on the sidelines—for far too long. Now is the time to change that fact. As you and your colleagues in Congress and the Administration take on the tough task of healthcare reform, the American Health Care Association and National Center for Assisted Living stand ready to work with you to achieve person-centered, cost-effective, and sustainable long term care that is part of our nation's overall healthcare system.

Statement of American Academy of Physician Assistants

Physician assistants (PAs) are an important part of the solution to the health care workforce shortage.

- The physician assistant profession was created barely 40 years ago in response to health care workforce shortage issues very similar to those being forecast today.
- PAs represent one of the fastest growing health professions. Today, there are nearly 75,000 PAs in clinical practice; 40 percent (30,000) practice primary care medicine.
- The number of PAs practicing as part of a physician-PA team will soon exceed 100,000. We believe this to be a strong indication of the utility and attractiveness of such a young profession.
- The educational pipeline for physician assistants is shorter than for physicians. Graduate PAs can be in the field in less than three years.
- Accredited PA programs in universities and academic health centers produce close to 6000 graduates a year.
- Studies show that in a primary care setting, PAs can execute at least 80 percent of the responsibilities of a physician with no diminution of quality and equivalent patient care satisfaction.

- By virtue of PA education in primary care and the ability of PAs to work in all medical and surgical specialties, PAs expand access to care in medically underserved rural and urban communities.
- By design, the physician assistant profession extends the reach of medicine and the promise of health to the most remote and in-need communities of our nation.

In addition to the need to produce more primary care physicians, it is critical that Congress support expansion of PA programs as they develop strategies for addressing health care workforce challenges.

- Funds should be made available to PA educational programs to increase the PA workforce, which in turn, will extend physicians' ability to provide.
- The Title VII, Public Health Service Act's, Health Professions Program is successful in training health care professionals for practice in medically underserved communities. Funding for PA educational programs is woefully underfunded and must be increased.
- The single largest barrier to PA educational programs educating more PAs is a lack of clinical training sites. Attention must be directed to investing in the number of these sites, including loan repayment for preceptors in primary care medical practices and/or the increased use of VA facilities as clinical training sites for PA educational programs.
- Funds must be made available to increase the number of faculty at PA educational programs. Eligible PA students are being turned away because of the lack of faculty and clinical sites.
- Faculty loan repayment, including funding to attract faculty from diverse backgrounds, is also critical for PA educational programs.
- Federally supported student loans and increased opportunities through the National Health Service Corps are key to attracting PA students and clinicians to primary care.
- Graduate medical education funding should be used to support the educational preparation of physician assistants in hospitals and outpatient, community-based settings.

Physician assistants are key to health care reform. However, to be fully utilized, current barriers to care that exist in Federal law must be addressed.

- The Medicare statute must be amended to allow PAs to order home health, hospice, and skilled nursing facility care, as welled to provide hospice care for Medicare beneficiaries.
- Medicaid should be updated to require states to reimburse all covered services provided by PAs under the fee-for-service plan. Additionally, Medicaid should recognize PAs as primary care case managers through managed care plans.
- The Federal Employee Compensation Act needs to be updated to allow PAs to diagnose and treat Federal employees who are injured on the job.

Physician assistants must be fully integrated into new models of care, such as the primary care medical home and chronic care coordination.

- Their orientation to team practice, their broad medical education, and orientation toward primary care make PAs a perfect addition to the management of patients in a primary care medical home, offering continuity, comprehensiveness, and coordination of care. In many rural communities, a PA is the only health professional available and is the primary care medical home.
- Likewise, PAs provide medical care to elderly populations and manage chronic medical conditions. PAs must be recognized in chronic care medical management and must be allowed to develop treatment plans for patients with multiple chronic care needs.
- Unless PAs are fully integrated into the primary care medical home and chronic care management models, health care reform is likely to pose new, unintended barriers to care for patients treated by PAs.

Additionally, the AAPA believes that a long range solution to the Medicare physician payment system must be part of health care reform.

On behalf of the nearly 75,000 clinically practicing physician assistants (PAs) represented by the American Academy of Physician Assistants (AAPA), thank you for the opportunity to submit written testimony for the March 11 Hearing Record of the Ways & Means Committee on Health Care Reform.

AAPA Principles for Health Care Reform

AAPA has a longstanding history of support for universal health care coverage. Among the Academy's key principles for health care reform

- The AAPA believes the primary goal of a comprehensive health care system reform is to ensure access to quality, affordable, and cost efficient health care for all residents of the United States.
- The AAPA supports a health care system that will provide basic services to all residents.
- The AAPA supports health care that is delivered by qualified providers in physician-directed teams.
- The AAPA supports reform that confronts the limits of care and resources.
- The AAPA believes that fair and comprehensive reform of the medical liability insurance system is needed.
- The AAPA endorses system reform that enhances the relationship between the patient and the clinician.

Physician Assistants

Physician assistants are licensed health professionals, or in the case of those employed by the Federal Government, credentialed health professionals, who

- practice medicine as a team with their supervising physicians
- exercise autonomy in medical decision making
- provide a comprehensive range of diagnostic and therapeutic services, including performing physical exams, taking patient histories, ordering and interpreting

Laboratory tests, diagnosing and treating illnesses, assisting in surgery, writing prescriptions, and providing patient education and counseling

- may also work in educational, research, and administrative settings.

PAs always work with physicians. However, this does not mean that the physician is necessarily on site, nor does it suggest that PAs do not make autonomous medical decisions. PAs employed by the State Department, for example, may work with a physician who is a continent away and available for consultation by telecommunication.

PAs are located in almost all health care settings and in every medical and surgical specialty. Nineteen percent of all PAs practice in non-metropolitan areas where they may be the only full-time providers of care (state laws stipulate the conditions for remote supervision by a physician). Approximately 41 percent of PAs work in urban and inner city areas. Approximately 44 percent of PAs are in primary care. Nearly one-quarter of clinically practicing PAs practice in surgical specialties. Roughly 80 percent of PAs practice in outpatient settings.

PAs are covered providers within Medicare, Medicaid, Tri-Care, and most private insurance plans. Additionally, PAs are employed by the Federal Government to provide medical care, including the Department of Defense, the Department of Veterans Affairs, the Public and Indian Health Services, the State Department, and the Peace Corps.

AAPA estimates that in 2008, over 257 patient visits were made to PAs and approximately 332 million medications were written by PAs.

Overview of Physician Assistant Education

Physician assistant programs provide students with a primary care education that prepares them to practice medicine with physician supervision. PA programs are located at schools of medicine or health sciences, universities, teaching hospitals, and the Armed Services. All PA educational programs are accredited by the Accreditation Review Commission on Education for the Physician Assistant, an organization composed of representatives from national physician groups and PAs.

The average PA program is 26 months and is characterized by a rigorous, competency-based curriculum with both didactic and clinical components. The first phase of the program consists of intensive classroom and laboratory study, providing students with an in-depth understanding of the medical sciences. More than 400 hours in classroom and laboratory instruction are devoted to the basic sciences, with over 70 hours in pharmacology, more than 149 hours in behavioral sciences, and more than 535 hours of clinical medicine.

The second year of PA education consists of clinical rotations. On average, students devote more than 2,000 hours or 50–55 weeks to clinical education, divided between primary care medicine and various specialties, including family medicine, internal medicine, pediatrics, obstetrics and gynecology, surgery and surgical specialties, internal medicine subspecialties, emergency medicine, and psychiatry. During clinical rotations, PA students work directly under the supervision of physician preceptors, participating in the full range of patient care activities, including patient assessment and diagnosis, development of treatment plans, patient education, and counseling.

After graduation from an accredited PA program, the physician assistant must pass a national certifying examination jointly developed by the National Board of Medical Examiners and the independent National Commission on Certification of Physician Assistants. To maintain certification, PAs must log 100 continuing medical education credits over a two-year cycle and reregister every two years. Also to maintain certification, PAs must take a recertification exam every six years.

The majority of PA educational programs offer master's degrees, and the overwhelming majority of recent graduates hold a master's degree.

Title VII Support of PA Education Programs

The Title VII support for PA educational programs is the only Federal funding available, on a competitive application basis, to PA programs. Unfortunately, the level of support has eroded from the highest level of $7.5 million in FY 2005 to $2.6 million in FY 2007.

Targeted Federal support for PA educational programs is authorized through Section 747 of the Public Health Service Act. The funds are used to encourage PA students, upon graduation, to practice in underserved communities. These goals are accomplished by funding PA education programs that have a demonstrated track record of: placing PA students in health professional shortage areas; exposing PA students to medically underserved communities during the clinical rotation portion of their training; and recruiting and retaining students who are indigenous to communities with unmet health care needs.

The Title VII program works.

- A review of PA graduates from 1990—2006 demonstrates that PAs who have graduated from PA educational programs supported by Title VII are 59% more likely to be from underrepresented minority populations and 46% more likely to work in a rural health clinic than graduates of programs that were not supported by Title VII.
- A study by the UCSF Center for California Health Workforce Studies found a strong association between physician assistants exposed to Title VII during their PA educational preparation and those who ever reported working in a federally qualified health center or other community health center.

The PA programs' success in recruiting underrepresented minority and disadvantaged students is linked to their ability to creatively use Title VII funds to enhance existing educational programs. Without Title VII funding, many special PA training initiatives would be eliminated. Institutional budgets and student tuition fees are not sufficient to meet the special, unmet needs of medically underserved areas or disadvantaged students. The need is very real, and Title VII is critical in leveraging innovations in PA training.

Need for Increased Targeted Support for PA Education

Federal support must be directed to PA educational programs to stimulate growth in the PA profession to meet the needs of universal health care coverage. Targeted funding should be directed to——

- The use of Title VII funds for recruitment and loan repayment for faculty in PA educational programs.
- Incentives to increase clinical training sites for PA education.
- Federally backed loans and loan repayment programs for PA students.

Eliminating Barriers to Care in Federal Law

Eliminating current barriers to medical care provided by PAs that exist in the Medicare, Medicaid, and the Federal Employees Compensation Act (FECA) laws would do much to expand access to needed medical care, particularly for patients living in rural and other medically underserved areas.

- AAPA believes that the intent of the 1997 Balanced Budget Act was to cover all physician services provided by PAs at a uniform rate. However, PAs are still not allowed to order home health, hospice, skilled nursing facility care, or provide the hospice benefit for Medicare beneficiaries. At best, this creates a misuse of the patient's physician's, and PA's time to find a physician signature for an order or form. At worst, it causes delayed access to care and inappropriate more costly utilization of care, such as longer stays in hospitals. For patients at end-of-life, it creates an unconscionable disruption of care.
- Although most States recognize services provided by PAs in their Medicaid Programs, it is not required by law. Consequently, some State Medicaid Directors pick and choose which services provided by PAs they will cover. Others impose

coverage limitations not required by State law, such as direct supervision by a physician.

- Although nearly all State workers' compensation programs recognize the ability of PAs to diagnose and treat State employees who are injured on the job, the Federal program does not. As a result, Federal workers who are injured on the job may be rerouted to emergency rooms for workers' compensation-related care, rather than to go to a practice where the PA is the only available health care professional.

The Medicare, Medicaid, and FECA statutes create Federal barriers to care that do not exist in State law. The barriers need to be eliminated to promote increases access to the quality, affordable medical care provided by PAs.

Integrate PAs into New Models of Care

AAPA is concerned that health care reform could create new, unintended barriers to care provided by PAs unless special attention is devoted to ensuring that PAs are fully integrated into the medical home and chronic care coordination models of care.

PAs always work with physicians, but in many rural and other underserved areas, the PA is the face of health care. The PA is the medical professional who develops the care plan and coordinates the care. PAs also own and/or provide care in rural health clinics and others settings that may serve as the patient's primary medical home. It is critical that the medical home and chronic care management models of care recognize the ability of PAs to develop and manage medical care plans, without unnecessary limitations. And, it is important that PA-run clinics and practices be eligible for reimbursement from the new models of care.

Medicare Physician Payment Reform

It is critically important that health care reform legislation contains a long term solution to Medicare's physician payment system. The current system is simply not sustainable, nor is it fair to the health care professionals who provide medical care for Medicare beneficiaries.

Statement of American College of Obstetricians and Gynecologists

On behalf of the American College of Obstetricians and Gynecologists (ACOG), representing over 53,000 physicians and partners in women's health, thank you for holding this hearing on health care reform. Women, the health care decision-makers of their families, are also health care purchasers, providers and patients, making them uniquely affected by our broken health care system. We look forward to working with the Committee to reform the health care system, and ensuring that health reform addresses the needs of women.

ACOG applauds Representative Schakowsky for introducing, and Subcommittee on Health Chair Stark and Committee Member McDermott for being original cosponsors of H. Con. Res. 48, which calls on Congress to pass legislation within 18 months that recognizes women's health as an integral part of the health care reform puzzle. ACOG supports this goal through our Health Care for Women, Health Care for All Campaign.

As women's health care physicians, we see first-hand why our Nation needs health care reform. We fight with insurers to ensure that our patients are covered for the care they need. We treat women without coverage and know that too many women with serious medical problems go without needed care. We see the effects of no prenatal care and the risks women face who have no screening or treatment for cancers. We're small businesses, too, and experience the problems of many others, in trying to cope with the rising cost of health insurance for our employees, and our families.

The Challenges:

Women and Health Care Use & Outcomes

Women have distinct health care needs and use more health care than men throughout their lives, including regular visits for reproductive health care. Women are more likely to seek preventive and routine care, are more likely to have a chronic illness that necessitates continuous health care, and are more likely to take a prescription drug on a daily basis than men.

- Uninsured women receive less preventive care, are diagnosed at more advanced disease stages, receive less therapeutic care, have higher mortality rates, and are less likely to have a regular source of care.
- Uninsured women are three times less likely to have had a Pap test in the last three years and have a 60% greater risk of late-stage cervical cancer.
- Uninsured women with breast cancer are 30–50% more likely to die from the disease.
- 13% of all pregnant women are uninsured, making them less likely to seek prenatal care in the first trimester of their pregnancies, less likely to receive the optimal number of prenatal health care visits during their pregnancies, and 31% more likely to experience an adverse health outcome after giving birth. Lack of prenatal care increases the risk of preterm birth. In 2005, preterm birth-related costs in the U.S. totaled over $26.2 billion; $51,600 for every infant born prematurely.
- Black women have higher fetal and infant mortality rates than white women. In 2004, the fetal mortality rate for black women was twice the rate for white women (11.25 compared to 4.98 per 1,000 live births and fetal deaths). Infant deaths in the first month of life were 2.5 times more likely for black mothers than white mothers (9.12 compared to 3.69 per 1,000 live births and fetal deaths).
- Women with disabilities are less likely to receive breast and cervical cancer screening than non-disabled women, and their reproductive health care needs are often overlooked.
- Employer-based insurance hampers lesbians from accessing health coverage through their partners since many companies do not recognize domestic partners.

Women and Health Care Costs

- Affordability is a key issue for women because, on average, they have greater annual health expenditures, but lower incomes than men. In 2007, the median income for women was $35,100 to $10,000 less than the median income for men.
- Insured or not, women have greater out-of-pocket costs and face greater medical debt than men. In 2004, 1 in 6 women with individual health care coverage reported that they postponed, or went without, needed health care because they could not afford such health care.
- As a result, women are disproportionately affected by higher medical costs that eat up more of their wages. And, since women already pay 68% more than men for out-of-pocket health care costs, due in large part to reproductive health care needs, higher cost-sharing adds to an already serious financial burden.
- 64% of uninsured women are in families with at least 1 adult working full-time. Health care costs are increasingly unaffordable for working families and employers, with employer-sponsored health insurance premiums having increased 87% between 2000 and 2006.
- Women also are financially vulnerable because they are more likely to obtain coverage through their spouse—putting them at risk in the case of divorce or death of a husband or their husband's employer cutting dependent coverage. Also, when a husband moves from job-based coverage to Medicare, his wife, if not Medicare-eligible herself, may lose her coverage at the same time.
- Women are more likely to find that maternity and other services they need are not covered by their insurers.
- High-deductible health plans, so-called "consumer-directed health plans" (CDHPs), offer lower premiums than traditional insurance but with higher cost-sharing requirements. These plans are often an attractive option for young, healthy individuals who are enticed by low monthly premiums, but maternity care is rarely covered. While many CDHPs advertise first-dollar coverage for preventive services, a recent study found that prenatal care was usually not considered a preventive service, requiring considerable out-of-pocket expense. In addition, because pregnancy usually spans 2 plan years, women often must satisfy two annual deductibles before any costs are covered.
- Women without group insurance face enormous problems in obtaining and affording coverage in the individual insurance market. Underwriting laws in most states allow women seeking insurance coverage in the individual market to be subject to higher costs because of their gender or

health status or face pre-existing condition exclusions that limit their coverage for the services they most need.

- Exempted from the requirements of the Federal Pregnancy Discrimination Act, small groups and individuals may be denied coverage for maternity care, or require the purchase of expensive riders for this coverage, often more than a year in advance. Women who are already pregnant or are in less-than-perfect health may be denied coverage altogether.

The Solution:

ACOG's Health Care for Women, Health Care for All Campaign, describes reforms needed to give all women access to meaningful and affordable coverage.

Elements of Reform

- Cover everyone: Health coverage should be accessible and affordable to everyone in the U.S., regardless of citizenship or residency status. If reforms are phased-in, universal coverage of pregnant women and infants should be the first priority.
- Guarantee Essential Benefits for All Women. Coverage Should Be Uniform and Affordable under All Insurance Nationwide: An insurance card does not guarantee access to needed services. Without coverage for the services they most use, underinsured women could face the same cost burdens as those without any insurance, with predictable results: delayed or missed care leading to worse health outcomes. Defining a core set of benefits will guarantee that no woman with insurance is denied basic care or burdened with the unaffordable out-of-pocket or catastrophic health care expenses that drive millions of Americans into bankruptcy every year. A core benefit package will cover preventable and primary care services to keep women healthy and keep health care affordable. Coverage must include:
    - Primary and preventive services, including family planning;
    - Pregnancy-related and infant care;
    - Medically and surgically necessary and appropriate services in all health care settings, including outpatient, hospital, nursing facility, hospice, and at-home care;
    - Prescription drugs; and
    - Catastrophic care
- Engage employers, individuals and Governments: Build on the strengths of our private-public financing and delivery system with coverage requirements for employers and individuals and improved public coverage. Large employers should be required to offer insurance to employees who work more 17.5 hours per week and their dependants. Small employers would have a choice of providing insurance or paying a percentage of payroll to the public plan. All individuals would be required to have insurance, either through their employer or through a public plan.
- Make coverage affordable: Small businesses should be eligible to receive tax credits or subsidies to make insurance affordable. Self-employed and low-income families who are currently priced out of the health care market should be guaranteed an affordable Federal plan. Low-income employees should pay no more than 20% of their plan's premium cost. Private insurance market reforms should include guaranteed issue and renewability and community rating. Coverage should not be denied due to preexisting conditions and annual premium increases should be limited. Discrimination based on health status, gender and other factors must be eliminated. Emphasizing prevention, reducing administrative costs, and fixing our broken medical liability system can lower health care costs for everyone.
- Invest in Primary and Preventive Care: ACOG supports benefits that emphasize and promote prevention—especially prenatal care and contraception. Prenatal care and risk-assessment are critical preventive services for all pregnant women and contraception is a medical necessity for women during three decades of their life span and should be covered to the same extent as other prescription drugs and services. Costly and burdensome "gatekeeper" rules that deny or delay women's direct access to obstetric, gynecologic, primary care services must not be permitted.
- Support Continuity of Care and Pilot-Test a Women's Medical Home: A woman's initial contact with an ob-gyn typically begins a long-term physician-patient relationship in which the ob-gyn provides continuity of care from adolescence through the reproductive years and pregnancy, to menopause and beyond. Continuity of care—seeing the same health care provider over time—enhances qual-

ity of care and patient satisfaction. It has been associated with greater use of preventive care, improved communication between the patient and physician, improved adherence to medication instructions, and improved physician recognition of medical problems. A woman discusses some of her most personal and important health care concerns with her ob-gyn: what a family history of breast cancer means for her own health, her risk of cardiovascular disease, how to manage her weight, where to seek mental health counseling, how to have a healthy baby. A majority of women see an ob-gyn annually, and sometimes an ob-gyn is the only physician routinely visited. Young women ages 18 to 34 who see an ob-gyn for all their primary care needs report greater satisfaction with their care than women seeing only a generalist or both an ob-gyn and a generalist.

Numerous legislative proposals were introduced in 2008 advancing the adoption of medical homes, but none explicitly refer to ob-gyns or women's health care. The Centers for Medicare and Medicaid Services (CMS) are beginning medical home demonstrations in 2010, with results expected in 2013. While ACOG believes that the medical home concept shows great promise in improving care coordination and health outcomes, wholesale adoption should be delayed until the results of current and future demonstration projects are evaluated.

In the meantime, we urge the Committee to approve a women's medical home demonstration, to specifically test how and how well a medical home can addressing women's unique health care needs, using the principles below:

- A seamless continuum of care for women across their life spans: A medical home for women links wellness and preconception care with prenatal care and family planning; these are linked with medical care, screening and follow-up care for health needs later in life.
- Patient choice, affordability and access: Every woman should have open access to a medical home with a choice of qualified providers and in a variety of settings. Comprehensive integrated care is especially important for low-income women who are uninsured and underinsured.
- Accountable to women: Care is patient and family centered, culturally appropriate, structured to ensure women receive complete and accurate health information to make their own health care decisions, and structured to assure confidentiality so that teens and women seek needed care in a timely way.
- Team care led by a physician: The patient's personal physician leads a team that collectively takes responsibility for ongoing care. For many women, their obstetrician-gynecologist serves as their personal physician and is the only provider that women see regularly during their reproductive years.
- Care is evidence-based with continuous quality improvement: A medical home for women is structured to encourage health care providers to pursue practices that achieve evidence-based outcomes so that women will enter their reproductive years healthy, maintain their reproductive health, and age well.
- Investment in interdisciplinary health education and training of providers: To understand and fulfill the functions of a medical home, innovative models of interdisciplinary education are essential.
- Reimbursement that reflects the added value of a women's medical home: Reimbursement must reflect the costs of HIT, care coordination, additional staffing and other requirements needed to fully develop a women's medical home, and allow practices to share in any potential cost savings from the medical home practice model.
- Eliminate Health Disparities: Health system reform should recognize and eliminate disparities in health care coverage, treatment and outcomes related to a patient's culture, race, ethnicity, socioeconomic status, disability and sexual orientation. Ensuring comprehensive coverage for everyone will minimize but not eliminate health disparities, which often result from a complex mix of factors related to income, housing, personal safety, education, and job opportunities. All health care providers should provide high quality, compassionate and ethically sound health care services to all patients in need of care. Services should be culturally appropriate and based on specialty-developed best practice guidelines to eliminate variations in health care treatment. Further, the health care workforce should reflect our country's diversity, and disparities research should be funded and analyzed.
- Enhance quality and patient safety. Our health system should strive for continual quality improvement—through medical education, physician-driven quality programs, health information technology, and research to determine the most effective evidence-based treatments. Quality and safety reforms should always put our patients' welfare and best interests first.

- All health care facilities should operate internal quality assurance programs and health professionals should be licensed.
- Health care professionals and facilities should attend patient safety training in order to keep professional liability insurance.
- State medical boards should strengthen their reviews and discipline low-quality providers.
- ACOG supports and agrees with the need for research to determine effective evidence-based interventions. Following are key principles to make sure that comparative effectiveness research (CER) results are useful in enhancing health-care quality and patient safety:
    - CER must address the specific and changing needs of women throughout their lives.
    - CER findings must not lead to cook-book approaches to coverage and payment, recognizing that individual patients may need different care, individualization that is best determined by the patient's physician.
    - CER must promote the best clinical value of treatment interventions, rather than restricting payment to only the cheapest procedures.
    - Population differences—co-morbidities, sex, race and ethnicity, and subpopulations, including pregnant women and the elderly—must be incorporated in the research design.
    - ACOG appreciates provisions within the American Economic Recovery and Investment Act that help usher in the widespread use of health information technology. As long as interoperability and specialty-specific standards are developed and financial support is provided to offset the large expense of acquiring a system, adoption of health information technology has the potential to reduce costs and improve patient care.
- Ensure Fair Reimbursement for Physician Services: Medicare pays physicians based on a complicated and flawed formula that threatens to slash physician payment by nearly 22% next year. The Sustainable Growth Rate (SGR), reduces physician payment when Medicare volume grows or for other factors over which physicians have no control, including the Gross Domestic Product and the high cost of physician-administered drugs. While each year Congress has stopped the pending cuts, the cost of permanently fixing the formula grows as well. Inadequate payment may cause doctors to stop accepting or to limit the number of Medicare patients they serve. Seniors and disabled beneficiaries may find it harder to find physicians in their areas or may have to wait longer for appointments. Congress must stop the cuts and include elimination of the payment formula in the overall health care reform plan. Physician payment should reflect the true cost of providing care to Medicare beneficiaries. Low reimbursement for services furnished to Medicaid beneficiaries also has the potential to hamper patient access to high-quality care. With Medicaid covering nearly 40% of all births and playing a critical role in pregnancy-related care it is vital that physicians are reimbursed at a fair rate for their services.
- Medical Liability Reform: America's broken medical liability system fails both injured patients and their physicians. Many patients with legitimate injury claims never enter the civil justice system, while as many as half of the claims that do enter the system are without merit. The system fails to do what it is supposed to do: accurately and efficiently identify cases of negligence, fairly compensate injured patients, and promote patient safety. The current medical liability system is random, unpredictable and ineffective, and threatens women's access to health care.

Good doctors who have been so important to their patients and their communities are dropping obstetrics, ending their surgical practice, or closing their medical practices completely. Medical students who love the idea of ushering tiny lives into this world are turning away from the litigious culture that surrounds ob-gyn. And America's women are left asking, "Who will deliver my baby?"

ACOG strongly supports comprehensive Federal legislation such as S. 45, the Medical Care Access and Protection Act of 2009, to reform the system, including placing a reasonable cap on noneconomic damage awards, as has been accomplished in California and Texas. At the same time, we believe there is enormous benefit in exploring promising alternatives that would more fundamentally fix America's broken liability system, including health care courts and early offers demonstration programs. ACOG has supported health care courts and early offers for many years. These alternatives would help guarantee that injured patients are fairly, quickly, and fully compensated for their economic and noneconomic damages by taking

claims out of the adversarial tort system and putting them into the hands of experts whose goals are fairness and patient safety.

Thank you for holding this hearing on the importance of health reform which expands coverage, improves quality and controls costs. We look forward to working with you to reform the health care system in order to ensure comprehensive and affordable coverage for all.

Statement of American Federation of State, County and Municipal Employees

We submit this testimony on behalf of the 1.6 million members of the American Federation of State, County and Municipal Employees (AFSCME) for the official record of the House Ways and Means Committee's hearing on Health Reform in the 21st Century: Expanding Coverage, Improving Quality and Controlling Costs.

The time for health care reform is now. President Obama delivered this message at the White House health care summit on March 5, as he has consistently throughout his presidential campaign and since taking the oath of office. We cannot wait while 46 million Americans lack health coverage, health care costs continue to spiral out of control, too many health plans do not provide comprehensive benefits, and our health care system often fails to deliver the high-quality care that we need. We must build on what works, including employer-sponsored coverage and public programs, and make the policy changes that are needed to reach our goal of quality, affordable health care for all.

Support Public Health Insurance Plan Option

One key component of a reformed health care system is inclusion of a widely available public health insurance plan. Today, consolidation in the private insurance industry has greatly narrowed price and quality competition. The addition of a public health insurance plan would play an important role in broadening consumer choice. When either a public or private plan does not meet a family's needs, they can vote with their feet, the measure of true competition.

A public health insurance plan option would also promote stability in the insurance market. Private plans often contract with new providers while dropping others, change benefits and cost-sharing, and sometimes move in and out of markets completely. This has the effect of disrupting care as well as results in unexpected increases in out-of-pocket expenses. A public health insurance option will provide a guarantee to families that a high quality plan will be available no matter what happens to their private coverage.

A public health insurance plan option alongside private insurance options would promote efficiency in the private market. Between 1997 and 2006, per enrollee spending in private insurance grew 59% faster than spending in the traditional, Government-administered Medicare program. A comparison of administrative costs shows that Medicare spends about 2% for overhead, while administrative costs (including profits) in private group coverage runs 12% to 15% of cost. To curb the unsustainable growth in health care costs, private insurers must find efficiencies, and competition with a public health insurance plan would provide a strong incentive for them to do so.

A public health insurance plan option would also improve health care quality and advance innovations. Currently, private health insurers have scant motivation to implement or improve disease management programs since they might become a magnet for sicker subscribers. Moreover, a financial disincentive exists to share best practices with those outside their network given competition for plan members. A new public health insurance plan would be well situated to be a leader in the adoption of evidence-based medical protocols, expansion of quality incentives, and development of innovative and transparent payment mechanisms. And, a public health insurance plan would help advance electronic medical records and the adoption of best practices.

Extensive support exists for including a public health insurance plan as one option in an insurance exchange. President Obama has consistently expressed his support for a new public health insurance option as have health care leaders in Congress and respected researchers and academics.

Karen Davis, President of The Commonwealth Fund, offered compelling testimony on this point at the March 11 hearing. She expressed her strong support for an insurance exchange with a choice of private plans and a new public health insurance plan, noting many of the same advantages we have expressed in this statement. In

response to questioning, she also allayed the "crowd out" fear, citing the Commonwealth Fund's prediction that private insurance would continue to have a substantial share of an expanded market. Davis also noted that with a public health insurance plan option, our country would save $3 trillion in health care costs by 2020, whereas without that option, cost savings would be $800 billion, less than one third of those savings.

Further research demonstrates that the general public strongly supports a public health insurance option in health care reform. In fact, polling shows that three-quarters of voters supported a public health insurance plan option. This support crosses all political lines as well as among both urban and rural voters.

Build on Employer-Provided Health Care

Any health care reform legislation must build upon the foundation of employer-sponsored coverage. Employers provide a ready-made, stable risk pooling mechanism, coverage with lower administrative costs than individual coverage, and the institutional skills and expertise to carry out complex negotiations with insurers that the average family is not equipped to perform.

According to Government figures from 2007, 70% of the 253 million people with health insurance received at least some of their coverage through employers. Employment-based insurance covers three-fifths of the population under age 65. To ensure that individuals can keep their current coverage if they are satisfied with it, it is vitally important to adopt policies that do not cause erosion in employer-provided insurance.

Eliminating or weakening the tax exclusion for employer health coverage contributions would dismantle the employer-based system. The tax exclusion for health benefits has been in the Tax Code for over 50 years.

The Commonwealth Fund's Davis warned in her testimony that capping the health benefits tax exclusion could result in employers dropping coverage entirely. As Subcommittee Chairman Stark noted at the hearing, we do not want to undermine employer coverage but rather build on what works when reforming the system.

During his presidential campaign, President Obama called taxing employee health benefits "the largest middle-class tax increase in history." Many employers also support retaining nontaxable health insurance benefits, viewing it as a valuable way to recruit and retain workers. The U.S. Chamber of Commerce opposes eliminating the tax exclusion of health benefits.

Employers' Responsibility to Contribute to the New Health Care System

The ultimate goal of health care reform is quality, affordable coverage for all. Families, employers and the Government should share in the responsibility of contributing to the system through progressive financing. While our health care system is based on employer-provided coverage, some employers are shirking their responsibility. The fact that some employers do not provide health benefits creates an uneven playing field that puts responsible employers at a competitive disadvantage. In addition, the cost-shifting that occurs to pay for uncompensated care means that those employers who provide coverage to their workers are also helping to pay for the health care received by those working for employers who do not provide coverage. In 2005 it was estimated that this cost added $900 to the average annual premium for family coverage. No doubt the cost is much higher today.

AFSCME urges Congress to support a "pay or play" approach where employers either provide a comprehensive set of benefits or make a substantial payment towards the cost of those benefits so their workers can obtain coverage.

Conclusion

In conclusion, AFSCME very much appreciates that the Ways and Means Committee is focusing its attention on health care reform as an absolute priority this year. We look forward to working with you to enact legislation that will establish affordable coverage for everyone in a system that is adequately financed through shared responsibility, protects our employer-based system, provides comprehensive benefits that cover what people need, and includes the choice of a public health insurance plan.

Statement of American Health Quality Association

This statement is submitted to the Ways and Means Committee for its hearing, "Health Reform in the 21st Century: Expanding Coverage, Improving Quality and Controlling Costs." The American Health Quality Association (AHQA) represents

the national network of state-based Quality Improvement Organizations (QIOs). QIOs serve as contractors to the Centers for Medicare and Medicaid Services (CMS) and other public and private payers, purchasers, and providers seeking to improve outcomes across the continuum of health care delivery settings.

Reforming the Health Care Delivery System: Change Must be Built From the Ground Up

Health care in the United States is often justly criticized for its high cost and suboptimal performance in meeting the needs of the public and the expectations of health care professionals. Dramatic improvements in quality and efficiency are needed in daily health care operations. The change must take place at the ground level, where care is delivered. Health care reform must emphasize and support improvements in the quality and efficiency of care delivered across the range of settings, as well as transitions between those settings. Payment reform provides motivation and capital to encourage greater quality and efficiency among providers. However, payment reform alone cannot speed the pace of learning and implementation of best practices among competing providers. We believe the promise of health care reform will not be fully realized without a field force working with providers to accelerate the pace of learning and improvement in care.

The QIOs are that field force of change management expediters. The national network of QIOs is a valuable public infrastructure, trusted by key stakeholders, experienced in responding to Federal direction, and effective in quality performance measurement, public education, and improvement.

Overview: QIO Contributions to Reforming the Health Care Delivery System

We propose five ways this field force of QIOs can speed the pace of improvement in the health care delivery system. The Medicare scope of work for the QIO program, and the Medicaid program's quality oversight system, should be expanded to satisfy the following aims:

- Ensure payment incentives do not unintentionally widen the quality gap between "have" and "have not" providers and practitioners.
- Assist health professionals in planning for, purchasing, and using health IT in daily practice to promote wellness, timely preventive care, and manage patients' chronic care needs.
- Support providers' incorporation of evidence-based comparative effectiveness findings into daily care practices.
- Link hospitals and providers of ambulatory care in community-based initiatives to improve the safety and reliability of transitions between care settings, reducing costly hospital readmissions.
- Analyze, report and explain how to use data on providers' quality performance to providers, practitioners, purchasers, and the public.

Safeguard Against Inequitable Outcomes Resulting from Payment Incentives

Payment reforms have been widely discussed as a method to encourage providers to self-assess and publicly report quality performance. These are useful tools for bringing about awareness of clinical shortcomings and stimulating improvement. Providers serving patient populations that are well-insured, healthier, better-educated, or from a higher socioeconomic stratum are well-positioned to hire consultants or draw on shared corporate resources to respond to financial incentives for reporting and improvement. However, many providers are less able to compete for lucrative partnerships, academic affiliations, or attract better educated, well-insured customers seeking elective procedures. These providers include safety net providers, providers disproportionately serving vulnerable patient populations, small community hospitals and rural providers.

These providers are likely to struggle to hire and retain the experienced staff and commercial consultants needed to lead implementation of cutting-edge, high-performance practices. Without special assistance, incentive payments are likely to widen the quality gap between the "have" and "have not" health care providers[1] This problem will worsen if Congress finds it is necessary to enact budget-neutral

[1] Vladeck. If Paying for Quality is Such a Bad Idea, Why is Everyone for It? 60 Wash. & Lee Law Rev. 1345, 2004; Cunningham et al. Caught in the Competitive Crossfire: Safety-Net Providers Balance Margin and Mission In a Profit-Driven Health Care Market. Health Affairs, August 2008; Chien et al. Medicare Care Research and Review, 2007; Lewin and Baxter. Health Affairs, Sept/Oct 2007; Felt-Lisk. Making Pay-For-Performance Work In Medicaid. Health Affairs, June 2007; Casalino. Will Pay-For-Performance And Quality Reporting Affect Health Care Disparities? Health Affairs April 2007.

incentive programs in which the cost of payments to those who qualify for incentives are offset by reductions in payment to those who do not.

Recommendation: Special assistance should be offered to these providers by focusing Medicare QIO assistance on meeting their needs. In the area of public reporting, QIOs have been successfully providing assistance to Critical Access Hospitals (CAHs) for several years, resulting in steady growth in the number of CAHs reporting quality performance even in the absence of payment incentives offered to PPS hospitals. A number of studies strongly suggest that QIOs have effectively assisted providers in improving care (see appended summary of studies).

While AHQA recommends making substantial QIO assistance available to providers and practitioners least able to qualify for incentive payments because of their size, funding, or service to vulnerable populations, we caution against unduly restricting QIO assistance so that it is available *only* to these providers. Both to improve equity and to permit effective learning techniques, it is important to permit QIOs to recruit significant numbers of high-performing providers to participate in quality improvement initiatives. This will ensure QIOs can engage both higher performing and lower-performing hospitals in learning collaboratives to share improvement strategies. This method aims to accomplish community-based quality improvement in which a large number of health care providers work together to offer patients the best possible care, raising the quality of care across the board and minimizing the likelihood that a consumer will choose or be referred to a low quality provider.

Implementing Health Information Technology and Health Information Exchange

Public policy debate about health information technology (HIT) has focused on the slow pace of adoption in the United States; a positive impact on the quality of care is generally assumed. While HIT been shown in several studies to improve processes of care where it is in place and used by clinicians,[2] some studies have not confirmed this finding.[3] Others note that while care processes may improve with use of HIT, there is still little evidence that HIT improves patient outcomes (other than in the care of end stage renal disease patients).[4] In their recent study, Linder and colleagues found no association between ambulatory care quality and possession of EHR technology, cautioning that "as EHR use broadens, one should not assume an automatic diffusion of improved quality of care—Policy makers should consider steps to increase the likelihood that further diffusion of EHR has the desired effect of improving quality of care."

The slow pace of HIT adoption is unquestionably a problem that calls for action. The American Recovery and Reinvestment Act (ARRA) took an important step in assisting providers afford the cost of EHR adoption. But physicians and health professionals lack training and experience in the process of evaluating their current care processes, conceiving a better way to organize their care teams, and retraining themselves to take advantage of the capabilities of new information systems. There is evidence many providers and office practices have purchased inadequate clinical decision support software (CDSS), or are not using their CDSS to improve care management despite having purchased a fully functional system.[5]

While the ARRA does contain technical assistance provisions for small physician offices, it will be vital for that technical assistance to be competent to aid physicians and medical practice staff through the entire change management process. Using the full capability of EHRs, including care management and improved health outcomes, requires a redesign of a practice's entire clinical workflow. There has been little in the way of technical assistance for small physician practices. Commercial consultancy firms have had little interest in serving typical office practices and small providers, even if those practices and providers could afford to hire them. This is unfortunate, because the majority of ambulatory care physicians work in practices of three or fewer physicians. Health care reform must ensure not only that EHRs are being purchased by small physician practices, but that their full implementation

[2] Kawamoto et al. Improving clinical practice using clinical decision support systems: a systematic review of trials to identify features critical to success. BMJ Online, March 2005; Garg et al, Effects of Computerized Clinical Decision Support Systems on Practitioner Performance and Patient Outcomes. JAMA, 2005; 293:1223–1238

[3] Linder et al. Electronic Health Record Use and the Quality of Ambulatory Care in the United States. Archives of Internal Medicine. 2007;167(13):1400–1405

[4] Pollak. Effect of electronic patient record use on mortality in End Stage Renal Disease, a model chronic disease: retrospective analysis of 9 years of prospectively collected data. BMC Medical Informatics and Decision Making. 2007; 7:38

[5] Eccles et al. Effect of computerised evidence based guidelines on management of asthma and angina in adults in primary care: cluster randomised controlled trial. BMJ, 2002;325:941

and use is being used to transform the quality and efficiency of care provided by the practice.

QIOs worked with hundreds of hospitals and 3,600 physician offices from August 2005–July 2008, assisting them in re-designing their clinical workflow to incorporate HIT into daily practice. The QIO-assisted practices exceeded expectations in using their EHRs for care management, and the QIO program influenced HIT vendors to make significant changes in their programming to enable physicians to generate care management reports. Demand was so strong that QIOs had to turn providers away. An independent evaluation found three-quarters of practices were satisfied with the QIOs' knowledge of technology options, their ability to appropriately assess the practice's technology needs, and their assistance in improving the quality and efficiency of care.[6, 7]

Recommendation: Medicare should build on the success of the QIO program helping providers and practices plan for adoption of HIT, select software and hardware, and modify daily clinical workflow to incorporate technology into their caregiving. QIOs also help providers report their performance, supporting public accountability. QIO assistance should not be limited only to practices that already possess EHRs, as it is today, but should once again be made available to speed the pace of adoption and reduce the number of providers that fail in their implementation efforts.

Ensuring Implementation of Comparative Effectiveness Research Findings

The Congressional Budget Office has reported that "hard evidence is often unavailable about which treatments work best for which patients and whether the added benefits of more effective but more expensive services are sufficient to warrant their added costs" and suggested that "generating additional information comparing treatments would tend to reduce Federal health spending somewhat in the near term," though perhaps not enough to offset the costs of research in the short term.[8] The Medicare Payment Advisory Commission (MedPAC) concluded that "the Congress should establish an independent entity whose sole mission is to produce and provide information about the comparative effectiveness of health care services."[9]

However, most studies trace the poor performance of the current system to failures by health care organizations, providers, practitioners and even patients to routinely implement, day-in and day-out, what is already known. The nation's continuing challenge is to move new research findings from the bookshelf to the bedside. Dissemination of comparative effectiveness research, too, is likely to languish on the bookshelf without a sustained national effort at incorporating that knowledge into the local, day-to-day clinical workflow.

QIOs are perfectly situated to accomplish this mission. Fostering integration of evidence-based medicine in everyday clinical care has been a primary purpose of the QIOs ever since the multi-state Cooperative Cardiovascular Project demonstrated in 1995 that QIOs improved use of evidence-based heart attack treatments and reduced mortality. Studies document that QIOs combine clinical expertise with change management to speed adoption of evidence-based medicine (see Appendix A).

Recommendation: The Medicare program should task QIOs to help physicians implement Comparative Effectiveness findings that the Secretary determines would yield clinically significant improvements in the safety or effectiveness of health care. The Secretary would be required to evaluate QIO work using measures that have been endorsed by the National Quality Forum.

Improving Transitions of Care and Reducing Readmissions

MedPAC reported to Congress in 2007 that unsafe and poor quality care occurs with disturbing frequency as patients transition between care settings. One result is that about 18% of Medicare patients discharged from a hospital are readmitted within 30 days; MedPAC estimated three-quarters of those readmissions are preventable, adding $12 billion to Medicare costs.[10] A similar proportion of patients discharged from a hospital experience an adverse event within 3 weeks of discharge

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[6] Narayanan et al. 2007 Provider Satisfaction Survey Analytic Report to CMS. Westat, March 2008.

[7] Terry. EHRs: The feds get something right. Medical Economics, March 16, 2007.

[8] Research on the Comparative Effectiveness of Medical Treatment: Issues and Options for an Expanded Federal Role. Congressional Budget Office, December 2007.

[9] Report to Congress: Promoting Greater Efficiency in Medicare. Medicare Payment Advisory Commission, June 2007.

[10] Ibid

from a hospital, with two-thirds of the problems being adverse drug events—most of them preventable.[11]

Systems to follow up hospitalizations and assure that patients receive safe and effective care after being sent home or to a nursing home are generally lacking. Following up with these patients after discharge is currently no one's job; patients and families must manage these transitions for themselves. The skilled health professionals working in hospitals, nursing homes, home health agencies and in physician offices are isolated from one another in care "silos" and often don't understand what the "downstream" providers need in the way of information and follow up. "Bundling" payments to providers and practitioners could encourage a shared financial as well as professional interest in better linkage of care between settings. However, bundling methodologies are not yet ready; when they are, providers will implement them faster with assistance.

For many years, QIO initiatives have focused on the hospital discharge component of care transitions. QIOs have helped hospitals more reliably give patients written discharge medication orders after hospitalization for heart attack, heart failure and community acquired pneumonia—to reduce the risk for readmission due to missing needed long-term drug therapy. Quality measures for these important hospital functions have steadily improved during this period. However, little has been done by QIOs or others to ensure that caregivers in the community have the information they need and are working together to provide timely follow up after a patient transitions from a hospital.

In 2008, CMS launched 14 QIO pilots to improve critical aspects of care transitions. These projects include discharge instructions for hospital patients; follow up "coaching" phone calls after discharge; and convening of community-based workgroups of hospital, physician, and post-acute care provider staff who have informal referral relationships that result in them often treating the same patients. The QIOs introduce practices to ensure the timely flow of information between the providers and practitioners, and trigger timely follow-up, such as physician visits within a few days of discharge. Results from the initial pilot suggest dramatic reductions in rehospitalizations are being achieved. These initial results bode well for saving Medicare money through safer and better quality care.

Recommendation: Medicare should expand the current 14-state QIO project nationally to improve coordination and follow up of patient care as patients transition from one care setting to another.

Publicize and Promote Reliance on Quality and Cost Performance Data

Currently, QIOs are founding members of twenty out of twenty-four chartered value exchanges (CVEs), entities designated by HHS Secretary Leavitt as community based partnerships to promote transparency in health care cost and quality. In several cases, QIOs are co-convenors of their local CVE organization.

QIOs currently have extensive access to Medicare claims data, but operate under strong confidentiality requirements that prohibit the release of that data to the public or to other providers. The restrictions in current law exceed those governing private third party payers, which commonly share clinical data with physicians and others when needed to improve care or hold providers accountable. The QIO statute should be amended to allow QIOs to release aggregated de-identified quality and cost data for hospitals, nursing homes, home health agencies and physician practices. Standards must set limits on this authority to ensure that only valid and reliable data is published.

Likewise, transparency data that is not explained or provided in a user-friendly manner will have little influence on patient decision-making. QIOs can analyze and explain complex data to the public in a format tailored to their communities, while respecting the limitations of the data. QIOs should also ensure that providers have an opportunity to review their data first in order to validate it and learn from QIOs how to interpret and appropriately respond to quality performance feedback reports.

Recommendation: Include in the Medicare QIO contracts the responsibility to conduct claims data analysis on cost and quality performance, educate the public (working with CVEs and local partners) about what the findings mean, and work directly with providers and purchasers to improve care.

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[11] Forster et al, The Incidence and Severity of Adverse Events Affecting Patients After Discharge from the Hospital. Annals of Internal Medicine, 2003; 138:161–167.

Studies of the Effectiveness of the QIOs in Promoting Population-based Quality Improvement:

An Annotated Bibliography

In addition to targeted, case-based quality improvement, since the launch of the Cooperative Cardiovascular Project in the mid-1990s, QIOs have implemented community-wide and statewide improvement initiatives to reduce the gap between scientific evidence and daily clinical care.

- Although the IOM could not find national studies published by late 2005 that proved QIO effectiveness to a scientific certainty, a number of state and multi-state studies published before and after the IOM review strongly suggest that QIO technical assistance to providers is valuable in improving the quality of care. 89% of respondents reported in a survey of 462 hospitals weighted to be representative that QIOs' influence on their quality improvement activities were "very positive" (59%) or "somewhat positive" (30%). (Medical Care and Review, June 2008)
- Nationwide, physicians, nursing homes, and home health agencies working intensively with QIOs achieved greater improvement on 18 of 20 clinical quality measures than providers that did not work intensively with a QIO. (Annals of Internal Medicine, September 2006)
- 33 hospitals reduced patient heart attack mortality by 21% to 26% working with the American College of Cardiology, the Michigan QIO, and supported by a local business coalition. (Journal of the American College of Cardiology, October 2005)
- A national QIO project reduced hospital post-surgical infections by 27%. The publication's editor called the outcome "a critical accomplishment in the surgical world, showing measurable and consistent improvement in performance." *(American Journal of Surgery, June 2005)*
- A QIO intervention improved the quality of cardiovascular care for patients in 24 Massachusetts hospitals, leading to "enhanced adherence to prevention guidelines" associated with better patient outcomes. (Archives of Internal Medicine, January 2004)
- QIO assistance to small rural hospitals substantially improved pneumonia care in 20 rural Oklahoma hospitals compared to a control group of 16 similar hospitals. Midway through the project, the QIO brought their intervention to the control hospitals, which improved to a similar degree. (Archives of Internal Medicine, February 2003)
- QIO interventions improved quality of bypass surgery in 20 Alabama hospitals over a two-year period, compared to control hospitals. (JAMA, June 2001)
- QIO quality measurement and assistance to hospitals improved adherence to evidence-based practice guidelines, significantly reducing heart attack mortality in four states compared to hospitals without QIO support. (JAMA, May 1998)

Statement of American Society of Association Executives

American Society of Association Executives. The American Society of Association Executives ("ASAE") is a Section 501(c)(6) individual membership organization of more than 22,000 association executives and industry partners representing nearly 12,000 tax-exempt organizations. Its members manage leading trade associations, individual membership societies, and voluntary organizations across the United States and in 50 countries around the globe. We advocate for voluntary organizations so that they may continue to improve the quality of life in the United States.

Importance of Associations in Health Care Coverage. From early on in America's history, associations have been key vehicles for delivering services and benefits such as health care. The belief that joining a membership organization enhances the personal and professional development of individuals and businesses and enhances access to a vast array of resources is at the core of all associations. Because of this, associations well positioned to play a critical role in providing health care insurance to millions of Americans.

Because of the common interests of their members, associations are organized for greater purposes than merely selling insurance, a critical distinction in the debate over the underlying motivation in providing access to health insurance. Associations are not affinity groups or businesses with the goal of profiting from the insurance

market. They are, however, structured to represent their members, and possess the infrastructure, administrative and communication mechanisms, and experience necessary to unify employers and employees into stalwart providers of health services.

Despite these inherent advantages to associations as conduits for providing health care, very few associations currently provide health insurance to their members. This is due, in large part, to the myriad of Federal regulations surrounding the insurance market. In a 2006 ASAE health care survey, only 24% of over 1,000 association CEOs said that their association provides health insurance to members. However, 61% of respondents said that if Federal regulations that limited their ability to offer some insurance to members were removed, they would consider offering insurance to their members.

The Small Business CHOICE Act of 2009. The committee today is examining the best way to expand coverage and address the cost of providing health insurance. The small business sector is particularly affected by reality of high medical costs. Often, it takes only one employee's increased cost of medical care to send a business' insurance cost skyrocketing or, in some cases, to have their entire plan cancelled. To address the issues of coverage and cost, Congress must include specific relief for small businesses in any health care reform legislation.

ASAE supports the Small Business CHOICE Act of 2009 (HR 859), bipartisan legislation introduced February 4th by Representatives Nydia Velazquez, Sam Graves, and nine other cosponsors. ASAE is joined in supporting the legislation by the American Medical Association, the National Association of Realtors, the National Association for the Self-Employed, and the National Restaurant Association, among other groups.

The Small Business CHOICE Act allows small businesses who belong to the same association or membership organization to form a "cooperative" in the catastrophic health insurance market to provide excess claims insurance for the employees of the small business. The cooperative (whose standards will be established by the National Association of Insurance Commissioners) creates a captive insurance company in one state that pays benefits when the annual maximum for the primary care policy has been exceeded.

Belonging to a cooperative would allow a small business to avoid sudden rate hikes in their insurance premiums, making the cost of providing insurance to their employees more affordable and readily available. With the cooperative assuming the costs that exceed the primary care limit, one high risk employee no longer makes providing insurance for employees an unaffordable benefit. Additionally, with the creation of a captive insurance company based in one state, the cooperative would not federally preempt state mandates and would still require primary care insurance to abide by state requirements.

Supporters of this legislation recognize that this is not comprehensive health reform and that, if this legislation were passed, it would not solve all of the issues in the health care debate. The advantage of this bill is that it would provide immediate cost and coverage relief to a major segment of the business community. Catastrophic insurance companies exist and currently offer plans for associations; however, one small business or association buying coverage drastically increases their primary health insurance rates. Allowing for pooling in the reinsurance market levels the market with large corporations and gives small businesses better access to the health care options available to their larger competitors.

Conclusion. The "Small Business CHOICE Act of 2009," introduced in the House in the 111th Congress by a bipartisan group of Representatives, would reduce the cost for providing employee health care for small businesses through pooling in the reinsurance market. The bill would create a captive insurance company whereby participants in the "cooperative pool" would abide by that state's mandates. Although the legislation is not comprehensive health care reform, it would provide immediate relief for small businesses in insurance costs that will help make health care coverage affordable and universal.

Argus Health Systems, Inc.
Kansas City, Missouri
March 25, 2009

The Honorable Charles B. Rangel, Chairman
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington D.C. 20515

Dear Chairman Rangel,

I am writing on behalf of Argus Health Systems, Inc. in response to the March 11, 2009, hearing held by the House Ways and Means Committee, Subcommittee on Health titled, "Health Reform in the 21st Century: Expanding Coverage, Improving Quality and Controlling Costs." The hearing reviewed the need for comprehensive health care reform to improve coverage, reduce health spending and improve quality of care.

Argus is a pharmacy benefit administrator that prides itself in providing independent pharmacy benefit services and aligning our goals with those of our health plan customers to better serve their plan members. Incorporated in 1988, the company is a subsidiary of DST Systems, Inc., the largest provider of third-party shareholder record keeping services in the United States today.

Since January 1, 2006, Argus has been successfully processing Medicare Part D. Currently, we support approximately five million beneficiaries for 26 Medicare Part D accounts through our infrastructure programs with Part D plan sponsors. In 2008, Argus processed 310 million Part D claims on behalf of Medicare beneficiaries. Over 90 percent of our business is supporting large managed care plans.

As President of Argus Health Systems, Inc., I would like to offer Argus' perspective regarding the importance of the pharmacy benefit in reducing costs and improving the quality of care when coverage is extended to all Americans. From my review of information available in the public domain, it appears that limited attention has been given to the ongoing role that prescription drugs play in contributing to healthier beneficiaries while containing costs elsewhere in the health system.

This apparent lack of inclusion may, in fact, be due to recent advances health plans and their pharmacy benefit administrators and managers have made in helping to contain prescription costs. As a result, this has not necessarily been a hot topic given all the competing issues in the health care reform debate. According to American Health Insurance Plan's (AHIP) analysis of PricewaterhouseCoopers' *Factors Fueling Rising Healthcare Costs*, prescription drugs account for 14 cents of each premium dollar while physician services consume 33 cents.

Despite the lower contribution to premium costs, prescription drugs should not be discounted as a potential area for controlling costs. The pharmacy benefit drives the most frequent interaction people have with the health care system—at their neighborhood pharmacy. Its effective management is important to help control costs, whether through interoperable health care information technology integration, or through medication therapy management provided by the pharmacist.

I am confident there are opportunities in a reformed health care system to manage prescription costs, while obtaining appropriate health outcomes.

Using PBAs and Transparency to Control Costs

To align incentives with value and effective cost control, it is important to understand the differences between pharmacy benefit managers (PBMs) and pharmacy benefit administrators (PBAs) and to ensure that all pharmacy benefit vendors are acting transparently and without conflicts of interest. When considering reforms to implement in our health care system, I ask that Congress undertake a thorough review of the pharmacy benefit business practices prevalent today to understand how lack of transparency as well as conflicts of interest can drive up the cost of prescriptions for the beneficiary.

One of the best definitions of transparency in the pharmacy benefit sector was provided by David Calabrese in Managed Care Executive, dated May 1, 2006.

> "Transparency is a form of business practice involving full disclosure of costs and revenues, allowing the customer to make more well-informed decisions regarding purchases. In the PBM industry, transparency lays the groundwork for more simplified PBM-client business relations, more accurate financial modeling and performance metrics and a greater comfort level among PBM consumers. 'Transparency,' however, is a relative term used freely in the marketing efforts of many PBMs. The genuine commitment to transparency lies in the actual business practices the PBM invokes to support this claim. 'True transparency'

> is a model in which all PBM revenue streams [drug-level rebates, funding of clinical programs, administrative fees, service fees, management fees, research/educational grants, etc.] are fully disclosed to the payer; the full value of retail and mail-order pharmacy discounts is passed onto the client; data is shared with the client; and the client is given ultimate decision-making control over its drug benefit design and formulary management. It is this commitment to true transparency which has begun to differentiate newer PBMs."

"Newer" PBMs identify themselves as pharmacy benefit administrators and provide full disclosure of all fees and allow health plans to audit them. They pass through rebates to the beneficiary and share data with their health plan customers. PBAs work as administrative and advisory partners with their health plan customers, acting under their direction, and do not enforce a formulary or drive beneficiaries to mail order regardless of whether this is appropriate for them or not. The PBA value is proven and is less costly than services offered by PBMs where other conflicts between managing costs and managing profits might otherwise exist.

Improving Health Care Delivery through Health Information Technology

To provide "accountable, accessible, patient-centered and coordinated care", the health care delivery system needs to be organized and redesigned to improve the patient experiences end-to-end, including via health information technology (HIT). Pharmacy benefit administration is a valuable tool in supporting these efforts with data exchange for medical and pharmacy claims integration. Pharmacy benefit administration provides one the best examples of how standards and standard processes have led to the use of advanced cost management techniques and data management and review that promote greater quality of care. Such standards have also provided a platform and foundation for pharmacists and prescribers to better serve beneficiaries through the use of readily available information. In addition to real-time point-of-sale prescription claims processing, several PBAs currently support the continued integration of functionality via batch and/or near-real time across all segments of the health benefit field. Additionally, PBAs support efficient medical care through use of medication history and by having diagnosis codes available at point-of-sale, enabling pharmacists to provide additional and comprehensive care to the patient. Recent experiences in Medicare Part D with vaccine administration and Medication Therapy Management have also been successful and can be expanded to the general population.

Strengthen Decision-Making with Comparative Effectiveness Assessment

To "aim high to improve quality, health outcomes, and efficiency", comparative effectiveness assessment is an important tool for improving clinical decision-making on behalf of patients, as well as to reduce costs. Argus supports funding for rigorous and independent (non-pharmaceutical manufacturer-based) research for prescription drugs, which will enable beneficiaries to receive the medication therapy they need. This type of research will allow for outcomes/effectiveness research to be conducted by academic institutions without fear of reprisal or liability from pharmaceutical manufacturers. It will also ensure health care providers have solid evidence available, rather than marketing information, for delivering optimal care in their practice.

Containing Growth in Specialty Medications

The utilization of specialty drugs continues to drive health-care costs. In 2007, CMS added the Part D specialty drug tier. According to information released by CMS in conjunction with the Symposium conducted on October 30, 2008:

> "Specialty tier medications represent a limited number of drugs that are used by a small proportion of enrollees. Overall only 4.4 percent of enrollees used specialty tier drugs in 2007. Of those enrollees, 61 percent were LIS beneficiaries. Expenditures for specialty tier drugs in 2007 accounted for 10 percent of total gross drug costs. Non-LIS enrollees pay approximately 20 percent of the medication cost for specialty tier medications, when all Medicare enrollees are included the average amount paid is much less."

Due to the importance of these drugs for beneficiaries, as well as the contribution they provide to total Part D drug costs, Argus recommends that serious considerations, be undertaken to determine how to best manage costs in this class of drugs while taking advantage of the value these drugs may have in providing quality outcomes for beneficiaries.

Thank you for taking the time to review these recommendations on how the pharmacy benefit can play an integral role with other steps being considered as part of

overall health care reform. I commend the House Ways and Means Committee, Subcommittee on Health for holding this hearing.

Sincerely,

Jonathan Boehm

Statement of Families, USA

According to the U.S. Census Bureau, an estimated 45.7 million Americans were uninsured in 2007. This widely quoted number, which was derived from the Census Bureau's annual Current Population Survey (CPS), is designed to be an estimate of how many people did not have any type of health insurance for the entire previous calendar year. Although the CPS numbers provide a useful annual estimate of coverage and a tool that can be used to track trends in coverage from year to year, they are limited in their ability to paint a complete picture of the insurance crisis.

Families USA conducted a study in order to take a closer look at the uninsured in America and to improve our understanding of how many people experience significant gaps in coverage. The Families USA study measured the number of uninsured people over a longer period of time than the CPS (two years in contrast to one). The Families USA study also measured people who were uninsured for different lengths of time.

Our analysis yielded disturbing results: We found that 86.7 million people under the age of 65—one out of every three non-elderly Americans (33.1 percent)—went without health insurance for all or part of 2007–2008.

By taking this closer look, we found that many more people were touched by a significant gap in health insurance than is reported by the CPS. These people are at risk, both in terms of their physical and their economic well-being, and they may be profoundly affected by being uninsured. No picture of the causes and consequences of being uninsured is complete unless it includes all people who experience a significant gap in health insurance coverage.

This study's findings are based exclusively on data projections from the CPS as well as the Census Bureau's Survey of Income and Program Participation (SIPP) and the Medical Expenditure Panel Survey (MEPS) from the Agency for Healthcare Research and Quality.

Key Findings

One in Three Uninsured: 2007–2008

- 86.7 million people under the age of 65 went without health insurance for some or all of the two-year period from 2007 to 2008.
- One out of three people (33.1 percent) under the age of 65 were uninsured for some or all of 2007 to 2008.

Number of Months Uninsured

- Of the 86.7 million uninsured individuals, three in five (60.2 percent) were uninsured for nine months or more. Nearly three-quarters (74.5 percent) were uninsured for six months or more.
- Among all people under the age of 65 who were uninsured in 2007–2008, one quarter (25.3 percent) were uninsured for the full 24 months during 2007–2008; 19.5 percent were uninsured for 13 to 23 months; 15.4 percent were uninsured for nine to 12 months; 14.3 percent were uninsured for 6 to 8 months; and 20.1 percent were uninsured for three to five months. Only 5.4 percent were uninsured for two months or less.

Work Status of the Uninsured

- Four out of five individuals (79.2 percent) who went without health insurance during 2007–2008 were from working families: 69.7 percent were in families with a worker who was employed full-time, and 9.5 percent were in families with a worker who was employed part-time.
- In addition, 4.6 percent were looking for work.
- Of the people who were uninsured during 2007–2008, only 16.2 percent were not in the labor force—because they were either disabled, chronically ill, family caregivers, or not looking for employment for other reasons.

Income Level of the Uninsured

- Three out of five individuals (58.7 percent) in families with incomes below the Federal poverty level ($21,200 a year for a family of four in 2008) went without health insurance in 2007–2008.
- More than half (52.0 percent) of individuals in families with incomes between 100 and 199 percent of the Federal poverty level (between $21,200 and $42,400 a year for a family of three in 2008) went without health insurance in 2007–2008.
- The likelihood of being uninsured decreases considerably with increased income, but nearly one in five (17.9 percent) people in families with incomes at four times the poverty level or above went without health insurance in 2007–2008.

Every Racial and Ethnic Group Is Affected

- Hispanics/Latinos, African Americans, and people of other racial or ethnic minorities were much more likely to be uninsured than whites: 55.1 percent of Hispanics/Latinos, 40.3 percent of African Americans, and 34.0 percent of other racial and ethnic minorities went without health insurance in 2007–2008, compared to 25.1 percent of whites.
- Although racial and ethnic minorities are more likely to be uninsured, whites accounted for nearly half (49.8 percent) of the uninsured in 2007–2008.

Every Age Group Is Affected

- Of the total 86.7 million uninsured people in 2007–2008, 60.1 million were uninsured adults (between 19 and 64 years of age).
- The likelihood of being uninsured declined among adults as they grew older. The percentage who were uninsured was highest among 19- to 24-year-olds (49.5 percent) and 25- to 44-year-olds (36.3 percent). The percentage who were uninsured declined for 45- to 54-year-olds and 55- to 64-year-olds, to 25.5 percent and 21.2 percent, respectively.

Statement of J. Kirk Peffers

Please bear in mind that the insurance industry has never healed anyone. It just takes 30% of health care dollars out of health care and denies permission for select health care to occur. It's an utterly useless middleman.

Statement of National Association of Professional Employer Organizations

The National Association of Professional Employer Organizations (NAPEO) thanks the Committee on Ways and Means for the opportunity to submit this statement for the hearing "Health Reform in the 21st Century: Expanding Coverage, Improving Quality and Controlling Costs". NAPEO is the largest trade association for professional employer organizations (PEOs) nationwide, with nearly 400 PEO members operating in all 50 states, representing approximately 90 percent of the revenues of the $64 billion industry.

PEOs Help Small Business

PEOs provide human resource services to their small business clients—paying wages and taxes and assuming responsibility and liability for compliance with myriad state and Federal laws. PEOs also provide worksite employees with access to 401(k) plans, health insurance, dental coverage, life insurance, dependent care and other benefits, which for many of these workers is the first opportunity that they have had to obtain these benefits through employment. The cost to small- or mid-sized businesses for individually establishing and administering this range of employee benefits is prohibitive. However, due to economies of scale and efficiency of administration, PEOs can make available diverse and improved employee benefit offerings.

Between 1980 and 2000, the number of labor laws and regulations grew by almost two thirds, according to the Small Business Administration, which estimated that owners of small- or mid-sized business spend up to a quarter of their time on employment-related paperwork. PEOs offer their clients and worksite employees the services and expertise of a personnel department comparable to that found in a large corporation. Few, if any, small businesses can afford a full-time staff con-

sisting of an accountant, a human resource professional, a legal compliance officer, a risk manager, a benefits manager, and a manager of information services. PEOs offer this expertise to their clients. While the owners of these small- and mid-sized businesses focus on the "business of their business," PEOs assume the responsibilities and liabilities of the "business of employment." Not only is the client company free to concentrate on its core business and increase profits, but it is better able to remain competitive by attracting and keeping the best employees with a benefit package comparable to a large employer. These advantages have led to a substantial growth in the PEO industry over the past two decades. Today, between 2 and 3 million workers are covered by a PEO arrangement.

PEOs Are Part of the Solution to Health Care Coverage

NAPEO supports innovations in Federal policy that enhance the ability of small businesses to offer health benefits to workers. Working Americans deserve comprehensive, affordable health care, retirement savings plans, and other employee benefits for themselves and their families and many small businesses struggle to meet these needs.

PEOs are part of the solution to healthcare access. PEOs are highly experienced in providing healthcare benefits for employees working at their small business clients. PEOs know the complex administrative tasks associated with providing health care to workers.

The PEO business model is one innovation that should be part of any health care reform legislation. A recent NAPEO member survey demonstrated that PEOs have substantially improved the health benefits offerings at their small business clients. About half of surveyed PEOs indicated that 50% or more of their small business clients have access to a more extensive health care offering as result of the PEO engagement. Almost a third of PEOs indicated that 20% or more of their new clients did not provide health benefits prior to engaging the PEO.

Among other benefits, PEO relationships serve to further an important policy goal of expanding access to quality affordable health care coverage. The average client of a PEO is a small business employing just 19 workers with an average salary of approximately $37,000 annually. Health care reform legislation must avoid unintended negative consequences to small businesses—such as limiting their ability to secure and offer health benefits to workers through a PEO, placing current coverage at risk or increasing insurance costs for small businesses.

Policy Issues

The Committee will undoubtedly consider a number of policy proposals, including employer mandates, tax credits, association or regional health plans, and plan benefit design. NAPEO believes that a "one size" fits all solution" is probably not the best model. It is important to maintain the viability of existing successful models including the PEO model for providing health benefits to workers.

This was accomplished successfully in Massachusetts, for example, when implementing regulations for that state's health care reform law were adopted recognizing the role of PEOs in worker health benefits. The intent was to ensure that small businesses that proactively covered workers in a health plan through a PEO relationship would not be penalized or receive disparate treatment. It is important that Federal legislation do the same—by making clear that if there is any employer mandate for coverage then it is the responsibility of the small business clients of the PEO to meet that mandate and also ensuring that workers in a PEO co-employment arrangement are appropriately attributed to the client for purposes of tax credits and any size of workforce thresholds.

On the other hand, many PEOs sponsor a fully-insured health plan as part of the employee benefit package provided to small business clients. The application of any national small group plan design principles to these large PEO plans would negate the efficiencies of PEO health plan sponsorship. The result could be less rather than more coverage. PEOs bring essential benefits to worksite employees by aggregating a large number of workers from many small businesses. This is consistent with one objective of health care reform—to improve health insurance coverage of employees of small businesses. To undermine the successful PEO health arrangement works against these goals and would have the unintended consequence of leaving large numbers of employees searching for new health plan coverage.

Improving health care access is an urgent national priority. For the small businesses that work with PEOs, clearly defining the relative roles and responsibilities of the PEOs and their small business clients will be critical to sustaining important health care coverage for millions of Americans. This balance was achieved in crafting rules for the 401(k) plans maintained by PEOs and we urge that analogous approaches be adopted as you consider a reformed health care system. NAPEO and

its member companies are prepared to assist the Committee in exploring all options and innovations, including the PEO model as one path to maintaining and expanding health insurance coverage.

Statement of the NATIONAL ASSOCIATION OF REALTORS®

The debate on health insurance in recent years has focused almost exclusively on the relationship between employers and employees, the deduction that employers receive for providing health insurance coverage and the exclusion from employees' income of health insurance benefits. A fair amount of attention has also been given to the challenges of small businesses that would like to provide health insurance, but are unable to do so. A third group in the workforce, however, has been consistently overlooked: the self-employed.

The needs of the self-employed are particularly acute, as those workers must fend for themselves in the individual insurance market. We believe that the plague of uninsured workers will persist *unless and until* there are corrections to the dysfunctions in both the individual and small-group health insurance markets. That market presents itself as one in which there is no negotiating, no leverage, no economies of scale and absolutely no efficiency.

Since 2003, self-employed individuals have been permitted to deduct from gross income the cost of their health insurance premiums. Regrettably, this provision benefits only those who can actually find and afford the insurance offered in the small group and/or individuals markets. We note, however, that tax benefits, no matter how thoughtfully crafted and designed cannot provide *access* to affordable insurance. A deduction is helpful, but only if insurance is available.

Real estate agents, realty firm owners, their employees and other self-employed individuals will struggle to find health insurance coverage unless there are significant reforms to the individual and small group insurance markets. We do believe, however, that tax incentives for this segment of workers, coupled with mechanisms that would create insurance coverage gateways and/or additional pooling mechanisms would create a far more rational and effective system than current law.

Research Findings

While NAR is currently in the process of updating our survey of the health insurance coverage of NAR's REALTOR® members, our 2006 survey showed that 28% of our members have had no health insurance coverage from any source.[1] By contrast, in 1996, only 13% of our membership had no coverage. In 1996 and in 2006, more than three-quarters of our members who had no health insurance reported that they were simply unable to afford what coverage they could find.

A real estate brokerage firm is built on a model of a broker/owner and sales agents. Under Code Section 3508, the broker/owner may treat the sales agents as independent contractors, so long as certain tests are satisfied. Thus, the broker/owner is often a self-employed person whose business is conducted by other self-employed persons.

To underscore the challenges our members who own realty firms have with finding health insurance, note that in 1996, 34% of real estate firms offered health insurance to their salaried employees. By 2006, this number had declined to only 13% of real estate firms. For these small businesses, as with individuals, the primary barrier to providing health insurance has been its cost.

The Government Accountability Office estimated that independent contractors and self-employed workers comprised 30 percent of the American workforce in 2000. Some experts estimate that by 2010, 41 percent of the U.S. workforce will be so-called "free agent" workers. We fear this shift in the composition of the workforce will be accompanied by increases in the number of the uninsured. Finding a solution to the insurance problem must become a top priority.

Recommendations

NAR does not have the particular expertise that would enable us to provide a full-blown individual market reform model. The work we have done over the past six years and the reports our members have provided about their experience in the individual and small group health insurance markets do, however, furnish a basis for several recommendations.

[1] As soon as the 2009 survey data are compiled, we will share it with the Committee

The self-employed must be able to enjoy the benefits of pooled risks, much as large group plans provide. Downsizing, changes in the economy and increases to the cost of coverage will likely deprive more and more workers any benefit of employer-provided insurance, thus forcing them into the individual market. Today, employer-provided group coverage is extended to groups of people whose sole common denominator is their employer. Enhanced risk-pooling opportunities in the individual market would facilitate greater market efficiency by combining groups of people whose sole common denominator is that they work for themselves. Pooled risk for individuals will also enhance economies of scale as insurance providers are able to consolidate and manage the expenses of administration, marketing and advertising.

Whatever the name used—gateway, coordinator, connector, etc.—a mechanism is needed to bring insurers and self-employed workers and small businesses together. We believe that a private, public or joint private/public venture must be developed to put self-employed persons in a position where they can compare apples to apples in their analysis of a more complete range of insurers and insurance products.

We do not seek a single-payer insurance system, nor do we seek a new entitlement. We *do* seek an official, reliable, regulated, information source (or sources) that will facilitate insurance market access for self-employed individuals. These workers need some sort of menu that could include information such as comparisons of available coverage options, identification of vendors that can provide various options and where to find those vendors, as well as some sort of approximate cost comparison data (current and/or historic).

Stakeholders including (but not limited to) insurers, regulators, legislators, health policy advocates and consumers must grapple with the question of essential coverage. No single policy or list of mandates can satisfy the competing tensions between (a) assuring all desired (or desirable) coverage and (b) creating affordable products. We believe that it is difficult, *but not impossible*, for the stakeholders to come up with categories or guidelines that might distinguish among an array of coverage options. Such a drive toward consensus may provide consumers, including self-employed individuals, with the information necessary to make informed judgments and leverage to encourage insurers and regulators to provide or require an effective array of benefit coverage choices.

Conclusion

Congress must address the challenges that the self-employed face in finding access to affordable health insurance. Maintaining a sensible tax regime for health insurance must remain an integral part of health insurance policy, but the only lasting resolution for health care access will come through reforming the individual and small firm insurance markets.

Thank you for your attention, time and efforts on this most important issue. NAR and its members stand ready to work with you in the coming months to enact meaningful health care reform.

Statement of Newbery, Ungerer & Hickert LLP

I've taught health law and policy as an adjunct professor at Washburn University School of Law for five years, and before my first retirement last year, served as General Counsel and Senior Vice President of Blue Cross and Blue Shield of Kansas for 30 years. I am now engaged in the private practice of law, continue to teach, but do not represent any entity in the health insurance industry.

I write the Committee today primarily with regard to the issue of making available a public option.

Considering the utility of a public option—the reasons for interest in a public option program to be offered alongside employer-sponsored or commercially-available nongroup health insurance—isn't as simple as it might seem, since it introduces different dynamics in the health insurance market.

Without significant changes in state and Federal law, a public option (whether that public option is a Medicare-like program or a something that looks like the Federal employee health benefits program with coverage available from several private insurers) necessarily creates a circumstance of having two markets subject to different pricing rules and offering rules, and introduces dynamics that require significant attention to how insurance markets behave. It isn't as simple as letting people opt for a separate public program.

A good starting point for thinking that through is the nongroup market. In most states today that is characterized by age rating and health underwriting, with in-

surers either rejecting or rating up persons with existing health conditions. If the public option is an alternative for all citizens, it is unlikely that it will involve age rating, and it will certainly involve guaranteed issuance of coverage. The natural result would be that younger or healthier persons would remain in the commercial market, while older or less healthy people likely would find the public plan more attractive (not incidentally, in some states that rely on risk pools for the uninsurable currently subsidized by assessments on insurers, the raison d' etre for such pools disappears and insurers might have an incentive to make their underwriting more strict than is currently the case, or to increase the slope of their age rating tables).

The same effect would occur in most states for small groups. Most states, following the NAIC model, allow use of age, industrial classification and group size among other characteristics in developing rates for small groups. This results in enormous differences in premiums among small groups (and can result in enormous volatility in premiums for very small groups when, for example, a younger worker leaves and an older worker takes her place, or vice versa). Again, the incentive would be for employees in groups composed largely of older employees to seek coverage through the public plan.

Those impacts would be magnified if health insurance remained a voluntary matter. That is, if there is no requirement to hold insurance, and the public option is a program involving flat community rating and guaranteed issuance of coverage, persons today in groups with high premiums, persons holding coverage through high risk pools, and uninsured persons who become aware of a condition creating a need for health services would move to the public option.

It is difficult to fool markets. While having two differently regulated markets might not result in the paradigmatical death spiral, the risk sorting that would occur absent fundamental changes in rules applicable in the private market would result in significantly higher average claims expenses in the public market, and significantly lower average claims expenses in the private market, meaning higher premiums in the former, and increasingly higher as the effects of adverse selection are felt in the claims costs.

To avoid that would require applying the same rules in all markets, displacing current state regulation with Federal regulation of rating and underwriting, particularly in the nongroup and small group markets. Guaranteed issuance of coverage in the nongroup market, a requirement in a few states, would be obligatory in all states. Age rating would have to be prohibited in the nongroup and small group markets (large groups might be a separate subject, although there are significant enough differences in the impact of age and health status among some to not disregard them): that is, one would have to be able to acquire the same coverage at the same rate, whether one did so through employer-sponsored coverage or on an individual basis, just as one would have to be able to do so under the public option.

But if that were the case—if all insurers were no longer sorting risks by health and age, were pooling claims costs among all insureds and creating a single flat community rate of the same kind a public option would involve—then what advantage would a public option provide? Would it reside in lower administrative costs? I suspect that in an environment in which insurers were not competing based on ability to select risks or on who could tailor their age slopes or industrial factors to get the best block of insureds, the basis for competition would be only administrative costs and the cost to the insurer of health care services. One would think that in such an environment, insurers would have strong incentives to become as lean as possible and to negotiate the best possible pricing mechanisms with health care providers (and perhaps not on per unit price alone).

In the end, what is the purpose of a public option? Health insurance is available universally today, although in some cases, only through a high risk pool at a significant premium. If a public option is desirable as a mechanism to make coverage more affordable to persons whose rates appear unaffordable because they are older or sicker individuals or in an older, less healthy group, the same result can be obtained by changing the rules applicable to rating and underwriting by private insurers (which concomitantly requires elimination of separate rating and tax treatment of employer-sponsored coverage). If a public option is desirable to achieve lower administrative costs, changing the rules of competition among insurers by eliminating risk segmentation as a means of competition (which again requires elimination of separate rating and tax treatment of employer-sponsored coverage) achieves that end.

To avoid the effect of antiselection—of persons obtaining coverage under a guarantee issue circumstance, whether under a system relying solely on private coverage or one involving a public option—a mandate is obligatory, which carries with it the need for income-sensitive premium supports.

If the purpose of a public option is to lower the primary input in the cost of health insurance—the cost of health care services—eliminating risk segmentation as a means of competition among private insurers would cause them to focus more strongly on how they pay health care providers and what they pay for. Of course, if a public option relied on Medicare-style pricing for health care services, it would have an insurmountable competitive advantage over private coverage. That is, if the same rating and enrollment rules apply to the private market as apply to a public option (as they should, to prevent the public option from becoming a dumping ground for the old and the ill), that advantage in the cost of care would result in the public option having a significantly lower price for the same benefits as private insurance. But if that is either the desired or the practical outcome, there is no logical reason not to move directly to a single-payer system.

The reason not to move to a single payer system is the same reason to be wary about a public option: the country does not need to see the promise of universal coverage vanish again, as it did in 1993, under an onslaught of advertising and lobbying from those whose oxen would be gored, health insurers and health care providers.

As is apparent from an article I published last year, "The Pool of Bethesda: Equity, Political Problems and Reinsurance Solutions in Mandated Individual Health Insurance," 11 Quinnipiac University Health Law Journal 145 (2008), I find the rationalization of the insurance market and the Tax Code and the equitable approach to financing of health care in the Health Americans Act an attractive alternative.

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